MEDICAL THERAPEUTIC PRIVILEGE

by

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“Wer einmal lügt dem glaubt man nicht, und wenn er auch die Wahrheit spricht.”

German proverb

“What tormented Ivan Ilych most was the deception, the lie, which for some reason they all accepted, that he was not dying but was simply ill, and that he only need keep quiet and undergo a treatment and then something very good would result. He however knew that do what they would nothing would come of it, only still more agonizing suffering and death. This deception tortured him – their not wishing to admit what they all knew and what he knew, but wanting to lie to him concerning his terrible condition, and wishing and forcing him to participate in that lie. Those lies – lies enacted over him on the eve of his death and destined to degrade this awful, solemn act to the level of their visitings, their curtains, their sturgeon for dinner – were a terrible agony for Ivan Ilych. He saw that no one felt for him, because no one even wished to grasp his position. Only Gerasim recognized it and pitied him. And so Ivan Ilych felt at ease only with him. Once when Ivan Ilych was sending him away he even said straight out: ‘We shall all of us die, so why should I grudge a little trouble?’ -- expressing the fact that he did not think his work burdensome, because he was doing it for a dying man and hoped someone would do the same for him when his time came.

Apart from this lying, or because of it, what most tormented Ivan Ilych was that no one pitied him as he wished to be pitied. At certain moments after prolonged suffering he wished most of all (though he would have been ashamed to confess it) for someone to pity him as a sick child is pitied. He longed to be petted and comforted. And in Gerasim’s attitude towards him there was something akin to what he wished for, and so that attitude comforted him. Ivan Ilych wanted to weep, wanted to be petted and cried over and then his colleague Shebek would come, and instead of weeping and being petted, Ivan Ilych would assume a serious, severe, and profound air, and by force of habit would express his opinion on a decision of the Court of Cassation and would stubbornly insist on that view. This falsity around him and within him did more than anything else to poison his last days.”

Leo Tolstoy The Death of Ivan Ilych (1886)
Translated by Aylmer Maude
1960 New York: Signet
p137–138
PREFACE

I should like to express my heartfelt gratitude to the following persons:

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SUMMARY

The therapeutic privilege is a defence in terms of which a doctor may withhold information from a patient if disclosure of such information could harm the patient. This study explores the defence of therapeutic privilege and provides a critical evaluation. A comparative investigation is undertaken, while arguments springing from a variety of disciplines are also incorporated.

A number of submissions are made for limiting the ambit of the defence. The main submission is that the therapeutic privilege should comply with all the requirements of the defence of necessity. In addition, it should contain some of the safeguards afforded to the patient by the requirements of the defence of negotiorum gestio so that therapeutic privilege is out of the question if medical treatment is administered against the patient’s will, or the doctor has reason to believe (or knows) that the patient will refuse to undergo an intended intervention once properly informed.

Key terms
Therapeutic privilege; contra-indication; truth-telling; therapeutic justification; therapeutic necessity; informed consent; duty to inform; right to know; beneficence; autonomy
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CHAPTER 1
INTRODUCTION

1.1 PURPOSE OF THE STUDY

In that landmark case in South African medical law, Castell v De Greef, Ackermann J (as he then was) 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”.

The purpose of this study is to explore this “so-called therapeutic ‘privilege’”, to give a critical evaluation of this defence and to flesh out its ambit. The first chapter of this dissertation serves as an introduction. The methodology applied in researching the topic is explained, the field of application of the therapeutic privilege, or its place in and relevance to medical law, is indicated, the term “therapeutic privilege” is explained and the history of the therapeutic privilege is surveyed from the bird’s eye view. In the next chapter, a few cases in which the therapeutic privilege enjoyed pertinent discussion, and in which the outcome hinged on its application, will be discussed in some detail. The third chapter will be devoted to a critique of the therapeutic privilege. Judicial, legal-academical, ethical and medical points of view will be considered. The fourth chapter deals with the question whether therapeutic privilege should be accepted as a defence eo nomine or whether the withholding of information in the ostensible best interest of the patient can be justified under other existing grounds of justification. The next chapter expounds the diverse formulations of the therapeutic privilege found in the literature and case law. These formulations are classified according to the kind of harm that is sought to be avoided under the therapeutic privilege and are critically evaluated, inter alia with regard to the criticism expressed in the third chapter. In chapter 6, the important role that improvement of communication skills can play in addressing the doctor’s dilemma is investigated. The seventh chapter looks at the issue of documentation. In the final chapter, I will note my conclusions and submissions.

1 1994 (4) SA 408 (C) 426H.

2 Van den Heever 1995 “The patient’s right to know: Informed consent in South African medical law” De Rebus 53 56 states that since the court did not allude to the ambit and parameters of the privilege, its precise nature and role in non-disclosure actions remain uncertain.
1.2 METHODOLOGY

A few words need to be uttered in respect of the methodology applied and the approach followed in researching the subject. The dearth of authoritative judgments on the issue of therapeutic privilege worldwide makes a comparative investigation imperative. However, this dissertation does not supply the reader with an account of the de lege lata and de lege ferenda positions in each individual jurisdiction researched. The law relating to the therapeutic privilege is not sufficiently developed and systematically expounded in any of the jurisdictions researched to justify such an approach. Moreover, the position as regards the therapeutic privilege in South African law is still very much underdeveloped and precious insights could be gleaned from looking not only at the position in other jurisdictions, but also at arguments springing from a variety of disciplines. For this reason, the views of legal commentators, ethicists, medical and psychological researchers and other health-care specialists are juxtaposed and presented in a broader argumentative perspective, while a comparative legal view is also integrated. Although an investigation into the related field of access to medical records falls outside the ambit of this study, it does provide some valuable insights into the nature of information to be withheld for therapeutic reasons.

1.3 FIELD OF APPLICATION OF THE THERAPEUTIC PRIVILEGE – ITS PLACE IN AND RELEVANCE TO MEDICAL LAW

It is trite law that any medical intervention undertaken without the patient’s consent (or the consent of somebody acting on his or her behalf) is in principle unlawful or wrongful unless some other ground of justification exists.  

In South African law consent by a patient to medical treatment is regarded as falling under the defence of volenti non fit iniuria, a ground of justification which excludes the unlawfulness or

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3 Such as necessity, negotiorum gestio and authority – see 4.2.1 infra.

wrongfulness element of a crime or delict.\textsuperscript{5} If a medical intervention is performed without the patient’s lawful consent, the doctor or hospital is exposed to liability\textsuperscript{6} for civil or criminal assault,\textsuperscript{7} civil or criminal \textit{iniuria},\textsuperscript{8} breach of contract\textsuperscript{9} or negligence.\textsuperscript{10} Liability can ensue irrespective of whether the intervention eventually proved to have benefited the patient and irrespective of whether it was performed with the necessary skill and care.\textsuperscript{11}

In the ordinary course of medical practice, a medical intervention is justified by \textit{volenti non fit iniuria}. Knowledge and appreciation are required for a successful reliance on this defence. Since the doctor-patient relationship is typically one of inequality in the sense that the consenting party is a layperson and the party acting upon consent is an expert, the requirements of knowledge and

\begin{itemize}
\item\textsuperscript{5} Castell \textit{v} De Greef 1994 (4) SA 408 (C) 420H, 423B–D; Van Oosten 1991a \textit{The doctrine of informed consent in medical law} 14–15. In Castell \textit{v} De Greef 1994 (4) SA 408 (C) 425F–G there is some indication that the doctor is also under a contractual obligation to furnish the patient with information – see the very interesting questions raised by Van Oosten 1995a: 178 in this connection.


\item\textsuperscript{7} Violation of the patient’s physical integrity. See Stoffberg \textit{v} Elliott 1923 CPD 148; Lampert \textit{v} Hefer 1955 (2) SA 507 (A) 508E–F; Esterhuizen \textit{v} Administrator, Transvaal 1957 (3) SA 710 (T) 718 ff; Richter \textit{v} Estate Hammann 1976 (3) SA 226 (C) 232 F–G; Burger \textit{v} Administrateur, Kaap 1990 (1) SA 483 (W) 489; S \textit{v} Sikunyana 1961 (3) SA 549 (E) 551; S \textit{v} Kii 1994 (1) SACR 14 (E) 18f–g. Cf S \textit{v} Binta 1993 (2) SACR 553 (C) 561–562c.


\item\textsuperscript{10} Van Oosten 1991a: 31; Van Oosten 1995a: 167. However, in Broude \textit{v} McIntosh 1998 (3) SA 60 (SCA) 67–68, the Supreme Court of Appeal questioned the conceptual soundness of pejoratively describing and juristically characterising a surgical intervention as an assault where the doctor’s sole object with the intervention was to alleviate pain or discomfort, and the doctor had explained to the patient what was intended to be done and had obtained the patient’s consent but had omitted to mention the existence of a material risk which, if disclosed, might have resulted in the patient’s refusing to undergo the intervention. The court considered it a bizarre implication of such a notion that, where the risk does not eventuate and the intervention is successful, the doctor’s conduct should still be regarded as an assault.

\end{itemize}
appreciation can typically only be fulfilled if the consenting party is furnished with appropriate information.\(^\text{12}\) Hence the informed-consent requisite.

The nature and the scope of the duty to inform cannot be discussed here in any detail.\(^\text{13}\) For the purpose of the present discussion it will suffice to mention that, in order to enable the patient to come to a rational decision, the doctor must give the patient a general idea in broad terms and in layman’s language of the nature, scope, administration, importance, consequences, risks, dangers, benefits, disadvantages and prognosis of, as well as the alternatives to, the proffered intervention.\(^\text{14}\) As regards the disclosure of risks, the court in *Castell v De Greef*\(^\text{15}\) held that in our law, for a patient’s consent to constitute a justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn a patient so consenting of a material risk inherent in the proposed treatment; a risk being material if, in the circumstances of the particular case:

(a) a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it; or

(b) the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.

The court added that this obligation is subject to the therapeutic privilege.\(^\text{16}\) Therapeutic privilege therefore constitutes one of the situations where the doctor’s duty of disclosure in terms of the doctrine of informed consent is restricted.\(^\text{17}\)


\(^\text{13}\) For a detailed exposition of the nature and scope of the duty to disclose, see Van Oosten 1991a: *passim*. See also Van Oosten 1995a: 170–171.


\(^\text{15}\) 1994 (4) SA 408 (C) 426F–H.

\(^\text{16}\) See fn 1 supra. This formulation of the duty to disclose was taken almost verbatim from *Rogers v Whitaker* (1993) 67 ALJR 47 52, a decision of the High Court of Australia described by Davies 1996 *Textbook on medical law* 158 as a judgment that reasserts the combination of the prudent patient test and the therapeutic privilege as expounded in *Canterbury v Spence* 464 F 2d 772 (1972).

\(^\text{17}\) The doctor’s duty of disclosure may also be restricted where the patient is already in possession of the requisite information, where the patient waives his/her right to information, where disclosure is physically impossible, and in the event of an emergency (in which case necessity or *negotiorum gestio* may justify non-disclosure). See Van Oosten 1995a: 172; Claassen & Verschoor 1992: 69–71, 75–78.
1.4 DEFINING “THERAPEUTIC PRIVILEGE”

The therapeutic privilege has been formulated by courts and commentators in many divergent ways\textsuperscript{18} so that a concise and accurate description of the “privilege” remains elusive.\textsuperscript{19} “Therapeutic privilege” can denote a professional privilege on the side of the doctor to withhold certain information from a patient, or it can signify a legal defence in terms of which the doctor can justifiably withhold certain information from the patient.\textsuperscript{20}

Perhaps the closest one can come to capturing the quintessence of the therapeutic privilege in a nutshell is to give a brief description of the circumstances giving rise to the need to recognise a defence of therapeutic privilege. It sometimes happens in medical practice that, when confronted with a situation where he or she has to inform a patient in accordance with the requirements of informed consent, the doctor faces conflicting duties: on the one hand the doctor has a medico-ethical duty to heal (or to do no harm)\textsuperscript{21} and on the other hand a legal-ethical duty to inform.\textsuperscript{22} In an attempt to solve this conflict an exception to the informed-consent requisite, called the “therapeutic privilege”,\textsuperscript{23} was created. Of all the exceptions to informed consent, the therapeutic privilege is the one that has received the most attention.\textsuperscript{24}

\begin{flushleft}
\textsuperscript{18} Cf chapter 5 infra.
\textsuperscript{19} Giesen 1988a International medical malpractice law 376.
\textsuperscript{20} See chapter 4 infra, and in particular 4.1 and 4.3.
\textsuperscript{22} Van Oosten 1991b: 31; Welz 1998 The parameters of medical-therapeutic privilege (Unpublished LLM dissertation, University of South Africa) 3, 6. Cf Abbuhi & Gerking 1975 “Informed consent of the emotionally disturbed patient” Legal Medicine Annual 217 218–219. Interestingly, the duty to inform itself could be argued to have arisen from the general duty not to do anyone physical harm – see eg BGH 16.1.1959 VZ 179/57 BGHZ 29 176 179–180.
\textsuperscript{23} Also known as “therapeutic justification” or “therapeutic necessity”, “Kontraindikation” or “Fürsorgeprinzip” in German, and, more blatantly, “mensonge médical” in French.
\end{flushleft}
The therapeutic privilege allows the doctor to withhold information that he or she would otherwise be obliged to disclose if disclosure would be “harmful” to a particular patient. Therefore, one can say that the therapeutic privilege aims at protecting patients who would suffer harmful effects if disclosure were to be made in accordance with the requirements of informed consent, and at freeing doctors from a legal requirement that would force them to violate their “primary duty” to do what is beneficial for the patient. It has been argued that to expect from a doctor to disclose information to a patient which would result in a serious curtailment of the success of treatment, would be to expect from the doctor to frustrate the patient’s recovery in

25 Or have a detrimental effect on (see Sprung & Winick 1989: 64; Tomkin & Hanafin 1995 Irish medical law 30, 34).

26 Meisel 1979 “The ‘exceptions’ to the informed consent doctrine: Striking a balance between competing values in medical decisionmaking” Wisconsin Law Review 413 460; Somerville 1984 “Therapeutic privilege: Variation on the theme of informed consent” Law, Medicine, and Health Care 4; Malcolm 1988 Treatment choices and informed consent 95; Kirby 1983 “Informed consent: What does it mean?” Journal of Medical Ethics 69 72; Cohen & Mariano 1982 Legal guidebook in mental health 194–195; Shartsis 1972 “Informed consent: Some problems revisited” Nebraska Law Review 527 530; Waltz & Scheuerman 1969 “Informed consent to therapy” Northwestern University Law Review 628 637, 641; Etchells, Sharpe, Burgess & Singer 1996 “Bioethics for clinicians: 2. Disclosure” Canadian Medical Association Journal 387 388. I use this very wide wording precisely because the ambit of this defence is still very much uncertain, as the purpose of this study suggests. As Somerville 1984: 4 indicates, even if the somewhat amorphously vague and wide term “harm” is used to formulate an inclusive definition, the possibilities of who decides on the applicability of the rules and on what basis they should decide, are varied: “[T]herapeutic privilege may apply when the reasonable physician in the same circumstances would have thought that the reasonable patient would be harmed by receiving the information normally required to be disclosed; when the reasonable physician would have thought that this particular patient would be harmed; when this particular physician would have thought that the reasonable patient would be harmed; or when this particular physician would have thought that this particular patient would be harmed.”

27 Watson v Clufts 136 SE 2d 617 (1964) 621; President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1982 Making health care decisions vol 3 App L 201; Landeswerck 1970 “Informed consent as a theory of medical liability” Wisconsin Law Review 879 890; Rice 1974 “Informed consent: The illusion of patient choice” Emory Law Journal 503 504; Kirby 1983: 72; Ludlum 1978 Informed consent 38–39. See also Giesen 1985a: 375 who describes the privilege as designed to permit health care workers to withhold disclosure which they judge would be counter-therapeutic and, thus, detrimental to a particular patient. See, however, Rothenberg 1994 Emergency medicine malpractice (2nd ed) 128 who warns that therapeutic privilege should be considered in the light of the caveat that the doctor’s primary duty is to inform the patient of his/her choices.

28 See 5.2.5 infra.
contravention of the doctor’s guarantee.  

A further rationale mentioned focusses on the effect that disclosure of information could have on the patient’s ability to make rational choices.

The main aspect in which the multitude of definitions of the therapeutic privilege differ from each other is the substance given to the concept of “harm”, its nature, its duration, its degree of seriousness.

It is submitted that no definition of the “harm” to be avoided under the therapeutic privilege can by itself provide an answer to the problem of setting parameters to this defence because we are dealing with a conflict of interests which, in turn, finds its origin in a conflict of duties. The avoidance of possible harm represents one side of the conflict only. Where a conflict of interests exists, resolution inevitably lies in a weighing-up of their respective weights.

The lopsidedness of attempted definitions of “therapeutic privilege” is an indication of the one-sidedness inherent in their conception. In the vast majority of formulations of the therapeutic privilege no mention is made of the violation of self-determination (with all the possible implications this might hold for other interests, amongst which, the patient’s health, morals and finances) that represents the other side of the equation.

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31 McInerney v MacDonald (1992) 93 DLR (4th) 415 430; Siebert 1982: 230; Dekkers 1981a Patiëntenrecht en patiëntengeleid 78 weighs up the conflicting rights (the right to information and the right to proper care) of the patient.

32 Plaut 1989 “The ethics of informed consent: An overview” Psychiatric Journal of the University of Ottawa / Revue de Psychiatrie de l’Université d’Ottawa 435 436 recognises that, in relation to the question of competency to give informed consent, the doctor’s decision “will remain an ethical one – how to balance the conflicting values of patient autonomy and patient health”. I think the same could be said of the doctor’s decision in relation to therapeutic non-disclosure. See Canterbury v Spence 464 F 2d 772 (1972) 788[26] where it is said that the therapeutic privilege “is but a recognition that, as important as is the patient’s right to know, it is greatly outweighed by the magnitudinous circumstances giving rise to the privilege".
1.5 A BRIEF HISTORICAL OVERVIEW OF THE THERAPEUTIC PRIVILEGE

The origin of the therapeutic privilege is not certain. It must be remembered that truth-telling has not always been regarded as a sacred virtue in medical ethics or practice. In fact, in the *Corpus Hippocraticum*, doctors are advised of the wisdom of “concealing most things from the patient while you are attending to him ... turning his attention away from what is being done to him” and are cautioned to reveal “nothing of the patient’s future or present condition” to him, since this may lead to the patient’s taking a turn for the worse. This advice should probably be read against the background of the classical Hippocratic ethic according to which doctors should do what in their judgment would lead to the most good or least harm for their patients.

During the Middle Ages, Christian monastic doctors followed Hippocratic traditions. In keeping with the Hippocratic ethic of beneficence and ideas on truth-telling, the Frenchman Henri de Mondeville advised his colleagues to promise a cure to every patient, but to tell the parents or friends if there is any danger. He also advised the surgeon’s assistants not to tell the patient what the surgeon said unless the news is pleasant. De Mondeville appears to have considered


35 The purpose of medicine as expressed in the Hippocratic Oath is to benefit the sick and to keep them from harm and injustice. See Faden & Beauchamp 1986: 62. In the *Epidemics* we find the following expression of Hippocrates’ ethics of beneficence: “As to diseases, make a habit of two things – to help, or at least to do no harm.” See Reiser, Dyck & Curran 1977: 7. See also Ulsenheimer 1988 *Arztstrafrecht in der Praxis* 64–65; Mulvaney 1996 “The therapeutic privilege: Defense in an informed consent action” *Medical Trial Technique Quarterly* 63 79 fn 73; Green 1981 “Truth telling in medical care” in Hiller (ed) *Medical ethics and the law* 183 185,190; Higgs 1994: 137.

36 *Circa* 1260–1325.


38 See Reiser, Dyck & Curran 1977: 15.
the maintenance of hope to be of sufficient therapeutic benefit to justify deception, and supported
the telling of lies in order to keep the patient in good spirits.\footnote{39}

With the arrival of the Enlightenment, a movement towards greater openness and truthfulness is
detectable, for example in the works of Rush and Gregory. However, this movement was not
attributable to a new realisation of and respect for the patient’s autonomy, but was again linked
up with the idea of beneficence.\footnote{40} Rush’s belief that doctors should share information with
patients was rooted in an Enlightenment philosophy according to which knowledge and freedom
of choice were believed to contribute causally towards the individual’s health.\footnote{41} Rush believed
that patients would be motivated to comply with doctors’ recommendations if these had been
explained to them. In this way truth-telling can contribute towards the patient’s health. Gregory
shared this view.\footnote{42} Whilst propagating “openness and candour which disdains all artifice”,
Gregory argued that it is sometimes both justifiable and necessary to deviate from the truth, for
example if a person is extremely ill, “but yet may recover if he be not informed of his danger”.\footnote{43}

One of the pre-eminent figures in the history of medical ethics at the end of the eighteenth century,
was Thomas Percival.\footnote{44} Like many before him, Percival followed beneficence as a guiding
principle in his ethics. He wanted to balance the openness advocated by Gregory with Hippocratic
principles.\footnote{45} His advice to doctors was not to make “gloomy prognostications” but to give timely
notice of danger to the friends of the patient and even to the patient himself, “if absolutely
necessary”.\footnote{46} Percival called for honest disclosure to be the norm except in emergency situations,
terminal cases and situations where truthfulness would lead to harm.\(^{47}\) Even though he was well aware of the moral arguments\(^{48}\) against deceit, his appeal to truthfulness primarily sprouted from his concerns over how untruthfulness would reflect on "the sincerity, the purity, and the probity of the physician himself".\(^{49}\) Veracity was considered to be a characteristic excellence of the virtuous man,\(^{50}\) and, hence, being untruthful would be at odds with gentlemanly behaviour. It is also interesting to note that Percival differed from Rush over the consequences of truth-telling. Whereas Rush reasoned that truth-telling promotes health, Percival believed that disclosing gloomy information to patients can cause them harm.\(^{51}\)

Percival's work formed the basis of numerous codes of ethics, notably the American Medical Association's first Code of Medical Ethics of 1847, and continued to influence the views of medical students and doctors for almost a hundred years.\(^{52}\) Percival's ambivalent stance in respect of the issue of truth-telling made him a forerunner of many modern advocates of therapeutic privilege.

In view of the long tradition of beneficent withholding of information, and even beneficent deception, it is not at all surprising that courts in the United States have adopted the therapeutic privilege almost as a matter of judicial notice.\(^{53}\) As has been pointed out by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research,\(^{54}\) something akin to the therapeutic privilege was referred to already in *Twombly v*


\(^{50}\) Leake (ed) 1975: 195.


\(^{53}\) Waltz & Scheuneman 1969: 642 fn 51.

\(^{54}\) President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1982: vol 1 95 fn 34.
Leach\textsuperscript{55} where it was remarked:

Upon the question whether it be good medical practice to withhold from a patient ... a knowledge of the extent and danger of his disease, the testimony of educated and experienced medical practitioners is material and peculiarly appropriate.\textsuperscript{56}

It is worth noting that the therapeutic privilege had been recognised before the legal duty to disclose was well-established in the United States.\textsuperscript{57} Two of the earliest articles discussing the therapeutic privilege were authored by Lund and Smith and appeared in 1946 in the *Tennessee Law Review*.\textsuperscript{58} By this time very few cases in the United States imposed a duty to disclose on the doctor. It was almost a decade before a court first used the term "informed consent".\textsuperscript{59} In *Hunt v Bradshaw*\textsuperscript{60} it was stated that "it is understandable that the surgeon wanted to reassure the patient so that he would not go to the operating room unduly apprehensive". In *Salgo v Leland Stanford, Jr Univ Bd of Trustees*\textsuperscript{61} the court formulated the therapeutic privilege as follows:

[T]he physician must place the welfare of his patient above all else and this very fact places him in a position in which he sometimes must choose between two alternative courses of action. One is to explain to the patient every risk attendant upon any surgical procedure or operation, no matter how remote; this may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse to undertake surgery in which there is in fact minimal risk; it may also result in actually increasing the risks by reason of the physiological results of the apprehension itself. The other is to recognize that each patient represents a separate problem, that the patient’s mental and emotional condition is important and in certain cases may be crucial, and that in discussing the element of risk a certain amount of discretion must be employed consistent with the full disclosure of facts necessary to an informed consent.

\begin{itemize}
\item \textsuperscript{55} 65 Mass (11 Cush) 397 (1853) 405-406.
\item \textsuperscript{56} See McCoid 1959 “The care required of medical practitioners” *Vanderbilt Law Review* 549 596.
\item \textsuperscript{57} President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1982: vol 1 95 fn 34.
\item \textsuperscript{58} Lund 1946 “The doctor, the patient, and the truth” *Tennessee Law Review* 344; Smith 1946 “Therapeutic privilege to withhold specific diagnosis from patient sick with serious or fatal illness” *Tennessee Law Review* 349.
\item \textsuperscript{59} President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1982: vol 1 95 fn 34.
\item \textsuperscript{60} 88 SE 2d 762 (1955) 766.
\item \textsuperscript{61} 317 P 2d 170 (1957) 181.
\end{itemize}
In South Africa, it has been accepted ever since the mid-1920's that doctors owe their patients a duty to disclose, but the doctrine of informed consent had not received pertinent recognition until the judgment in *Castell v De Greef*. In 1948, Watermeyer CJ observed in an *obiter dictum* that it “may sometimes be advisable for a medical man to keep secret from his patient the form of treatment which he is giving him”. This observation is often quoted as providing the starting point for the recognition of the defence of therapeutic privilege. In the 1976-case of *Richter v Estate Hammann*, Watermeyer J remarked as follows:

A doctor whose advice is sought about an operation to which certain dangers are attached – and there are dangers attached to most operations – is in a dilemma. If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation when the doctor knows full well that it would be in the patient’s interests to have it.

This remark has also been referred to as a rudiment upon which a therapeutic-privilege defence might be built. As we have already seen, in *Castell v De Greef* the existence of the therapeutic-privilege defence was expressly acknowledged. Ackermann J pointed to the fact that a number of authors have commented on the dangers inherent in the so-called therapeutic

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64 *SA Medical & Dental Council v McLoughlin* 1948 (2) SA 355 (A) 366.

65 Strauss 1991: 19 and Van den Heever 1993: 624 are of the opinion that this observation is the only (pre-*Castell*) reference to the defence of therapeutic privilege to be found in our case law. See also Van Oosten 1991a: 45 fn 33, 50–51 fn 45; Van Oosten 1991b: 33; Van Oosten 1995a: 172; Welz 1998: 1. This observation was also alluded to in *Castell v De Greef* 1994 (4) SA 408 (C) 418E–F. Welz 1999 “The boundaries of medical-therapeutic privilege” *The South African Law Journal* 299 299 remarks that this statement alludes to the issue of confidentiality in the context of the doctor-patient relationship.

66 1976 (3) SA 226 (C).

67 At 232G.

68 Van Oosten 1991b: 33. Cf Van Oosten 1991a: 45, 50–51 fn 45; Van Oosten 1995a: 172; Welz 1999: 299. Incidentally, it has been said that the two statements quoted from the *McLoughlin* and *Richter* cases are too vague to be conclusive – see the authorities referred to in this fn. Ackermann J also alluded to the remark made in the *Richter* case in *Castell v De Greef* 1994 (4) SA 408 (C) 417J–418A. It is a controversial question whether information may indeed be withheld in order not to frighten a patient into forgoing an intervention he/she really needs. See 5.3.1 *infra*.

69 1994 (4) SA 408 (C) 426H.

70 Cf fn 1 *supra*.
privilege, and in particular the inroads that it might make on patient autonomy. He found it unnecessary to pursue this issue further in the case at hand because therapeutic privilege had not been invoked. 71 He expressed the view that it "does, however, form part of the wider debate concerning consent to medical treatment and whether emphasis should be placed on the autonomy and right of self-determination of the patient in the light of all the facts or on the right of the medical profession to determine the meaning of reasonable disclosure". 72 Later on in the judgment, Ackermann J, in adopting the new formulation of the extent of the doctor's duty to inform, took a firm stance in this "wider debate" and showed the direction in which the emphasis should be shifted in future. 73 Speaking about the formulation laid down in Rogers v Whitaker 74 (later on to be accepted by him), he remarked: 75

It is in accord with the fundamental right of individual autonomy and self-determination to which South African law is moving. This formulation also sets its face against paternalism, from many other species whereof South Africa is now turning away. It is in accord with developments in common law countries like Canada, the United States of America and Australia, as well as judicial views on the continent of Europe.

1.6 LEGAL SYSTEMS THAT RECOGNISE THE THERAPEUTIC PRIVILEGE

The therapeutic privilege has established itself in the legal systems of a great many countries from different legal traditions. Among these can be counted Austria, 76 Belgium, 77 Denmark, 78 Finland, 79

72 At 418G–H.
73 See Dreyer 1995 "Redelike dokter versus redelike pasiënt Castell v De Greef 1994 SA 408 (K)" Tydskrif vir Hedendaagse Romeins-Hollandsse Reg 532 538 who concludes that, although Ackermann J did not reject the application of the therapeutic privilege, he is not positive about it. Welz 1998: 1–2 states that Ackermann J appears to hold the view that the therapeutic privilege does not accord fully with the present-day developments of our law which clearly promote patient autonomy and self-determination. Cf Welz 1999: 299–300.
74 (1993) 67 ALJR 47 52. See fn 16 supra.
75 At 426D–E.
76 Steiner 1985 "Austria" in Deutsch & Schreiber (eds) Medical responsibility in Western Europe: Research study of the European Science Foundation 1 31; Schmölke 1994 "Risikoaufklärung in der Unfallchirurgie" Unfallchirurgie 53 54; Wachsmuth & Schreiber 1984 "Grenzen der ärztlichen
France, Germany, Greece, Hungary, Ireland, Israel, Italy, Japan, Luxembourg,

Aufklärungspflicht im westeuropäischen Vergleich” Deutsche Medizinische Wochenschrift 153 154.


78 Leenen, Gevers & Pinet 1993: 42.

79 Leenen, Gevers & Pinet 1993: 42, 58.


83 Leenen, Gevers & Pinet 1993: 43.

84 Tomkin & Hanafi 1995: 34.


86 Busnelli & Zana 1985 “Italy” in Deutsch & Schreiber (eds) Medical responsibility in Western Europe: Research study of the European Science Foundation 361 384.


88 Leenen, Gevers & Pinet 1993: 43.
Monaco,89 the Netherlands,90 Norway,91 Poland,92 Portugal,93 Sweden,94 Switzerland95 and the United Kingdom.96

89 Leenen, Gevers & Pinet 1993: 43.


92 Leenen, Gevers & Pinet 1993: 44.


CHAPTER 2
KEY JUDGMENTS CONCERNING THERAPEUTIC PRIVILEGE

2.1 INTRODUCTION
It is important for a proper understanding of the defence of therapeutic privilege to investigate some practical examples of therapeutic non-disclosure. There is a real scarcity of authoritative judgments on the therapeutic privilege. Very few cases actually turn on the application of this defence. One such case where the defence was upheld, is Nishi v Hartwell, a case which is frequently cited in American law. The defence was also upheld by the South Australia Supreme Court in Battersby v Tottom. On the other hand, in Meyer Estate v Rogers the Ontario Court rejected the existence of the therapeutic privilege as such.

Because of the scarcity of case law on the issue of therapeutic privilege these three cases will be discussed in detail and a few critical comments will be made where applicable.

2.2 NISHI V HARTWELL¹
2.2.1 The facts
Doctor Nishi had a history of hypertension and chronic kidney ailments. Prior to his being referred to first defendant, he suffered severe and recurring attacks of chest pain. On the strength of X-rays he had taken, first defendant suspected that Nishi was suffering from aneurysm. First defendant recommended thoracic aortography to determine whether Nishi was in fact suffering from aneurysm. This procedure was the recognised procedure for making the determination. Nishi consented to undergo the procedure at the hands of second defendant. First defendant explained the procedure to Nishi.

The procedure entailed the exposure of an artery in the inguinal region, followed by an injection of a contrast medium through a catheter. The contrast medium is used for the purpose of

¹ 473 P 2d 116 (Hawaii 1970).
outlining the aorta under X-ray. Neither first defendant nor second defendant informed Nishi of the possibility that the contrast medium may cause paralysis even though both of them were aware of such a collateral hazard.

Second defendant competently performed the procedure. However, after the procedure, Nishi was paralysed from the waist down and had lost control over his bowel and bladder. This condition occurred as a side-effect of the contrast medium used.

Nishi brought action against first and second defendants claiming damages suffered as a result of undergoing the thoracic aortography. He died during pendency of actions and his wife’s (the plaintiff’s) right to recover individually and as executrix of her deceased husband’s estate depended on whether her husband had a good claim during his lifetime. The circuit court dismissed their action against the defendants.

2.2.2 The judgment and critique

On appeal, Marumoto J explained that the doctrine of informed consent imposes upon a doctor a duty to disclose to his or her patient all relevant information concerning a proposed treatment, including the collateral hazards attendant thereto.² He continued that the doctrine also recognises that the doctor’s primary duty is to do what is best for his or her patient and that a doctor may withhold information regarding untoward consequences of a treatment where full disclosure will be detrimental to the patient’s total care and best interest. No hard and fast rule exists as to the circumstances under which information may be withheld and the kind of information that may be withheld, and each case will depend on its particular facts.³

Marumoto J cited the reasons advanced by first defendant for withholding the information as follows:⁴

Each person is different. This man was very well educated, a fine man, but in addition, he was very frightened about his condition, he was apprehensive, and this actually guided

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² At 119[7].
³ At 119[7]–[8].
⁴ At 120.
our hand in much of what we did because if a man has a serious heart disease, with hypertension, and you thereupon frighten him further, you have a problem which you have created ... I mentioned he had high blood pressure, he had pain in his chest which we were trying to find an answer to, and if I had sat down with Dr Nishi and said, “We are about to inject something into you which has a remote chance of causing you to be paralyzed, you may get an immediate reaction which will cost you your life,” if I had said these things to Dr Nishi, I think it would have been a terrible mistake ... You will recall, also, that Dr Nishi is a professional man, he’s a dentist. I would dare say he’s given thousands of injections of novocaine and he knows as well as I ... that every time you inject anything into somebody, a hazard exists, so that it didn’t seem necessary to tell this professional man, “Now is it a hazard?” He knows it. And, therefore, not very much was said to him by me about the dangers of the procedure. I wished to reassure him that we were doing everything we could to find the cause of his pain ...

First defendant’s testimony strikes me as peculiar and self-contradictory. The defence invoked is that of therapeutic privilege – the patient, it was said, would be frightened if he were to be informed of the risks associated with the injection of the contrast medium. And yet, it was averred, the patient did not have to be informed since, being a dentist, he knew that injections carry risks.\(^5\) If he knew, why would he be frightened by being told? This would be tantamount to telling the mouse that the cat has paws.

Second defendant gave two reasons for omitting to mention the collateral hazard: (i) he thought that full disclosure would not be in Nishi’s best medical interest in view of his psychological condition; and (ii) Urokon was practically the only satisfactory contrast medium then available for the procedure and the chance of the collateral hazard materialising from its use was relatively minimal.\(^6\)

The court pointed out in a footnote that at least half of the surgeons in the United States used Urokon “despite the existence of other contrast media considered by some to be less toxic”, but which did not facilitate the best possible X-rays.\(^7\) Although this footnote was inserted seemingly

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\(^5\) See, however, Shartsis 1972 “Informed consent: Some problems revisited” *Nebraska Law Review* 527 636 fn 52. Shartsis reasons that this testimony, cited by the court, appears to give a second and independent reason for the court’s decision, ie, that the patient already knew the risks. The author states that the normal risks involved in routine injections do not include paralysis or death, but rather a small possibility of infection, and argues that this testimony therefore offered no grounds of defence whatsoever.

\(^6\) Two in 3 800, in fact. Cf Shartsis 1972: 536.

\(^7\) At 120.
to underscore the point made by second defendant, it clearly shows that alternative treatment was available that, in my opinion, should have been drawn to the patient's attention. Depending on how safe these alternative contrast media were, such disclosure would either have exposed the patient to less significant harm, or would not have exposed the patient to any harm. Add to this the possibility that Nishi could have chosen to subject himself to the risks involved only at the hands of other (perhaps better equipped or skilled) specialists, and the case for not informing him begins to lose some of its shine of beneficence.

Be that as it may, Marumoto J mentioned that the defendants' evidence had been uncontradicted. Without further ado, he simply continued to say that this evidence brought the defendants' omission to disclose clearly within the exception to the duty of full disclosure which excuses the withholding of information for therapeutic reasons, and found that the circuit court properly granted the defendants' motion to dismiss. One cannot help to wonder what the outcome would have been if the doctors' testimony had been subjected to the kind of cross-examination expert testimony usually faces.

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8 Shartsis 1972: 536–537.
9 Cf 4.4.2 and 4.4.3 infra.
10 Shartsis 1972: 536.
11 Cf Shartsis 1972: 537.
12 At 121. Shartsis 1972: 535–536 (and in particular fn 50) explains that the plaintiff brought suit under battery. Under this theory of the case, the question is simply whether the plaintiff consented to the touching. Therefore, if battery had been accepted as the appropriate form of action, expert testimony should have been irrelevant. Because the plaintiff chose to sue under battery, no preparations were made to bring forth expert witnesses to support the plaintiff's case. The only doctors to take the stand were the defendants — and they appeared as adverse witnesses. The court dismissed the suit at the close of the plaintiff's case, because the plaintiff failed to come forward with expert testimony to prove a prima facie case of negligence. Shartsis 1972: 536 fn 50 argues that, while the court was prepared to say that the "right of a plaintiff to relief does not depend upon his allegations or his theory of the case" (at 119), it is clear that under the plaintiff's theory of battery it was to the plaintiff's prejudice and detriment not to come forward with expert witnesses. Had the plaintiff come forward with expert witnesses, the case would presumably have gotten to the jury. The dissenting opinion of Abe J discusses this problem. See also Shartsis 1972: 544–548 for a discussion of battery and negligence.
13 Patterson 1985 "The therapeutic justification for withholding medical information: What you don't know can't hurt you, or can it?" Nebraska Law Journal 721 739 is of the opinion that it is far from certain that the testimony could have stood the test of probing cross-examination.
However, Marumoto J held the view that the dismissal of the action may also be supported on another ground. In his opinion negligence should be decided by reference to relevant medical standards which should be proved by the plaintiff. In this case, the plaintiffs did not adduce any expert medical testimony to establish a medical standard.\(^{14}\) The court found that, even though they were not testifying as experts, the defendants’ testimony could be deemed to be expert medical testimony in so far as it disclosed what the practice of competent and responsible medical practitioners was in a particular medical situation. The testimony by the defendants, who were called by the plaintiff as adverse witnesses, established the medical standard applicable to this case. The medical standard so established was that a competent and responsible medical practitioner would not disclose information which might induce an adverse psychosomatic reaction in a patient highly apprehensive of his condition.\(^{15}\)

The formulation of the therapeutic privilege laid down in *Nishi v Hartwell* has been criticised for being so wide “as to devour the disclosure rule itself”, and for being “clearly bad law”.\(^{16}\) The decision has been criticised for failing to consider the interest of the patient and his family in receiving information so they might prepare for contingencies, and for failing to provide protection against manipulating the consent of the patient by selective provision of information.\(^{17}\)

In my opinion, the possibility that Nishi did know about the risks associated with the injection of contrast medium cannot be ruled out. (The court certainly did not reject first defendant’s testimony to that effect.) Assuming that there were no alternatives to the use of Urokon,\(^{18}\) that would then have brought the matter to a close. By allowing the defence of therapeutic privilege, the court created a bad precedent which was followed in cases involving adverse reactions to contrast media where the (lay) patients were not likely to have known of the risks involved. I am not suggesting that all the risks associated with, for example, contrast media should be disclosed,

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15 At 121[12]. See Shartsis 1972: 535 and in particular fn 50.


18 Which, as we have seen (fn 7–8 and the accompanying text *supra*), is questionable.
and that all the contrast-media cases decided in favour of the doctor are therefore incorrect. There are too many factors influencing a decision to withhold or disclose such risk, for instance the probability of its materialising, the severity of the risk should it materialise, whether (and if so, to what extent) the adverse reaction is reversible. But where the patient knows of the possibility of adverse reactions to an intravenous injection, informing him or her is not necessary because the patient’s decision to undergo the procedure is informed. If the patient is not aware of the risk, but the risk is too remote or the consequences of its materialising are too insignificant to require disclosure, it is not the suggestion that disclosure will unnecessarily frighten the patient, but the fact that it is immaterial because of its being unlikely or insignificant that abrogates the need for disclosure. To hold otherwise would imply that, save for doctors, humankind is not capable of appreciating and accommodating the remoteness or insignificance of a risk. In other words, one must assume that no reasonable person would be frightened (unduly) by, for example, a one in a million chance of a minor skin rash developing.

2.3 BATTERSBY V TOTTMAN

2.3.1 The facts

The appellant (the patient-plaintiff in the court a quo) had experienced episodes of serious mental illness, sometimes described as “mental neurosis” and sometimes as “reactive depression” since 1961. Between 1966 and 1970 various forms of treatment were tried in relation to the patient’s illness, including two operations, electro-convulsive treatment and a variety of drugs. Amongst the drugs used, the most successful proved to be thioridazine hydrochloride, or melleril.20

The recommended maximum dosage of melleril is 800 milligram per day. One of the side-effects of melleril use is damage to the retina of the eye as a result of retina pigmentation which could ultimately lead to blindness. The risk is dose-related in that it increases with the dose.

Between 1966 and 11 April 1970 the doses of melleril administered to the patient varied between 100 milligram and 1500 milligram per day. The patient was severely depressed, had hallucinations

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19 (1985) 37 SASR 524.

20 See 528 (per Zelling J). Cf 538 where Jacobs J reports that she responded only to melleril.
and suicidal tendencies, varying in degree according to the crises and strains she experienced in her personal life. From 11 April to 18 April 1970 a dosage of 2400 milligram per day was administered. On 18 April, the respondent ("the doctor") took over the patient's day to day treatment in the public hospital where, at that stage, she was an in-patient. He was "frightened" by this high dosage of the drug and gradually reduced the dosage from October 1970 onwards until by January 1971 it was 850 milligram per day. Meanwhile, the patient's condition had improved to such an extent that she was discharged from the hospital. From January until November 1972 the doctor kept the dosage below 900 milligram per day.

By that time the patient's health had taken a turn for the worse. Her hallucinations returned and she was very suicidal, but she was able to continue as an out-patient. Despite an increased dosage of 2400 milligram, she remained depressed and in November 1973 was readmitted, severely disturbed, very angry and suicidal. For the period of two years spanning from November 1972 until November 1974 the dosage was kept at a staggering 2400 millgram per day.

The doctor was "acutely conscious of the fact that he was prescribing massive, perhaps unprecedented, doses of the drug for the [patient] and over a period of years – matters which pointed to a relatively high risk when the retinopathy case studies were considered".21 He was, however, of the opinion that the advantages to be derived by the patient from treatment with the drug outweighed the risk of damage to the eyes.

The doctor did not warn either the patient or the patient's relatives of the risk of damage to the eyes. He feared that, if he did inform her of the risk, she would either have an hysterical reaction and get the symptoms of an actual eye defect (and therefore be taken off the melleril), or she would stop taking the melleril of her own accord. Moreover, the doctor neither arranged for the patient's eyes to be regularly monitored by an eye specialist (which, according to the trial court, would be the preferable course, so that the eyes could be properly dilated and examined with the best equipment by an expert), nor did he himself perform any ophthalmoscopic examination on the patient. Again, he imputed his failure to take these precautions to his fear that the patient either may have an hysterical reaction or may stop taking melleril.

21 Zelling J quoting the trial court at 530.
In November 1974 the doctor noticed increasing skin pigmentation of the patient’s body, examined her eyes and discovered that she had pigmentary retinopathy due to the excessive dosage. He reduced the dosage as speedily as possible until by March 1975 the patient was no longer taking melleril tablets at all. She was put on counselling treatment, some courses of electro-convulsive treatment and another drug. She responded very well to this combination treatment and left the hospital by September 1975. By the time of her trial she was considered mentally normal. However, her eyesight was seriously and permanently damaged as a result of the melleril treatment to such an extent that she had to use a guide-dog. She subsequently sued the doctor and the hospital for damages for negligence.

2.3.2 The judgment

2.3.2.1 General

The appeal against the trial court’s finding that negligence had not been established was based on the following three grounds: (i) that the doctor ought not to have prescribed the high doses of melleril or ought not to have prescribed them over such a long period of time; (ii) that the doctor should have advised the patient of the risk of damage to her eyes which the contemplated treatment with melleril carried so that she could make an informed decision as to whether to undergo it and, if she decided to do so, would be alert for tell-tale signs of retinopathy; and (iii) that having decided to proceed with the treatment, the doctor should have arranged to have the patient’s eyes regularly monitored by an eye specialist, so as to detect the first signs of damage to her eyes.

Two of the three judges (King CJ and Jacobs J) held that all three grounds of appeal failed and that the judgment of the trial judge should be affirmed.

In a dissenting judgment, Zelling J held that although the first ground of appeal failed, the appeal succeeded on the second and third grounds, and that the trial judge should have found that the doctor had been negligent in failing to warn the patient of the possible damage to her eyesight from the treatment with the drug and in failing to have the patient’s eyes monitored by an eye specialist.
I shall deal with each ground in turn as discussed by each of the three judges.

2.3.2.2 That the doctor ought not to have prescribed the high doses of melleril or ought not to have prescribed them over such a long period of time

Since the court was unanimous in its finding that the first ground must fail, I shall be very brief in discussing the reasons. Although conceding that the dosage was very large and administered over a long period, King CJ drew attention to the fact that, on the basis of the then state of medical knowledge, the doctor had believed that the impairment of eyesight would be halted by the discontinuance of the administration of melleril and might abate. The doctor had not been aware, and could not have become aware that the impairment may be progressive, as it was in the appellant’s case, even after the cessation of the melleril treatment.22 King CJ described the patient’s plight as desperate, being acutely depressed and facing the prospect of spending the remainder of her life closely confined in a mental institution with a constant risk of suicide. King CJ assessed the doctor’s conduct against a professional standard, and held that the decision to take the risk of prolonged treatment with large doses of melleril had been “a considered professional judgment made after consideration of all aspects and was supported by a body of medical evidence”. Hence, the doctor had not been negligent.23

The appellant attacked the judgment of the trial court arguing that it was negligent to prescribe the excessive dosages of melleril for such a long period of time without giving adequate consideration to alternative treatments. Zelling J described this argument as “justifiable” on the evidence, and the doctor’s treatment of the patient as “wooden”, remarking that the doctor seemed “to have clung to melleril much like the law’s famous tabula in naufragio”.24 Nevertheless, he found that, with such a “difficult patient” and in this “difficult situation”, the doctor cannot be said to have been negligent.25

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22 At 526.
23 At 526.
24 At 532.
25 At 532–533.
Jacobs J went even further and described the patient’s illness as “unusually difficult”. He identified the risks which the doctor had had to weigh as the patient’s “life, if high-dose melleril was discontinued, or some possible impairment of her vision if he persisted in the only treatment known to be effective”. Jacobs J dismissed the appellant’s assertion that the doctor should not have waited until the symptoms of retinopathy were observed before trying some alternative treatment as one that “invokes the wisdom of hindsight”. By a strange twist of logic, the judge himself then invoked the wisdom of hindsight to explain his dismissal of the assertion.

The trial Judge was satisfied that the [alternative] treatment which then succeeded, where it had previously failed, probably succeeded because the long-term high-dose melleril had been of good effect. There is no basis for asserting, or even suspecting, that the alternative treatment would have worked at a significantly earlier time.

2.3.2.3 That the doctor should have advised the patient of the risk of damage to her eyes which the contemplated treatment with melleril carried so that she could make an informed decision as to whether to undergo it and, if she decided to do so, would be alert for tell-tale signs of retinopathy

King CJ reiterated the “paramount consideration that a person is entitled to make his own decisions about his life”. He then added that, in his opinion, the doctor would be in breach of his duty to the patient “if he withheld from a mentally normal and emotionally sound patient information as to a material risk simply because he found that the patient might make an unwise decision, perhaps based upon unreasonable considerations, not to undergo the treatment”. He quoted his own formulation of the therapeutic privilege from his judgment in F v R:

Even where all other considerations indicate full disclosure of risks, a doctor is justified in withholding information, and in particular refraining from volunteering information, when he judges on reasonable grounds that the patient’s health, physical or mental, might

26 At 538.
27 At 538–539.
28 At 538–539.
29 At 527.
30 At 527.
31 At 527.
be seriously harmed by the information. Justification may also exist for not imparting information when the doctor reasonably judges that a patient’s temperament or emotional state is such that he would be unable to make the information a basis for a rational decision.\textsuperscript{33}

The Chief Justice applied the above reasoning to the facts \textit{in casu}, and found both reasons which could justify non-disclosure to be present:\textsuperscript{34}

I think that the appellant’s mental and emotional condition as understood by Dr Tottman and as found by the learned trial Judge, placed the doctor in the position of having to make the decision for her for two reasons. First, mere knowledge of the risk to her vision would be sufficient to give rise to a real risk of hysterical blindness. Second, she was quite incapable by reason of her abnormal mental condition of using the information as the basis for calm or rational decision. She was likely to react hysterically and irrationally and to refuse treatment not on rational grounds or as a result of calm deliberation but as a result of distorted mental processes produced by her mental illness. The result of refusal of the treatment, in the belief of the doctor formed on reasonable grounds, was likely to be indeterminate close confinement in a mental institution with a high risk of suicide. I agree with the learned trial Judge that in the circumstances the doctor’s decision not to acquaint the patient with the risk to her vision attendant upon the treatment was not negligent.

As becomes apparent from the passage quoted, the Chief Justice acknowledged that the patient had not made the decision to undergo the treatment, but rather that the doctor made it. From his reasoning it becomes clear that the Chief Justice did not mean to say that the inability to deal with information on a rational basis \textit{per se} justified non-disclosure, but that her possible refusal of treatment provided the rationale. There is a real difference between the two that must not be overlooked.\textsuperscript{35} In the case of the former the need for divulgence is absent because the process of decision-making would be tainted owing to an inability to receive, accommodate and interpret the information. In the case of the latter, the evaluator projects what the patient’s decision will be and finds it unacceptable for lack of being in keeping with his or her own concept of rationality. An

\footnotesize{\textsuperscript{33} Wallace 1995 \textit{Health care and the law} (2nd ed) 95–96 criticises this approach to the giving of information (which appears to apply to patients of either sound or unsound mind), for so severely limiting the right of a patient to be fully informed, that such a right cannot truly be said to exist.}

\footnotesize{\textsuperscript{34} Kennedy & Grubb 1994: 214 are clearly mistaken where they allege that “Battersby deals with only one aspect of the doctrine of therapeutic privilege, \textit{viz} that the doctor may withhold information if his disclosing it to the patient would probably cause actual physical (or mental) harm to the patient (hysterical blindness in this case)”. In fact, it is very difficult to see how the fear of a possibility of hysterical blindness (\textit{per se}) could have justified the withholding of information that led to actual blindness or near-blindness.}

\footnotesize{\textsuperscript{35} See 5.3.2 \textit{infra}.}
inquiry as to a person’s ability to deal with information in a rational way involves an inquiry as to the person’s cognitive abilities, which inquiry was not embarked upon by the Chief Justice. I can hardly see how it could be possible to predict the outcome of a truly disturbed thought process.

Jacobs J maintained that the doctor’s decision not to inform the patient of the side-effects of the melleril treatment was dictated by the options open to him.\textsuperscript{36} He knew that the patient had a deep-seated concern for her eyes. On the cause for this fear, and its relevance to the decision-making process, the learned judge made the following pronouncements:\textsuperscript{37}

Whether it was a product of the mental disorder itself, or arose from her fear of the effects of past treatments, such as brain surgery and E.C.T., or was otherwise justifiable or not, does not really matter. Dr Tottman did not believe she was capable of making a calm and reasonable response, but he had no doubt what her response would be. And he knew it would leave him with no option, with no alternative treatment that offered any prospect of success. All had been tried and failed. He believed that to acquaint her with the risk, and to give her a “choice” was almost to sign her death warrant, a likely consequence which almost certainly would not have been present to her disordered mind in making a “choice”. In a case of such acute difficulty, the law should not distrust the judgment of a competent and compassionate medical practitioner, or deny him the right to make the decision that he did without incurring liability for it, unless the Court is clearly satisfied that he was wrong.

I have great difficulty in accepting the remark by Jacobs J that it “does not really matter” whether the patient’s deep-seated concern for her eyes was “justifiable or not”. If this fear had been made out as “irrational”, the remark might have been easier to accept, given the contextualisation of this fear within “a case of acute difficulty”. But the judge’s dismissal of fears, “justifiable” and “unjustifiable” alike, as being of no consequence, smacks of indifference to the patient’s clearly communicated values. The patient expressed her concern for her eyesight at a time when she was suffering from the mental illness.\textsuperscript{38} The mental illness was not her only health concern even in the midst of suffering its effects. I think any doctor, and any court of law engaged in pronouncing on matters of informed consent, should treat such concerns seriously.\textsuperscript{39} Even if a treatment

\textsuperscript{36} At 542.
\textsuperscript{37} At 542.
\textsuperscript{38} See also 533, where Zelling J quotes from the judgment of the court \textit{a quo}.
\textsuperscript{39} Cf Manderson 1988 “Following doctors’ orders: Informed consent in Australia” \textit{The Australian Law Journal} 430 438. See also Siebert 1982 \textit{Strafrechtliche Grenzen ärztlicher Therapiefreiheit} 233 who
decision were to be made by someone other than the patient, the clearly expressed values of such patient must be taken into consideration in making that decision.\textsuperscript{40} This will go some way in steering the decision-maker towards realising the aims of informed consent.

Zelling J rejected the reasoning of the court \textit{a quo} on the issue of informing the patient.\textsuperscript{41} He pointed out that the risk of damage to the appellant’s eyes had been a known risk which could have led to serious eye damage and even blindness, that the dosage had been “unprecedented”, and that the serious risk in fact eventuated.\textsuperscript{42} In his opinion, the doctor cannot answer the patient’s claim by saying that she might have had her treatment seriously affected or might have become suicidal if she had been told the truth.\textsuperscript{43} Although his denial of the doctor’s right to heal or to withhold information under these circumstances is initially framed in absolute terms, he later reasoned that it is a matter of weighing-up:\textsuperscript{44}

> In my view no doctor is entitled to give a patient treatment which may blind her or seriously damage her eyesight without first discussing it with the patient and obtaining her consent to the treatment. She said unequivocally that she would not have consented to the treatment if she had known of the risk and she was not challenged on the point. The severity of the consequences of the decision to give such treatment, when balanced against the plaintiff’s mental condition, comes down heavily in favour of her being consulted.

expresses the opinion that in informing the patient on the risks involved in a medical intervention, the particular personal circumstances of the patient should not be lost out of sight. In fact, if certain risks appear to have a particular significance for the patient owing to certain special personal needs or wishes, it becomes ever more important for the doctor to inform the patient thereof.

\textsuperscript{40} In German law, where a patient is incapable of being informed ("Aufklärungsunfähig") the patient’s legal representative ("gesetzlicher Vertreter") must be informed. If the urgency of the intervention does not admit of informing such a third party, the doctor’s actions are nevertheless lawful as long as they are in the patient’s own interest and are in keeping with the patient’s presumed will ("mutmaßlicher Wille") – § 683 of the Bundesgesetzbuch. See Eberbach 1986 "Die ärztliche Aufklärung unheilbar Kranker" Medizinrecht 180 181. See also Kirby 1983 “Informed consent: What does it mean?” Journal of Medical Ethics 69 72 who says that in those highly exceptional cases where no information should be disclosed to the patient, it would be wise, if not self-protective, for the doctor and the hospital involved to secure discussions with members of the family or close friends and relatives of the patient. This should be done to forestall the suggestion that the medical practitioner has simply substituted his/her own assessment of the patient’s good for the patient’s assessment thereof.

\begin{itemize}
\item \textsuperscript{41} At 534–535.
\item \textsuperscript{42} At 534.
\item \textsuperscript{43} At 534.
\item \textsuperscript{44} At 534.
\end{itemize}
Zelling J accepted King CJ’s formulation of the therapeutic privilege in *F v R* that “a doctor is justified in withholding information ... when he judges on reasonable grounds that the patient’s health, physical or mental, might be seriously harmed by the information”. In his opinion, “this indicates a balancing test where one has to balance the seriousness of the risk of telling her, against the likelihood of, in this case, serious eye damage, to the plaintiff”. It would seem that Zelling J’s interpretation of the facts, and not the law, brought him to a dissenting conclusion.

My view is, that the balance comes down heavily in favour of telling the patient something as serious as this. After all ... a doctor could hardly chop off a patient’s leg without discussing it with the patient first. I see no reason why a doctor should be able to send a patient blind and be excused by saying “I thought it was in your best interests for you to be blinded rather than have your treatment hampered.” ... [One of the witnesses] said that the most severe side-effect of melleril was not melleril retinopathy but death by cardiac arrest from taking melleril. Surely it could not be put to a court that it was better for the patient to die from cardiac arrest due to the administration of the drug, rather than to tell her of the drug’s side-effects and risk a possible suicide. When one deals with effects as serious as the ones I have detailed, and in particular in this case blindness or near blindness or very serious damage which could have led to blindness if persisted in, the patient must be allowed to make her own decision, whether the doctor thinks she is well enough to do so or not, except in the case of a person who is too young to make decisions or is, by reason of mental infirmity, unable to consider and weigh the risks inherent in the treatment. Despite the plaintiff’s mental troubles, she was not in that position.

He added what to my mind is the most important key to this case: if melleril had only been used for a short time and in moderate doses to stabilise the patient’s position, the case would have been different. This remark by Zelling J was uttered in respect of the doctor’s duty to inform. It does

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45 At 534.
46 (1983) 33 SASR 189 192.
47 It is significant that Zelling J does not subscribe to, or even mention, the second ground upon which, in terms of King CJ’s judgment in *F v R* (1983) SASR 189 192 a doctor is justified to withhold information, and which reads as follows: “Justification may also exist for not imparting information when the doctor reasonably judges that a patient’s temperament or emotional state is such that he would be unable to make the information a basis for a rational decision.” Cf 5.2 and 5.3 infra.
48 At 534.
49 At 534–535.
50 Wallace 1995: 70 remarks that in this *dictum* Zelling J voiced a faint protest against the overwhelming tendency of the courts to favour the opinion of doctors.
51 At 535.
not reflect on the possible negligence in respect of the treatment administered. It should be seen as an indication that the judge would have considered the temporary withholding of information to be justified. It is submitted that such an approach is sound, for it allows the doctor to take emergency action without informed consent. In fact, if it is kept in mind that the risk of retinopathy is dose-related and increases in relation to the period over which it is administered, it could even be argued that the non-disclosure of that risk is not even *prima facie* unlawful where melleril is administered in moderate dosages over a short period. Under such circumstances, the risk of retinopathy is simply not material.

2.3.2.4 *That having decided to proceed with the treatment, the doctor should have arranged to have the patient’s eyes regularly monitored by an eye specialist, so as to detect the first signs of damage to her eyes*

Even though this ground had caused the Chief Justice “considerable anxiety”, and even though he did not find the doctor’s explanation for not arranging regular ophthalmoscopic examinations by an eye specialist “particularly convincing”, and even though he had had “considerable doubts” on this aspect of the case, he reached the conclusion that he could not say that the doctor’s professional judgment was so erroneous as to be one which a reasonable doctor who possessed ordinary competence and exercised reasonable care in his or her decision-making, could not reach in the situation in which the doctor found himself.

Unlike the Chief Justice, Jacobs J found the doctor’s explanation convincing. Had the doctor subjected the appellant to regular and frequent examinations by an eye specialist, he would have had to inform her of the reasons for doing so, which would have led to her refusing the only satisfactory treatment available. In the opinion of Jacobs J, the doctor was far from oblivious or indifferent to the need to monitor the appellant’s eyes for the possible side-effects of retinopathy.

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52 At 527.
53 At 527.
54 At 528.
55 At 528.
56 At 542.
The regime of "unobtrusive supervision" employed by the doctor was sufficient under the circumstances.

Zelling J described the informal observations and inquiries by the doctor as "useless", adding that they turned out to be useless and should have been known to the doctor to be useless.\(^{57}\) He noted that the doctor himself expressed regret at not sending the patient to an ophthalmologist.\(^{58}\)

Zelling J drew attention to the fact that, when the retinal pigmentation was discovered, the doctor immediately referred the patient to an ophthalmologist, irrespective of whether or not she had suicidal tendencies.\(^{59}\) The judge could not see any reason why regular ophthalmoscopic examination could not be included as part of her ongoing treatment. The patient could have been told that it was part of her treatment. He added:

> All the grave consequences propounded by the respondent and by the respondent’s medical supporters in the box were disregarded the moment the damage was known to have happened and there was the obvious possibility that he would be sued for negligence. These precautions could just as easily have been taken earlier and the appellant today would not have the serious damage to her sight that the Judge has found that she undoubtedly has.\(^{60}\)

This case serves as a disturbing reminder that withholding information can leave the patient at the mercy of the doctor and illustrates how easily the withholding of information can lead to inadequate and dangerous treatment being administered. It further illustrates how important it is not to confuse the situation where the patient is incapable of making a treatment decision with the situation where the doctor regards the patient’s anticipated response to information as irrational.

\(^{57}\) At 536.

\(^{58}\) At 536.

\(^{59}\) At 536.

\(^{60}\) At 536.
2.4 MEYER ESTATE v ROGERS

2.4.1 The facts
A patient who had been suffering recurrent problems with her urinary tract over a period of ten years was referred to a specialist in urology who recommended that she undergo an intravenous pyelogram (IVP). An IVP is a diagnostic procedure during which dye is injected into the patient’s vein and X-ray photographs are taken to trace the course of the dye within the body to examine the kidneys, ureter and bladder. The patient went for the IVP and the radiologist injected her with the dye hypaque. The patient became restless, agitated and hostile, and actively resisted attempts by a number of hospital personnel to keep her on the table. Help was summoned, and after an unsuccessful attempt to sedate her, the patient suffered respiratory arrest. Attempts to resuscitate her were unsuccessful. She never regained consciousness and died four days later, the cause of death being cerebral anoxia by means of anaphylactoid shock resulting from injection of hypaque.

Severe reaction was known to occur in about one in 2 000 cases, and death in between one in 40 000 and one in 100 000. The defendant-radiologist admitted explicitly that he intentionally refrained from informing the patient of the risk of death. He acted in accordance with the Canadian Association of Radiologists’ recommendation that patients should not be informed of the risks attached to “low risk” procedures such as IVP. The Association felt that the risks associated with fully informing patients of low risk procedures outweighed the risks of not informing them. The source of this impression was a published study in which it was hypothesised that the most important factors in the production of contrast media reactions are the patient’s fear and apprehension.

2.4.2 The judgment
In an action for wrongful death, the Ontario Court per Maloney J held that the position recommended by the Canadian Association of Radiologists directly contravenes the standard required by the Canadian law on informed consent, namely that all material risks be disclosed. The risk of death is obviously a material risk. Therefore, he asserted, the radiologist would clearly

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be in breach of the standard, "unless it can be shown that Canadian law recognizes the exception to that standard known in United States jurisprudence as ‘therapeutic privilege’." 62

He thereupon surveyed the law relating to therapeutic privilege in the law of the United States, England and Canada. 63 According to his interpretation, the "American exception" of therapeutic privilege was originally intended to excuse doctors from upsetting patients whose psychological, not physical, health 64 may be detrimentally affected by receiving the information. 65 Maloney J saw the juxtaposition of physical harm alongside psychological harm as "a later interpolation". 66 Nevertheless, he acknowledged that there are many later American cases and texts which take up

62 At 312.

63 Therapeutic privilege in regard to contrast media was also touched upon in a South African article by Van Niekerk & Strauss 1986 "The conventional versus the new radiological contrast media" South African Medical Journal 799. On the position regarding the use of the therapeutic privilege in cases of reactions to contrast media in Belgian and French law, see Anrys 1974 La responsabilité civile médicale 78. The author notes that French jurisprudence acknowledges that a radiologist who injects a solution used in numerous countries and whose efficacy is certain and complications rare, does not have to frighten a patient by disclosing exceptional complications.

64 The insistence on a strict division between physical and psychological health is reminiscent of the outdated mind-body dichotomy (see Alan & Alan 1997 "The right of mentally ill patients in South Africa to refuse treatment" The South African Law Journal 724 726 fn 13). Nowadays, in South African law, it is accepted that the right to the corpus relates to both the physique and the psyche (see Bester v Commercial Union Verzekeringmaatskappy van SA Bpk 1973 (1) SA 769 (A) 779; Boswell v Minister of Police 1978 (3) SA 268 (EC) 272–273; Neethling 1998 Persoonlijkheidsreg (4th ed) 32; Labuschagne 1995b "Deliktuele aansprakelijkheid weens liggaamskending as gevolg van sperravnernietiging: ‘n Verreikende uitspraak van die Duitse Bundesgerichtshof" Tydskrif vir Hedendaagse Romeins-Hollandse Teg 148).

65 At 312F–313e. This view rests on Maloney’s interpretation of the following passage from Canterbury v Spence 464 F 2d 772 (1972) 788–789: "Two exceptions to the general rule of disclosure have been noted by the courts. Each is in the nature of a physician’s privilege not to disclose ... The second exception obtains when risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view. It is recognized that patients occasionally become so ill or emotionally distraught [sic] on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient. Where that is so, the cases have generally held that the physician is armed with a privilege to keep the information from the patient, and we think it clear that portents of that type may justify the physician in action he deems medically warranted. The critical inquiry is whether the physician responded to a sound medical judgment that communication of the risk information would present a threat to the patient’s well-being. The physician’s privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself." See 5.2.2.4 infra.

66 At 313f.
the notion that physical harm can also be avoided under the doctrine of therapeutic privilege and accordingly, that therapeutic privilege had been accepted as a defence in IVP cases in some American jurisdictions.

Maloney J then pointed out that, even in the United States, the therapeutic privilege is not without its "distractors" and substantiated this by quoting a couple of passages by Meisel in which the latter criticises the privilege and expresses the opinion that the danger that the therapeutic privilege poses to self-determination is so great that we should seriously consider its abolition.

English law, the judge said, is not helpful in deciding this case, as the House of Lords had rejected the doctrine of informed consent altogether, and therefore had had no need to consider any exceptions to it.

In surveying Canadian law, Maloney J dealt with a passage from Reibl v Hughes in which it was said that a particular patient may, because of emotional factors, be unable to cope with facts relevant to recommended surgery or treatment and the doctor may, in such a case, be justified in withholding or generalising information as to which he or she would otherwise be required to be more specific.

67 Cf Kirby 1983: 72.
68 At 313f.
69 At 314b–d.
70 At 315e. Cf Van Oosten 1991a The doctrine of informed consent in medical law 403. See, however, O'Malley-Williams v Board of Governors of the National Hospital for Nervous Diseases (1975) 1 BMJ 635; Bolam v Friern HMC (1957) 2 All ER 118 124 (cf fn 147 infra, chapter 5); Sidaway v Bethlem Royal Hospital Governors (1985) 1 All ER 643 653 (cf fn 116 infra, chapter 5), 659 (cf fn 145 infra, chapter 5). Mason & McCall Smith 1991 Law and medical ethics (3rd ed) 247–248: "Although there was some lack of unanimity on general issues, there are two specific aspects of the information issue which appear to be confirmed as a result of Sidaway. The first is that material risk of a procedure must be disclosed, subject only to therapeutic privilege which a doctor might be required to justify ... Secondly, the case fully confirmed the 'therapeutic' or professional privilege to withhold information that might be psychologically damaging to the patient. This, again, follows the direction in Bolam ..." See also Kennedy 1985 "England" in Deutsch & Schreiber (eds) Medical responsibility in Western Europe: Research study of the European Science Foundation 113 143.
He commented on this passage as follows.72

One cannot help noticing the hesitancy of ... tone, enhanced by the use of the tentative word “may” three times in one sentence: it may be the case that a patient may be unable to cope, and the doctor may be justified in withholding ... I would also note that the Supreme Court of Canada’s comments on therapeutic privilege are obiter dicta. In my opinion, the Supreme Court of Canada has not, in Reibl, adopted or even approved the therapeutic privilege exception in Canada. The instant case may well be the first one in Canada where that issue falls squarely to be determined.

The judge came to the conclusion that the therapeutic-privilege exception does not form part of the law of Canada,73 adding that he did not believe that it should become part of Canadian law because there had already been in the United States an unwarranted extension of the privilege beyond its original scope which protected patients only from potential psychological harm, and, as Meisel said, the privilege had the potential to “swallow” the doctor’s duty to disclose. Consequently, the Court held that the defendant ought to have informed the patient of the risk.74

The Court nevertheless dismissed the action because a fully informed reasonable person in the patient’s position would have consented to undergoing the test, and consequently, the defendant’s failure to disclose the material risk could not be said to have caused the patient’s death.75

72 At 314g–h.
73 At 316g–h.
75 At 318h–319a.
CHAPTER 3
CRITICAL EVALUATION OF THE THERAPEUTIC PRIVILEGE

3.1 INTRODUCTION
Since the contours of the therapeutic privilege are by no means clear,¹ and since it is one of the aims of this study to define a few contours, a discussion of the pros and cons of allowing such a privilege would be rather abstract.

The therapeutic privilege as a legal phenomenon is a fairly new innovation. Case law pronouncing on the therapeutic privilege is scarce. Any definition abstracted by way of inductive reasoning would at best lead us onto a dark and virtually featureless plain. Even though "the therapeutic privilege" is a widely recognised and frequently discussed phenomenon, commentary thereon, for the greater part, lacks in depth, differentiation and detail. Many a commentator ventures no further than the making of a few generalised (almost perfunctory) comments hardly amounting to anything more than the taking-up of a position either for or against "the therapeutic privilege". The same can be said of the obiter dicta. A particularly popular approach seems to be to express oneself in favour of the therapeutic privilege, just to add the rider that the therapeutic privilege must be narrowly defined so as to avoid it from swallowing (or engulfing) the general duty of disclosure. Such is the slow progress of the law. Fortunately, however, there are those who have suggested specific instances which to their mind should be brought under the therapeutic privilege.²

In this chapter, I attempt systematically to expose and evaluate the criticism levelled by the commentators and the judiciary.³ The exposition will proceed on the premise of a loosely defined

¹ Meyers 1981 Medico-legal implications of death and dying 83.
² See chapter 5 infra.
³ I have found that many of the stalwart advocates of discretionary therapeutic privilege base their arguments on moral precepts of Halacha law. See, eg, Wixen 1992 "Therapeutic deception: A comparison of Halacha and American law" The Journal of Legal Medicine 77; The Society for Justice-Ethics-Morals (date not furnished) Ethical and moral dilemmas and human relationships: Collection of
privilege (or defence) allowing a wide (or unlimited) discretion on the part of the doctor. From the criticism may loom up the outer boundaries of this dark passage through liability. If we were to grope the way along its outer boundaries, we may be able to conjure in the mind’s eye the expanse covered by the defence. Although some overlap may exist between the points of criticism listed below, each has its own focus, and therefore merits separate discussion.

3.2 THE PRIVILEGE UNDERMINE THE PATIENT’S RIGHT TO SELF-DETERMINATION

3.2.1 General

The most fundamental objection to the therapeutic privilege is that it is paternalistic and undermines the patient’s right to self-determination, which right is the cornerstone of the informed-consent doctrine. Underlying the idea of a therapeutic privilege is the classical Hippocratic ethic according to which doctors should do what in their judgment would lead to the greatest good or least harm for their patients. The corollary of such an ethic is the proposition

Halachic sources adapted for health-care and therapy on the subject of moral dilemmas confronting medical personnel and social workers 44–56; Rosner 1974 “Emotional care of cancer patient: To tell or not to tell” New York State Journal of Medicine 1467 1468. See also Pfeffer 1993 “Ethics and the oncologist” Medicine and Law 235 236–237. In an interesting study on Israeli doctors’ attitudes towards truth-telling, it was found that doctors who were Orthodox Jews were less likely to inform patients of their illness than doctors whose orientation was Conservative Judaism, or those who were non-religious – see Schindler 1983 “Reaction to truth telling among Israeli physicians” Omega 277.


5 See fns 34–35 supra, chapter 1.

that therapy is the ultimate goal. If therapy becomes the ultimate goal, the withholding of truth can easily come to be considered a medical instrument. This becomes apparent from the writings of some who advocate the withholding of harmful information. For example, Meyer advocates that what is 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. Like the transfusion of blood, the dispensing of certain information must be distinctly indicated, the amount given consonant with the needs of the recipient, and the type chosen with the view of avoiding untoward reactions.

Meyer’s proposition that the doctor must ensure that the information given is consonant with the patient’s need for information is sound. However, his suggestion that information must be “chosen with the view of avoiding untoward reactions” must be rejected. If the approach he advocates were to be followed it would mean that the doctor has carte blanche to withhold any information as long as withholding the information would serve the ultimate goal of therapy, irrespective of how slight the untoward reaction might be and irrespective of the seriousness of the affront to self-determination.

Judge Jacob Türkel outrightly proclaims the use of the “drug named illusion” in treating the terminally ill patient:

In my opinion, in the majority of cases, it is our duty to lie to the terminal cancer patient and in any case, he/she shall not be told the whole truth except what is of vital importance and most necessary, for example, as for purpose of medical treatment. In principle, I cannot see any difference between giving an analgesic drug, or other drugs, to such a patient and the giving of the drug named illusion. The common assertion that such a patient knows anyhow his/her condition is, as far as I can see, irrelevant; the problem of how to give the treatment without telling the truth, is a problem with which the doctors have to struggle. In any case, I do not agree to give up, for its own sake, the relief

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10 Türkel 1985 “Remarks on telling the truth or lying” Medicine and Law 91 92.

11 As does Welz 1998: 16.
provided by illusion and hope. Also the well-known story about the cancer patient who
dies pretending to his relations that he does not know his condition, as they pretend to
him, does not impress me. A man dies more or less in the way he has lived. If we can
grant the patient the chance to present his loved ones with the illusion that he does not
know, we should not take it away from him.12

The acceptance of such an attitude towards the issue of truth-telling can be the start of the
slippery slope leading to wholesale paternalism. The ethic of medical beneficence in its logical
extreme would endorse the telling of lies in order to induce a false sense of well-being. The better
the lie, the more emphatic in its assurances of good health and the absence of risks and untoward
consequences, the greater the possible positive effect on the health of the patient. In fact, it is
difficult to conceive of any situation in which a lie promising of great health will not do any good
(provided its falsity remains undiscovered).

Bok warns that no matter how cogent and benevolent the reasons for resorting to deception may
seem, when those reasons are considered in secret, without the consent of the doctored, “they
tend to be reinforced by less benevolent pressures, self-deception begins to blur nice distinctions
and occasions for giving misleading information multiply”.13 A good example of how easily a
decision to withhold information can necessitate other deceptions and influence treatment
decisions is the following. It is reported that in Japan, where doctors generally follow a policy
not to inform patients that they have cancer, an anti-cancer drug called “Krestin” is said to be
popular because doctors can prescribe it without telling patients that they have cancer.14 Krestin
is taken orally, and it does not have debilitating side-effects that might give patients clues as to

12 See also Welz 1998: 15 who seems to endorse the view taken by Türkel. For more examples, see Abbuhi
& Gerkin 1975: 220; Ryckmans and Meert-Van de Put 1971 Les droits et les obligations des médecins
ainsi que des dentistes, accoucheuses et infirmières vol 1 (2nd ed) 440 (proclaiming that, under certain
special circumstances, the doctor has the right and the duty to be reticent, since he/she must, above all,
try to realise the most propitious circumstances for successful therapy); Esterhuizen v Administrator,
Transvaal 1957 (3) SA 710 (T). In the last-mentioned case, the doctor, who was the only person with
knowledge of the danger and severe consequences which might or would ensue from radiation treatment,
was asked why he did not think that he should have afforded the minor patient’s parents an opportunity
to consider the situation. He replied (at 717 of the report) that it had been his function to cure the disease
if it had been possible.

13 Bok 1977: 252.

who have not been informed of a diagnosis of cancer sometimes suspect that they have cancer because
of the type of treatment that they receive. See fn 245 and the accompanying text infra, chapter 5.
the diagnosis. However, critics assert that Krestin is not an effective drug, and the Japanese Hospital Association has condemned the drug.

The threat that the therapeutic privilege holds for self-determination is not only a concern amongst ethicists, but also amongst lawyers. Our law endorses the principle of self-determination. The acceptance of a therapeutic privilege to some extent reintroduces or retains\(^{15}\) the doctor-based standard of disclosure.\(^{16}\) Allowing the doctor to decide whether or not to disclose information based on the best medical interests of the patient, opens the backdoor for medical paternalism.\(^{17}\) The court in *Canterbury v Spence*\(^{18}\) expressed its concern that the therapeutic privilege must be carefully circumscribed,\(^{19}\) for otherwise it might devour the disclosure rule itself. Kennedy,

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15 See *Carr v Strode* 904 P 2d 489 (Hawai‘i 1995) 498; *Bernard v Char* 903 P 2d 676 (Hawai‘i App 1995) 686–688; Hanson 2001 “Informed consent and the scope of a physician’s duty of disclosure” *North Dakota Law Review* 71 74. See also Katz 1984 The silent world of doctor and patient 75. Christoffel 1982 *Health and the law* 275 comments that the doctrine of therapeutic privilege takes an important question away from the jury and gives it back to the expert witnesses. When deciding on the reasonableness of a defence of therapeutic privilege, the jury is lead by the expert testimony of the defendant’s peers as to whether they would have withheld information under similar circumstances.

16 Since the reasonable doctor test was in fact rejected in *Castell v De Greif* 1994 (4) SA 408 (C), this could certainly not have been intended by Ackermann J, and should be read as a warning against affording the doctor a privilege, in the true sense of the word, to withhold information.


18 464 F 2d 772 (1972) 789. In similar vein, see *BGH* 23.11.1982 VI ZR 222/79 *BGHZ* 85 327 333.

expressing the same fear about the corrosive effect that the therapeutic privilege may have on patient self-determination, takes the view that the therapeutic privilege is a device created by doctors to do what is in the best interests of doctors. Although, as he points out, it may be justified on some occasions, there is no effort to specify these occasions. This means that the particular doctor’s judgment is made the basis on which to proceed. Kennedy condemns the therapeutic privilege for being a device which pays lip-service to the principles of truth-telling and self-determination, while creating a discretionary exception which is capable of swallowing these principles when the doctor decides the occasion requires it. He pleads for more certain guarantees that patients’ interests, as defined by themselves, be allowed to prevail.

The therapeutic privilege gives the doctor the right to withhold information from a patient if disclosure of that information may be harmful to the patient. An informed consent cannot be made unless all material facts are at the disposal of the patient. The patient is precluded from making a decision within the context of his or her own value system. It can be stated that the therapeutic privilege assumes that patients’ personal choices and the obligations of doctors in terms of their commitment to do no harm generally tend to the same end. However, this assumption is flawed, for it is a fundamental premise of informed consent itself that divergence between the interests of patients and those of doctors may exist.

Savatier 1951 Traité de la responsabilité civile en droit Français: Civil, administratif, professionnel, procédural vol 2 Conséquences et aspects divers de la responsabilité (2nd ed) 385.


Giesen 1988a: 383, 386–388; Veach 1982: 81. Kirby 1983: 70 affirms that originally, the notion of informed consent was explained in the legal casebooks as “being based upon the need for the patient to be able to ‘take courage’ as he, or she, faced up to the dire predicament of pre-anaesthetic medicine”. Kirby asserts that the broader concept of self-determination provides the rationale for the latter-day view of informed consent. As has been pointed out by Wallace 1986 “Informed consent to elective surgery: The ‘therapeutic’ value” Social Science & Medicine 29, it was later argued that the primary need is for the patient to understand enough to be able to weigh the decision in the light of his/her life plans and values – see eg Strong 1979 “Informed consent: Theory and policy” Journal of Medical Ethics 196 197–198.

Faden & Beauchamp 1986: 135; President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1982 Making health care decisions vol 1 44–45. Faden & Beauchamp 1986: 148 draw attention to the fact that the divergence of interests underlies the controversies over the therapeutic privilege.
Because of the extremely low level of transparency at which the decision to withhold information is made, the patient does not even know (or is very unlikely ever to find out) that such a decision was made.\textsuperscript{23} Meisel explains that, for this reason, the manner in which exceptions to the requirements of informed consent such as the therapeutic privilege are defined may have only a limited effect on the actual balance of values that prevails.\textsuperscript{24} Doctors have authority and control over relevant information and patients traditionally have a deferential attitude towards doctors. Meisel argues that the balance between individualism and health is determined not by the formal legal rules, but by the doctor's power in the first instance to determine whether the conditions are such that an exception to the requirements of informed consent, such as the therapeutic privilege, should be invoked.\textsuperscript{25} Patients who make a decision believing it to be based on all material facts, where in fact it is not, are left in a weaker position to assert their own values than those whose values are openly disregarded by the doctor.

In the light of what has been said in the previous paragraph, it is not at all surprising that so few cases in which the therapeutic privilege is raised are ever judicially considered. That the withholding of information for fear of harming a patient could be not as uncommon as is reflected by the small number of cases in which it comes to light, is borne out by research on whether or not psychiatrists inform patients of their diagnosis. Green and Gantt surveyed 246 psychiatrists across the United States in order to establish how often they informed patients and their families of a diagnosis of one of the major psychoses.\textsuperscript{26} Almost 90 percent of the psychiatrists reported that they always or usually told both the family and the patient of diagnoses of manic depressive illness and unipolar depression. Only 76 percent of the psychiatrists always or usually informed the family of a schizophrenic patient's diagnosis, and only 58 percent always or usually told the patient of a diagnosis of schizophrenia. The authors interviewed respondents on the reasons for withholding diagnoses of schizophrenia. One of the reasons was the psychiatrists' fear that

\textsuperscript{23} Patterson 1985 "The therapeutic justification for withholding medical information: What you don’t know can’t hurt you, or can it?" \textit{Nebraska Law Review} 721–723.

\textsuperscript{24} Meisel 1979: 471.

\textsuperscript{25} Meisel 1979: 471.

\textsuperscript{26} Green & Gantt 1987 "Telling patients and families the psychiatric diagnosis: A survey of psychiatrists" \textit{Hospital and Community Psychiatry} 666.
"divulging the diagnosis would demoralize the patient". Unfortunately, no statistics are available on the frequency with which this reason for withholding information is invoked. Machizawa et al.\textsuperscript{28} researched Japanese psychiatrists' attitudes towards informing patients of the exact nature of their disease. Percentages of psychiatrists who responded not to inform the patients were as follows: 70 percent with regard to disintegrative schizophrenia, 54 percent for schizophreniform disorder, and 61 percent for borderline personality disorder. Although it may be argued that Japanese doctors are less likely to inform patients than for instance American doctors, it is nevertheless interesting to note the finding that, where they do decide not to inform, the major reason given for withholding information was that the information is harmful to the patient and interferes with the therapeutic process.\textsuperscript{29}

It is also interesting to note that, despite the low incidence of case law relating to the therapeutic privilege, of all the exceptions to informed consent, the therapeutic privilege has received most attention.\textsuperscript{30} Giesen remarks that in Germany, like in other jurisdictions, a definite imbalance exists between the extent of the discussions on therapeutic privilege by certain legal commentators and its practical significance in case law.\textsuperscript{31} He insists that in Germany, no principle laid down by the courts is as well-known to the medical profession as the therapeutic privilege. Bearing in mind Meisel's argument, one can only speculate as to the extent to which the attention given in medico-legal literature to the therapeutic privilege has influenced doctors' practices of divulging information to (or rather, withholding it from) patients.

\textsuperscript{27} Green & Gantt 1987: 667.

\textsuperscript{28} Machizawa, McDonald-Scott, Sawamura & Sato 1989 "A questionnaire survey of diagnostic communication" Journal of Mental Health 89.

\textsuperscript{29} Cf Kristof 1995: 4 who reports that Japanese doctors do not disclose bad news (regarding cancer) to patients primarily because of fear that it would upset the patient and worsen the prognosis.

\textsuperscript{30} Sprung & Winick 1989 "Informed consent" in Vevaina, Bone & Kassoff (eds) Legal aspects of medicine: Including cardiology, pulmonary medicine, and critical care medicine 65.

\textsuperscript{31} Giesen 1990: 163–164.
It is sometimes argued, although not entirely convincingly, that by declining patients the opportunity to decide whether or not they would like to receive the information the doctor fears will cause them harm, the doctor disregards even that aspect of patient autonomy.\textsuperscript{32}

Where the information withheld pertains to the risks attached to a proposed intervention, the patient is left with an unrealistically rosy picture and a decision to undergo such intervention taken upon such unbalanced information cannot be said to be an informed consent.\textsuperscript{33} Where no further intervention is advised but an unfavourable diagnosis or prognosis is withheld,\textsuperscript{34} the patient is denied the opportunity to come to terms with inescapable reality\textsuperscript{35} and to arrange his or her affairs accordingly. Sometimes disclosure of a diagnosis or of the suspicion of a certain diagnosis is necessary to convince the patient of the need to undergo treatment or further diagnostic interventions, or to have his or her health monitored. This is amply demonstrated by the cases discussed below.

3.2.2 \textit{Makino v The Red Cross Hospital}\textsuperscript{36}

Leaving the patient with an unrealistic picture could of course have very serious repercussions on the health of the individual, and the health standards of society. A poignant example can be found in Japanese case law\textsuperscript{37} in \textit{Makino v The Red Cross Hospital}.\textsuperscript{38}

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\textsuperscript{33} For examples of cases where the patient was not informed of a particular risk which later eventuated, see Nishi v Hartwell 473 P 2d 116, Battersby v Tottman (1985) 37 SASR 524 and Meyer Estate v Rogers (1991) 78 DLR (4th) 307, discussed in chapter 2 supra.

\textsuperscript{34} Which, according to Katz & Capron 1975 \textit{Catastrophic diseases: Who decides what}? 99, doctors are particularly likely to do.

\textsuperscript{35} Meyer 1978: 158–159.

\textsuperscript{36} 1325 HANJI 103, 1373 HANJI 68, 1530 HANJI 53.


\textsuperscript{38} Nagoya District Court Judgment, 29 May 1989, 1325 HANJI 103.
\end{flushleft}
Mrs Makino went to the defendant-hospital for consultation, complaining about a pain in the stomach. The doctor suspected a gall-bladder condition after listening to her complaint and conducting a clinical examination. X-rays and blood samples were taken. Makino was told to return to the hospital on a later date for an echogram to be conducted of the liver, gall-bladder and pancreas. One of the doctors at the hospital made a preliminary diagnosis of cholecystic cancer. Makino was not informed of this preliminary diagnosis.

She skipped her next appointment and returned to the hospital four days later when she met with another doctor who looked at her examination report which pointed out the suspicion of cholecystic cancer, and told her that she needed to undergo a computed tomography or CT-scan. Makino returned for the CT-scan and the doctor who took charge of the CT-scan found a strong possibility of cancer.

Four days later, Makino was examined by yet another doctor who also suspected cancer. Since there was still a possibility of acute cholecystis or a benign tumour, the doctor tried to persuade Makino to be hospitalised for further tests that would lead to a final diagnosis. He told Makino that her “cholecystis is swollen by a rather bad gall-bladder”.\(^{39}\) (The plaintiffs later claimed that this misinformation had led Makino to an incorrect assessment of her condition.)

Makino was hesitant and explained that she had planned to go on an overseas trip. The doctor emphasised the importance of being hospitalised as early as possible and Makino agreed to be hospitalised as soon as she returned from her trip. She made an appointment to enter the hospital but later cancelled the appointment, believing that a gallstone operation could be put off\(^{40}\) and never went back to the hospital. About three months after her last consultation, her health took a serious turn for the worse.\(^{41}\) She was hospitalised in a different hospital, where she received, in vain, an operation, chemotherapy, immunotherapy, and radiotherapy. She died six months after this breakdown.

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39 At 107, as translated by Higuchi 1992: 459.


41 The cancer had spread to her liver – Brahams 1989: 173.
Makino’s family brought an action claiming that timely disclosure of the cancer diagnosis would have impelled her to seek immediate treatment and could have saved her life.\textsuperscript{42} The district court held that the doctor had not breached his duty to inform the patient. The doctor had not yet made a final diagnosis, but had merely formed a strong suspicion. The court took into consideration the psychological blow the patient would supposedly sustain upon being told of the suspicion, together with the prevailing medical practice of not informing patients of a diagnosis of cancer, and the fact that the doctor had warned the patient twice of the necessity of hospitalisation.\textsuperscript{43} In the light of these considerations the court found that the doctor’s prevarication about gallstones and his failure to point out the likely consequences of declining to be hospitalised lacked legal significance.\textsuperscript{44} Judge Ito held that, although it is a doctor’s duty to explain to the patient his or 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.\textsuperscript{45} The court said that the patient’s decision-making was evidence of her disobedience to the doctor. Hence she was solely responsible for her decision to refuse surgery.\textsuperscript{46} The court also held that a doctor was not obliged to disclose any information to the patient’s family.\textsuperscript{47}

The court’s decision was affirmed by the Nagoya High Court\textsuperscript{48} and the Supreme Court of Japan.\textsuperscript{49} The Supreme Court took the view that the doctor – who had no knowledge of how the patient might react to news regarding the possibility of cancer, since it was the first time that he had seen her – had acted in keeping with the general practice of doctors at the time.\textsuperscript{50} Leflar comments\textsuperscript{51}

\begin{itemize}
\item \textsuperscript{42} Leflar 1996: 53; Leflar 1997: 711.
\item \textsuperscript{43} Leflar 1996: 53; Leflar 1997: 711.
\item \textsuperscript{44} Leflar 1996: 53; Leflar 1997: 711.
\item \textsuperscript{45} Brahams 1989: 173.
\item \textsuperscript{46} Tanida 1991 “Patients’ rights in Japan” \textit{The Lancet} 242 243; Brahams 1989: 173.
\item \textsuperscript{47} Tanida 1991: 243.
\item \textsuperscript{48} Nagoya High Court 1373 HANJI 68.
\item \textsuperscript{49} Supreme Court (Petty Bench) 1530 HANJI 53.
\item \textsuperscript{50} Leflar 1996: 53–54; Leflar 1997: 711.
\item \textsuperscript{51} Leflar 1996: 53–54; Leflar 1997: 711.
\end{itemize}
that in so doing, the Supreme Court took a stance that simultaneously maintained the Japanese judiciary's traditional deference to the medical profession and implicitly recognised the possibility that the courts may well be swayed in future by changes in social attitudes.  

3.2.3 A South African case

A case with similar facts arose on home turf. The plaintiff (who was herself a general practitioner) asked the defendant, an orthopaedic surgeon, for his opinion on a lump on the calf of her left leg. The defendant took a biopsy and had it sent to a pathologist for investigation. The pathologist's report returned the result of a malignant melanoma. The plaintiff alleged that the defendant had not informed her of this result, but rather had deceived her by stating in writing that the lump was benign.

The plaintiff further alleged that, had the appropriate surgical steps been taken in response to the pathologist's report, her life would have been prolonged by two to three years. Therefore, the doctor's negligent failure to inform her of the malignant nature of the lump had denied her that extra life span. She claimed substantial damages for loss of life span and loss of enjoyment and other advantages sustained as a result of the doctor's failure to apprise her of the true nature of the growth.

Because of her poor prognosis the plaintiff was granted permission to take her evidence on commission. The plaintiff died before this task could be completed and her executors withdrew the action. Margo — an advocate who later became a judge — who had been briefed to take the evidence on commission, reflects on the case as follows:

I put to her... that there were cases in which a patient's welfare would be advanced if her medical adviser deceived her on aspects of her illness and improvement. Her firm answer was that she was opposed to medical advisers playing God with their patients' lives.


53 The case is discussed by Margo 1998 Final postponement: Reminiscences of a crowded life 119–121.

54 Margo 1998: 121.
3.2.4 BGH 25.4.1989 VI ZR 175/88 BGHZ 107 222

In a case with some similarities to that of Makino’s case and the one discussed by Margo, the Bundesgerichtshof took quite a different – and, in my opinion, more acceptable – line than the one taken in Makino’s case. It is important to bear in mind that, in this case, the plaintiff alleged that the failure to inform had led to metastasis. This case involved a man in his thirties (the plaintiff) who complained of trouble with his left eye and was treated, first by first defendant (an ophthalmologist) in second defendant’s hospital, and later, on being referred by first defendant, at a university eye clinic.

After unsuccessful attempts to remedy a detachment of the retina, the plaintiff’s left eye was surgically removed in second defendant’s hospital. The eye was sent to a university eye clinic for histological examination. The director of the university eye clinic wrote to first defendant, informing him that the interim results point to a reticulum cell sarcoma, and suggesting a series of diagnostic measures. One month later, the director again wrote to the first defendant, informing him of the results of the histological examination. The diagnosis was one of a high grade non-Hodgkin lymphoma. In the letter the director expressed his as well as the pathologists’ interest in the question whether the lymphoma was the only manifestation of the tumour and asked to be informed of the results of further tests which he believed would already have been carried out. One week later, first defendant had a computer tomogram of the plaintiff’s skull and abdomen taken that did not show up any sign of a malignant tumour. No further examinations were done.

Three years later, the plaintiff again showed up at the second defendant’s hospital complaining of problems with his right eye. A computer tomogram showed a focal malignancy in the head. The plaintiff was immediately started on sitostatic treatment in the university eye clinic. As a result of the eye disease, the patient became unfit to continue his work and had to give up his job.

The plaintiff claimed material and immaterial damages. The plaintiff complained that first defendant had never informed him of the nature of the disease of the left eye and the results of the histological examination, and had not asked him to undergo further examinations and check-ups.

55 At 223. 

48
He claimed that this failure to inform had led to metastasis and to serious damage of the right eye as a result of which he became unfit for his work.

The defendants’ defence was that the first defendant had informed the plaintiff’s wife and father about the disease. They alleged that, in view of the plaintiff’s psychological instability, first defendant had decided not to inform him personally. Moreover, they alleged, even if the plaintiff would have been asked to undergo further examinations, he would not have responded to these requests. They also alleged that it would not have made any difference to the course of the disease had it been treated earlier.

The Bundesgerichtshof held in favour of the plaintiff. The alarming results of the histological examination and the serious danger of the spreading of metastasis necessitated extensive clinical examinations and check-ups to be started immediately. The computer tomogram of the skull and lower-abdomen was insufficient. The situation would have called for, for instance, a thorough anamnesis, clinical examinations concentrating on palpation of the peripheral lymph node areas, a proper laboratory diagnosis, X-rays, and in the case of uncertainty, a computer tomogram of the thorax, a skeletal scintigram, and possibly further X-rays and a lumbar punction. Therefore, the treatment the patient received was not sufficient.

The court held that the omission to inform the patient of the urgency to obtain results of further medical examinations constituted a clear contravention of the medical standard, which contravention cannot be justified by medical considerations in any particular case.\textsuperscript{56}

The court rejected the contention that second defendant had acquitted himself of his duty to inform by disclosing the information to the plaintiff’s next of kin.\textsuperscript{57} The unfounded contention raised by first defendant that, because of his “psychological instability” the plaintiff would not be able to cope with the disclosure of a cancer diagnosis, did not entitle the first defendant to speak to the wife and father of the plaintiff but not to the plaintiff himself. There was no justification

\textsuperscript{56} At 225–226.

\textsuperscript{57} At 226–227. The Bundesgerichtshof left open the question to what extent the doctor had violated his duty to keep secret by informing the patient’s next of kin over his head.
to speak to the plaintiff’s relatives about the disease and the then still to be taken diagnostic and therapeutic measures, and to leave it up to them to apprise the plaintiff of the urgency of further tests. The doctor is not allowed to acquit himself of his duty to inform the patient therapeutically in this manner. The court added that the doctor “hatte dem Kläger den Befund und die sich daraus ergebenden Konsequenzen selbstverständlich in schonender Form eröffnen können und müssen”. 58 He then had to discuss with the plaintiff all that seemed to be necessary from a medical perspective, and if the plaintiff’s willingness to cooperate would appear doubtful, he had to emphasise the urgency of further tests and the dangers of neglecting to undergo such tests. 59 Such a duty to inform the patient therapeutically appertains to the doctor’s duty to treat (“Behandlungspflichten”). 60

Of particular interest is the court’s handling of the contention, raised by the doctor, that the plaintiff would be incapable to cope with the diagnosis of cancer owing to his “psychological instability”. The court’s finding leaves some room for interpretation. The finding can be read to mean that, because the contention was not verified, it cannot negate the doctor’s duty to inform the patient personally, but had it been verified, the doctor would have been held to have acquitted himself of his duty to inform by telling the plaintiff’s next of kin. The finding is also susceptible of the interpretation that such a contention (which happened not to have been verified in the particular instance) cannot justify the doctor’s withholding the information from the patient and instead informing the patient’s next of kin over his head – especially (or specifically) where the information would serve to convince the patient of the necessity of undergoing further interventions. 61 In my opinion, the second interpretation is the more acceptable. The headnote

58 At 226.
59 At 226–227.
61 Is this the interpretation that Giesen gives to the court’s judgment when he places the words “durch näheren Sachvortrag nicht belegt” between brackets? (See Giesen 1990: 166: “So hat der BGH auch jüngst hervorgehoben, dass die (durch näheren Sachvortrag nicht belegte) Vorstellung des Arztes, der Patient werde wegen seiner ‘psychischen Labilität’ die Eröffnung der Diagnose einer Krebskrankung nicht verkaufen, den Arzt nicht berechtige, über den Kopf des Patienten hinweg mit dessen Angehörigen ... über die Krankheit und die nunmehr vorzunehmenden diagnostischen und therapeutischen Massnahmen zu sprechen und es ihnen zu überlassen, den Patienten über die Dringlichkeit weitere Untersuchungen zu unterrichten.”) By so doing Giesen detracts from the force of these words, signalling
certainly suggests that, as a general rule, informing a patient’s next of kin cannot substitute the direct conversation between doctor and patient. Also, the court’s insistence that first defendant could have, and should have, broken the news of the diagnosis and the consequences following thereupon in a more gentle or considerate (“schonender”) form, adds some weight to the argument in favour of the second interpretation. It would not be expected of a doctor to break news in a “gentler” or “more considerate” (than normal) form unless the patient’s ability to cope with such news were affected or diminished.

Also interesting is the court’s finding that a doctor cannot, as first defendant had done, acquiesce in a patient’s apparent unwillingness to undergo a further intervention when the doctor knows that the patient’s health is under serious threat but has not informed the patient accordingly.

The court pointed out that although the plaintiff allowed the computer tomogram of the scull and lower-abdomen to be performed, he did not comply with the further requests to be examined that the defendants claim to have made. When first defendant telephoned the plaintiff’s father to plead his son’s compliance in further tests, the father replied that his son should be left in peace. The court did not accept the defendants’s contention that the father’s reaction should be seen to justify the doctor’s decision not to inform the plaintiff. In fact, the court viewed the father’s negative attitude as a further warning-signal. At the latest, the time to inform the patient of the

that they are, to some extent, dispensable.

62 "Die therapeutische Aufklärung naher Angehöriger, soweit sie überhaupt ohne Einwilligung des Patienten zulässig ist, kann in aller Regel nicht das direkte Gespräch zwischen Arzt und Patienten ersetzen." (At 222.)

63 At first glance it strikes me as peculiar that the court dismissed the contention for not being verified, and yet would have required first defendant to bring the news in a gentler form. It is submitted that the only logical interpretation would be one that would make the specified requirement dependent on the condition that the contention be verified: if the patient is indeed psychologically frail, the doctor would not be allowed to inform the patient’s next of kin over his/her head, but would rather be expected to break the news in a gentler or more considerate form. The use of the subjunctive “hätte ... eröffnen können und müssen” supports this interpretation.

64 At 228.

65 At 227.

66 At 227.
The court recognised the vital role of timing: at the latest, the time had come when attempts to obtain the patient’s cooperation without informing him of the nature and seriousness of his condition had proved unsuccessful. This is a sober approach that allows the doctor much needed leeway in minimising the negative impact of unfavourable information without foredating the patient’s right to know.

The court came to the conclusion that, under these circumstances, the defendant is to be blamed for not giving the plaintiff in this stage of his disease the medical advice and treatment he so urgently needed.

3.3 THE PRIVILEGE UNDERMINES THE TRUST PLACED IN DOCTORS

Withholding information from patients (or lying to them) has the potential to undermine the trust placed in doctors. Already early in the previous century, Cabot had his concerns that practices

67 At 227.

68 At 228. Note, again, the reference to the time-element, when the court speaks of the “phase of the disease” and the “urgent” necessity of the medical advice and treatment. See the earlier expressed opinion of Wawersik 1981 “Die Auswirkungen juristischer Aufklärungserfordernisse auf das Arzt-Patient-Verhältnis” in Jung & Schreiber (eds) Arzt und Patient zwischen Therapie und Recht 90 92. Wawersik refers to the situation where a patient refuses consent to undergo a treatment for fear of the side-effects. He is of the opinion that the patient would be more willing to give his/her consent if one were to inform him/her of the diagnosis and were to say to him/her that his/her disease is more dangerous than the intended treatment.

of deception undermine the patient’s trust:

We think we can isolate a lie as we do a case of smallpox, and let its effect die with the occasion that brought it about. But is it not common experience that such customs are infectious and spread far beyond our intention and beyond our control? They beget, as a rule, not any acute indignation among those who get wind of them (for “how,” they say, “could the doctor do otherwise”), but rather a quiet, chronic incredulity which is stubborn ...

Patients who find out the truth after having been deceived – whether through getting a second (or further) opinion, or by discovering it through the materialisation of an undisclosed risk, the experiencing of an undisclosed discomfort, the lack of experiencing a promised benefit or (in the case of a terminal disease) the instinctive knowledge of death’s approach – are likely to lose faith in the doctor who deceived them, and perhaps even in the medical profession. This holds true only for the patient who discovers “the” truth. But patients who learn contradicting “truths”, who detect discrepancies or incongruities in the information given to them, find themselves in a very unfortunate predicament, especially if already under treatment. As a layperson the patient has to rely on the medical expert for satisfying his or her informational needs. The atmosphere is fraught with suspicion and distrust, and the perplexed patient is left to suffer anxiety. Once a patient is deceived by non-disclosure it becomes ever more difficult to break the bad news, precisely because the patient may, upon disclosure, on top of the anxiety to be expected upon a disclosure

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73 Hébert 1994: 2109. Hermann 1985 “Psychosocial support: Interventions for the physician” Seminars in Oncology 466 468 remarks that patients and families are exquisitely sensitive to discrepancies in the communication of caregivers and endure needless anxiety if they perceive incongruity.
at the outset, be caused to lose trust and to feel betrayed.\textsuperscript{74} For this reason the course of non-disclosure may, in many instances, prove to be a course from which it is very difficult to turn. Medical staff may feel the need to continue the deception despite coming to believe that the patient needs to be informed, and may feel obliged to continue devising ways and means of maintaining the deception. The potential devastating effect thus snowballs as the occasions of deception multiply.

The negative impact of practices of untruthfulness are not restricted to the individual patients, but extend to the entire community. In the words of St Augustine:\textsuperscript{75} “When regard for truth has been broken down or even slightly weakened, all things will remain doubtful.” The ramifications in the medical context are serious. Myerscough explains that unwillingness to acknowledge the truth (particularly in the case of mortal illness) is almost inevitably disastrous for the doctor-patient relationship, because it can greatly erode confidence, trust and rapport.\textsuperscript{76} The patient’s relatives are often taken aside and informed of the patient’s condition. They then assist in attempting to deceive the patient. Should they later become patients, they are familiar with how the pretence is staged. The implication is that untruthfulness weakens the doctor’s ability to reassure patients whose illness is not in fact serious.\textsuperscript{77}

Ultimately all patients, even those who have been told the truth must ask themselves whether they have been told the truth or whether the encouraging words from their doctor are meant to deceive them into a false sense of well-being; whether the doctor has informed them fully or, to “protect” them from “harmful” information, is keeping information from them.

In the case of serious illness (or the possibility of death) being undisclosed, the danger of distrust seems to be very real. Regardless of what they have been told, most seriously ill or dying patients

\textsuperscript{74} See, eg. the case discussed by Gillan 1994: 47. Cf also 3.4 infra.

\textsuperscript{75} Deferrari (ed) 1952 St Augustine: Treatises on various subjects 78.

\textsuperscript{76} Myerscough (ed) 1989 Talking with patients: A basic clinical skill 60–61.

\textsuperscript{77} See the case of Mr Jaspers, discussed in Higgs 1982a “Truth at the last – a case of obstructed death?” Journal of Medical Ethics 48 ff.
appear to know how sick they really are, as is documented in several studies. Thus, attempts to
shield the patient from the truth are quite likely to be futile. Seriously ill or dying children are
particularly vulnerable to the practice of deception and the distrust that it creates. Like adults,
they are usually aware of how sick they really are, yet the practice of deception is encouraged by
adults’ frequent underestimation of their perceptiveness.

Finally it needs to be mentioned that the fostering of trust is thought to be very important in
promoting good results from treatment.

3.4 EXERCISING THE PRIVILEGE ENTAILS THE POSSIBILITY OF SIGNIFICANT HARM ENSUING, SHOULD THE PATIENT LEARN THE TRUTH DESPITE EFFORTS TO SHIELD THE PATIENT FROM IT

3.4.1 General

Therapeutic privilege rests on the assumption that the patient can in fact be protected from the
truth. This is of course not always possible and patients often either discover the truth or sense
that information is being withheld. The person sensing that he or she is being “protected” from
knowing some ostensibly unbearable secret, is deprived of the opportunity to react to the
knowledge in an appropriate way and may even conjure up a state of affairs in his or her

78 See 5.4.7 and 5.4.8 infra.

79 Partilo & Haddad 1996 Health professional and patient interaction (5th ed) 363; Doyle 1989 “Talking

Spinetta 1980 “Disease-related communication: How to tell” in Kellerman (ed) Psychological aspects of
childhood cancer 257 258; Sanger 1979 “Honesty and sensitivity in managing emotional problems of
the child with cancer” in Pochely (ed) Pediatric cancer therapy 275 278.

81 For objections to disclosure to children, see Foley 1989 “Children with cancer: Ethical dilemmas”
Seminars in Oncology Nursing 109 110; Leiken 1981 “An ethical issue in pediatric cancer care:
Nondisclosure of a fatal prognosis” Pediatric Annuals 37.

82 See fns 253–254 infra, chapter 5.

83 Patterson 1985: 751; Appleton 1983 “The importance of psychiatrists’ telling patients the truth” in
gorovitz, Macklin, Jameton, O’Connor & Sherwin (eds) Moral problems in medicine (2nd ed) 214
passim; Simon 1992 Clinical psychiatry and the law (2nd ed) 148.
imagination that is much worse than the undisclosed reality.\textsuperscript{84} The Supreme Court of Canada (per La Forest J) in \textit{McInerney v MacDonald}\textsuperscript{85} acknowledged that, for this reason, non-disclosure can itself affect the patient’s well-being.\textsuperscript{86}

Discovering the truth may cause the patient to suffer emotional and psychological distress from learning about the deception on top of the anxiety which comes with the knowledge of the risks or diagnosis.\textsuperscript{87} The American Academy of Pediatrics warns that should a child not be informed of his or her HIV/AIDS status, the child may nevertheless inadvertently learn of the nature of his or her illness in a manner which is not supportive.\textsuperscript{88} By informing the patient in a sensitive and appropriate manner, the doctor in fact pre-empts the patient’s discovering the truth in a less than optimally benign way.

The following examples illustrate how the withholding of information could lead to the patient’s suffering harm upon discovering the truth.


\textsuperscript{85} This was said in the context of refusing access to medical records “in the patient’s best interests”. McQuoid-Mason 1996 “Medical records and access thereto” Medicine and Law 499 512 alludes to the opinion held by some that “an ignorant patient is a happy patient”. He then points out, however, that evidence suggests that patients who ask to see their medical records are no less anxious when their request is refused than they would have been if access were provided, and adds that studies indicate that patient access to medical records is a positive step and poses no threats to patients’ health-care. It must be stressed, however, that certain considerations come into play in the typical case concerning access to medical records that are absent in the typical case of therapeutic privilege. Of significance, in the case of access to medical records, is the patient’s request to be informed. It is generally (more readily) accepted that a patient should be given information, truthful information, if he/she so requests.


\textsuperscript{88} American Academy of Pediatrics: Committee on Pediatric AIDS 1999: 165.
3.4.2 The case of the defective artificial heart valves

In 1978 a well-known manufacturer of artificial heart valves discovered a design or manufacturing problem which could lead to the fracture of the outlet strut of their valves. The fracture of the outlet strut results in unrestricted blood flow through the heart, causing heart failure which requires immediate open heart surgery. The manufacturer decided that informing the patients directly would be tantamount to an infringement of the doctor-patient relationship. Rather they decided to send out letters to surgeons who had implanted the valve to inform them of the possibility of strut fracture, and to leave the decision whether or not to inform the patients to the doctor. The manufacturer consulted a panel of medical experts on the question whether or not to inform the patient or the doctor.

The panel suggested that doctors who were caring for patients who had had this prosthesis implanted should individualise the decision as to which patients should receive information regarding outlet strut fracture. The panel expressed its concern that “there may be substantial negative psychological effect on a patient who receives information about a potential problem of outlet strut fracture, particularly when the risk of failure is low and explantation may not be warranted”. The Food and Drug Administration’s general policy for dealing with warnings about any prescription device was to notify the doctor, who may then decide whether it is appropriate to warn each individual patient. The doctor should take into account that patient’s specific situation and characteristics and the potential risk presented by the device. In the case of the defective heart valves, the process of weighing up the pros and cons of warning the patient about a fracture would typically involve balancing the extent to which a warning might enable the patient to get medical attention more quickly against the potential anxiety which the warning might induce and its negative effect on the patient’s quality of life.

89 See Fielder 1993 “Getting the bad news about your artificial heart valve” Hastings Center Report no 2 22 22–28.

90 Fielder 1993: 23.

91 Fielder 1993: 23.

92 Fielder 1993: 23, quoting the acting commissioner of the Food and Drug Administration.
The panel of experts were of the (probably incorrect)\textsuperscript{93} opinion that explantation of the valve was more dangerous than the risk of valve failure. They felt that informing the patients of the risk of valve fracture would only create anxiety about a condition for which no treatment existed.\textsuperscript{94}

Ironically, while the reason for letting doctors decide about informing individual patients was to allow them best to attend to the patients’ needs and anxieties, a very large number of patients learned about the valve’s potential for fracture from television shows or newspaper articles discussing allegations of sloppy manufacturing lodged by former employees of the manufacturer. Very few patients were informed by their doctors. Of course this proved to be a recipe for creating serious anxiety.\textsuperscript{95}

\subsection*{3.4.3 The case of undisclosed schizophrenia}

Another example of the harm to which the unsuccessful repression of the truth can lead, is provided by the case history\textsuperscript{96} of a patient in his early twenties who had not been told of his diagnosis of schizophrenia.\textsuperscript{97} The patient, who had to give up his studies, had been unable to hold down a job and lived with his parents, was of above average intelligence and read a great deal, particularly on psychiatry and mental illness. His parents believed he was trying to tell them that he knew he had schizophrenia, or was seeking confirmation from them that this was, or was not, his problem. They discussed the possibility of informing the patient with the psychiatrist who told them that he believed the patient should not be told, since, in his opinion, the patient would not be able to handle the news. The patient’s parents, confronted with a lot of questions from the patient about his condition, his future, and the reason for having to stay on medication, felt unable on the one hand to respond honestly and on the other to lie deliberately. This led to an increase

\textsuperscript{93} See Fielder 1993: 23 and the sources he cites. Fielder further argues that, even if explantation poses greater risk than valve failure, the patient still has the right to decide whether or not to opt for explantation.

\textsuperscript{94} Fielder 1993: 23.

\textsuperscript{95} Fielder 1993: 24.

\textsuperscript{96} Atkinson 1989: 23–24.

\textsuperscript{97} See Green & Gantt 1987: 667 who found that about 10–15\% of psychiatrists in the United States rarely or never inform either the patient or the patient’s family of a diagnosis of schizophrenia.
in tension in the family and the patient was left with no frame of reference, no information, no support and no way of being able to make rational decisions for himself. When the patient applied for a job, he was turned down and upon inquiring about the reason for being unsuccessful, was told by an employee at the job centre that he was not suitable for the job “because of his schizophrenia”. The patient and his parents felt considerable resentment against the psychiatrist.

3.4.4 Goorkani v Tayside Health Board

In the interesting Scots case of Goorkani v Tayside Health Board the patient was awarded compensation for having been deprived of the opportunity to adjust, gradually and rationally, to the possibility that a serious risk associated with treatment might materialise. The patient suffered from an eye disease called “Behcet’s disease”. Despite treatment, the patient lost the sight in his right eye.

He then experienced inflammation in his left eye. The doctor decided to treat the serious condition by way of immuno-suppressive treatment in the form of a drug called “Chlorambucil”. This drug was administered over a period of some nineteen months. It proved effectual and saved the sight of his left eye, but left him irreversibly infertile. Despite being aware that treatment with Chlorambucil over a long course of time was likely to bring with it the risk of infertility, the doctor never informed the patient accordingly. Lord Cameron held that the doctor had been negligent in failing to inform the patient of the risk of infertility.

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98 Gerlè, Lunden & Sandblom 1960 “The patient with inoperable cancer from the psychiatric and social standpoints” Cancer 1206 studied 101 patients, of whom in one group an effort was made to maintain a conspiracy of silence with family and doctor alone knowing the diagnosis, while the other group were told, along with their families, the truth of their diagnosis. The patients were followed through until death. The authors found that there was initially greater expression of emotional upset in the families who were told the truth together with the patient, but that the emotional difficulties in the families of those patients “shielded” from the truth far outweighed those where patient and family were told the truth simultaneously.


101 At 95L.
However, the court accepted that it was reasonably certain that, if it had not been for the treatment with Chlorambucil, the patient would have lost the sight of his left eye and would have been rendered blind. Lord Cameron had to determine what the patient would have done had he been offered the choice of taking Chlorambucil and becoming infertile, or not taking it and going blind. He was not satisfied that the patient had proved that he would not have taken the Chlorambucil if he had been informed.¹⁰²

Nevertheless, Lord Cameron continued that, in these circumstances, the loss, injury and damage sustained as a consequence of the failure to warn the patient of the risk of infertility is restricted to the degree of distress and anxiety which arose from the discovery of the risk and the fact that he was almost certainly infertile.¹⁰³ The court thought it reasonable to assume that if the patient had discussed the risk of infertility with his wife and had given an informed consent, there would have been less tension in the marital relationship.¹⁰⁴ The court assessed the amount to be compensated by having regard to “the loss of self esteem, the shock and anger at the discovery of his infertility, together with the frustration and disruption which ignorance and the sudden shock of discovery brought to the marital relationship”.¹⁰⁵

3.5 THE PRIVILEGE IS OPEN TO ABUSE

The therapeutic privilege is open to abuse.¹⁰⁶ According to the United States President’s Commission on Ethical and Legal Implications of Informed Consent, despite all the anecdotes about patients who committed suicide, suffered heart attacks, or plunged into prolonged depression upon receiving bad news, there is little documentation to support claims that informing patients is more dangerous to their health than not informing them.¹⁰⁷ The Commission is of the

¹⁰² At 95L.
¹⁰³ At 95L–96A.
¹⁰⁴ At 96E.
¹⁰⁵ At 96F.
¹⁰⁶ For examples of self-serving reservation of information, see Dekkers 1981b Patiëntenvoorzichtig: De onmacht en de pijn 141–142.
¹⁰⁷ President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1982: vol 1 96. See also Teff 1985 “Consent to medical procedures: Paternalism, self-
opinion that there is much to suggest that therapeutic privilege has been vastly overused as an excuse for not giving patients information to which they are entitled.

The potential for abuse of the privilege sprouts from its inherent inconsistency with the patient’s right to know and to decline treatment. The privilege allows doctors to manipulate patients into consent. Those most at risk to be the victims of manipulation are patients who are mentally competent but who may, upon being properly informed, refuse a medically indicated intervention for what the doctor or the medical community regards as incorrect or inappropriate reasons. Some even see this as the purpose of the therapeutic privilege. Molnar, for instance, refers to the argument that if medical practitioners were to advise patients of all complications and risks attached to an operation, no patient would ever have any operation. If the patient obviously needs surgery, the author continues, a medical practitioner may deliberately withhold information from the patient to avoid anxiety and distress and to ensure that they undertake the procedure. The privilege can also be used to manipulate patients into consent for the doctor’s financial gain or in the interest of experimentation.


110 Those who are not mentally competent are, at least to some extent, protected by the rules providing for others to consent on their behalf. See Ex parte Dixie 1950 (4) SA 748 (W); Strauss 1991 Doctor, patient and the law: A selection of practical issues (3rd ed) 37–39, 4–8.

111 See eg Manderson 1988: 430.


113 It is wrong to suggest, as Molnar does, that the majority of the High Court of Australia in Rogers v Whitaker (1992) 109 ALR 625 accepted this notion of the therapeutic privilege. In her separate judgment (at 637 of the report) Justice Gaudron said that she saw no basis for any exception or therapeutic privilege which is not based in medical emergency.
Wyden\textsuperscript{114} documents an instance where the doctor(s)'s decision to withhold information is ostensibly justified by the therapeutic privilege, but, in my opinion, illustrates the glaring abuse – in the interest of experimentation – of what has become known as the therapeutic privilege. This case involves a study of induced relapse in schizophrenia.\textsuperscript{115} The 28 schizophrenic patients involved in the study were withdrawn from neuroleptics and challenged with L-Dopa (in the form of the medication Sinemet) for seven days. The aim of the study was to determine how long it will take before the patients relapsed into schizophrenia. At the commencement of the research seven of the research subjects were not psychotic and another seven were assessed to be in remission. All of the research subjects relapsed into schizophrenia. The consent forms they signed disclosed neither the likelihood of relapse, nor that the side-effects of Sinemet were severe. When complaints were made about the failure to disclose these risks, the director of the project defended their decision to withhold information, reasoning that talking to patients about psychosis or schizophrenia “might cause unnecessary anxiety”.

Even if a court were to pronounce the invocation of the therapeutic privilege to be unwarranted in a case such as the one documented by Wyden, the case nevertheless illustrates the ease with which doctors could extend the scope of its application in practice, thereby eroding the principle of patient self-determination. This case was discovered only after severe damage had already been done. The majority of instances will remain undetected. The therapeutic privilege provides the less than respectably honest doctor with a concept that would allow him or her to defend – or even rationalise! – their attempts to conceal the truth under circumstances where non-disclosure amounts to abuse.

\textsuperscript{114} Wyden 1998 \textit{Conquering schizophrenia} 181–187, and in particular 184–185.

\textsuperscript{115} Davidson, Keefe, Mohs, Siever, Lesonczy, Horvath & Davis 1987 “L-Dopa challenge and relapse in schizophrenia” \textit{American Journal of Psychiatry} 934.
3.6 THE PRIVILEGE MAY AFFORD AN EASY DEFENCE TO MANUFACTURE AFTER THE FACT, AND THUS MAY SHIELD NEGLIGENCE

The therapeutic privilege could provide the doctor with an easy defence to manufacture after the fact when faced with a suit alleging lack of informed consent. Apart from its usefulness to the doctor who deliberately decides not to inform a patient for fear that the latter may refuse consent, the therapeutic privilege could provide a shield to cover the negligence of doctors who were unable to reach a timely or accurate diagnosis of the true illness.

3.7 THE PRIVILEGE MAY BE USED TO LEGITIMISE DOCTORS' NATURAL AVERSION TO DISCLOSING UNPLEASANT INFORMATION

It would indeed take a person with a morbid appetite for the dismal and a taste for the sadistic to be an eager bearer of bad news. The doctor, who is trained to heal, should certainly not be thus inclined.

Buckman identifies and discusses a number of factors, either peculiar to the doctor as a human being or stemming from medical professional training, which make the task of breaking bad news difficult for the doctor. These include: (i) fear of causing pain (doctors are taught to relieve pain, and if it is necessary to inflict pain, they are accustomed to giving an anaesthetic or analgesic to minimise or remove it); (ii) sympathetic pain (doctors are quite likely to experience considerable discomfort simply by being in the same room as someone who is going through the distress caused by bad news), (iii) fear of being blamed (there are two elements to doctors' fear of being blamed: first, people have a great propensity to blame the messenger for the bad news and to direct their sense of anger or outrage at the messenger, and secondly, during their training, doctors are

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117 As to liability surrounding a negligent diagnosis, see Strauss 1991: 21.


imbued with a feeling that when a person's health deteriorates there must be somebody at fault); (iv) fear of the untaught (doctors feel uneasy to break bad news if they are not taught how to do it properly); (v) fear of eliciting a reaction (doctors are taught not to do anything unless they know what to do if it goes wrong, and unless they are taught how to cope with patients' emotional reactions, they will be tempted to avoid any interview that might produce this "side-effect"); (vi) fear of saying "I don't know" (in their professional training, medical students are never rewarded for saying "I don't know", and they expect their standing to be diminished if they confess that they do not know all the answers); (vii) fear of expressing their emotions (doctors are taught, with good reason, not to display emotions such as rage or panic, in the interest of calm and logical decision-making and in the interest of maintaining the trust of patients. However, inadvertently they are also encouraged to view the ideal professional as one who never shows any emotions at all and is consistently unflappable and brave); (viii) fear of one's own illness/death; and (ix) fear of the medical hierarchy (doctors, especially younger doctors, may find it very difficult to respond to the patient's desire for information and support if it seems that they have to contravene somebody else's rulings to do so).

In the light of the foregoing it is not surprising to learn that, according to some studies, the doctor's own emotional reluctance, embarrassment, fears, dis-ease and anxieties to confront the patient with stark diagnoses and risks often provide the motive for non-disclosure. The

121 See fns 234–237 and the accompanying text infra, chapter 5.
results of the study done by Mosconi et al.,\textsuperscript{124} for instance, confirm those of earlier research which found that doctor and patient demographic characteristics were significant predictors of the amount of information that was conveyed to cancer patients. These results suggest that decisions about what to tell the patient were not based solely on the doctors’ judgments about the patient’s psychological needs. The researchers conclude\textsuperscript{125} that the information that doctors give patients may be related to their own level of comfort in disclosing the diagnosis of cancer and in the subsequent communication that such disclosure would necessitate, rather than to patients’ abilities to accept such information.

Relatives are prone to the same tendency. Where families claim that the patient should be protected from the truth because he or she “will not be able to handle it”, it is usually the family members who cannot deal with the facts.\textsuperscript{126}

Meyer is of the opinion that the natural disinclination to be a bearer of bad news tempts many a doctor to abandon personal judgment and authorship in his or her discourse with patients.\textsuperscript{127} Instead, the doctor relies upon a set formula, either always to tell or never to tell, which he or she employs with dogged and indiscriminate consistency. He maintains that reliance on such a standard policy disregards the overall clinical picture and the personality or psychological make-up of the patient.\textsuperscript{128} These comments should not be taken up lightly, for they bring to the fore a very important point. If they hold true, it would mean that the rules of informed consent are under serious threat of being undermined by the therapeutic privilege which acts as a smoke-screen behind which doctors can safely take retreat for imposing their perceptions and believes on patients’ lives.


\textsuperscript{125} Mosconi, Meyrowicz, Liberati & Liberati 1991: 278–279.

\textsuperscript{126} Javaheri, Javaheri & Kazemi 1999: 670.

\textsuperscript{127} Meyer 1978: 156–157.

\textsuperscript{128} Cf Purtilo & Haddad 1996: 44.
Where the motivation to withhold the truth from patients originates from the doctor’s unwillingness to be the bearer of bad news, one would expect the temptation to withhold the truth to increase with the grimness of the information. It stands to reason that this poses a serious threat to the self-determination of the patient.

3.8 THE COST-IMPLICATIONS OF NON-DISCLOSURE

There are two apparently contradictory arguments with regard to the cost-implications of non-disclosure. On the one hand it is argued that withholding the truth may lead to unneeded or experimental treatment being administered. This line of reasoning was taken in *Arato v Avedon*. In this case, a surgeon withheld statistical life expectancy data from a patient because the patient “had exhibited great anxiety over his condition, so much so that his surgeon determined that it would have been medically inappropriate to disclose specific morbidity rates”. The patient’s oncologists’ motivation for withholding the information was their belief that cancer patients “wanted to be told the truth, but did not want a cold shower” and that “the direct and specific disclosure of extremely high mortality rates for malignancies such as pancreatic cancer might effectively deprive a patient of any hope of cure, a medically inadvisable state”. The plaintiffs argued that the doctors failed adequately to disclose the “shortcomings” of chemotherapy and radiation therapy in treating the patient’s cancer and thus failed to obtain an informed consent. They argued that the mortality information, especially the statistical morbidity rate of pancreatic cancer, was material to the patient’s decision whether or not to undergo postoperative treatment; had he known the bleak truth concerning his life expectancy, he would not have undergone the rigours of an unproven therapy, but would have chosen to live out his last days at peace with his wife and children, and arranging his business affairs. Instead,

129 Probably the hardest news to break to a patient is that he/she is dying. See 5.4 infra.
131 858 P 2d 598 (Cal 1993) 602.
132 At 600–601.
133 At 601.
134 At 602.
135 At 602.
the plaintiffs asserted, in the false hope that radiation and chemotherapy could effect a cure, the patient failed to order his affairs in contemplation of his death, an omission that led to the failure of his contracting business and to substantial real estate and tax losses following his death.\textsuperscript{136}

On the other hand it is argued that if the truth is withheld from patients, they will often object to decisive and costly forms of treatment since the urgency of undergoing the treatment will not be apparent while the cost will be.\textsuperscript{137} These two arguments are not truly contradictory for both would seem to convey the idea that by withholding information from the patient, the latter is precluded from doing a realistic cost-benefit analysis.

The law of delict \textit{inter alia} aspires to achieve an efficient allocation of resources.\textsuperscript{138} Implied in this aspiration is an endeavour to minimise costs, which includes efforts to minimise the frequency and severity of incorrect decisions, and efforts to minimise the costs of gathering and considering information. In its endeavour to minimise costs, the law places the responsibility for particular decisions on the persons who are in the best position to avoid costs which might arise from that decision-making. In the making of health-care decisions, doctors are best equipped to make diagnoses and prognoses and to suggest suitable treatment or treatment alternatives. However, patients know their own values and religious concerns, capacity for pain and suffering, and future business and social plans best. In a system endorsing self-determination, these values must be taken into consideration in making health-care decisions.\textsuperscript{139} For doctors to acquaint themselves with patients' non-medical needs would be very expensive. To be as cost-efficient as possible, doctors must make expert decisions, and patients must make evaluative decisions concerning their health.

\textsuperscript{136} At 602.


\textsuperscript{138} Montange 1974 "Informed consent and the dying patient" \textit{The Yale Law Journal} 1632 1645–1646. See also Patterson 1985: 737.

\textsuperscript{139} In the interest of what Eberbach 1986 "Die ärztliche Aufklärung unheilbar Kranker" \textit{Medizinrecht} 180 181 calls "eine autonome, eigene Wertvorstellungen umsetzende Entscheidung".
But is it important, purely in the interest of keeping down costs, that the non-medical needs of patients should be taken into account? It would seem so, for otherwise patients might avoid or delay consulting doctors for fear that their non-medical needs would be disregarded. This may result in the deterioration of health standards and concomitant costs for society.

3.9 THE LACK OF PROFESSIONAL EXPERTISE IN PREDICTING THE EFFECT OF DISCLOSURE OF INFORMATION ON PATIENTS

The therapeutic privilege has been criticised on the basis that the medical profession lacks the expertise to predict (or at least is susceptible to a high error rate in assessing) whether disclosure of certain information to a particular patient will have a positive or negative therapeutic effect, or no therapeutic effect at all. The argument goes that in the absence of professional expertise, there is no justification for shifting decision-making authority to the doctor.

To the question whether stress is related to illness, Bieliuskas responds in summary that the answer appears to be in the affirmative, but the strength of the relationship has not been clearly demonstrated. The many variables of stressors, mediating factors, stress, and coping have made the task of establishing a strong relationship extremely difficult. What is clear is that each of the components of the stress-illness paradigm may have individual variations and may depend on past experience with stressors, the social and psychological context of a stressor and the individual at a given time, the individual variability of hormonal patterns, and individual coping abilities.

140 Montange 1974: 1646.

141 Ironically this argument has been used to justify the invocation of the therapeutic privilege – Reitelmann 1965: 77 refers to Roemer who points out that the doctor is sometimes unable to foresee how the patient will react to the diagnosis of a life-threatening illness because it is impossible for the doctor to recognise beforehand all the external circumstances which determine the patient’s behaviour. Roemer diagnosed cancer in a patient of his, but refrained from telling her anything about it. However, he informed the patient’s husband, who before long shared this information with his wife. Apparently the patient thereupon suffered a breakdown and it took an effort on the part of the doctor to wake the patient’s will to recover. After some time the patient’s father died of stomach cancer. When the patient learned about this, she gave up all hope of recovery and it was no longer possible to keep alive her will to live. See, however, the commentary on this case by Reitelmann 1965: 77–78.


144 Bieliuskas 1982 Stress and its relationship to health and illness 91.
3.10 THERAPEUTIC PRIVILEGE RESTS ON A FALSE MEDICAL ASSUMPTION

3.10.1 General

Already in 1969, Waltz and Scheuneman intimated that "to some it may seem questionable whether disclosure of risks would result in psychological damage or permanent rejection of a needed therapy with significant frequency".\textsuperscript{145} However, they continued, "these possibilities are recognized assumptions in medical practice".\textsuperscript{146} Other authors followed suit, saying that medical experience by no means lends support to the idea that telling patients ominous truths will aggravate a serious condition or cause serious (psychological) harm to their health,\textsuperscript{147} or would result in the refusal of necessary treatment and in non-compliance with the therapeutic regimen prescribed.\textsuperscript{148} These assumptions at the root of the therapeutic privilege have increasingly been challenged by research findings.\textsuperscript{149}

Conversely, the evidence upon which the idea that disclosure may harm is built, appears somewhat unimpressive and rather anecdotal.\textsuperscript{150} To cite an example: Allen suggests that, because of the possibility of inducing anxiety, which he says is a relevant factor in idiosyncratic reactions, radiologists should not obtain informed consent prior to urographic examination.\textsuperscript{151} His only source of reference for the assertion that anxiety may lead to idiosyncratic reactions, is Lalli.\textsuperscript{152}

\textsuperscript{145} Waltz & Scheuneman 1969: 641.
\textsuperscript{146} Waltz & Scheuneman 1969: 642.
\textsuperscript{147} Capron 1974: 387–388; Katz & Capron 1975: 99–100; Fletcher 1978: 150–151; Green 1981: 185. For an opposite view, see Wixen 1992: 77–79. At least in one case, BGH 23.11.1982 VZ 177/81 BGHZ 85 339 344, which dealt with access to medical records, it was accepted that some schools of thought within the field of psychiatry will not agree that examination by a patient of his/her medical records may have unfavourable outcomes.
\textsuperscript{149} See 3.10.2 and 3.10.3 infra.
\textsuperscript{151} Allen 1977 “Informed consent: A medical decision” Radiology 807.
\textsuperscript{152} Lalli 1974 “Urographic contrast media reactions and anxiety” Radiology 267.
Lalli, however, goes no further than to state that anxiety appears to be the most important factor in idiosyncratic reactions to urographic contrast media and to urge radiologists to perform these examinations in such a manner as to reduce this anxiety rather than increase it. Allen simply assumes that anxiety is produced by informed consent.\textsuperscript{153}

Another example, and one which is frequently encountered in German legal literature, is that of the well-known German literary figure, Theodor Storm. Laufs\textsuperscript{154} uses Storm's case to indicate that there is no shortage of "impressive evidence" for the view that doctors must often deceive seriously ill patients. At a rather advanced age, Storm was taken ill with cancer of the stomach and demanded the truth about his illness from his doctor. Apparently, the disclosure of the incurable, terminal nature of his disease caused him to break down. The concerned family arranged for an expert opinion declaring the diagnosis to be wrong and the illness to be harmless. Storm immediately believed this, jumped up and enjoyed a great summer, in the course of which he celebrated his seventieth birthday in good spirits and victoriously completed his "Schimmelreiter".\textsuperscript{155}

What this anecdote shows is that humankind got the "Schimmelreiter" from a dying man who, despite his wish to be told the truth, was denied the opportunity to come to grips with his terrible prognosis. At best, it shows that the impact of bad news is reversible through lying.

We shall now take a closer look at some of the evidence from empirical research on the effects of divulging information to patients.

\begin{flushleft}
\textsuperscript{153} Cf also the view of Maloney J in \textit{Meyer Estate v Rogers} (1991) 78 DLR (4th) 307 312 that the position recommended by the Canadian Association of Radiologists (namely not to inform patients of the risks attached to "low risk" procedures such as IVP) directly contravenes the standard required by the Canadian law on informed consent (namely that all material risks be disclosed) – see 2.4.2 supra.

\textsuperscript{154} Laufs 1992 "Die ärztliche Aufklärungspflicht" in Laufs & Uhlenbruck (eds) \textit{Handbuch des Arztrechts} 342 344.

\textsuperscript{155} Cf Brenner 1983 \textit{Arzt und Recht: Leitfaden und Nachschlagewerk des medizinischen Rechts für die ärztliche Praxis} 37.
\end{flushleft}
3.10.2 Evidence that questions the assumption that telling patients the truth may result in the refusal of necessary treatment and in non-compliance with the therapeutic regimen prescribed

Alfidi questioned a number of doctors in the United States concerning their reactions to obtaining an informed consent from the patient who is about to undergo a diagnostic or therapeutic procedure. The most frequently encountered reaction (and one which he himself advocated for many years) was: "If I give my patients a comprehensive explanation of what is to be done and what possible complications might ensue, the result would be the wholesale refusal of patients to undergo the procedure." When the author began his statistical study of informed consent, he expected to prove that patients would indeed refuse angiography after being informed of its possible complications. However, he found that only two percent of the patients in his study refused angiography on the basis of the consent form listing and explaining the possible complications of angiography. The results of his research led him to believe that a straightforward statement of complications will result in only a small percentage of patients refusing a special procedure. Hence, already in 1971, Alfidi expressed the opinion that the concern that "informing a patient of possible complications will result in his refusal of the procedure is now outmoded". In a later study, Alfidi found that, despite being given information on relatively minor as well as serious risks (including death) associated with angiography, 98.8 percent of patients consented to the procedure. Denney et al found that none of the patients involved in their study refused to undergo the particular procedure, despite being well informed of the risks involved.

156 Cf 5.3.1infra.
158 Alfidi 1971: 1325.
159 Alfidi 1971: 1325.
160 Alfidi 1971: 1329.
161 Alfidi 1971: 1329.
Johnson and James\(^{164}\) are convinced that there is no strong basis for the fear that informing the patient will lead to the patient’s refusing treatment or developing untoward reactions. In their experience, full disclosure made in a calm, simple and direct manner does not have the aforementioned results, but, in fact, establishes a better rapport between doctor and patient.

In one of their observational studies, the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioural Research found that refusal of treatment was not triggered by too much information, but by too little.\(^{165}\) According to the Commission, patients who refused to undergo certain interventions typically did so because the nature, purpose, and attendant risks of the procedures had not been adequately explained.\(^{166}\)

### 3.10.3 Evidence that risk disclosure does not even raise patients’ level of anxiety\(^{167}\)

In a study to establish whether patients who are provided with details about the risks associated with anaesthesia on the eve of surgery are better informed, and whether the information increases their anxiety, 40 patients scheduled for surgery requiring general anaesthesia were randomly allocated to either a routine or a detailed information group.\(^{168}\) In this study Inglis and Farnill found that most patients in both groups knew the risks of common complications such as nausea and sore throat. The group who received detailed information on the risks, had gained more accurate knowledge of the likelihood of two rare complications, namely death and serious tooth damage. Notwithstanding, there was no difference between the groups in respect of their levels of anxiety.\(^{169}\) The researchers’ conclusion was that provision of detailed information about the

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165 President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1982: vol 1 102.

166 President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research 1982: vol 1 102.

167 Cf 5.2.1infra.


169 Cf the results of the study by Holliman, Soileau, Hubbard & Stevens 1986 “Consent requirements and anxiety in university undergraduate students” *Psychological Reports* 179.
risks of the complications of general anaesthesia did increase patients’ knowledge but did not increase patients’ levels of anxiety.

Kain et al conducted research to identify the perioperative anaesthetic information parents want from the anaesthesiologist, and to determine whether the provision of detailed anaesthetic risk information is associated with increased parental anxiety. The investigation consisted of a cross-sectional study followed by a randomised controlled trial. In the first phase, baseline and situational anxiety, coping strategy, and temperament were obtained from parents of children who had to undergo surgery. A questionnaire examining the desire for perioperative information was administered to all parents. In the second phase, 47 parents were randomly assigned to receive either routine anaesthetic risk information or detailed anaesthetic risk information. The effect of the intervention on parental anxiety was assessed over four time points: prior to the intervention, immediately after the intervention, on the day of surgery in the holding area, and at separation to the operating room. For the first phase, 95 percent of parents preferred to have comprehensive information concerning their child’s perioperative period, including information on all possible complications. For phase two, when the group who received detailed information were compared to the group who received routine information, there were no significant differences in parental anxiety over the four time points. The researchers’ conclusion: Parents of children undergoing surgery desire comprehensive perioperative information, and when provided with highly detailed anaesthetic risk information, the parental anxiety level did not increase.

Earlier research by Lankton et al in which 28 gynaecologic patients were studied with regard to their emotional responses to a detailed disclosure of the risks associated with anaesthesia also indicated that there was no increased apprehension and no refusal to undergo surgery in those patients who received detailed information. In fact, Denney et al, in their study of emotional responses of patients undergoing elective hysterectomy, found that knowledge of risks and possible complications of the surgery did not increase preoperative anxiety levels or deter patients


from undergoing surgery, and was possibly beneficial in that anxiety levels post-operatively were lower in experimental subjects than in control subjects.\textsuperscript{172}

In a prospectively controlled pilot study of 100 patients undergoing an invasive radiological procedure to test patients' acceptance of risk disclosure and whether this increases anxiety and rate of procedure cancellation, two sheets with differing amounts of information on adverse outcome were randomly allocated and patients provided a graded response to statements following the procedure.\textsuperscript{173} Phatouros and Blake found no significant differences between the two groups with respect to either subjective anxiety caused by the information or risk of procedure cancellation.

Kerrigan \textit{et al} found no significant increase in anxiety in men undergoing elective inguinal hernia repair who were given a very detailed account of potential complications.\textsuperscript{174}

Margalith and Shapiro\textsuperscript{175} involved 96 patients with ureteral calculi in a study whose purpose was to identify those subjects who would benefit from participation in clinical decision-making. The experimental group were given information about two alternative treatments, including information on the advantages and disadvantages of each. Their questions were also addressed by the doctor, and the patient was asked to choose the method he or she preferred. The control group were not given information, not allowed to choose, and were treated according to the doctor's decision. Subjects' level of anxiety was compared within each group on three occasions: before meeting with the doctor, immediately afterwards and upon hospitalisation for treatment of the stone. The researchers found a statistically significant decrease in anxiety after meeting with the urologist among patients who perceived that they had received information. Contrary to what they initially anticipated, no increase in anxiety was found in any group of patients. The

\textsuperscript{172} Denney, Williamson & Penn 1975: 205.

\textsuperscript{173} Phatouros & Blake 1995 "How much now to tell? Patients’ attitudes to an information sheet prior to angiography and angioplasty" \textit{Australasian Radiology} 135.

\textsuperscript{174} Kerrigan, Thevasagayam, Woods, McWelch, Thomas, Shorthouse and Dennison 1993 “Who’s afraid of informed consent” \textit{British Medical Journal} 298.

\textsuperscript{175} Margalith & Shapiro 1997 “Anxiety and patient participation in clinical decision-making: The case of patients with ureteral calculi” \textit{Social Science & Medicine} 419.
researchers suggest that emphasis should be placed on providing information and enhancing patients’ perception of receipt of information.

Centeno-Cortés and Núñez-Olarte through their study attempted to assess the degree of knowledge of the diagnosis, and the attitude towards that information, in 97 terminally-ill cancer patients. They evaluated, *inter alia*, the emotional status and fear of these patients. Whereas 32 percent of the patients were informed, 68 percent were uninformed. The researchers found no statistically significant differences in the patients’ perceived symptoms of anxiety, despair, sadness, depression, insomnia, fear, etcetera between the informed and uninformed groups. However, the study clearly demonstrated the beneficial effects of information: 75 percent of the informed patients shared their concerns about the illness and its consequences with their relatives, whereas only 25 percent of the uninformed patients were able to do the same; the informed patient identified better with the attending doctor, had a more satisfactory relationship with the doctor, and had a better understanding of what was explained. The informed patients not only did not lose hope, but they had higher confidence in the treatment they received.

Mosconi *et al* assessed the information that breast cancer patients received about their diagnosis and surgical treatment from the perspective of both the doctor and the patient. One of the aims of their study was to determine how the nature of doctor-patient communication is associated with satisfaction with communication. In the past a number of authors predicted that dissatisfaction might result from disclosure of a cancer diagnosis and suggested that many patients would be unable to understand or integrate this very threatening information. Mosconi *et al* found some support for this possibility: a sizeable minority of patients who participated in their study reported not knowing their diagnosis even though their doctors stated that they had been told. According to the authors there are two possible reasons for this phenomenon: (i) the mode of communication was ineffective or incomplete; or (ii) the patient was incapable, either


177 Cf also Pfeffer 1993: 236.


cognitively or psychologically, of grasping the information. They suggest that the problem be addressed by training doctors how to communicate more effectively with anxious or medically unsophisticated patients.¹⁸⁰ The authors find the data reassuring in that patients who knew less than they were told were no more dissatisfied than patients who had not been told that they had cancer. They explain that patients may be able to deny or forget information that they are not able to deal with.¹⁸¹ It should be noted, however, that patients’ level of satisfaction with communication is not necessarily an indication of the level of anxiety or psychological distress experienced as a result of such communication.


CHAPTER 4

THE THERAPEUTIC PRIVILEGE, A SEPARATE AND
INDEPENDENT DEFENCE EO NOMINE?

4.1 THE TERM “THERAPEUTIC PRIVILEGE”

The term “therapeutic privilege” is not a happy one. It has once been remarked:

A phrase begins life as a literary expression; its felicity leads to its lazy repetition; and repetition soon establishes it as a legal formula, undiscriminatingly used to express different and sometimes contradictory ideas.¹

This is true also of the phrase “therapeutic privilege”. The term creates the impression that the doctor may use his or her professional discretion² in deciding whether or not to disclose information that may have a detrimental effect on the patient’s physical or mental health. A professional discretion to withhold information that may have a detrimental effect on the patient’s health is inconsistent with a legal duty on the part of the doctor to disclose information. The doctor cannot be under a legal duty to disclose and at the same time have a professional discretion to disclose or forego disclosure.³ The “therapeutic privilege” constitutes an exception to the duty to disclose in terms of the doctrine of informed consent, and therefore represents a situation where no legal duty to disclose exists. In other words, the “therapeutic privilege” limits the legal duty to comply with the requirements of informed consent, and, therefore can be categorised as a legal defence. As will appear from the discussion below, the term “therapeutic necessity” cannot be

¹ Per Mr Justice Frankfurter in *Tiller v Atlantic Coastline Railway* 1943 318 US 54 68.

² Van Oosten 1995a “Castell v De Greef and the doctrine of informed consent: Medical paternalism ousted in favour of patient autonomy” *De Jure* 164 177.


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accepted. In my opinion, the term “therapeutic justification” is a more accurate description of this exception to the informed consent requisite. However, the term “therapeutic privilege” has taken root so firmly that it appears unlikely to be supplanted by any other term.

4.2 GROUNDS OF JUSTIFICATION IN THE MEDICAL SETTING

4.2.1 General

Taking into consideration the criticism levelled at the “therapeutic privilege”, and at the same time acknowledging the need for such an exception in practice, we will now attempt to establish whether therapeutic privilege can be brought under any of the recognised grounds of justification, or whether it should be regarded as a separate and independent ground of justification.

As we have already seen, the need to acknowledge therapeutic privilege has its origin in a conflict of duties, namely the legal-ethical duty to inform and the medico-ethical duty to heal or to do no harm. It is generally accepted that no right is absolute, and likewise, the law does not lay absolute duties upon legal subjects. Both the duty to disclose medical information and the duty to heal are relative duties.

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4 A term also used by Patterson 1985 “The therapeutic justification for withholding medical information: What you don’t know can’t hurt you, or can it?” Nebraska Law Review 721.

5 In its wide, abstract meaning. See chapter 3 supra.


7 1.4 supra.

8 That the duty to heal is a relative duty is evinced by the fact that the administration of medical treatment against the patient’s will is, generally speaking, regarded as unlawful, as well as by the fact that a substantial body of medico-legal commentators is in favour of the justification of euthanasia in certain circumstances – Van Oosten 1991b: 34. Cf. Strauss 1983 “Truth-telling in medicine: A legal perspective” De Rebus 66.
There are a number of grounds of justification for a medical intervention. These can be classified as consent, necessity, *negotiorum gestio* and authority. Of course, a situation that cannot be brought under any of these four grounds of justification is not necessarily unlawful. It is generally accepted in South African law that there is no *numerus clausus* of grounds of justification and that the general criterion to determine lawfulness is the legal convictions of society. The four grounds of justification mentioned above do, however, represent those already recognised and clearly defined grounds of justification that are relevant to the field of medical interventions. Two of these grounds of justification, *negotiorum gestio* and necessity, deserve closer attention.

### 4.2.2 *Negotiorum gestio*

*Negotiorum gestio* is a defence that justifies an act which, although committed in order to safeguard some interest of a person who is not capable of giving his or her consent (the *dominus negotii*), also infringes some interest(s) of the latter, provided the act is committed in a real state

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9 Cf, however, Strauss 1991 *Doctor, patient and the law* (3rd ed) 31 who states that legally there are only three possible grounds of justification for a medical intervention, viz (i) consent by the patient or, where applicable, by someone legally capable of consenting on his/her behalf; (ii) *negotiorum gestio* and (iii) necessity. Van Oosten 1999 “Some reflections on emergencies as justification for medical intervention” in Ahrens, Von Bar, Fischer, Spickhoff & Taupitz (eds) *Festschrift für Erwin Deutsch Zum 70 Geburtstag* 673-674 mentions the grounds of justification listed in the text, but adds duty as a further category. Claassen & Verschoor 1992 *Medical negligence in South Africa* 75–78 mention emergency (necessity), unauthorised agency and therapeutic privilege as grounds of justification which can justify treatment of patients in the absence of informed consent.

10 Necessity and *negotiorum gestio* are both species of the *genus* emergencies – see Van Oosten 1999: 674, 675–676.

11 Eg statutory authority or court authorisation – see Van Oosten 1999: 674. Perhaps “capacity” can also be used to denote these situations.


13 See eg *Clarke v Hurst* 1992 (4) SA 630 (D) 653B; Van Oosten 1999: 673 fn 4.

14 Authority being irrelevant in the present context. See Van Oosten 1991b: 34, in particular fn 16.


16 Van Oosten 1999: 676; Van Oosten 1991b: 35. *Negotiorum gestio* cannot be a ground of justification where the consent of the person whose interests were infringed could have been obtained, but was not
of emergency,\textsuperscript{17} is performed in the best interest of the \textit{dominus negotii},\textsuperscript{18} is not committed against the will of the \textit{dominus negotii},\textsuperscript{19} and does not cause more harm than is necessary in order to safeguard the interests protected.\textsuperscript{20}

The defence of \textit{negotiorum gestio} in its traditional common-law guise, does not specifically cater for the situation where a doctor administers treatment on a patient without the latter’s consent. \textit{Negotiorum gestio} typically protects the pecuniary interest of the \textit{dominus},\textsuperscript{21} where the latter is (physically) absent.\textsuperscript{22} However, there appears to be no reason why \textit{negotiorum gestio} cannot also include the administration of someone’s personality interests,\textsuperscript{23} or cannot be used to protect the life and health of the \textit{dominus},\textsuperscript{24} where the latter is psychologically (though not physically) absent by reason of, for instance, unconsciousness, intoxication, delirium or a coma.\textsuperscript{25} Strauss and Strydom suggest that the name “analogous unauthorised administration”\textsuperscript{26} be used in such

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obtained – De Wet & Swanepoel 1985 \textit{Strafreg} (4th ed) 97; Snyman 1999: 129; Van der Merwe & Olivier 1989 \textit{Die onregmatige daad in die Suid-Afrikaanse reg} (6th ed) 108; Burchell 1997: 152; Labuschagne 1994 “\textit{Negotiorum gestio} (saakwaarneming) as verweer in die straf-en deliktereg” \textit{Tydskrif vir die Suid-Afrikaanse Reg} 811 811, 812. According to De Wet & Swanepoel 1985: 97 this is the case even if the person whose interests were infringed would have consented if he/she had been asked.


\textsuperscript{19} Van Oosten 1995a: 177; Van der Merwe & Olivier 1989: 108; Strauss & Strydom 1967: 241–243; Strauss 1991: 94; Claassen & Verschoor 1992: 77–78; Van Oosten 1999: 676–677 (the patient must not have placed a prior prohibition on such intervention and would have consented to it had he/she been in a position to do so). Cf Snyman 1996: 110–111.

\textsuperscript{20} Van der Merwe & Olivier 1989: 108.


\textsuperscript{22} Strauss & Strydom 1967: 238; Claassen & Verschoor 1992: 76.

\textsuperscript{23} Strauss & Strydom 1967: 238.

\textsuperscript{24} Van Oosten 1999: 678–679.


\textsuperscript{26} “Analoë saakwaarneming”.
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circumstances. 27 Van Oosten, 28 on the other hand, takes the view (correctly, it is submitted) that it is not a question of changing the name of the defence, but rather of extending its ambit. 29

However, in the therapeutic non-disclosure context the problem still remains that the patient is not even psychologically absent. Van Oosten reasons that, since the defence only applies where the patient is incapable of giving consent, and, therefore, a fortiori, incapable of receiving information, negotiorum gestio does not even enter the picture. 30

Another reason Van Oosten advances for excluding the possibility of relying on negotiorum gestio in a situation of therapeutic non-disclosure, is that the said defence does not operate as a ground of justification where medical treatment is administered against the patient’s will. 31 If the patient would in any event have refused medical treatment which was intended to save his life 32 or protect his health, negotiorum gestio is out of the question. 33 However, Van Oosten’s opinion on this matter is based upon the assumption that, in line with therapeutic non-disclosure, but also in contradistinction to negotiorum gestio, necessity operates as a ground of justification irrespective of whether the medical intervention was eventually performed against the patient’s will. 34 Since the judgment in Castell v De Gref, 35 it is clear that therapeutic non-disclosure cannot be justified

29 As far as the inclusion of the administration of a person’s personality rights is concerned, at any rate. Van Oosten fails to even mention the traditional requirement of physical absence, and hence finds it unnecessary to extend the ambit of the defence to include the situation where the patient is psychologically (though not physically) absent.
31 Van Oosten 1991b: 35.
32 See, however, Snyman 1996: 111 who submits that the conduct of a doctor who performs a life-saving operation on an unconscious patient is justified (on the basis of presumed consent) even if the patient had made known prior to the operation that he does not approve of such operation.
33 Van Oosten 1991b: 35. See also Van der Westhuizen 1979 Noodtoestand as regverdigingsgrond in die strafreg (Unpublished LLD thesis, University of Pretoria) 7 fn 20.
34 Van Oosten 1991b: 35.
in South African law where the doctor knows that the patient would refuse the intended intervention if informed of the risk(s) attached to it,\textsuperscript{36} and, hence, \textit{a fortiori}, if the medical intervention was eventually performed against the patient’s will.

The defence of \textit{negotiorum gestio} is sometimes treated under the name “presumed consent”\textsuperscript{37} for it is argued that, although the conduct of the \textit{gestor} is always aimed at the protection of the other party’s interests, it is the presumed consent of the latter that constitutes the most characteristic quality of the defence.\textsuperscript{38} Weyers has even mentioned the possibility that this defence should apply in the case of therapeutic non-disclosure.\textsuperscript{39} He remarks that, in German law, it is permissible to withhold information from a patient if special circumstances which are to be found in the personality of the particular patient were to create the expectation that informing the patient may lead to serious and irremediable damage to the patient’s health. In such a case, the question arises whether the presumed will of the patient should not be determined by questioning relatives.\textsuperscript{40}

\subsection*{4.2.3 Necessity}

Necessity is a ground of justification that justifies the act committed by a person in protection of the person’s own or somebody else’s legally recognised interest that is endangered by a threat of harm (the author of which may be either a human being or a natural force) which has already commenced or is imminent and cannot be averted in another way, provided the person is not

\begin{itemize}
\item \textsuperscript{36} See 5.3.1.4 \textit{infra}. This is acknowledged by Van Oosten 1995a: 177.
\item \textsuperscript{37} “Vermoedelijke toestemming” in Afrikaans, “mutmassliche Einwilligung” in German.
\item \textsuperscript{38} Snyman 1996: 107, 113. See also Labuschagne 1994: 813, 814; Strauss & Strydom 1967: 237. Van Oosten 1999: 679–680 says that “presumed consent” is a misnomer and a ludicrous concept which ignores the fact that consent is a subjective and unilateral expression of will on the patient’s part.
\item \textsuperscript{40} Weyers 1978: A24.
\end{itemize}
legally compelled to endure the danger and the interest protected by the protective act is not out of proportion to the interest infringed by the act.\textsuperscript{41}

In contradistinction to \textit{negotiorum gestio}, necessity can successfully be relied upon even if the patient was capable of giving consent and capable of receiving information (in other words, not only in the patient’s physical or psychological absence)\textsuperscript{42} as in the case of therapeutic non-disclosure.\textsuperscript{43}

It is characteristic of the defence of necessity that the interests of an innocent third person are sacrificed to protect the interests of another (the endangered person) or that of the community.\textsuperscript{44} In the typical case of therapeutic non-disclosure, this characteristic of the defence of necessity is absent.\textsuperscript{45} By withholding the information the doctor infringes the patient’s interests (autonomy

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\textsuperscript{42} & Van Oosten 1991b: 35; Van Oosten 1999: 677. \\
\textsuperscript{43} & Van Oosten 1991b: 35. \\
\textsuperscript{44} & Strauss & Strydom 1967: 237–238; Claassen & Verschoor 1992: 75; Strauss 1991: 91; Snyman 1999: 113; Somerville 1984 “Therapeutic privilege: Variation on the theme of informed consent” \textit{Law, Medicine, and Health Care} 4 6; Van Oosten 1991b: 35 (who does not mention the possibility of acting in necessity in the interest of the community). \\
\textsuperscript{45} & This is also the case in the vast majority of medical interventions in general where the patient is usually also the person in whose interest the defensive act is undertaken – Strauss & Strydom 1967: 238; Claassen & Verschoor 1992: 75. \\
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in respect of one’s body, possibly dignity, possibly privacy and, once an intervention is undertaken without informed consent, physical integrity) in order to protect the patient’s health or life.

A number of authors maintain that the defence of necessity may be relied upon even where the act intended to ward off the danger is directed not against the interests of an innocent third person, but against other interests of the person threatened by the danger. Van der Merwe and Olivier take the view that, although in such an instance it would be more sound to speak of negotiorum gestio instead of necessity, not all cases where the endangered and protected persons

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46 Autonomy with respect to one’s body enjoys recognition in our case law. In *Castell v De Groot* 1994 (4) SA 408 (C) 418G Ackermann J speaks of “the autonomy and right of self-determination of the patient”, and later on at 426D he speaks of “the fundamental right of individual autonomy and self-determination to which South Africa is moving”. The trend towards greater recognition of autonomy and self-determination has been given fresh impetus by the enactment of s 12(2) of the Constitution of the Republic of South Africa of 1996, which provides that everyone has the right to bodily and psychological integrity, which includes the right (i) to make decisions concerning reproduction; (ii) to security in and control over their body; and (iii) not to be subjected to medical or scientific experiments without their informed consent. The Constitution makes the individual’s right to security in and control over his/her body an aspect of the individual’s fundamental right to bodily and psychological integrity. See also Visser 1997 “Enkele gedagtes oor die moontlike invloed van fundamentele regte ten aansien van die fisie-psigiese integriteit op deliktuele remedies” *Tydskrif vir Hedendaagse Romeins-Hollandsé Reg* 495, especially 496–498, 503; Neethling 1998 *Persoonlikheidsreg* (4th ed) 33 fn 276.

47 Van Oosten 1995a: 166; Visser 1997: 497 says that the first principle or value on which the Republic of South Africa is based according to the Constitution, is human dignity. Human dignity has a recognised meaning in the law of personality and can, in a sense, be seen as the basis for all fundamental rights, including the fundamental personality right relating to the corpus.

48 Van Oosten 1995a: 166.

49 The violation of the patient’s autonomy may negatively impact upon other interests of the patient, eg his/her financial interests, religious concerns, and dignity. Seen in this light, a person’s right to self-determination in respect of his/her body should include the right personally to attach significance to the corpus in relation to other values and interests and to assess the importance of the corpus within a framework of personally held values and interests.

coincide will amount to *negotiorum gestio*. To illustrate their point, they give the example of the person who expressly prohibited the protection of his or her interests.

Strauss accepts that the defence of necessity may be relied upon even where the act intended to ward off the danger is directed not against the interests of an innocent third person, but against other interests of the person threatened by the danger. However, he submits that in regard to medical treatment of a person whose life or health is in serious danger as a result of injury, disease or ill-health, such treatment against his or her express will is in principle not justifiable on the basis of necessity, unless the act is directed solely to protection of the community interest. He explains:

The reason for this is that in our society, the mentally competent individual’s right to control his own destiny in accordance with his own value system, his *selfbesikkingsreg*, must be rated even higher than his health and life (unless it would clearly offend against the community interest).

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51 Van der Merwe & Olivier 1989: 83 fn 14.
52 In similar vein, Van der Westhuizen 1979: 7 fn 20 states that if a patient refuses to give his/her consent to an operation which is necessary to save his/her life, *negotiorum gestio* is not available as a defence, but necessity is. This line of reasoning creates the impression that in such instances, that which cannot be achieved under *negotiorum gestio* can be achieved under necessity without regard being had to the importance of safe-guarding the patient’s autonomy.
54 The word “solely” is perhaps too exclusive. (Cf Van Oosten 1999: 678 fn 28.) It is difficult to imagine how acting in someone’s best interests can be directed “solely” at the protection of the community interest. Does the community have an interest in the well-being of an individual? It is submitted that the answer to this question should be “yes”. This is evidenced by, eg, the involuntary committal of drug addicts to rehabilitation centres and the compulsory inoculation against serious illnesses. However, it is to be expected that, in further development of our law, group morality will increasingly yield to individual morality (see fn 91 and the accompanying text infra). This development may result in a growing unwillingness to justify under necessity, on the strength of the community interest, an act committed against such person’s wishes.
57 A similar explanation is offered elsewhere: Strauss 1991: 31. Cf the early contribution by Millner 1937 “The doctor’s dilemma” *The South African Law Journal* 384 387. Millner stresses that, in the main, the law “acquiesces in the proverbial right of each man to go to the devil in his own way”.

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However, Strauss does make provision for certain “exceptional circumstances” where treatment against the patient’s will can be justified on the basis of the doctrine of necessity. 58

The law will not protect the health fanatic who forcibly attempts to prevent me from using a lot of sugar in my coffee, because he maintains – quite correctly so – that in the long run it will harm my health and may even shorten my life. On the other hand, the doctrine of necessity will clearly avail the policeman who forcibly restrains me from committing suicide by jumping off a window-ledge in a high building. A doctor would also clearly have the right to save the life of a would-be suicide who has taken an overdose of pills, by pumping out the content of the stomach or by administering a neutralising agent. 59

Strauss deals only with the situation where treatment is administered against the patient’s express will. He does not deal with the situation where the treatment is administered without the patient’s informed consent and the doctor knows or has reason to believe that the patient may refuse to submit to the treatment once informed. Since Strauss generally subscribes to the notion that necessity may be a defence even where the act intended to ward off the danger is directed not against the interest of an innocent third person, but against other interests of the person threatened by the danger, one may be tempted to deduce that, according to Strauss’s analysis, the situation referred to in the preceding sentence may be brought under the necessity defence. But then again, if one were to apply the reasoning he offers as explanation for not allowing the defence of necessity to justify treatment against the patient’s express will to this kind of situation, one would be tempted to argue that, since allowing necessity as a defence in such a situation also amounts to a disregard for the patient’s self-determination, this should in principle be out of the question.

58 Strauss 1991: 93.
59 It is interesting that both examples cited by Strauss as justifiable under necessity deal with suicide attempts. It could be argued that the interruption of a suicide attempt can be justified because it may be in accordance with the suicide’s own long-term values. See 5.2.2.3 infra. Van Oosten 1999: 678 fn 28 remarks that Strauss either contradicts himself or obscures his own distinction between unauthorised administration and necessity by stating, on the one hand, that a doctor clearly has the right to save the life of a would-be suicide, and on the other, that medical treatment of a patient whose life or health is in serious danger against the patient’s express wishes will be justifiable in necessity only if it is administered solely for the protection of society’s interests.
60 See fns 55-57 and the accompanying text supra.
Moving specifically to situations of therapeutic non-disclosure, Strauss submits\textsuperscript{61} that where it would undoubtedly have been detrimental to the patient had he or she been informed in precise terms of the nature of the treatment, and the doctor deliberately decided not to tell the patient, the doctor should in the absence of any ill consequence to the patient not be held liable for assault.\textsuperscript{62} In such a case, he says, “the doctrine of necessity ought to be applied, in any event where the patient has not expressly refused medical treatment”.\textsuperscript{63} Elsewhere,\textsuperscript{64} the learned author makes a similar submission.\textsuperscript{65}

There is one situation ... in which in my opinion a doctor may, by virtue of the doctrine of necessity, treat a patient capable of expressing his will, without having first obtained the latter’s informed consent. That is the situation where the doctor – after careful consideration and in good faith – deliberately refrains from informing a patient (who is anxious to be cured) of the nature of the (serious) disease diagnosed, because such information may have the effect that the patient would become depressed and desperate to such an extent that he refuses further medical treatment. The cancer patient comes to mind in this context.\textsuperscript{66}

In the former submission, Strauss refrains from expressing an opinion as to whether or not necessity will be applicable where the patient expressly refused medical treatment, leaving open the possibility that, in such circumstances, therapeutic non-disclosure (i) can be justified, but not under the doctrine of necessity; (ii) can be justified under the doctrine of necessity. If, in such circumstances, therapeutic non-disclosure can be justified under the doctrine of necessity, this would be an example of “exceptional circumstances” where treatment against a patient’s will can be justified on the basis of the doctrine of necessity even though the act committed in necessity

\textsuperscript{61} Hereinafter referred to as the “former submission”.

\textsuperscript{62} Strauss 1991: 19.

\textsuperscript{63} Strauss 1991: 19. Cf Kennedy & Grubb 1994 Medical law: Text with materials (2nd ed) 377 who narrow the ambit of the defence of necessity by stating that once a patient had clearly refused treatment “no appeal to necessity can justify the doctor’s intervention notwithstanding the good intentions of the doctor”.

\textsuperscript{64} Strauss 1991: 92.

\textsuperscript{65} Hereinafter referred to as the “latter submission”.


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was not directed solely to protection of the community interest. It is not clear what the basis for justifying the act would be if justification would not be allowed under the doctrine of necessity. It is clear, however, that, unless the patient has expressly refused medical treatment, Strauss sees necessity as the applicable ground of justification. Therefore, if the doctor fails to inform the patient, but either believes that the patient would consent to treatment if properly informed or does not know whether or not the patient would consent if properly informed, the applicable ground of justification will be necessity.

Likewise, even if the doctor has not informed the patient properly for fear that the patient will refuse treatment, the applicable ground of justification will be necessity. This corresponds with the view taken in the latter submission. In the latter submission Strauss makes it clear that necessity can be a defence even where non-disclosure serves the purpose of securing the patient’s consent to further treatment.

These two submissions need to be taken into reconsideration in light of the judgment in Castell v De Greef. Although Ackerman J specifically dealt with the situation where the doctor refrains from drawing a particular risk to the patient’s attention, well knowing that she would refuse to consent if informed of the risk, there appears to be no reason not to apply the same logic to the situation where the doctor refrains from informing the patient of the nature of the disease she is suffering from, believing that she would refuse consent to further treatment if properly informed. The latter submission deals with the situation where information about the diagnosis is material to the patient’s decision to undergo or refuse the treatment proposed. In such a situation the

67 See fn 58 and the accompanying text supra.

68 Which cannot be the case under negotiorum gestio – see fn 16 and 19 supra. It must be added, however, that there is also another type of harm mentioned in the latter submission, and that is the depression (and despair) the patient might experience upon disclosure. The possibility that the patient may suffer (serious) depression can provide a reason for invoking the therapeutic privilege. It is submitted that, where the doctor fears that the patient will refuse treatment as a result of the depression, it is the fear of depression following disclosure, and not the effect that depression may have on the patient’s decision that provides the rationale for allowing the therapeutic privilege. See 5.3.2.3 infra.

69 1994 (4) SA 408 (C). See in particular 420F–421D of the report. See also fn 35 and the accompanying text supra, as well as 5.3.1.4 infra.

70 Provided, of course, that the disclosure of such information is required in terms of the doctrine of informed consent. See Van Oosten 1991b: 36–38.
doctor’s duty to inform the patient of the diagnosis “forms part and parcel of his duty to inform the patient of the nature, scope, administration, importance, consequences, risks, dangers, benefits, disadvantages and prognosis of as well as the alternatives to the proposed treatment and should therefore, be dealt with on the same footing, inclusive of the therapeutic-necessity defence in appropriate circumstances”.\textsuperscript{71} Such an approach would leave no room for the latter submission.

\textit{Castell} v \textit{De Greef} limited the ambit of the therapeutic privilege defence to instances where the doctor does not know whether or not the patient would refuse the intended intervention if informed of the risk attached to it. This quite severely limits the ambit of the former submission.

In his most recent contribution dealing with the issue of emergencies as justification for medical interventions, Van Oosten refrains from expressing an opinion on the question whether or not necessity is capable of operating, in extreme cases, as a justification where the protected legal interest is not that of society but that of the patient – a question which he himself describes as a “notoriously controversial and ticklish issue”.\textsuperscript{72} However, he is prepared to suggest that “therapeutic necessity” might be one such extreme case where this might be the case.\textsuperscript{73} Strangely enough, in one of his earlier writings, Van Oosten, in stark contrast to this hesitant tone, expressed the view that necessity is “eminently suitable” to accommodate cases of therapeutic non-disclosure,\textsuperscript{74} and in another, said that the “obvious and appropriate legal defence that springs to mind” in this context is necessity.\textsuperscript{75}

In substantiating his (earlier) emphatic embrace of necessity as the applicable ground of justification, Van Oosten argues that once therapeutic privilege is seen as a legal defence in terms of which a doctor is excused from the duty to inform a patient where disclosure would cause the patient greater harm than a medically indicated intervention, the only difference between

\textsuperscript{71} Van Oosten 1991b: 37.
\textsuperscript{72} Van Oosten 1999: 677–678.
\textsuperscript{73} Van Oosten 1999. 677–678, fn 27. See also 682, fn 53.
\textsuperscript{74} Van Oosten 1991b: 36.
\textsuperscript{75} Van Oosten 1995a: 177.
therapeutic non-disclosure and necessity as a ground of justification in the medical context would lie in the number of parties involved in the former as apposed to the latter.\textsuperscript{76} In the former, two parties are involved, namely doctor and patient, whereas in the latter, three parties are involved, namely doctor, patient and either third parties or society at large.\textsuperscript{77} Van Oosten reasons that the question whether there is a need for therapeutic privilege as a separate and independent defence or whether it might just as well be treated as part and parcel of the necessity defence should not be decided in favour of a separate defence of therapeutic privilege by the mere reason that, in the case of therapeutic non-disclosure, the interest protected and the interest violated reside in one and the same person.\textsuperscript{78} He explains:

Necessity also operates as a defence regardless of whether the threat averted has been caused by a human being or by force of nature and regardless of whether the person who acted in necessity violated the interests of an innocent party or contravened a statutory prohibition. These differences are all purely formal ones that do not affect the material requirements of the necessity defence at all. Hence, from this point of view, there seems to be no reason in principle or in practice why therapeutic non-disclosure should not be treated as part and parcel of the necessity defence.\textsuperscript{79}

4.3 IS NECESSITY OR \textit{NEGOTIORUM GESTIO} SUITED TO ACCOMMODATE THERAPEUTIC PRIVILEGE OR SHOULD THERAPEUTIC PRIVILEGE BE REGARDED AS A SEPARATE AND INDEPENDENT DEFENCE? CONCLUSION

In the typical case of therapeutic non-disclosure, the interest protected and the interests infringed vest in one and the same person, namely the patient. It is submitted that the ground of

\textsuperscript{76} Van Oosten 1991b: 35.

\textsuperscript{77} The author correctly points out that the Karneades example of necessity illustrates that necessity requires neither a third person nor the protection of a societal interest – Van Oosten 1991b: 35; Van Oosten 1999: 678.

\textsuperscript{78} Van Oosten 1991b: 35.

\textsuperscript{79} Van Oosten 1991b: 35. Hébert 1994 “Truth-telling in clinical practice” \textit{Canadian Family Physician} 2105 2111 also understands therapeutic privilege to be a variant of the emergency exception to the rule of disclosure. In \textit{Rogers v Whitaker} (1992) 109 ALR 625 637 Gaudron J said that “as at present advised, I see no basis for any exception or ‘therapeutic privilege’ which is not based in medical emergency or in considerations of the patient’s ability to receive, understand or properly evaluate the significance of the information that would ordinarily be required with respect to his or her condition or the treatment proposed”. Cf Wallace 1995 \textit{Health care and the law} (2nd ed) 71; Molinar 1997 “Consent in the 90’s” \textit{Medicine and Law} 567 576.
justification that best matches the situation where the act is aimed at the protection not of the community interest, but of the interests of the patient himself or herself, is negotiorum gestio.\textsuperscript{80} This common law defence\textsuperscript{81} would allow for emergency medical procedures to be taken without the patient's consent, but at the same time gives some recognition to the patient's autonomy in that it is not allowed to act contrary to the patient's wishes.

However, as we have seen, negotiorum gestio is not suited to cater for therapeutic non-disclosure cases because of the requirement that the dominus must not be capable of giving his or her consent. Although it has been argued that negotiorum gestio does not enter the picture in the context of therapeutic non-disclosure because it does not operate as a ground of justification where medical treatment is administered against the patient's will, this argument can no longer be valid after the judgment in Castell v De Greef.

The position taken in Castell v De Greef\textsuperscript{82} is to be welcomed. It adds some weight to the argument that usually where the legal interest violated and the legal interest protected vest in the same person, the applicable ground of justification is negotiorum gestio rather than necessity. In my opinion, the reason is to be found in the protection that the autonomy of the dominus enjoys under the defence of negotiorum gestio.\textsuperscript{83} In the medical context, the requirement of negotiorum gestio that the gestor may not embark upon a course of action against the will of the patient, protects the autonomy of the patient.\textsuperscript{84} Furthermore, if the consent of the dominus has not been obtained in circumstances where it was possible to be obtained, such conduct remains unlawful.


\textsuperscript{81} By way of extension of its field of application from that of safeguarding people's pecuniary interests in their absence, to safeguarding their health (personality) interests in their psychological absence (see the discussion under 4.2.2 supra).

\textsuperscript{82} 1994 (4) SA 408 (C) 4201–421D.

\textsuperscript{83} Van Oosten 1999: 682 admits that "the defence of unauthorised administration highlights and endorses adherence to the fundamental principle of patient self-determination whenever possible".

\textsuperscript{84} Kirby 1983 "Informed consent: What does it mean?" Journal of Medical Ethics 69 72 stresses that where the therapeutic privilege is exercised, there should be no room for the suggestion that the doctor has simply substituted his own assessment of the patient's good for the patient's assessment thereof.
This requirement also fits in well with a system endorsing self-determination since it lends support to the idea that in the usual case of the interest protected and the interest threatened vesting in the same person, that person is to weigh up the two interests in terms of his or her own value system; the only circumstances under which someone else (the gestor) may substitute his or her judgment for that of the person whose interests are at stake (the dominus), is where the dominus is incapable of consenting (as a result of his or her physical or psychological absence) and even then, the gestor is not allowed to act against the will of the dominus (expressed at an earlier occasion whilst fully competent). If a patient’s autonomy is denied by ignoring his or her wishes, reliance upon negotiorum gestio is out of the question.\textsuperscript{85}

Necessity, on the other hand, contains no requirement which would exclude it from operating as a defence in the typical case of therapeutic non-disclosure. However, it is submitted that the defence of necessity is not eminently suitable to cover such cases, because of the lack of protection afforded to the patient’s autonomy in terms of its requirements. Van Oosten’s view cannot be accepted, for if it were, it would mean that, under the doctrine of necessity, a person’s autonomy may lawfully be negated in what someone else believes to be that person’s best interests. It would imply that one’s decisions may lawfully be subjected to a veto by others, and that one’s decisions may lawfully be overridden in order to “protect” one from becoming “a victim” of one’s own “incorrect” decisions. Although, as Van Oosten points out, necessity can justify either the violation of the interests of a third party or the contravention of a statutory provision, and although it is also true that in both instances the material requirements are the same, it should be added that the nature of the interests violated do indeed influence the scales of justice. It is submitted that, as a general rule, a defence of necessity will be more likely to succeed where the interest violated relates merely to an abstract provision of the law, and will be subjected to closer scrutiny where a third party’s interests are infringed.\textsuperscript{86} In my opinion, where the interests infringed and the interests protected vest in the same person, it is imperative that the utmost scrutiny be employed in the interest of giving due recognition to a person’s right to autonomy in

\textsuperscript{85} And in the absence of an overriding community interest, so is reliance upon necessity – see fn 55 and the accompanying text supra.

\textsuperscript{86} This submission is also made by Snyman 1999: 120. Snyman explains that in the case of the former, a concrete situation of emergency in which the accused finds himself/herself must be weighed against what is merely an abstract possibility of harm to society, the state or the legal order.
respect of his or her body. The importance of autonomy or self-determination in South African medical law has been strongly emphasised in Castell v De Greef,\textsuperscript{87} and the individual’s right to “security in and control over” his or her body, has been enshrined in the Constitution.\textsuperscript{88}

Decisions taken ostensibly in the patient’s interests and on his or her behalf should be subjected to scrutiny, for the very reason that the decision is taken by one whose interests are, to a limited extent, inextricably linked to those of the patient. The therapeutic privilege may never be used in the doctor’s interests. Such an abuse of the privilege may for example occur in situations in which the doctor, by withholding information, conceals his or her own ignorance or lack of experience, hushes up his or her own mistakes or negligence, tries to avoid extra work or effort, or pursues a predominantly financial object.\textsuperscript{89}

The starting point for affording protection to the patient’s autonomy in this context lies in Strauss’s submission that treatment against a patient’s express will in an emergency is in principle not justifiable on the basis of necessity, unless the act is directed to protection of the community interest. This submission lends recognition to the idea that a person’s autonomy should be rated higher than his or her health and life, but that the community interest may sometimes outweigh the patient’s autonomy. One must add, however, that, in the further development of our law, we could expect to see the scope for justifying an intervention against a person’s wishes on account of the interests of the community narrowing\textsuperscript{90} as a result of an increasing tendency for group morality to give way to individual autonomy.\textsuperscript{91} Be that as it may, where non-disclosure serves

\textsuperscript{87} 1994 (4) SA 408 (C) 418G, 420J, 421C–D, 426D–E.

\textsuperscript{88} The 1996 (current) Constitution of South Africa s 12(2). Interestingly enough, the discourse surrounding the issue of therapeutic non-disclosure has always been led outside the constitutional arena, even in the legal literature of those countries who do have a constitution. The first inklings of ideas in respect of its constitutional dimensions have, however, been heard – see, eg, Patterson 1985: 721 756–759. In any event, it is clear that the therapeutic privilege may be consistent with the values underlying a constitutional democracy, and it cannot summarily be disposed on account of the introduction of a Bill of Rights.

\textsuperscript{89} Dekkers 1981b Patiëntenvooring: De onmacht en de pijn 141–142.

\textsuperscript{90} Moutsopoulos 1984: 246–247, 250 clearly indicates the importance of truth-telling in fostering democratic values.

\textsuperscript{91} On the evolutionary process of autonomising that is operative in the criminal law, see Labuschagne 1995a “Aanranding en misdaadkondensering: Opmerkings oor die strafregtelike beskerming van biopsigiese
the purpose of protecting society's interests, the apposite ground of justification is necessity. This case can, however, not be classified as an instance of therapeutic non-disclosure (or therapeutic privilege) since therapeutic non-disclosure serves a therapeutic purpose.

It is my submission that therapeutic privilege should be a legal defence, since one cannot be under a legal duty to disclose and have a professional discretion to refrain from disclosure at the same time. Therapeutic privilege should be a separate and independent legal defence. One must accept, in the final analysis, that therapeutic privilege cannot be brought under any of the existing grounds of justification, precisely because it represents a departure from the basic principle of self-determination. The separate and independent defence of therapeutic privilege should contain all the elements of the defence of necessity. In addition, it should contain some of the safeguards afforded to the patient by the requirements of the defence of negotiorum gestio. Very good reason exists for limiting the operation of negotiorum gestio to the situation where the patient is incapable of consenting to an intervention, and for refusing justification under negotiorum gestio where the intervention was undertaken against the patient's will. Since the defence of negotiorum gestio governs the typical case of the protected and violated interest vesting in the same person, it ought not to be possible to get around these requirements by relying on necessity in stead. However, since requiring the patient to be incapable of consenting would render the therapeutic privilege useless, one would have to accept that there can be no such requirement. To this extent recognition of the defence inevitably boils down to taking with the one hand what is given with the other. Nevertheless, therapeutic privilege should be out of the question if medical treatment is administered against the patient's will. It should also be out of the question if the doctor has

outonomie" De Jure 367. Labuschagne 1995a: 368 argues that the process of autonomising allows for individual autonomy to circumscribe criminal law. This implies that group morality increasingly yields to individual morality. He is convinced that, in future, individual autonomy will play an important role in defining crimes and that the community interest will increasingly be equated to individual autonomy. This process of autonomising supports the ever broadening base of human rights (Labuschagne 1995a: 381).

Van Oosten 1991b: 36.

An example would be where the doctor does not inform the patient of the fact that the proposed intervention is a mastectomy, because the patient had told him that she will never undergo such operation, and the doctor is of the opinion that it is in the patient's best medical interest to undergo a mastectomy and feels that the patient may become extremely upset if informed of the need to undergo such an operation. The patient consents to explorative surgery and the doctor performs a mastectomy.
reason to believe (or knows) that the patient will refuse to undergo an intended intervention once properly informed. In contradistinction to negotiorum gestio,⁹⁴ there should be no objection to the use of therapeutic privilege to justify an omission to inform (or a subsequent intervention) where the patient would in any event have consented if he or she had been informed.

4.4 IMPLICATIONS OF THE ADOPTION OF SELECTED REQUIREMENTS OF THE DEFENCES OF NECESSITY AND NEGOTIORUM GESTIO AS SUBMITTED

4.4.1 General
As we have already seen, certain pre-eminent writers on South African medical law have suggested that therapeutic privilege is subsumed by the defence of necessity. I am however of the opinion that most of the instances that could be brought under a wide definition of therapeutic privilege with its emphasis on the doctor’s duty to do no harm, cannot be brought under the necessity defence. In other words, restricting the ambit of the therapeutic privilege defence so as to coincide with that of necessity effectively excludes a number of instances commonly believed to resort under the former. In my submission directly above, the defence should be further circumscribed by refusing to uphold the defence where the doctor has reason to believe (or knows) that the patient would not consent to treatment once properly informed, or acts against the patient’s will.

Three of the requirements of necessity would make it very difficult for the doctor to pass muster in the therapeutic non-disclosure context, namely (i) the requirement of the existence of an emergency; (ii) the requirement that the conduct must be the only reasonable means of escaping the danger; and (iii) the requirement of proportionality.

⁹⁴ Cf fn 16 supra.
4.4.2 The existence of an emergency

The warding off of the threat of harm (or the defensive act) in the therapeutic non-disclosure context (usually) takes the form of an omission, namely the doctor's refraining from informing the patient according to the requirements of informed consent. The threat of harm exists in the disclosure of information. But the disclosure serves the purpose of obtaining consent, and logically precedes consent but follows upon the doctor's decision to suggest an intervention. Suggesting an intervention which is not factually urgent (ie medically indicated/necessary) in circumstances where disclosure of, for example, the risks attendant thereto holds the potential of harming the patient in effect comes down to wilfully creating the circumstances which may actuate the risk of harm. These circumstances can at any time be removed by delaying the intervention, or at least by holding the disclosure of the potentially harmful information in abeyance. Furthermore, foregoing the proposed intervention or opting for a different kind of treatment may be a sensible alternative to undergoing the treatment.

Therefore, it can be safely assumed that the doctor will not be allowed to rely on either necessity or the separate and independent therapeutic privilege submitted above where the intervention for which he or she failed to obtain an informed consent is an elective procedure (or a procedure which is not factually urgent).

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95 Strauss 1991: 91; Snyman 1999: 118; Neetling, Potgieter & Visser 1999: 87; Van der Walt & Midgley 1997: 98. Incidentally, this is also a requirement for the defence of unauthorised administration. In connection with cancer cases and cases where AIDS is diagnosed, see Strauss 1991: 10-11.

96 This is true of so-called "self-determination disclosure" (see Van Oosten 1995a: 169). It is also true of the disclosure of a diagnosis where such disclosure is material to the patient's decision to undergo or refuse the intervention proposed (see Van Oosten 1991b: 37).

97 Farber 1982 "Informed consent" Journal of Dermatologic Surgery and Oncology 38 39.


100 See eg Simon 1992 Clinical psychiatry and the law (2nd ed) 131; Abbuil & Gerking 1975 "Informed consent of the emotionally disturbed patient" Legal Medicine Annual 217 224.
In such an instance, nothing prevents the doctor from informing the patient of the existence of certain unidentified risks the disclosure of which may cause him or her harm.\textsuperscript{101} It can then be left up to the patient to determine how much additional information he or she should like to hear. If the patient waives the right to receive the information the subsequent medical intervention is lawful.\textsuperscript{102}

In \textit{Bang v Charles T Miller Hospital}\textsuperscript{103} the patient was not informed that the particular procedure (prostate resection) would involve the severance of his spermatic ducts. The operation was not factually urgent, because the patient might have chosen to take the risk of infection. The court held that, since alternatives existed\textsuperscript{104} and there was no emergency, the doctor should have informed the patient accordingly so as to allow him to choose from the alternatives.\textsuperscript{105}

\begin{footnotesnote}
\footnotesref{102} I would argue for an exception to the general rule of disclosure to operate where the patient makes known his/her wish not to hear unpleasant information. See Moutsopoulos 1984 “Truth telling to patients” \textit{Medicine and Law} 237 247–248; Fletcher 1978 “Medical diagnosis: Our right to know the truth” in Beuchamp & Perlin (eds) \textit{Ethical issues in death and dying} 146 154–155; Higuchi 1992 “The patient’s right to know of a cancer diagnosis: A comparison of Japanese paternalism and American self-determination” \textit{Washburn Law Journal} 455 469–473; Patterson 1985: 721 762–771; Kirby 1983: 71–72; Schoene-Seifert & Childress 1986: 93; Meisel 1977: 106 fn 158; Martin 1993 “Lying to patients: Can it ever be justified?” \textit{Nursing Standard} vol 7(18) 29 30, 31; Quill & Townsend 1994 “Bad news: Delivery, dialogue, and dilemmas” in Beuchamp & Walters (eds) \textit{Contemporary issues in bioethics} (4th ed) 131 134; Beumer 1981 \textit{Patiënt en recht} 22. This exception would seem to accord with the very tenet underlying the argument in favour of disclosure, namely patient autonomy. Whether or not the doctor will be liable for disclosing information against the patient’s declared wish not to be informed, is a question which falls outside the ambit of this study.
\footnotesref{103} 88 NW 2d 186 (1958).
\footnotesref{104} Which, in respect of the specific contrast medium used, might have been the case in \textit{Nishi v Hartwell} 473 P 2d 116 (Hawai’i 1970). It is not clear whether, in the circumstances, alternatives existed to undergoing an aortography (ie, forgoing the aortography) or whether it was necessary. It is submitted that, as a general rule, a procedure carried out for mere diagnostic purposes should be less likely to be seen as necessary. If one accepts that, in the circumstances, an aortography was necessary, one is reminded that “Urokon was practically the only satisfactory contrast medium then available for the procedure” (at 120). However, the court also referred to the fact that at least half of the surgeons in the United States used Urokon “despite the existence of other media considered by some to be less toxic”, but which did not facilitate the best possible X-rays (at 120). See fn 7–9 and the accompanying text \textit{supra}, chapter 2.
\footnotesref{105} The Minnesota Supreme Court said that “it is our opinion that a reasonable rule is that, where a physician and surgeon can ascertain in advance of an operation alternative solutions and no immediate emergency exists, a patient should be informed of the alternative possibilities and given a chance to decide before the
Rawlings v Lindsay\textsuperscript{106} the patient sustained permanent damage to certain facial nerves in the course of surgery for the removal of her wisdom teeth. The doctor had not told her of the risk of such damage. The court found that, since the impaction of the patient’s wisdom teeth could not be regarded as a grave medical situation, and since their removal could well have been delayed for years, there was no basis for the assertion that the doctor should have minimised his discussion of the risks in the interests of the welfare of the patient.\textsuperscript{107}

Even if the intervention for which the doctor failed to obtain an informed consent is factually urgent, reliance on necessity is still impossible unless the intervention is also temporally urgent. The patient should be afforded the opportunity to shop around for optimal treatment conditions, and if disclosure poses a risk of harm to the patient’s health, the doctor should postpone the intervention\textsuperscript{108} and the required disclosure in the interest of the patient’s self-determination and health.\textsuperscript{109} Should the risk of harm through disclosure persist while the physical condition of the patient or the circumstances of the case change so as to make an intervention temporally urgent, the doctor may in appropriate circumstances rely on necessity or the independent and separate defence of therapeutic privilege submitted above.

One could therefore conclude that the doctor can rely on necessity or the independent and separate defence of therapeutic privilege submitted above only if the proffered intervention is both factually and temporally urgent.\textsuperscript{110}

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\textsuperscript{106} See Bang v Charles T Miller Hospital 88 NW 2d 186 (1958) 190. \textsuperscript{107} (1982) 20 CCLT 301. \textsuperscript{108} At 307. Cf Esterhuizen v Administrator, Transvaal 1957 (3) SA 710 (T) 716–717, 722. \textsuperscript{109} If a disclosure of serious risks is made, the patient may decide to postpone treatment until he/she feels capable of undergoing and coping with the possible materialisation of such risks – Shartsis 1972: 537. \textsuperscript{110} Van Oosten 1991a: 312; Carnerie 1986: 89–91. \textsuperscript{110} Meisel 1979 “The ‘Exceptions’ to the informed consent doctrine: Striking a balance between competing values in medical decisionmaking” Wisconsin Law Review 413 could be interpreted to support such a conclusion. Montange 1974 “Informed consent and the dying patient” The Yale Law Journal 1632 1655–1656 (note fn 126) advocates a general requirement of tactful disclosure permitting of only one exception, namely the exercise of the therapeutic privilege when the competent patient expressly waives his/her right to a disclosure. It is argued that the importance of self-determination is so great that informed consent may never be waived in a non-emergency situation, unless the courts ensure that the patient is not intimidated into waiving an informed consent by pressure from a hurried doctor. See also
\end{flushright}
4.4.3 The doctor's conduct was the only reasonable means of escaping from the threat of harm

In order to succeed with a defence of necessity, the doctor must show that his or her conduct was necessary in order to avert the danger,¹¹¹ or that his or her conduct was the only reasonable possible means of escaping from the threat of harm.¹¹² This requirement overlaps with the requirement of the existence of an emergency in so far as one way of averting the harm attached to disclosure of information relating to an intervention that is not urgent (factually and/or temporarily) is to postpone the disclosure and/or the intervention.¹¹³ But it goes further. It implies that the doctor must consider the possibility of alternative interventions. Where the disclosure of, for example, risks associated with a certain urgently indicated intervention may cause a patient harm, and alternative forms of intervention exist which are not associated with the risks the disclosure of which may cause the patient harm, the patient should be advised of such alternatives.¹¹⁴ It also means that if it is to be expected that a factually but not temporally urgent intervention will in due course become temporally urgent, and the threat of harm to the patient through disclosure is feared as a result of a pre-existing (morbid) mental state (eg depression or anxiety), the doctor should treat or have treated the mental condition.

Good communication can often provide the alternative: tactful disclosure may sometimes provide patients with the information necessary to make an informed decision while avoiding excessive discomfort.¹¹⁵

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¹¹⁴ See my comments on Nishi v Hartwell 473 P 2d 116 (Hawai‘i 1970), 2.2.2 supra.

4.4.4 The requirement of proportionality

The requirement of proportionality between the harm occasioned and the interest threatened, dictates that the defensive conduct (the omission to disclose information) must not be more harmful than is necessary to escape the danger.\textsuperscript{116} Since the rationale for the therapeutic privilege is the avoidance of harm, only information that would harm the patient should be withheld.\textsuperscript{117} In order to maximise the information that can be disclosed without causing harm, the doctor should consider tailoring potentially harmful information in such a way as to avoid the worst sting without misleading the patient.\textsuperscript{118} It should be kept in mind that therapeutic privilege is an exception, self-determination constituting the rule.

The requirement of proportionality also implies that, in general, the interest which is sacrificed must not be more valuable than the interest which is protected.\textsuperscript{119} In the case of therapeutic non-disclosure, the patient’s autonomy is inevitably sacrificed. The interest protected is usually that of the patient’s life or health. Of course, non-disclosure may also have the effect of harming the patient’s health or life. An example would be the case where a certain risk attached to a procedure is not disclosed, the patient consents to the intervention, and the risk materialises. It is clear that the weighing-up process can be very difficult because the interests involved differ in nature. The high value placed on patient autonomy in South African law must be kept in mind when balancing the interests endangered with the interests protected.\textsuperscript{120}

\footnotesize{communication has other advantages, including enhancement of the accuracy of history-taking, provision of more useful medical records, augmentation of patients’ compliance with therapeutic regimens, increase of patients’ satisfaction, and improvement of patients’ physiologic and psychologic responses to therapy. See chapter 6 infra.}


\textsuperscript{118} See, eg, Quill & Townsend 1994: 131ff and particularly 133–136 on how to answer in the patient’s informational needs in respect of diagnosis.


\textsuperscript{120} Higgs 1994: 141 reasons that not telling the truth is usually the same as telling a lie, and a lie requires strong justification.
CHAPTER 5
THE CONCEPT OF “HARM” DEFINED

5.1 INTRODUCTION

The therapeutic privilege has as its object the avoidance of harm. The plethora of definitions of the therapeutic privilege are far from unanimous in their formulations of the harm justifiably to be avoided under the therapeutic privilege. Therefore, the scope of the therapeutic privilege is, to a large extent, determined by the interpretation given to the term “harm”. In this chapter, I will attempt to determine which of the potential effects of disclosure can be categorised as “harm”. The instances that are mentioned by the courts and authors, can, in the main, be divided into six broad categories: (i) where non-disclosure is claimed to be justified by concerns that disclosure may lead to psychological or physical harm to the patient, or may be detrimental to the patient’s best (medical) interests; (ii) where non-disclosure is claimed to be justified on account of the effect that disclosure may have on the patient’s decision or decision-making capabilities; (iii) seriously ill or dying patients; (iv) where the patient is moribund and disclosure of the truth would be inhuman; (v) where disclosure will seriously prejudice third parties; (vi) psychiatric treatment (or the use of the therapeutic privilege to withhold information that has no objective scientific basis); and (vii) the withholding of information in order to attain or maintain the placebo effect. The distinction that is most often made by writers and courts, is that between the first two of the mentioned categories.¹

¹ See eg Linzbach 1980 Informed consent: Die Aufklärungspflicht des Arztes im amerikanischen und im deutschen Recht 68; Bly v Roads 222 SE 2d 783 788.
5.2 WHERE NON-DISCLOSURE IS CLAIMED TO BE JUSTIFIED BY CONCERNS THAT DISCLOSURE MAY LEAD TO DIRECT PSYCHOLOGICAL OR PHYSICAL HARM TO THE PATIENT, OR MAY BE DETRIMENTAL TO THE PATIENT’S BEST (MEDICAL) INTERESTS

5.2.1 Where disclosure would cause anxiety and distress

5.2.1.1 Anxiety per se

One of the most frequently mentioned effects sought to be avoided under the therapeutic privilege is anxiety per se. In *Kenny v Lockwood* the patient had been operated on for Depuytrene’s contracture of the hand. The patient brought action against the doctors of a clinic claiming that they had “falsely and recklessly, without caring whether it was false or true, or without reasonable ground for believing it to be true” represented the operation as “simple”, and had said that the patient’s hand “would be all right in three weeks”. The Ontario Court of Appeal reiterated that it is the duty of a surgeon to deal honestly with a patient as to the necessity, character and importance of an operation, its probable consequences, and whether success might reasonably be expected to ameliorate or remove the trouble. The court added, however, that “such duty does not extend to warning the patient of the dangers incident to, or possible in, any operation, nor to details calculated to frighten or distress the patient”. Although this passage is sometimes cited as authority for the proposition that the therapeutic privilege should be allowed where the effect of disclosure would be to frighten or distress the patient, a literal interpretation of this passage would allow for the disclosure of information that has the effect of frightening or distressing the patient, but not for the disclosure of risks that is used in order to frighten or distress the patient,

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2 See eg Kirby 1983 “Informed consent: What does it mean?” *Journal of Medical Ethics* 69 72.


4 (1932) 1 DLR 507.

5 At 508.

6 At 525.

7 At 525.
for instance, in order to influence the patient's decision to undergo or forgo treatment. If one were to follow a literal interpretation, this poorly formulated passage merely spells out that there is no duty on a doctor to attempt to frighten a patient.⁸

Be that as it may, some other cases in the United States have defined the harm to be avoided by non-disclosure as the anxiety that disclosure might cause.⁹ In *Patrick v Sedwick*,¹⁰ a case in which the therapeutic privilege was accepted, the court confirmed¹¹ that a doctor need not inform a patient of all the hazards involved in an operation and that they may tailor the extent of their preoperative warnings to the particular patient to avoid the unnecessary anxiety and apprehension which such appraisal might arouse in the mind of the patient.

Of course, disclosing all possible risks to a patient may cause “unnecessary” anxiety, but the law does not require the disclosure of all risks.¹² Rather it requires the disclosure of all material risks¹³—material, because they can influence the patient’s decision to undergo such risks.

In *Tatro v Lueken*¹⁴ the court accepted the doctor’s explanation for not informing the patient of the risk of vesicovaginal fistula associated with a hysterectomy. His explanation was to the effect

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⁸ Ryckmans & Meert-Van de Put 1971 *Les droits et les obligations des médecins ainsi que des dentistes, accoucheuses et infirmières*, vol 1 (2nd ed) 440 maintain that, even if one were to accept that a doctor may sometimes lie to a patient, such a lie should be allowed only if it is aimed at concealing the seriousness of the disease, and never if it is aimed at inducing the patient to believe that the symptoms of his/her disease are much more serious than they actually are.

⁹ Eg *Lester v Aetna Cas & Sur Co* 240 F 2d 676 (1957) 679.


¹¹ At 458[3].

¹² Cf *Reitelmann 1965 Die ärztliche Aufklärungspflicht und ihre Begrenzung* 46–47. In *Wasem v Laskowski* 274 NW 2d 219 (1979) 266 the court said that the doctor should not be required to disclose “extremely remote possibilities” that at least in some instances might only serve to falsely or detrimentally alarm the particular patient. Cf *Scaria v St Paul Fire & Marine Ins Co* 227 NW 2d 647 (1975) 653.

¹³ *Sard v Hardy* 379 A 2d 1014 (1977) 1022.

¹⁴ Kan 512 P 2d 529 (1973).
that, should he have scared the patient prior to surgery, she might have died or she might have developed serious complications and her emotional make-up would probably have been harmed.\footnote{At 537.} 

In Ball v Mallinkrodt Chemical Works\footnote{381 SW 2d 563 (1964) 567–568.} the Court of Appeals of Tennessee – in what can be described as a formulation of the therapeutic privilege which, in respect of the doctor’s discretion, is one of the most permissive – remarked \textit{obiter} that information on the risk of paralysis may be withheld if it poses the possibility of upsetting the patient.

On the other hand, the Bundesgerichtshof held\footnote{BGH 28.11.1957 4Str 525/57 BGHSt 11 111.} that a doctor is, as a general rule, not relieved from the duty to obtain the patient’s consent if it would be impossible for him or her to fulfill the duty without upsetting the patient.\footnote{At 115.} In this case, the patient had been found to have had a myoma. In the course of the operation to excise the myoma the doctor discovered that the myoma was not positioned on the surface of the uterus, but had in fact grown into the uterus. As it was not possible to remove the myoma without simultaneous removal of the uterus, the doctor removed the entire uterus. The patient had not agreed to such a far-reaching intervention. The doctor averred that he did not mention, prior to the operation, the possibility of the removal of the uterus if in the course of the operation it should prove necessary, because he did not want to worry the patient any more than was absolutely necessary.\footnote{At 113.} The court held that this consideration did not justify the doctor’s omission to inform the patient.\footnote{At 115. Cf Shaw 1986 “Informed consent: A German lesson” \textit{International and Comparative Law Quarterly} 864 877; Ulsenheimer 1988 \textit{Arztstrafrecht in der Praxis} 65. Robertson 1983 \textit{The rights of the critically ill: The basic American Civil Liberties Union guide to the rights of critically ill and dying patients} 6–7 holds the opinion that saving the critically ill patient from anxiety and grief is not sufficient justification for withholding information regarding diagnosis and prognosis.}
It cannot be denied that a certain degree of anxiety is likely to result from the disclosure of unfavourable information. 21 Giesen is of the view that a worsening of the patient’s general condition or mood caused by the patient’s being informed is an unavoidable detrimental effect which must be accepted in the interest of the individual’s inalienable right to self-determination. 22 In 1986, United States Supreme Court Justice Byron White in Thornburgh v American College of Obstetricians 23 bashed the idea that concerns about increasing a person’s anxiety with regard to an intervention provide grounds for an exception to the rules of informed consent. The judge not only accepted that informed-consent provisions may produce some anxiety in the patient and influence her in her decision, but expressed the opinion that such provisions owe their existence to the possibility that the information may have these effects. 24

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21 See Patterson 1985 “The therapeutic justification for withholding medical information: What you don’t know can’t hurt you, or can it?” Nebraska Law Review 721 736.


23 106 S Ct 2169 (1986) 2199–2200. In this case, the constitutionality of a number of provisions of the Pennsylvania Abortion Control Act of 1982 was challenged. One of these provisions prescribed the method for securing informed consent, and required the woman to be informed of “the fact that there may be detrimental physical and psychological effects which are not accurately foreseeable”, the “particular medical risks associated with the particular abortion procedure to be employed”, and the “medical risks associated with carrying her child to term” (see 2178 of the report). Justice Blackmun, who delivered the opinion of the Court, remarked (at 2178) that the States “are not free, under the guise of protecting maternal health or potential life, to intimidate women into continuing pregnancies”, adding that close analysis of the provisions under attack “shows that they wholly subordinate constitutional privacy interests and concerns with maternal health in an effort to deter a woman from making a decision that, with her physician, is hers to make”. Justice Blackmun held (at 2179) that the “specific and intrusive informational prescriptions” are invalid, inter alia because “much of the information required is designed not to inform the woman’s consent but rather to persuade her to withhold it altogether”. He reasons (at 2180[9]) that the requirements that the woman be informed by the doctor of detrimental physical and psychological effects and of all particular medical risks compound the problem of medical attendance, increase the patient’s anxiety, and intrude upon the doctor’s exercise of proper professional judgment. Justice Blackman calls this type of compelled information “the antithesis of informed consent”.

24 Justice White thereupon expressed his approval of the observation by Appleton 1985 “Doctors, patients and the Constitution: A theoretical analysis of the physician’s role in ‘private’ reproductive decisions” Washington University Law Review 183 211 that “the greater the likelihood that particular information will influence [the patient’s] decision, the more essential the information arguably becomes for securing her informed consent”. Justice Rehnquist joined in Justice White’s dissenting judgment and Justice O’Connor (at 2215), in her separate dissenting judgment, agreed with Justice White’s judgment on the issue of the informed consent requirements. Justice Burger, in his separate dissenting judgment, agreed with much of Justice White’s and Justice O’Connor’s dissents. Cf his sentiments on the issue of the informed consent requirements at 2190–2191. See also Beauchamp 1997 “Informed consent” in Veatch (ed) Medical ethics (2nd ed) 185 204: “White is suggesting that the legal status of the doctrine of therapeutic privilege is no longer as secure as it once was.”
According to the theory of beneficence which claims the doctor’s duty to do no harm as the reason for invoking the therapeutic privilege, almost any invocation of the privilege to withhold or distort information can be justified in order to avoid some anxiety for a patient.25 It is submitted that the doctor should have special reason for believing that a patient would be adversely affected by disclosure before the therapeutic privilege can justify an omission to inform the patient.26 If not, loose standards “can permit physicians to climb to safety over a straw bridge of speculation about the psychological consequences of information”.27

5.2.1.2 The secondary effects of anxiety

Sometimes justification for the therapeutic privilege is sought in the secondary effects of anxiety.28 The secondary effects mentioned include the possible deterioration of the patient’s psychological or physical health,29 the effect that anxiety may have on the success of the treatment,30 the effect that anxiety may have on the patient’s morale,31 and the possibility that anxiety may deter a patient


27 Faden & Beauchamp 1986: 38. See also Beauchamp 1997: 204.

28 Sometimes mention is made of the possible detrimental effect “of the information” on the patient’s health without any reference to the possibility of causing the patient anxiety. In other words, anxiety is not required as the precipitator of the detrimental effect on the patient’s health. See eg Tomkin & Hanafin 1985 Irish medical law 34.


31 Anrys 1974: 7; Savatier 1951 Traité de la responsabilité civile en droit Français: Civil, administratif, professionnel, procédural vol 2 Conséquences et aspects divers de la responsabilité (2nd ed) 385.
from undergoing treatment. In *Hook v Rothstein* the doctor testified that he refused to advise the patient of all the known risks because he was afraid that the patient would still undergo treatment and that the resulting anxiety would cause a reaction. The possibility that anxiety may cause an adverse reaction is often advanced as reason for not informing patients of the risks attached to injection with a contrast medium.

### 5.2.1.3 The patient’s psychological state and physical condition

The Swiss Tribunal Fédéral held that doctors should not be required to furnish a patient with information that could frighten him or her to the extent that his or her physical or psychological well-being is prejudiced. It is the doctor’s duty to assess the risks attached to a full disclosure and to limit the information so as to be compatible with the patient’s physical and psychological state. This approach of the Tribunal Fédéral is sound in so far as it heeds any pre-existing anxious state of mind on the part of the patient, or a known tendency towards excessive anxiety, or a physiological state responsive to psychological impulses. Perhaps this is the idea behind Laskin CJC’s remark in *Reibl v Hughes*, that “it may be the case that a particular patient may, because of emotional factors, be unable to cope with facts relevant to recommended surgery or treatment and the doctor may, in such a case, be justified in withholding or generalizing information as to which he would otherwise be required to be more specific”. The wording Laskin CJC chose in the earlier case of *Hopp v Lepp* certainly seems to suggest such an interpretation: “No doubt, a surgeon has some leeway in assessing the emotional condition of the patient and how the prospect of an operation weighs on him, the apprehension, if any, of the


33 316 SE 2d 690 (SC App 1984) 704.


35 *ATF* 105 II 284 287. See also *ATF* 108 II 59 61.


patient, which may require placating.\textsuperscript{38} In \textit{Hajgato v London Health Association}\textsuperscript{39} the doctor noted that the patient was very anxious and labile, and decided not to tell the patient that an infection – which was very unlikely to set in – might result in a destruction of her hip because he believed that doing so will only unduly upset the patient. Conversely, in \textit{White v Turner}\textsuperscript{40} the patient was described as “healthy and intelligent” which, in the court’s opinion, meant that there was no reason to withhold information from her.\textsuperscript{41} In \textit{Rawlings v Lindsey},\textsuperscript{42} one of the factors which urged the court to hold that the doctor could not justifiably minimise his discussion of the risks associated with the surgery in the interests of the welfare of the patient, was the fact that her attitude toward her dental health was “mature and intelligent”.

This approach to a certain extent amounts to a recognition that individual patients vary in their needs, their resources, and their ability to integrate threatening information.\textsuperscript{43} It admits that the doctor may use his discretion if the patient’s mental and emotional condition warrant special treatment.\textsuperscript{44} It is a recognition that not every patient has the constitution to cope with the truth.\textsuperscript{45} Some may be able to tolerate a full disclosure without it affecting their health or their ability to reason, whereas others may not.\textsuperscript{46} It has been pointed out that, because the doctor’s decision must be made in light of the condition and psychological disposition of the particular patient, it

\textsuperscript{38} (1980) 112 DLR (3d) 67 77.

\textsuperscript{39} (1982) 36 OR (2d) 669 678.

\textsuperscript{40} (1981) 31 OR (2d) 773 793.

\textsuperscript{41} The procedure in this case was done primarily for cosmetic purposes. In such cases, even minimal risks must be disclosed. Cf \textit{Hankins v Papillon} (1981) 14 CCLT 198 203.

\textsuperscript{42} (1982) 20 CCLT 301 307.


\textsuperscript{44} Jazvac 1978: 192.

\textsuperscript{45} Brenner 1983 \textit{Arzt und Recht: Leitfaden und Nachschlagewerk des medizinischen Rechts für die ärztliche Praxis} 35.

\textsuperscript{46} Abbuhi & Gerking 1975 “Informed consent of the emotionally disturbed patient” \textit{Legal Medicine Annual} 217 219. Cf also Abbuhi & Gerking 1975: 223.

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is meaningless to speak of a customary standard delineating the scope of the therapeutic privilege. Moreover, uniform disclosure is not likely to be a constructive communication approach.

In *Roberts v Wood* the doctor was not held liable for failure to inform the patient of a risk of injury to the recurrent laryngeal nerves during a thyroidectomy. The court stated that anxiety, apprehension and fear generated by a full disclosure may have a very detrimental effect on some patients. In view of the patient’s emotional state and her concern over the thyroidectomy as well as a gynecological operation which were to be performed at the same time, and the fact that the patient had previously experienced a thyroidectomy, the court came to the conclusion that the patient was properly informed of the seriousness of the operation.

In *Salgo v Leland Stanford Jr University Board of Trustees* a patient was diagnosed with having the symptoms of acute arteriosclerosis. The doctor told the patient that he needed to undergo an aortography. The doctor described the procedure in detail, but, because of the patient’s nervous condition, he neglected to mention the danger of paralysis as a consequence of the aortography. The patient consented to the procedure and the doctor injected Urokon and took the necessary X-rays. The patient was left paralysed from the waist down. Suit was instituted on a number of theories including the doctor’s failure to inform the patient of the dangers involved in the operation. The court, in reviewing the law of informed consent, ordered that the jury be informed that, in recognition of the fact that the patient’s mental and emotional condition is important and in certain cases may be crucial, doctors are allowed to employ a certain amount of discretion in discussing the element of risk associated with a procedure.

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48 Schain 1990: 929.
50 At 583.
51 317 P 2d 170 (1957).
52 At 181[12].

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In *Woods v Brumlop* the patient received shock treatments. As a result of such treatments the patient was seriously injured, sustaining a compression fracture to her spine and complete loss of hearing in her right ear. The patient sued for malpractice, claiming that the doctor had entirely failed to advise her of the dangers inherent in the treatment. The defendant-doctor justified his actions on the ground that the patient was emotionally upset and the treatment was recognised as an aid in recovery from emotional imbalance and a disclosure of all the dangers would only aggravate her emotional, mental condition. Although sustaining a trial court verdict in favour of the plaintiff, the Supreme Court of New Mexico recognised that the doctor’s argument had merit.

It is submitted that the psychological state and physical condition of the patient are important factors to be considered in deciding whether to withhold information from a patient. The patient’s condition could lay a factual basis for the assumption that the information might cause the patient harm. In *Natanson v Kline*, the Supreme Court of Kansas hesitantly acknowledged that there may be a privilege, on therapeutic grounds, to withhold the specific diagnosis of cancer or some other dread disease from an unstable, temperamental or severely depressed patient if disclosure of the diagnosis would seriously jeopardise the recovery of such patient. The court

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53 377 P 2d 520 (1962).

54 At 525.

55 Cf Steiner 1985 “Austria” in Deutsch & Schreiber (eds) *Medical responsibility in Western Europe: Research study of the European Science Foundation* 1 31 who limits the operation of therapeutic privilege to particularly anxious individuals. In *Hall v United States* 136 F Supp 187 (WD LA 1955) 193 the court concluded that it would be bad practice to warn a patient who is giving birth that she might die or become paralysed as a result of a spinal anaesthetic because such a patient finds herself in an elevated state of nervous tension and anxiety. In *Carman v Dipold* 379 NE 2d 1365 (1978) 1370 the court, in holding that the defendant doctor was not negligent in failing to obtain informed consent to a vaginal delivery of a breech baby, said that it would have been imprudent to obtain the patient’s consent because she was tense and her blood pressure had gone up during labour. See Ketler 2001 “The rebirth of informed consent: A cultural analysis of the informed consent doctrine after Schreiber v. Physicians Insurance Co. of Wisconsin” Northwestern University Law Review 1029 1041–1043. See also Woolery 2000 “Informed consent issues throughout the birthing process” *The Journal of Legal Medicine* 241 247.

56 350 P 2d 1093 (1960).

57 At 1103. Cf Landsverk 1970 “Informed consent as a theory of medical liability” *Wisconsin Law Review* 879 890, who extends the application of the rule to the withholding of information on possible harmful effects, and adds to this list of susceptible patients, the unduly apprehensive patient; Meyers 1990 *The human body and the law* (2nd ed) 127; Strauss 1991 *Doctor, patient and the law: A selection of practical issues* (3rd ed) 10; Claassen & Verschoor 1992 *Medical negligence in South Africa* 70. See also Allen,
took pains to point out, however, that in the ordinary case there would appear to be no such warrant for suppressing facts.  

5.2.1.4  Anxiety produced by withholding information

In considering whether to withhold information in order to spare the patient the anxiety expected to result as a result of disclosure, it must be borne in mind that (as has already been pointed out) withholding information often produces anxiety, and may even produce more anxiety than disclosing it would produce.  Seligman cites an example.  One of his clients was viewed by an oncologist as emotionally unstable and was provided with as little information as possible to avoid upsetting her. The client sensed that the oncologist was concealing information from her and

Newman & Souhami 1997 “Anxiety and depression in adolescent cancer: Findings in patients and parents at the time of diagnosis” European Journal of Cancer 1250. These researchers found that the levels of anxiety and depression in a group of adolescent patients newly diagnosed with cancer were not significantly above that found in a normal adolescent population. However, they also point out that an important minority of adolescents are very anxious and/or depressed, and that medical staff working with adolescent patients should identify these individuals. (At 1254.)

The court’s reasoning was accepted as a “sound rule” in Grosjean v Spencer 140 NW 2d 139 (1966) 144[4], the Supreme Court of Iowa however failing to recognize the limitations placed on the therapeutic privilege in Natanson v Kline. Natanson v Kline is also referred to in DiFillipo v Preston 173 A 2d 333 (1961) 339.

See 3.4 supra; Lidz, Meisel, Zerubavel, Carter, Sestak & Roth 1984 Informed consent: A study of decisionmaking in psychiatry 25; Phatouras & Blake 1995 “How much now to tell? Patients’ attitudes to an information sheet prior to angiography and angioplasty” Australasian Radiology 135 137 (who postulate that “by providing more information on adverse outcome, subjective anxiety is actually reduced in so much that the fear of the unknown is removed, given that the patient has time to digest this and ask relevant questions”); Denney, Williamson & Penn 1975 “Informed consent: Emotional responses of patients” Postgraduate Medicine 205 (who, in their study of the effects on patients of detailed written information about a forthcoming hysterectomy, found that the post-operative anxiety levels of patients who had read the written information were significantly lower than those of control-subjects); Roter 1983 “Physician / Patient communication: Transmission of information and patient effects” Maryland State Medical Journal 260 263–264; Patterson 1985: 743–745; Simpson, Buckman, Stewart, Maguire, Lipkin, Novack & Till 1991 “Doctor-patient communication: The Toronto Consensus Statement” British Medical Journal 1385; Saunders 1978 “Appropriate treatment, appropriate death” in Peckham & Carter (general eds) The management of malignant disease series vol 1 Saunders (ed) The management of terminal disease 14; Marten & Mauer 1983 “Psychosocial interactions of the dying child, his parents, and healthcare professionals” in Schowalter, Patterson, Tallmer, Kutscher, Gullo & Perez (eds) The child and death 235 237; Maher & Pask 1995 “When truth hurts…” in Adams & Deveau (eds) Beyond the innocence of childhood vol 2 Helping children and adolescents cope with life-threatening illness and dying 267 276; Foley 1989 “Children with cancer: Ethical dilemmas” Seminars in Oncology Nursing 109 110; Waeckerl 1971 “Children’s awareness of fatal illness” American Journal of Nursing 1168; Adams & Deveau 1984 Coping with childhood cancer: Where do we go from here? 16.

Seligman 1996 Promoting a fighting spirit: Psychotherapy for cancer patients, survivors, and their families 226.
suspected such information to be bad news. She became fearful, which caused her to cry during many of her oncology appointments. This strengthened the oncologist’s opinion that the woman was emotionally unstable. Seligman reports that, once he had explained to the oncologist that his patient was a strong and resourceful woman who craved information, the oncologist became more direct with the patient and her distress lessened.

5.2.2 Where disclosure would endanger the patient’s life or detrimentally affect his or her physical or mental health

5.2.2.1 General

It has often been heard that a privilege to withhold information exists where candid disclosure might have a detrimental effect on the physical or psychological well-being of the patient or would endanger the patient’s life. An example that is frequently encountered in German literature is that of a patient suffering from Basedow-syndrome. Even the slightest emotional excitation, it is argued, can be deadly. Since even the disclosure of the mere intention to operate could excite the patient to the level of endangering his or her life, it is simply out of the question to inform the patient of the need to undergo an operation (and hence the reasons for having to undergo the operation and the risks associated with such operation). Another example mentioned, is that of the patient who suffers from diseased coronary vessels and who may die as a result of a coronary thrombosis if informed of the possibility – albeit a slim possibility – of a deadly risk associated with a proffered intervention.

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61 Pauscher v Iowa Methodist Medical Center 408 NW 2d 355 (Iowa 1987) 361; Sard v Hardy 379 A 2d 1014 (1977) 1022. Cf Harnish v Children’s Hospital Medical Center Mass 439 NE 2d 240 (1982) 244.

62 See Wilts 1971 “Die ärztliche Heilbehandlung in der Strafrechtsreform (Schluss)” Monatsschrift für Deutsches Recht 92 94 ff.

63 Siebert 1982 Strafrechtliche Grenzen ärztlicher Therapiefreiheit 229.


65 Deutsch, Schreiber & Lilie 1985 “Germany” in Deutsch & Schreiber (eds) Medical responsibility in Western Europe: Research study of the European Science Foundation 211 245.

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5.2.2.2 Limitations on the scope of the defence

The scope for using the therapeutic privilege to avoid psycho-physical injury is sometimes sought to be restricted by suggesting that it be required that disclosure will cause "real damage" to the patient's health,\textsuperscript{66} will seriously endanger the life or health of the patient,\textsuperscript{67} or will lead to physical and/or psychological reactions which would directly ("unmittelbar") endanger the patient.\textsuperscript{68} It has also been suggested that the scope be limited by requiring that concrete grounds should exist for fearing that disclosure would result in seriously damaging the patient's health,\textsuperscript{69} or by only allowing it when it can be assumed with certainty that disclosure would have such result.\textsuperscript{70} Another suggestion is to limit the application of the therapeutic privilege to instances where the potential harmful effects of imparting the information are accurately determinable,\textsuperscript{71} or can be clearly defined or outlined by the doctor.\textsuperscript{72}

The courts too have tried to lay down rules for limiting the scope of the therapeutic privilege. In \textit{Hook v Rothstein}\textsuperscript{73} the court said that information may be withheld if the doctor reasonably believes that a complete and candid disclosure will have a detrimental effect on the patient's well-being. The scope of the privilege was narrowed down in \textit{Canterbury v Spence}\textsuperscript{74} when the court reserved such a privilege for the case where a patient would become so ill or emotionally distraught on disclosure as to pose psychological damage to the patient, and insisted that the

\begin{footnotesize}
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\item \textsuperscript{66} Weil 1998 "Informed consent to medical treatment – the Israeli experience" \textit{Medicine and Law} 243.
\item \textsuperscript{68} Brüggemeier 1986: 434.
\item \textsuperscript{69} Siebert 1982: 230.
\item \textsuperscript{70} Reitelmann 1965: 76-77.
\item \textsuperscript{71} Reitelmann 1965: 79.
\item \textsuperscript{72} Reitelmann 1965: 78.
\item \textsuperscript{73} 316 SE 2d 690 (SC App 1984) 703[35].
\item \textsuperscript{74} 464 F 2d 772 (1972) 789[27].
\end{itemize}
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privilege does not contemplate operation save where the patient’s reaction to risk information, as reasonably foreseen by the doctor, is menacing.\(^{75}\)

In Germany, too, the Bundesgerichtshof was cautious in pronouncing on the circumstances giving rise to the therapeutic privilege. In *BGH 16.1.1959 VI ZR 179/57 BGHZ 29 176* the following facts came before the court. The patient saw A, a gynaecologist, for irregular bleeding. The doctor told her that she had an infection of the uterus that could degenerate into cancer, and referred her to a gynaecological hospital. She was admitted to the hospital and was diagnosed with first stage cancer of the cervix. The doctors at the hospital (the defendants) planned to do a hysterectomy and the patient consented. In preparation for the operation the patient underwent deep-X-ray radiation and other radiation treatment after which she was discharged from hospital. After her readmission the doctors found in the follow-up examination a shrinking on the left-hand side of the uterus and an infiltration as thick as a finger on the right. The doctors decided not to go through with the operation and to subject the patient to further radiation treatment. The course of treatment had to be ceased before it could be completed because the patient developed fever and experienced pain. The patient was discharged. After some time the patient started experiencing severe back-ache and renal colic. She suffered from hydronephrosis, her bladder capacity was diminished and she had a diffused infection of the bladder with some pointed bleeding focusses. Both her ureters had to be implanted in the rectum.

At the time of the trial the patient was still suffering from pain and infection of the urinary tract, did not have full control over her urine-flow, often had to stay in bed and was constantly under medical treatment.

The doctors had not informed the patient before starting the treatment of the possibility of causing injury to the nearby organs.

The patient claimed compensation, maintaining *inter alia* that the defendants had violated their duty to inform. The patient asserted that the defendants had had to inform her of the dangers and

\(^{75}\) At 789[28]–[29].
possible complications of radiation treatment. Had she been informed thereof, she would have insisted on continuing with the originally intended operation.76

The doctors maintained that they were not obliged to inform the patient in any more detail on the nature of the disease she was suffering from and the treatment she was about to receive. They argued that it was imperative for the doctor not to inform the patient about the dangers inherent in the treatment in order not to increase such dangers by placing a psychological burden on the patient.77

The Bundesgerichtshof upheld the court a quo’s decision in favour of the patient.

The Bundesgerichtshof agreed that the doctors who had treated the plaintiff had had to inform her of the possible harmful effects of the radiation treatment. The court held that, although the doctor is not obliged to inform the patient in detail about all possible disadvantageous effects of the therapy,78 the complications suffered by the plaintiff were typical effects of radiation treatment that occur in at least five to six percent of cases, and therefore had to be drawn to the patient’s attention.79

The court was of the opinion that the case under discussion did not require going into the question of the extent to which the doctor may by way of exception refrain from informing a patient when informing the patient could result in seriously endangering the patient’s health or life.80 The court pointed out that there were insufficient grounds to suggest that the plaintiff would have suffered harm to her health had the doctors informed her.81 Prior to being admitted to the gynaecological hospital, the patient had been informed by her doctor, A, that she had an infection which could

76 At 178.
77 At 178.
78 At 181.
79 At 182.
80 At 182.
81 At 182–183.
degenerate into cancer. It had not been established, and had never been maintained, that this information had any negative effect on her. Furthermore, the patient had consented to the planned hysterectomy and must have been aware of the gravity of her illness. The Bundesgerichtshof found that the prerequisites for being released from the duty to inform the patient had not been met in the case at hand.\textsuperscript{82}

It would have sufficed to explain to the plaintiff that radiation treatment could affect the bladder and kidneys and that the possibility of accompanying unpleasant permanent injury could not be ruled out. A sufficient explanation of the dangers of the planned treatment had been possible even without expressly disclosing the diagnosis of cancer.\textsuperscript{83}

Since patients differ considerably the doctor may adjust the disclosure to suit the informational requirements of the individual patient.\textsuperscript{84} The doctor is allowed a reasonable measure of leeway in deciding on the nature of information to be disclosed and the way it is to be disclosed. However, it is clear that the doctor is not given \textit{carte blanche} to refrain from informing the patient. The question whether a patient should at all be informed cannot be left to the doctor's discretion, but is a matter in which the court has the final say.\textsuperscript{85}

On appeal the doctors asserted that if they had informed the patient about the side-effects they would also have had to tell the patient that she had cancer in order to obtain the patient's consent.\textsuperscript{86} This, they asserted, would be impossible on medical and humanitarian grounds.\textsuperscript{87}

The Bundesgerichtshof conceded that the consent of the patient to radiation treatment could perhaps in many cases of this nature only be obtained if the patient is also informed of the gravity

\begin{thebibliography}{87}
\bibitem{82} At 183.
\bibitem{83} At 183.
\bibitem{84} At 183–184.
\bibitem{85} At 184.
\bibitem{86} At 184.
\bibitem{87} At 178.
\end{thebibliography}
and the life-threatening nature of the disease. This does not mean that the patient must immediately be apprised of “the naked cancer diagnosis”. Rather, the doctor should first enquire tentatively and carefully about what the patient has already come to know about his or her condition. In so far as it then still proves to be necessary, the doctor should inform the patient about the diagnosis in a cautious manner. The doctor should also inform the patient of the gravity of the condition if only to arouse the patient’s will to be healed. It is the doctor’s therapeutic task to find the right words to convey this information to the patient. However, should it prove impossible to obtain the patient’s consent to a necessary treatment without apprising the patient of the diagnosis of cancer, the doctor may not shy away from it. Only in the particular case where the disclosure of the nature of the patient’s disease would lead to a serious and irremediable injury to the patient’s health, could it be justifiable to disregard informing the patient.

The rule laid down in this case has been criticised for being very strict and narrow-minded. Tempel remarks that the drawing of such an inflexible borderline does not fit into the landscape developed by the Bundesgerichtshof of weighing up different considerations against each other.

88 At 184.
89 At 184.
90 At 184–185.
91 At 185. Cf BGH 9.12.1958 VI ZR 203/57 BGHZ 29 46 56 where it was said that no authority exists “dass eine restlose Aufklärung auch dann zu verlangen sei, wenn durch sie das Leben oder die Gesundheit des Patienten ernstlich gefährdet würden”. For a discussion of the question to what extent the duty to disclose extends to the precise description of a finding, see Schmidt 1939 Der Arzt im Strafrecht 105–106. Cf Robertson 1983: 7, Wawersik 1981 “Die Auswirkungen juristischer Aufklärungserfordernisse auf das Arzt-Patient-Verhältnis” in Jung & Schreiber (eds) Arzt und Patient zwischen Therapie und Recht 90 92. It has been submitted that even in the case of minor illness doctors should not disclose the diagnosis. Reitelmann 1965: 30 says that many patients will thereupon consult layman’s literature to find out more about the diagnosis. This kind of literature usually conveys a false picture of the illness and is taken up far too seriously. The patient suddenly discovers new symptoms, develops hypochondriac ideas and is taken ill with neurosis.

92 Tempel 1980 “Inhalt, Grenzen und Durchführung der ärztlichen Aufklärungspflicht unter Zugrundelegung der höchstrichterlichen Rechtsprechung” Neue Juristische Wochenschrift 609 614. Cf Laufs 1992: 360. Note that the Bundesgerichtshof has not, as yet, decided a single case in which it had released the doctor from the duty to inform on account of medical contraindications – Giesen 1990: 163.

Laufs is of the opinion that the introduction of a reasonable measure of flexibility seems advisable.\footnote{Laufs 1992: 360.}

The criticism expressed against the rule laid down in this case is not convincing. The right to self-determination does not automatically cease to exist in the face of the possibility of psycho-physical harm resulting in pursuance of that very right. It would be as illogical to say that since any medical intervention holds the potential of physical harm (and often death) no medical intervention should be allowed. In such cases, a conflict of interests arises, and it is impossible to arrive at any satisfactory outcome without first weighing up the interests at stake.\footnote{McInerney v MacDonald (1992) 93 DLR (4th) 415 430; Siebert 1982: 230.} Obviously, this means that, the worse the patient's physical and mental health would be affected by the information, the less reason would exist for burdening the doctor with a duty to inform.\footnote{Ulsenheimer 1988: 65.} But since the interests that are to be weighed up in this process are dissimilar in nature, it is paramount to take note of the relative weights attached \textit{ex hypothesi} to the interests of psycho-physical integrity and autonomy, respectively.\footnote{With regard to the German position, Ulsenheimer 1988: 65 remarks that the courts have placed the emphasis on the realisation of the patient's right to self-determination.}

\subsection*{5.2.2.3 The risk of suicide}

A specific instance which I believe will readily be justified under the therapeutic necessity, is where disclosure would hold, or increase, the risk of suicide,\footnote{Brüggemeier 1986: 434; Brenner 1983: 37; Uhlenbruck 1992a “Die Pflichten des Arztes aus Behandlungsübernahme und Behandlungsvertrag” in Laufs & Uhlenbruck (eds) \textit{Handbuch des Arztrechts} 298 312.} for instance in the case of a severely depressed patient.\footnote{Bednar, Bednar, Lambert & Waite 1991 \textit{Psychotherapy with high-risk clients: Legal and professional standards} 167. See also Van Oosten 1995b “HIV infection, blood tests and informed consent” in Joubert (ed) \textit{Huldigingsbundel vir / Essays in honour of SA Strauss} 281 305.} As has been mentioned,\footnote{Fn 59 supra, chapter 4.} both of the examples cited by Strauss\footnote{Strauss 1991: 93.}
as justifiable under necessity deal with the frustration of suicide attempts. It could be argued that the interruption of a suicide attempt can be justified because it may be in accordance with the suicide's own long-term values. Skegg\(^{103}\) reasons that a widely accepted rationale for intervening in suicide attempts is to be found in the likelihood that, if restored to a better condition, the patient will be glad to go on living.\(^{104}\) Research indicates that most persons who commit suicide feel ambivalent about their death.\(^{105}\) It is therefore not always clear that the person who attempts suicide wants to die, but rather that he or she does not see any other way out.\(^{106}\) Murphy points out that most persons who commit suicide are suffering from clinically recognisable illnesses often carrying an excellent prognosis.\(^{107}\) If one considers that the decision to take one's own life is irreversible once successfully executed, and the (mentally) competent, insistent suicide whose attempt is thwarted will probably have ample opportunity to make further attempts at his or her life,\(^{108}\) it would, in my opinion, be reasonable and justifiable to allow the frustrating of suicide

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104 In fact, Skegg takes it one step further. Applying the same rationale, he argues that the doctor should be allowed to administer treatment to an acutely ill or depressed patient who may have a sufficient understanding to give consent, but whose current condition predisposes him to refuse it. He mentions the example of a patient suffering from a kidney disease who demanded to be taken off dialysis. After her health improved, the patient indicated that she actually wanted to stay on the programme.


106 See also Prinsloo & Louw 1989 “Selfmoord” in Louw (ed) Suid-Afrikaanse handboek van abnormale gedrag 189–190 who dismiss the idea that people who commit suicide want to die as a misconception.

107 Murphy 1983 “Suicide and the tight to die” in Gorovitz, Macklin, Jameton, O’Connor & Sherwin (eds) Moral problems in medicine (2nd ed) 442.

108 As is evidenced by the fact that almost 30% of those whose attempts failed, make subsequent attempts – Kaplan & Sadock 1988 Synopsis of psychiatry: Behavioral sciences / Clinical psychiatry (5th ed) 453.
attempts. Motto uses two psychological criteria as grounds for limiting a person’s right to suicide: (i) suicide must be based on a realistic assessment of the person’s life situation; and (ii) the degree of ambivalence regarding suicide must be minimal.

Other considerations colour the scene where the disclosure of the diagnosis of a (serious) infectious disease is at stake and non-disclosure could endanger the lives of third parties. For instance, if the news of an HIV-positive status would put a suicidal patient at risk of making an end to it all, the risk of the patient’s infecting other members of society must be brought into the equation.

It has become quite popular to refer to the case where suicide is feared as an instance where the therapeutic privilege could be invoked. However, suicide following disclosure may be rarer than is commonly supposed and even where the fear of suicide exists, sensitive disclosure might sometimes provide an alternative to non-disclosure. McLean and McKay argue convincingly that since it falls within the psychiatrist’s area of competence, he or she should be the one to judge whether the disclosure of certain information may make a patient suicidal. It is submitted that

109 Cf, nevertheless, Neethling 1998 Persoonlikheidsreg (4th ed) 33 fn 276 who sees suicide as the exercise of a person’s autonomy ("selfbeskikkingsbevoegdheid") in respect of his/her life. It is further interesting to note that the right to life is enshrined as a fundamental right separate from the right to bodily and psychological integrity – s 11 of the Constitution of the Republic of South Africa 108 of 1996. (On the unique nature of the right to life, see Neethling 1998: 19-20.)


111 See Van Oosten 1995b: 305 fn 126. The American Academy of Pediatrics recommends full disclosure to HIV-infected adolescents in order to reduce the risk of transmitting the infection to others through unprotected sex or behaviours associated with illicit drug use – see American Academy of Pediatrics: Committee on Pediatric AIDS 1999 “Disclosure of illness status to children and adolescents with HIV infection” Pediatrics 164 165.


the threat to the patient’s life can, in most instances, only be inferred from actual knowledge of the patient’s personality and psychological condition.\textsuperscript{115}

5.2.2.4 \textit{Psychological and physical harm}

Finally, it deserves to be mentioned that, although some courts and authors would restrict the harm lawfully to be avoided under the therapeutic privilege to psychological harm,\textsuperscript{116} this restriction seems to me to be without any merit.\textsuperscript{117}

5.2.3 \textbf{Where the risks attached to disclosure are as serious or more serious than those attached to the disease or the proposed intervention}

Brenner argues that the disclosure of information may in no case pose a greater threat than the illness.\textsuperscript{118} The disclosure of information must be incomplete if, after balancing the patient’s interests, it appears that a comprehensive disclosure could expose the patient to harm that does not bear reasonable proportion to the illness. The stronger the patient is affected emotionally or intellectually by the illness, the smaller the doctor’s duty to inform.


\textsuperscript{117} See fn 64 and 65 and the accompanying text supra, chapter 2. Cf eg Kirby 1983: 72.

Brenner cites the following examples belonging to this category: the doctor need not inform the patient that the indicated intervention is life-threatening when the patient is suffering from Basedow's disease, since, in his words, a Basedow psychosis can be fatal. An anxious patient may be withheld the degree of seriousness of a coronary thrombosis when it is to be feared that the patient might again suffer a coronary thrombosis upon being fully informed. However, should the patient who has suffered a coronary thrombosis decide to override the doctor's orders, the doctor may inform the patient unsparingly in order to avert mortal danger to the patient. Presumably this qualification holds good only if the risk inherent in unsparingly informing the patient is not one of mortal danger, or is one which poses a smaller risk of mortal danger to the patient than does the patient's decision not to follow the doctor's orders.

There is nothing wrong with allowing the therapeutic privilege where the harm caused by informing the patient would exceed the harm caused by non-disclosure, provided the infringement of the patient's autonomy is also taken into consideration when determining the weight of the harm that would be caused by non-disclosure. When applying the rule it must be borne in mind that the more serious the illness the patient suffers from (or the more serious the risks involved in treatment), the more important for the patient's exercise of his or her self-determination it becomes to share such information.

5.2.4 Where disclosure may be detrimental to the patient's best (medical) interests

In *Holt v Nelson* the Court of Appeals of Washington said that a doctor may not be responsible for failing to disclose a risk to a patient where full disclosure would be detrimental to the patient's best interests. Such a definition of the therapeutic privilege could be interpreted to be in accordance with the principles of the necessity defence, since the necessity defence is based on consequentialist theory and aspires to avoid the greater harm (or to achieve the greater good).

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119  Brenner 1983: 36.

120  See also fn 127 and the accompanying text infra.


122  Cf *Wilkinson v Vesey* 295 A 2d 676 (1972) 687-688; Holder 1975 Medical malpractice law 227–228.
However, I believe that the definition in *Holt v Nelson* is vague at its best and extremely partial to (the doctor’s perception of) the patient’s medical interests at its worst. As will have become apparent by now, I believe that, for a number of reasons, notably the focus of their professional training, doctors are likely to view their patients’ best interests as defined by medical practice, effectively making the determination of the patient’s best interests a matter of exercising a clinical judgment. The formulation in *Holt v Nelson* is probably based on that in *Nishi v Hartwell*, in which the court said that the doctrine of informed consent recognises that the “primary duty of a physician is to do what is best for his patient and that a physician may withhold disclosure of information regarding any untoward consequences of a treatment where full disclosure will be detrimental to the patient’s total care and best interests”.

McClean and McKay have pointed out that for a doctor to be in a position to claim that he or she knows that the withholding of information is in the best interests of the patient, the doctor needs to judge not only whether the giving of information will be harmful, but also whether the withholding of the information will not turn out to be more harmful. In order to make such judgments, the doctor has to possess knowledge which extends well beyond purely medical matters. The doctor often does not possess the necessary information to make such judgments. Moreover, the doctor may be treading outside his or her area of competence and may be trespassing on that of the psychiatrist when predicting the effect that disclosure of certain information may have on the patient’s well-being.

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123 Cf 3.2 and 3.8 supra.
124 *Lee v South West Thames RHA* [1985] 2 All ER 385 389.
126 Cf Lewis & Tamparo 1993 *Medical law, ethics, and bioethics in the medical office* (3rd ed) 100. See the criticism against the formulation of the therapeutic privilege in *Nishi v Hartwell* by Kennedy & Grubb 1994 *Medical law: Text with materials* (2nd ed) 214, fn 16 supra, chapter 2. Cf *Cornfeldt v Tongen* 262 NW 2d 684 (1977) 700 where it was stated that the therapeutic privilege constitutes an exception to the objective standard of disclosure and excuses the withholding of information where disclosure would be unhealthful to the patient.
5.2.5 Where the information would cause the patient to react in a way that would call into question the success of the intervention

There is some authority for the view that the therapeutic privilege is warranted if the patient’s recovery could be prejudiced should he or she be apprised of the gravity and severity of his or her condition or of the drastic nature of the treatment indicated or if there is good reason to believe that the disclosure of certain information would seriously inhibit the healing process, for instance by undermining the placebo component of treatment. Here, the emphasis lies not on conserving the status quo or preventing the deterioration of the patient’s well-being, but on maintaining the curative potential of the proffered medical intervention or the inherent potential to be cured. Thus it has been argued in the German legal literature that the disclosure of the diagnosis of a serious illness should remain the exception since most people are not able to bear the truth without serious impairment of the healing process.

In Switzerland the Tribunal Fédéral accepted that alarming a patient may compromise the success of a proposed intervention. Where this may be the effect of informing the patient, doctors are released from their duty to disclose, because, according to the court, the duty to inform finds its limits in the very definition of medical science which has as its object the conservation as well as the restoration of health.

131 See Giesen 1988a International medical malpractice law 382 and the authorities cited there. Cf also 5.8 infra.
133 ATF 105 II 284 287.
134 At 287.
In two German cases decided in 1971 the Bundesgerichtshof remarked *obiter* that a doctor may modify an explanation or even "relinquish" the duty to inform the patient if compelling therapeutic considerations so dictate.\textsuperscript{136} This would appear to come close to admitting of a "right to cure" on the part of the doctor. However, three years later the Bundesgerichtshof, in a much more restrained voice, left open the question whether circumstances could ever justify not involving the patient in decisions about medical interventions.\textsuperscript{137} Only in 1982 did the Bundesgerichtshof again take up the discussion of specific therapeutic considerations that could justify non-disclosure. The court stated\textsuperscript{138} that it cannot be denied that there may be exceptional cases in which the doctor may and should withhold certain information (whether pertaining to the risks associated with an intervention or to findings and diagnoses) from the patient for therapeutic reasons. However, the Bundesgerichtshof emphasised the need to set very narrow limits to such exceptions.\textsuperscript{139}

\section*{5.3 WHERE NON-DISCLOSURE IS CLAIMED TO BE JUSTIFIED ON ACCOUNT OF THE EFFECT THAT DISCLOSURE MAY HAVE ON THE PATIENT'S DECISION OR DECISION-MAKING CAPABILITIES}

\subsection*{5.3.1 Where disclosure may lead to refusal of an intervention\textsuperscript{140}}

\subsubsection*{5.3.1.1 Authority in support}

It is sometimes suggested that doctors may escape liability for lack of informed consent under the aegis of the therapeutic privilege where their decision to withhold information was motivated by

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\textsuperscript{138} BGH 23.11.1982 VI ZR 222/79 BGHZ 85 327 333.
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\textsuperscript{139} See Giesen 1990: 166.
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\textsuperscript{140} See Patterson 1985: 752–755.
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\textbf{125}
fear that the patient might reject a proffered intervention – whether life-saving,\textsuperscript{141} necessary\textsuperscript{142} or merely judged to be in the patient’s best interest\textsuperscript{143} – once properly informed.\textsuperscript{144}

There are even a few obiter dicta in support of the suggestion that doctors may exercise the privilege if there is a possibility (or probability) that the patient may refuse to undergo an indicated intervention.\textsuperscript{145} In \textit{O’Malley-Williams v Board of Governors of the National Hospital for Nervous Diseases}\textsuperscript{146} the court seems to have restricted the operation of the privilege to the non-disclosure of remote risks which may “unduly” influence the patient’s decision, and in \textit{Bolam v Friern HMC}\textsuperscript{147} to the non-disclosure of minimal risks which may cause the patient to refuse the only therapy which offers some hope of cure.\textsuperscript{148}

5.3.1.2 \textbf{Practical importance}

The importance in practice of this motivation for withholding information must not be underestimated.\textsuperscript{149} In fact, it has been said that it seems unlikely that there would be much dispute

\textsuperscript{141} Weil 1998: 243.

\textsuperscript{142} Ryckmans & Meert-Van de Put 1971: 440; Anrys 1974: 78; Steiner 1985: 31; Molnar 1997 “Consent in the 90’s” \textit{Medicine and Law} 567 576; Holder 1975: 227 (adding that this is particularly true when the risks are highly improbable). In \textit{Canterbury v Spence} 464 F 2d 772 (1972) 778 the doctor gave evidence that disclosure of certain information is not good medical practice because it might deter patients from undergoing needed surgery.

\textsuperscript{143} In \textit{Pericle v St Paul Fire & Marine Ins Co} La App 349 So 2d 1289 (1977) 1297 the doctor testified that he gave no further explanation because he felt the patient might reject surgery which he believed to be in the patient’s best interest. Cf \textit{Ferguson v Hamilton Civic Hospitals} (1983) 23 CCLT 254 287.

\textsuperscript{144} Cf Martin 1979 \textit{Law relating to medical practice} (2nd ed) 374–375. See also Abuhl & Gerking 1975: 223. Abuhl & Gerking 1975: 217 go so far as to label a patient who, upon full disclosure of the risks of a medical or surgical treatment, will unreasonably refuse needed surgical or medical treatment which a normal person would not refuse after evaluating the risks “emotionally disturbed”!

\textsuperscript{145} ZeBarth v Swedish Hospital Medical Center Wash 499 P 2d 1 (1972) 9–10; \textit{Sidaway v Bethlem Royal Hospital Governors} [1985] 1 All ER 643 659; \textit{Haughian v Paine} (1987) 37 DLR (4th) 624 644.

\textsuperscript{146} [1975] 1 BMJ 635.

\textsuperscript{147} [1957] 2 All ER 118 124.

\textsuperscript{148} Cf McLean 1989 \textit{A patient’s right to know} 103–104; Jackson & Powell 1992: 526.

\textsuperscript{149} Examples of cases where the doctor’s decision not to inform the patient was motivated by this consideration are to be found in the so-called “Elektroshockkurseiten” – see Reitelmann 1965: 35.
over informed consent if doctors did not fear that their patients might wish to make decisions against medical advice.\textsuperscript{150} Many doctors believe that information may be withheld if disclosure thereof will cause the patient to refuse treatment.\textsuperscript{151} Molnar seems to be of the opinion that the raison d'être of the therapeutic privilege is to ensure that patients undergo necessary medical procedures.\textsuperscript{152} Alfidi states that his questioning a number of doctors on their reactions to obtaining informed consent revealed the most common attitude among them to be that if they give their patients a comprehensive explanation of what is to be done and what possible complications might ensue, the result would be the wholesale refusal of patients to undergo the procedure.\textsuperscript{153} Johnson and James list five of the most common reasons expressed by doctors for failing to inform their patients adequately of risks.\textsuperscript{154} The first of these is the “fear of patient refusal for a clinically necessary procedure”. The authors explain\textsuperscript{155} that, to doctors, refusal by a patient means a constraint on doing what they believe is best for the patient under the circumstances.\textsuperscript{156}

5.3.1.3 \textit{Authority against}

The vast majority of legal, ethical and medical commentators are opposed to affording the doctor a defence of therapeutic justification to curtail disclosure on therapeutic grounds in circumstances where the doctor considers intervention to be necessary and fears that the patient, if fully

\textsuperscript{150} Faden & Beauchamp 1986: 148.

\textsuperscript{151} Meisel & Kuczewski 1996 “Legal and ethical myths about informed consent” Archives of Internal Medicine 2521 2525.

\textsuperscript{152} Molnar 1997: 576. See also Van den Heever 1993: 624 who states that psychological profiles of some patients are often indicative of the fact that full knowledge of the medical intervention or diagnosis may discourage them from submitting to the proposed treatment. This leads him to conclude that there are situations where full disclosure of information could be detrimental to the patient and should not be required legally.

\textsuperscript{153} Alfidi 1971 “Informed consent: A study of patient reaction” Journal of the American Medical Association 1325. However, the author found this fear to be unwarranted – see fn 160–162 and the accompanying text supra, chapter 3.

\textsuperscript{154} Johnson & James 1979: 12.

\textsuperscript{155} Johnson & James 1979: 13.

\textsuperscript{156} See also Plaut 1989 “The ethics of informed consent: An overview” Psychiatric Journal of the University of Ottawa / Revue de Psychiatrie de l'Université d'Ottawa 435 437.
informed, will refuse to consent.\textsuperscript{157} In the United States, “therapeutic” non-disclosure that serves the purpose of securing consent has been excluded from justification in a number of obiter dicta.\textsuperscript{158} In \textit{Canterbury v Spence}\textsuperscript{159} the court rejected the notion that the doctor may remain silent simply because divulgence might prompt the patient to forego therapy that the doctor feels the patient really needs. The court was of the opinion that such a paternalistic attitude presumes instability or perversity on the part of even the normal patient.

The Bundesgerichtshof is no more permissive.\textsuperscript{160} It took notice of the argument that an unrestricted disclosure of possible complications would cause patients so much anxiety that they would, in most cases, decline to consent to shock-treatment and be deprived of the chance to be cured. Doctors had argued that in such cases the refusal cannot be viewed as a genuine, considered decision since it is induced by anxieties, fears, uncontrollable moods and prejudices.\textsuperscript{161} The Bundesgerichtshof rejected the argument. In the absence of any fear that disclosure will prejudice the (competent) patient’s health or the success of treatment, the doctor will not be relieved of his or her duty to inform the patient of the typical risks associated with the treatment merely because of the serious possibility that the patient will refuse to undergo the treatment.\textsuperscript{162}


\textsuperscript{159} 464 F 2d 772 (1972) 789.

\textsuperscript{160} See \textit{BGH 9.12.1958 VI ZR 203/57 BGHZ} 29 46.

\textsuperscript{161} Cf Grünwald 1961: 25.

\textsuperscript{162} \textit{BGH 9.12.1958 VI ZR 203/57 BGHZ} 29 46 55–56.
The position in South Africa

What is the position in South Africa? In Richter and Another v Estate Hammann,\textsuperscript{163} it was acknowledged that doctors may sometimes find themselves in a dilemma when informing patients:

A doctor whose advice is sought about an operation to which certain dangers are attached – and there are dangers attached to most operations – is in a dilemma. If he fails to disclose the risks he may render himself liable to an action for assault, whereas if he discloses them he might well frighten the patient into not having the operation when the doctor knows full well that it would be in the patient’s interests to have it.

This observation has been interpreted to allude to the therapeutic privilege.\textsuperscript{164} It is submitted that these words could also be interpreted to give expression to the difficulty in which doctors sometimes find themselves, without at the same time intimating that they should be allowed to withhold information. In other words, it should not be read as an indication that the therapeutic privilege is warranted where the doctor finds himself or herself in such a dilemma. It merely states as a fact that doctors sometimes are confronted with the possibility\textsuperscript{165} of frightening patients off treatment they believe the patient needs.

Be that as it may, there can be little doubt after the decision in Castell v De Gref\textsuperscript{166} that a doctor would be liable if his or her failure to obtain an informed consent was motivated by the fear that the patient will forgo a proffered intervention.\textsuperscript{167} Ackermann J strongly (and, it is submitted, correctly)\textsuperscript{168} rejected the notion that the doctor’s fear, knowledge even, that a patient will forgo

\begin{itemize}
  \item \textsuperscript{163} 1976 (3) SA 226 (C) 232G.
  \item \textsuperscript{164} See fn 68 supra, chapter 1; Castell v De Gref 1994 (4) SA 408 (C) 417J–418A. Cf Van Oosten 1992 “The doctor’s duty of disclosure and excessive information liability” Medicine and Law 663 634–635; Welz 1998: 1.
  \item \textsuperscript{165} Which is more often imagined than real – see 3.10.2 supra.
  \item \textsuperscript{166} 1994 (4) SA 408 (C).
  \item \textsuperscript{167} See Van Oosten 1995a “Castell v De Gref and the doctrine of informed consent: Medical paternalism ousted in favour of patient autonomy” De Jure 164 177.
  \item \textsuperscript{168} Cf 4.3 supra.
\end{itemize}
a medically indicated intervention if informed of the risks involved, could justify withholding information:

It is clearly for the patient to decide whether he or she wishes to undergo the operation, in the exercise of the patient's fundamental right to self-determination. A woman may be informed by her physician that the only way of avoiding death by cancer is to undergo a radical mastectomy. This advice may reflect universal medical opinion and may be, in addition, factually correct. Yet, to the knowledge of her physician, the patient is, and has consistently been, implacably opposed to the mutilation of her body and would choose death before the mastectomy. I cannot conceive how the 'best interests of the patient' (as seen through the eyes of her physician or the entire medical profession, for that matter) could justify a mastectomy or any other life-saving procedure which entailed a high risk of the patient losing a breast. Even if the risk of breast loss were insignificant, a life-saving operation which entailed such risk would be wrongful if the surgeon refrains from drawing the risk to his patient's attention, well knowing that she would refuse consent if informed of the risk. It is, in principle, wholly irrelevant that her attitude is, in the eyes of the entire medical profession, grossly unreasonable, because her rights of bodily integrity and autonomous moral agency entitle her to refuse medical treatment. It would, in my view, be equally irrelevant that the medical profession was of the unanimous view that, under these circumstances, it was the duty of the surgeon to refrain from bringing the risk to his patient's attention.\(^{169}\)

5.3.1.5 Critical comments

Doctors have been called upon to strive to make patients sufficiently aware of the facts of their condition to facilitate their participation in treatment without at the same time giving them cause to believe that such participation is futile.\(^ {170}\) This immediately summons the question: what if such participation is futile? Or, what if this participation might be futile? In other words: is the tailoring of information and the selective disclosure of information that have been proposed not precisely required to forestall the patient's (healthy) scepticism about the efficacy of a proposed intervention? Why would a rational patient refuse treatment which objectively promises to be effectual? Why would a doctor fear that a patient will not participate in an effectual treatment? Are we to assume that a rational patient, once put in possession of all the information necessary to make an informed consent, will choose, against all good reason, not to participate in a medically indicated treatment?

\(^{169}\) At 420J–421D of the report. Cf Kelly v Hazlett 15 OR 2d 290 (Ont HC 1976) 297 – the surgeon regarding his patient’s concern for a cosmetic result over a functional one as being “irrational”.

If a particular medical intervention is indicated and is known to be efficacious if carried out by capable hands, it is the doctor’s responsibility to convey this to the patient. The doctor may even emphasise the need to intervene.\textsuperscript{171} In the ordinary case, the rational patient confronted with the objective reality will choose the rational option. If, however, the patient opts not to undergo the treatment, perhaps on account of some non-medical interest or need, perhaps even on the strength of an emotional impulse or caprice, or because of being genuinely tired of life, it is his or her right to do so.\textsuperscript{172} If the tailoring of information and the selective disclosure of information are then not propagated because of a fear that rational people ordinarily act irrationally, is it not indicative of the doctor’s wish to conceal the uncertainty or questionableness of the merits of a proposed intervention?

The notion that harm can be interpreted to include the possibility of rejection of a proffered intervention proceeds from the assumption that therapy is the ultimate goal and that the doctor has a right to heal.\textsuperscript{173} This notion is inconsistent with the theoretical underpinnings of informed consent and would allow the most deplorably obvious form of paternalistic manipulation to operate in a relationship marked by inequality.\textsuperscript{174} As Patterson correctly points out, the entire concept of informed consent is illusory if it provides on the one hand that information must be provided to the patient in order that he or she may make an informed decision concerning treatment, and on the other hand that the information could be withheld if it might prompt the patient to make a decision which conflicts with that of the doctor.\textsuperscript{175} It basically boils down to allowing the patient to make decisions only if the doctor is of the opinion that the information will lead the patient to make what the doctor believes to be a rational decision.\textsuperscript{176} The idea that a failure to disclose material information can be justified where the patient might refuse “necessary”

\begin{itemize}
\item \textsuperscript{171} See eg \textit{Hopp v Lepp} (1980) 112 DLR (3d) 67 77; \textit{BGH} 9.12.1958 \textit{VI ZR} 203/57 \textit{BGHZ} 29 46 56.
\item \textsuperscript{172} \textit{Briggemeier} 1986: 434.
\item \textsuperscript{173} See fn 7–12 and the accompanying text \textit{supra}, chapter 3.
\item \textsuperscript{174} Cf Montange 1974 “Informed consent and the dying patient” \textit{The Yale Law Journal} 1632 1638–1639.
\item \textsuperscript{175} \textit{Patterson} 1985: 753.
\item \textsuperscript{176} See \textit{Wills} 1971: 94.
\end{itemize}
treatment of course begs the conclusion that the treatment is "necessary", when necessity should be a matter for the patient to determine.\textsuperscript{177}

Finally, it should be pointed out that the doctor would be unwise to give the impression that what he or she was trying to avoid through the withholding of information, was the possibility of the rejection of the proffered intervention. Causation is one of the elements of both a delict and all materially defined crimes. In the context of therapeutic non-disclosure, this element is satisfied once it is proved that the patient would not have consented to the intervention. The doctor might be cutting his or her own throat by giving an indication that disclosure would prompt the patient to refuse a proffered intervention.

5.3.2 Where disclosure may lead to an "irrational" decision or may foreclose a rational decision

5.3.2.1 General

Of kindred character, but slightly more obscure (or rather, less blatant) in its paternalistic undertones, is the suggestion that the therapeutic privilege should be reserved for those instances where disclosure of information may lead to an "irrational" or "inadequate"\textsuperscript{178} decision.

Justification for withholding information has also been claimed on account of the undesirable effect that disclosure might have on the patient’s decision-making capabilities. Thus it has been argued that the therapeutic privilege should be warranted if disclosure might foreclose a rational decision,\textsuperscript{179} or would render the patient unable to engage rationally in decision-making.\textsuperscript{180} The

\textsuperscript{177} Shartsis 1972: 531.


\textsuperscript{179} Cornfeldt v Tongen 262 NW 2d 684 (1977) 700. See also Ketler 2001: 1035–1036, 1045.

\textsuperscript{180} Lidz, Meisel, Zerubavel, Carter, Sestak & Roth 1984: 19. Cf Fielder 1993 "Getting the bad news about your artificial heart valve" Hastings Center Report no 2 22 24. Meisel & Kuczewski 1996: 2525 are even more cautious in delineating the scope of this defence when they argue for it to operate when "disclosure would so upset a patient that he or she could not rationally engage in a conversation about therapeutic options and consequences". Garneau & Diener 1989: 759 are of the opinion that the doctor who invokes therapeutic privilege considers his/her patient as virtually incapable of coming to a proper decision once fully informed. Jackson & Powell 1992: 525–526 discuss therapeutic privilege and the situation where a person is unfit to receive information (eg as a result of being semi-conscious) in the same breath.
court a quo in *Smith v Auckland Hospital Board,* for example, reasoned that the paramount consideration is the welfare of the patient, and given good faith on the part of the doctor, the exercise of his or her discretion in the area of advice must depend on the patient's overall needs. One of the factors to be taken into account should be "the intellectual and emotional capacity of the patient to accept the information without such distortion as to prevent any rational decision at all".

5.3.2.2  **Critical comments**

Meisel appraises this category of formulations of the therapeutic privilege as the one that most honours individualism because it is framed in terms of the primary functions of the doctrine of informed consent, namely to promote patient primacy in medical decision-making and to promote rational decision-making. This appraisal might be correct if we were to assume that this exception aims to protect patients from becoming incompetent on learning bad news. However, most definitions falling within this category do not support such an assumption. Patterson does not share Meisel's sentiments but believes that this category is only a more appealing representation of the idea that non-disclosure is justified simply because the (competent) patient might reject the doctor's recommendation. To cite one example in support of Patterson’s


182  At 250, lines 41–45.

183  At 250, lines 45–52. Although, at first glance, the phrase quoted may seem to refer to a patient’s capacity to consent, when read together with what Woodhouse J had to say in the preceding paragraph, the true reason for this consideration appears to be to avoid frightening patients to such an extent that they refuse to undergo essential interventions. There (ie at 250, lines 33–40) Woodhouse J expresses his preference for an approach according to which complete absence of warnings or even a "soft answer" may be justifiable depending on the circumstances, and opines that unless this were so, some patients would be deprived of essential treatments by an unreasoning fear. See also *Battersby v Toltman* (1985) 37 SASR 524 527.

184  Meisel 1979 “The ‘exceptions’ to the informed consent doctrine: Striking a balance between competing values in medical decisionmaking” *Wisconsin Law Review* 413 462.

185  CDFworkin 1982 “Autonomy and informed consent” in President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research *Making health care decisions* vol 3 63 80; Patterson 1985: 753.

186  As suggested by Robertson 1983: 7. However, the difficulty of proving the likelihood that this would be the effect of disclosure remains.

187  Patterson 1985: 753. See also Kirby 1983: 72.
impression, it has been suggested that the therapeutic privilege operates "where disclosure might prevent the patient from coming to a rational decision by scaring or frightening him into refusing an indicated intervention". Since this formulation makes no secret of it that the "harm" to be avoided is rejection of a proffered intervention, it is submitted that it cannot survive *Castell v De Greef*.

It is submitted that Patterson's impression deserves serious consideration. In terms of this exception to the requirement of informed consent, a patient's self-determination is limited by the doctor's perception of rationality coupled with the doctor's prophetic capabilities. Put differently, the competent patient has the right to make informed decisions as long as the doctor does not fear that the information necessary for the making of an informed decision will lead the patient to a decision which the doctor considers to be irrational. Proponents of this exception might argue that a patient makes an irrational decision if he or she attaches undue weight to particular unfavourable information. However, such an argument presumes that the doctor rather than the patient is the one to decide what weight is due or undue. For the doctor, a rational decision will most likely be one in terms of which the patient's health interests receive top priority. The patient on the other hand may discount the health interests likely to be served by a certain medical intervention against other non-medical interests in the process of making an evaluative, non-technical decision. And since the patient is the one directly affected by the decision, he or she should be the one making the decision.

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188 Van Oosten 1991b "The so-called 'therapeutic privilege' or 'contra-indication': Its nature and role in non-disclosure cases" *Medicine and Law* 31:32.

189 1994 (4) SA 408 (C) 420J–421D. See fns 166–169 and the accompanying text supra, as well as 4.3 supra.

190 See eg *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] 1 AC 871 899; Davies 1996 *Textbook on medical law* 153 says that to inform a patient of minuscule risks associated with general anaesthesia might distort the patient's perception of the benefits and burdens of the therapy and harm patient welfare. No doubt minuscule risks associated with all interventions under general anaesthetics need not always be disclosed. However, invoking the therapeutic privilege on the assumption that disclosure of such risks might distort the patient's perception of risks and benefits, distorts the true nature of the therapeutic privilege and clouds the issues at stake. It is illogical to argue that disclosure of information giving a realistic account of risks (minuscule or grave) could distort the patient's perception of risk. See Reitelmann 1965: 89.

Failure on the part of the doctor to elicit the patient’s understanding of benefits and risks, and to address points of disagreement which exist between himself or herself and the patient, could lead to inappropriate labelling of the patient as being irrational.\textsuperscript{192}

It would seem to be wellnigh impossible to show that the patient would be unable to make a rational decision once in possession of the information\textsuperscript{193} (assuming, for argument’s sake, that such a universally objective notion of rationality exists). Doctors are no experts on the processes of decision-making, and allowing them to make a decision based on their own subjective fear not pertaining to any aspect of their professional expertise would in fact be irrational.\textsuperscript{194}

It is submitted that the patient should be informed. If the information does indeed frighten the patient into refusing a proffered intervention, the doctor may decide provisionally to acquiesce in the patient’s refusal until any psychologic factors, such as fear, anxiety, depression or denial, which might have influenced the patient’s decision are adequately addressed and resolved.\textsuperscript{195} In medical literature, the need has been expressed to develop methods of talking with patients that uncover the patient’s reasons for refusal as well as strategies that help the doctor decide what to do when psychologic factors influence the patient’s ability to decide.\textsuperscript{196} It is submitted that the normal rules applicable in cases of an incompetent patient should apply once it has been established that the patient’s refusal could be attributed to an inability to make any rational decision.\textsuperscript{197}


\textsuperscript{193} Dworkin 1982: vol 3 80.

\textsuperscript{194} Cf Patterson 1985: 755.

\textsuperscript{195} Cf Connelly & Campbell 1987 “Patients who refuse treatment in medical offices” \textit{Archives of Internal Medicine} 1829 1833.

\textsuperscript{196} Connelly & Campbell 1987: 1833.

\textsuperscript{197} Cf Hébert 1994 “Truth-telling in clinical practice” \textit{Canadian Family Physician} 2105 2111.
5.3.2.3 *The impact that the impairment of the patient’s well-being may have on his or her ability to make rational decisions*

More acceptable are those formulations in which the fear of an inability to make rational decisions is derived from the possible impact that disclosure might have on the patient’s (emotional) well-being. In *Canterbury v Spence*,\(^\text{198}\) for example, the court recognised that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision.\(^\text{199}\)

It is submitted that the harm to be avoided under such formulations is the effect that disclosure may have on the patient’s psychological well-being,\(^\text{200}\) and not the effect that the impairment of the patient’s well-being may have on the patient’s decision-making. This would bring the basis of the inquiry closer to (if not within) the doctor’s field of expertise.\(^\text{201}\)

5.3.2.4 *Non-disclosure of information that may confuse the patient with technicalities*

The suggestion that the therapeutic privilege should apply where disclosure might prevent the patient from coming to a rational decision by confusing him or her with technicalities,\(^\text{202}\) cannot be accepted.\(^\text{203}\) The purpose of informing a patient in terms of informed consent is to elucidate, not to confuse. The withholding of information that has the tendency to confuse the patient therefore cannot constitute an exception to the rule of informed consent, but is in fact dictated by (or a necessary implication of) the rule. This subcategory of instances therefore does not fall

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\(^{198}\) 464 F 2d 772 (1972) 789.


\(^{200}\) The court in *Canterbury v Spence* 464 F 2d 772 (1972) 789 said that the critical inquiry is whether the doctor responded to a sound medical judgment that communication of the risk information would present a threat to the patient’s well-being. Cf fn 162 and the accompanying text *supra*.

\(^{201}\) Although, as has been pointed out, the medical profession still has to prove its expertise in predicting the effect that disclosure may have on the patient’s health – see 3.9 *supra*.

\(^{202}\) Van Oosten 1991b: 32.

\(^{203}\) Brenner 1983: 38 limits the scope for such a defence to complicated treatments and to treatment measures (including pharmaceuticals) of which the possible effects are often not foreseeable. Brenner distinguishes these cases from instances of the administration of drugs for the purpose of clinical trials or drugs which are known to carry a considerable risk of failure. In the latter instances, comprehensive information is required.
under the defence of therapeutic privilege, nor does it fall within the ambit of any defence claiming justification on therapeutic grounds. Withholding information in such instances is simply not unlawful because the law does not lay a duty on the doctor to make available information that could confuse the patient with technicalities.

5.3.2.5 When will a decision to refuse an indicated intervention be irrational?

Rational motivations for refusal would include, for instance, the possible inefficiency of an intervention and the unacceptability of its side-effects. A decision will be irrational if, for instance, it can be attributed to denial or delusional ideation. Take the following example. The doctor believes that the patient will object to having an operation if properly informed for fear that it will be painful, when in fact the patient will have minimum pain and the pain will be managed through the use of drugs. It is arguable that such a fear on the part of the patient is irrational, because the fear does not rest on any factual basis. Even so, it is very difficult to imagine how a doctor can possibly foresee with any degree of certainty that a patient will act irrationally in such a way. If such irrational conduct is feared on the basis of the patient’s medical history or disposition, the question is to be asked whether such a patient is in fact capable of making the decision. If not, the patient should be treated in accordance with the rules applicable to patients incapable of giving consent.

In the example mentioned, the patient’s fear will not be the result of any information being disclosed, precisely because it does not depend on the true state of affairs to be expected as a result of the intervention. It is therefore difficult to see how non-disclosure of the true facts can influence the patient’s decision. It is one thing to fear that a patient will make an irrational decision once in possession of certain information. It is quite another to fear that the patient will attach greater significance to the information than the doctor believes should be attached to it.

205 Cf Landsverk 1970: 891.
5.4 SERIOUSLY ILL OR DYING PATIENTS

5.4.1 General

Doctors are often confronted with the decision whether or not to inform a patient that he or she is seriously or terminally ill. In *Natanson v Kline* the Supreme Court of Kansas in an *obiter dictum* hesitantly acknowledged the existence of a privilege to withhold the diagnosis of a "dread disease" from a patient. The court was at pains to limit the discretion to withhold information on this ground and placed a very heavy burden of proof on the doctor. Only where the patient is unstable, temperamentally or severely depressed does the possibility arise that the withholding be justified, and then only if the disclosure of the specific diagnosis of a dread disease like cancer may seriously jeopardise the patient's recovery.

In a case that served before the Tribunal Fédéral Suisse the defendant informed the plaintiff that it was necessary for him to undergo an operation in order to remove a tumour at the base of his colon. The defendant failed to inform the plaintiff of the cancerous nature of the tumour. During the operation the defendant decided to remove the patient's colon and a part of his small intestine. The plaintiff averred that if he had been duly informed of the established diagnosis and the extent of the operation planned, he would have postponed the operation in order first to consult a number of specialists.

The court affirmed that Swiss doctrine in principle admits of the duty of the doctor to inform the patient of his or her condition, notably of the nature of his or her illness, the foreseeable consequences of the proposed treatment and of forgoing therapy. The court added that the duty to inform cannot, however, extend to information that would only alarm the patient, and, consequently, would prejudice the patient's physical or psychological condition, or would


207 350 P 2d 1093 (1960) 1103.

208 *ATF* 105 II 284.

209 At 287.
compromise the success of the treatment. The court remarked that the duty to inform finds its limits in the very definition of medical science, which has as its object the conservation and the restoration of health.

The Tribunal Fédéral held that information given to a patient must not stir up a state of apprehension in the patient prejudicial to his or her health. An ominous or fatal prognosis — such as often accompanies a diagnosis of cancer — can be withheld from the patient, but must in principle be disclosed to his or her near relations. The doctor ought to assess the risks attached to a full disclosure and limit the information so as to be compatible with the patient’s physical and psychological state.

The defendant had communicated the diagnosis to the patient’s doctor and to the spouse of the plaintiff, and these two persons, who knew the patient and his reactions much better than he did, had dissuaded him from revealing the diagnosis to the plaintiff. From the reports furnished to the defendant by the plaintiff’s doctor, it appeared that the plaintiff had consulted the latter on a number of occasions because he had been depressed, had professional worries and feared that he had a stomach ulcer. The patient’s doctor was of the opinion that the plaintiff was not psychologically in a condition to bear the disclosure of the diagnosis. The court concluded that, in these circumstances, the defendant could not be expected to ignore this advice and to furnish information for which the plaintiff had not asked when the patient was duly informed of the existence of a tumour and of the necessity of a resection.

The decision leaves many questions unanswered. Was such a radical resection the only reasonable treatment? Or is there a possibility that another doctor would treat the disease differently? The

210 At 287.
211 At 288.
212 At 288.
213 At 288.
214 At 288–289.
215 At 289.
court’s dictum which holds that an ominous or fatal prognosis may, in principle, be withheld from the patient goes way too far.216 One can only speculate as to how the plaintiff eventually came to know of the diagnosis. In my opinion, nothing can be said for a decision not to inform the patient of the extent of the operation. Certainly, such a radical resection of the small intestine and colon cannot be kept secret for very long. Is it not to be expected that, once the patient discovers such a disturbing fait accompli, he or she will start inquiring into the reason for such a vastly extended resection? And would such inquiry not ultimately lead the patient to discover the diagnosis? What did the court mean by “information that could compromise the success of the treatment”? Why did the doctor keep information on the extent of the proposed intervention from the patient, supposing he knew that the patient will probably find out eventually? Could it be that the doctor was afraid that the patient might decline consent if informed accordingly?

In an early case in Germany the Reichsgericht took quite a different stance. In this case217 the patient consented to the doctor’s proposal of the removal of a lump in her right breast by way of incision. In the course of the operation, the doctor found sufficient reason to believe that the lump was cancerous, whereupon he removed the entire right breast. Only when the dressings were removed, which was done a considerable period of time after the operation, did the patient discover that her breast had been amputated. The pathological examination of a piece of the removed lump led to the diagnosis of an intracanalicular adenofibroma without any malignant growth.

The patient’s claim for damages and compensation was brought on the basis that the defendant—doctor had performed this drastic operation without her knowledge and against her will. She averred that, in the circumstances, the intervention was not necessary, and that had the defendant proceeded with the necessary care, he would have known this.

The defendant alleged that he had suspected breast cancer before the intervention. The plaintiff was at that stage still deeply touched by her mother’s recent death of breast cancer. The doctor’s

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216 Cf the Bundesgerichtshof’s judgment where it was held that the doctor could not inform a patient’s next of kin over his head, 3.2.4 supra.

217 RG 8.3.1940 III 117/39 RGZ 163 129.

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defence was that he did not inform the patient about the possibility of cancer because he wanted
to go easy on her and spare her the knowledge. His suspicion was confirmed in the course of the
operation. At that time he was under the impression that it was necessary to remove the entire
breast in order to save the plaintiff’s life.

The court granted that in a case of this nature, it may be difficult or even impossible to obtain the
patient’s consent to an intervention which the doctor considers to be necessary without at the
same time suggesting to the patient that he or she might be suffering from cancer. Although this
may be highly undesirable for the doctor, the patient’s right to self-determination is so
fundamental and is based on such well-founded considerations that it must nevertheless prevail
against the reservations expressed. Obviously, the doctor will try to protect the patient from
harmful anxiety, will even lead the patient to a hopeful assessment of his or her condition, and will
not needlessly draw the patient’s attention to all the bad consequences that the illness might bring
about. However, the overriding principle remains: the doctor must ensure that the patient has
a clear and accurate idea of the nature and consequences of the intervention (even though he or
she need not be acquainted with all the details) and that he or she actually consents prior to the
intervention. The court took the view that if the disclosure of information which is necessary to
obtain an informed consent leads to the depression of the patient’s mood or even his or her
general condition, we are dealing with inevitable detrimental effects that must be accepted as part
of the bargain.218

5.4.2 The significance of the knowledge of an unfavourable diagnosis or prognosis
for patient self-determination

Schlund is of the opinion that if a patient can only be convinced of the necessity of undergoing
a test or treatment by being given an indication of the nature and meaning of the disease he or she
is suffering from, the doctor may not shy away from it, even in the case of a grave illness.219 Of
great importance, in my opinion, is the significance that any information bears on the self-
determination of the patient. In a resolution on the treatment of the terminally ill and dying, the


219 Schlund 1994 “14 Grundätze zur Risikoaufklärung durch den Arzt” Hals-, Nasen-, Ohren-Heilkunde
143.
Deutsche Gesellschaft für Chirurgie decided that the patient should be told the truth in so far as it appears to be necessary and humanly bearable, having regard to the patient’s personal circumstances.\textsuperscript{220} The Gesellschaft held the opinion that it is important for the doctor carefully to consider whether, in each particular case, the disclosure of the truth is necessary to enable the patient to make decisions.\textsuperscript{221}

\subsection{5.4.3 The use of circumlocution and euphemism}

While authority is to be found for the total non-disclosure of a fatal (or even serious) diagnosis or prognosis, others advocate the use of circumlocution and euphemism to lull patients. Laufs, for instance, opines that the word “cancer” may be avoided by the doctor, and may, if necessary, be taken back.\textsuperscript{222} The effects of euphemism in communicating with cancer patients were investigated empirically in a study conducted in Australia.\textsuperscript{223} Dunn \textit{et al} tested some assumptions about the use of euphemism in communicating with cancer patients. For instance, does an unambiguous statement about the diagnosis of cancer cause patients to respond with greater anxiety than when uncertainty or ambiguity is allowed to persist? Does the maintenance of hope require some degree of diagnostic ambiguity? Do patients adjust better to cancer when the diagnosis is explicit? The study revealed that the overall anxiety levels were significantly lower in the sample than published norms for general medical and surgical patients. Exposure to the word “cancer” as distinct from “illness” increased anxiety, but did not alter adjustment scores.

\textsuperscript{220} Brenner 1983: 38.
\textsuperscript{221} Brenner 1983: 38.
\textsuperscript{222} Laufs 1992: 374. McIntosh 1976 “Patients’ awareness and desire for information about diagnosed but undisclosed malignant disease” \textit{The Lancet} 300 reports on a study in which 74 hospital patients with diagnosed but undisclosed malignancy were interviewed and observed to ascertain their awareness of, and desire for information on, their condition. At admission to the ward 88\% of these patients either knew or suspected that they had a malignant tumour. McIntosh poses that the great majority of them, however, had no wish to augment that knowledge. He concludes that the non-disclosure of their diagnosis or prognosis allowed many patients to maintain the hope either that they might not have cancer or that the outlook of their disease might be favourable.
\textsuperscript{223} Dunn, Patterson, Butow, Smartt, McCarthy & Tattersall 1993 “Cancer by another name: A randomized trial of the effects of euphemism and uncertainty in communicating with cancer patients” \textit{Journal of Clinical Oncology} 989.
They conclude that the use of the word “cancer” generated anxiety to levels similar to those reported in general medical and surgical patients, but did not produce any distortion in reported adjustment.

5.4.4 The importance of proper timing of disclosure

Although in the case of terminal illness there is usually no urgency in matters of disclosure (apart from disclosure of information necessary for urgent treatment which is seldom necessary), it must be kept in mind that the closer one is to death the more likely one is to be aware of the realities of dying. On the other hand, one is also more likely to be incompetent or subject to duress, either because of the effects of the illness or the mental strain involved in expecting death. Thus, the timing of disclosure can indeed be instrumental in maximising the exercise of patient autonomy. It is important to engage, from the outset, in open communication that heeds the patient’s readiness to learn bad news. This would enable the dying patient time to digest information in small doses, to make decisions concerning treatment, cessation of treatment, pain management, financial affairs and personal affairs. It would also enable the patient to draft an advance directive or a will whilst fully competent and to name a surrogate decision-maker.

5.4.5 The emotional difficulties surrounding open communication

It has been pointed out above that the doctor’s own emotional reluctance, embarrassment, fears, uneasiness and anxieties to confront the patient with grim diagnoses and risks often provide the motive for non-disclosure. Therefore, it would seem logical to expect the unwillingness to make proper disclosures to increase with the grimness of the information. It goes without


228 See 3.7 supra.

saying that dealing with the dying can emotionally be a very taxing experience, and that having to break the news of terminal illness presents doctors with one of the most difficult tasks in respect of their duty to inform.\textsuperscript{230} It is not surprising to learn that, in this context, some of those who avow to the principle of truth-telling do not practice what they preach.\textsuperscript{231} The need to ensure that the patient’s right to self-determination is not undermined because of the doctor’s attempts to escape the emotional difficulties surrounding open communication, is greatly increased when dealing with the dying. The knowledge of impending death has great significance for patient self-determination.\textsuperscript{232}

5.4.6 Personal factors predisposing doctors towards withholding information

There are certain personal factors which may predispose doctors towards withholding information from a fatally ill patient. It is important for decision-makers to recognise such personal factors in order to avoid these from interfering with objective decision-making.\textsuperscript{233} If these personal factors are responsible for the doctor’s decision to withhold information, it is far from certain that the patient’s best interest is served by such a decision.

\textsuperscript{230} Buckman 1992 \textit{How to break bad news: A guide for health care professionals} 29–39 discusses certain factors (social attitudes to dying and patient fears of dying) that increase the difficulty of the task of informing the dying. See also Loge, Kaasa & Hytten 1997 “Disclosing the cancer diagnosis: The patients’ experiences” \textit{European Journal of Cancer} 878 881.

\textsuperscript{231} See eg Faria & Souhami 1997 “Communication with the cancer patient: Information and truth in Brazil” \textit{Annals of the New York Academy of Sciences} 163 168.

\textsuperscript{232} See eg Cummings 1994 “Ethical issues and the breast cancer patient” \textit{Archives of Pathology and Laboratory Medicine} 1077 1080; Freedman 1993: 573, 574. Scanlon & Fleming 1989: 982 demonstrate that truthful information about diagnosis and prognosis enables the patient to express his/her preferences in respect of the palliative care and nutrition he/she should receive during the advanced stages of his/her illness.

One such factor is the doctor's own fear of death. Some researchers have found a significantly higher fear of death among doctors compared with other groups. Veatch asserts that if an individual has a high or low fear of death and then asks himself or herself what the impact of disclosure of terminal illness would be on another, he or she may systematically misjudge the impact by appealing primarily to his or her own high or low fear of death.

Another such factor — and, in my opinion, a more important one — is the doctor's fear of therapeutic failure. A number of authors have argued that to the doctor who is committed to life, a patient's death, even if inevitable, represents failure. It is said that terminal illness and dying patients symbolise doctors' helplessness and the limits of their skills. Green points out that among the medical specialists dealing with cancer, those able to provide effective treatment

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234 See eg Buckman 1992: 27–28; Green 1981 "Truth-telling in medical care" in Hiller (ed) Medical ethics and the law 183 186. Some psychologists have theorised that the fear of death may be partly responsible for providing the motivation to be a health-care professional – Schulz & Aderman 1976: 12.


237 See also Bugen 1979: 141–142. Bugen found that doctors' anxiety directly affects their perception, and that perception may in turn affect the way they respond to the patient. Bugen remarks that doctors' perceptions and behaviour toward a person with a life-threatening illness may reflect their own discomfort and not that of the patient. Also interesting is Bauer's report on his experience with doctors suffering from cancer – see Brenner 1983: 36–37.


(eg dermatologists) report a much higher willingness to reveal the truth. This, he says, lends support to the claim that medical truth-telling is more strongly related to the doctor’s own sense of competence than to the patient’s immediate reaction.242

5.4.7 Futility of attempts to shield fatally ill patients from the truth

Attempts to shield fatally ill patients from the truth are very likely to be futile. Most seriously ill and dying patients appear to know how sick they really are.243 Centeno-Cortés & Núñez-Olarte244 attempted to assess the degree of knowledge of the diagnosis in a group of terminally ill patients. Data collected showed that 68 percent of patients had not been informed of their diagnosis. Of this group 60 percent had a high degree of suspicion of their diagnosis (6 percent having stated that they were certain of a cancer diagnosis, although nobody had told them).

Equally noteworthy are the results of a survey conducted in Kalinin with the object to determine the awareness of their disease of a group of patients who had been conclusively diagnosed as suffering from oncological diseases and were receiving treatment in hospital.245 A policy of concealment was followed by most doctors. The results show that 9 percent of the patients were accurately informed of their diagnosis (some of whom received the truth indirectly from relatives, or gathered it from their own medical documents which had passed through their hands) while 27 percent of patients believed that they did not have cancer and were receiving treatment for other

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diseases. The most significant finding of the survey was that 64 percent of the patients suspected that they did have malignant tumours. Suspicion had been aroused as a result of conversations with other patients, careless words from medical staff, the names of hospital departments (eg "radiological department") and the type of treatment they underwent. Expressed as a percentage of all patients who had not been informed, just over 70 percent of patients suspected malignancy.

Seale studied communication and awareness in 639 patients who had died. This was done by interviewing, inter alia, the person who could tell the interviewers the most about the last year of the deceased patient's life. The data (which reflect the respondents' perceptions) show that among those patients who knew what was wrong with them, 23 percent of those who died of cancer and 18 percent of those who died of other conditions gained this knowledge despite not having been told by anyone. Among those patients who were aware that they would die, 52 percent of those who died of cancer and 85 percent of those who died of other conditions gained this knowledge despite not having been told by anyone.

5.4.8 Possible negative effects of non-disclosure

The fact that so many seriously ill and dying patients are aware of the severity of their illness has some serious implications for the use of therapeutic privilege. The potential for distrust arising from non-disclosure of the seriousness of the illness is considerable. Moreover, patients who are surrounded by medical staff or family members denying their state of serious illness often find themselves in a situation where they collaborate in maintaining the denial of truth in order to spare others the seemingly unbearable knowledge of their own awareness of the truth.

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248 Cf 3.3 supra.

Pemberton sketches the very sad denouement of this drama:

When the stage has been set by distrust and denial of the personal right to know the truth, all participants play their assigned roles through to the end, and the patient usually lives and dies in isolation and loneliness ... By withholding the truth the doctor and family think they are being kind. The terrible irony of this situation is that the patient, who has the greatest need for their love and concern, is left in loneliness and isolation through their kindness.

Children are particularly vulnerable to practices of deception. Like adults, seriously ill or dying children are usually aware of how sick they really are, but their perceptiveness is often underestimated. Research has shown that attempts to protect children from knowledge of
terminal illness and death are often futile. It is not only the attempt to shield children from knowledge that is often futile, but also the attempt to shield children from the distress they might experience as a result of being aware of the illness. In their research on family coping with childhood cancer, Claflin and Barbarin found that, although limiting information may spare one from initial emotional distress, in the long term, young children suffering from cancer reported experiencing as much disruption and distress from their illness as did their older, better informed counterparts. The researchers conclude that their data provide additional grounds for questioning the assumption that non-disclosure by adults causes children to experience less distress than they would have if informed. Verbal non-disclosure fails to mask the salient and distressing aspects of the illness.

Attempts to protect the child from the truth may inhibit the child from seeking support, affect interaction with others, hinder proper communication, create additional anxiety, impair trust, complicate the child’s response to the crisis, lead to loneliness and deprive the child of the opportunity to come to terms with inescapable reality. Withholding information may even impact negatively on the child survivor’s long-term psychosocial adjustment. As survival rates for paediatric cancer patients increase, the long-term psychosocial adjustment of survivors should be a concern. Research by Slavin et al suggests that honesty and openness with paediatric cancer patients can be advocated out of a practical concern about the mental health of those patients who will ultimately survive the disease, as well as out of a humanitarian concern about the feelings of children with cancer.

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256 Claflin & Barbarin 1991: 169. See also American Academy of Pediatrics: Committee on Pediatric AIDS 1999: 164. Although studies on the impact of HIV infection/AIDS disclosure to children are limited, preliminary work suggests that children who know their HIV status have higher self-esteem than infected children who are unaware of their status, and that parents who have disclosed the status to their children experience less depression than those who do not.


isolation, guilty fantasies and unexpressed fears that have been found among seriously ill children. 260

It is not only the patient that may be affected by non-disclosure, but indeed non-disclosure may lead to tension between health-care providers. 261 The responsible doctor’s practice of non-disclosure to the patient may place other health-care workers such as medical consultants, nurses and social workers in a position where they find it difficult to discharge their functions. 262

5.4.9 Inadequate or inappropriate medical care resulting from non-disclosure

Freedman shows that the failure to disclose the diagnosis of a terminal illness to the patient may directly result in inadequate or inappropriate medical care. 263 He cites 264 the case of a patient, in her seventies with widespread metastatic seedings in the pleura and pericardium from an unknown primary tumour. Her family insisted that she not be informed of the diagnosis or prognosis. When she started suffering from a subjective experience of apnea, it was decided to put her on a morphine drip to alleviate her symptoms. However, the family expelled the nurse from the room in order to prevent her from administering the morphine. The reason for their objection was that if the patient were to learn that she was receiving morphine, she would deduce that her situation was grave. 265 Thus she was denied adequate comfort measures. 266 In another case, the family of a patient suffering from advanced but treatable blood cancer, insisted that the patient not receive

262 Freedman 1993: 572. A number of authors have raised the issue of the ethical dilemma faced by the nurse who knows that the doctor withheld the truth from (or deceived) a patient – see EG Evans 1995 “An ethical dilemma: The dishonest doctor” Nursing Forum vol 30(3) 5; Erlen 1995 “Should the nurse participate in planned deception?” Orthopaedic Nursing vol 14(2) 62; Gillan 1994 “The right to know: The nurse’s role in informing patients” Nursing Times vol 90(35) 46.
263 Freedman 1993: 574.
265 Freedman 1993: 573.
266 Freedman 1993: 574.
chemotherapy in order to spare her the knowledge of her disease\textsuperscript{267} and the side-effects of treatment.\textsuperscript{268} Another example of non-disclosure resulting in a deterioration of patient-care is given by Gillan.\textsuperscript{269} The patient was admitted to a surgical unit with an intestinal obstruction for which he subsequently underwent surgery. The cause of the obstruction was found to be cancer and the patient had multiple deposits on the peritoneum and liver. He was informed of the diagnosis of cancer but not of the full extent of the disease. He was also informed that the bowel had been resected and was told that it was hoped this would solve his problems. The patient seemed positive and believed that he would recover quickly. The doctors spoke with the family and decided that the patient should not be informed of his poor prognosis as they feared that he would lose hope and give up. The nursing staff found lying to the patient or evading his questions difficult and started avoiding him. The situation became worse as his condition deteriorated. The evasion of truth in a sense hindered the nursing staff from fulfilling their duty of care in a moral sense.\textsuperscript{270}

5.4.10 The maintenance of hope

It is often argued that informing patients of a grim outlook will destroy their hope.\textsuperscript{271} While it is certainly important to offer the patient some hope, creating unrealistic expectations may result in the administering of unnecessary treatment and its accompanying unpleasant, and even harrowing, side-effects. Say for instance the doctor is confronted with informing a cancer patient who has only a minimal chance of cure, or one to whom only palliative treatment can be offered. In an attempt to nurture the patient’s hope of cure, the doctor carefully paints the patient’s outlook in

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\textsuperscript{267} See also fn 14 supra, chapter 3 (dealing with the popularity of an oral anti-cancer drug among Japanese doctors, because this form of treatment does not give away clues as to the patient’s diagnosis).

\textsuperscript{268} Freedman 1993: 574.

\textsuperscript{269} Gillan 1994: 46–47.

\textsuperscript{270} Cf Erickson & Hyerst 1979: 302.

\textsuperscript{271} Purtilo & Haddad 1996: 363. See eg Gillan 1994: 46–47. It has been claimed that hopelessness may lead to death – see Reitelmann 1965: 33–34.
unrealistically rosy hues. Inherent in this approach is the danger that the oncologist may feel obliged to offer the patient chemotherapy when, in fact, it would be of only marginal effect, if of any effect at all.\textsuperscript{272}

Although to some – those who see the breaking of a grim diagnosis or prognosis as a "death sentence", or describe it as "cruel" or "inhumane" – the preservation of hope is an end in itself, others see it as a factor that may positively influence the patient’s prognosis, or that may contribute to the avoidance of relapse. In a methodologically rigorous investigation Cassileth \textit{et al}\textsuperscript{273} assessed the ability of certain factors to predict survival and relapse in newly diagnosed patients with advanced malignant disease. They followed patients with unresectable cancers to determine the length of survival, and patients with stage I or II melanoma or stage II breast cancer to determine the time to relapse. The factors they selected have been shown to predict longevity in the general population or survival in prospective studies of patients with cancer. One of the factors selected was hopelessness/helplessness.\textsuperscript{274} This factor had frequently been linked both to causal and prognostic factors in malignant disease.\textsuperscript{275} The authors draw the following conclusions: (i) psychosocial factors shown to predict longevity in general populations or longer survival in patients with cancer are not useful clinical predictors of the length of survival in newly diagnosed patients with advanced metastatic disease; and (ii) these factors do not predict the time to recurrence of disease in patients with high-risk primary melanoma or stage II breast cancer. They point out that their study did not address the possibility that psychosocial factors or events might influence either the cause of disease or the outcome for patients with more favourable cancer diagnoses.\textsuperscript{276} However, the authors are of the opinion that the results of their investigation suggest a need for caution in interpreting studies that claim a positive association between

\textsuperscript{272} Pfeffer 1993: 236–237.


\textsuperscript{274} Which was assessed by using Beck's hopelessness scale.

\textsuperscript{275} Fox 1983 "Current theory of psychogenic effects on cancer incidence and prognosis" \textit{Journal of Psychosocial Oncology} 17; Cassileth, Lusk, Miller, Brown & Miller 1985: 1552. Eg Greer, Morris & Pettingale 1979 "Psychological response to breast cancer: Effect on outcome" \textit{The Lancet} 785 found that a fighting spirit and optimism were associated with recurrence-free survival.

\textsuperscript{276} Cassileth, Lusk, Miller, Brown & Miller 1985: 1555.
psychosocial factors and survival generally. In any case, their study of patients with advanced, high-risk malignant diseases suggests that the inherent biology of the disease alone determines the prognosis, overriding the potentially mitigating influence of psychosocial factors. If this should be the case, there would be little room for the argument against disclosure based on the patient’s best medical interest where the patient is diagnosed with an advanced, high-risk malignant disease. In other words, offering hope to those whose prognosis is hopeless might be therapeutically useless, whereas offering hope to those whose prognosis is not hopeless is merely realistic, and has nothing to do with the therapeutic privilege.

Some are convinced that, in almost every case, it is possible to confront patients with the truth, even if he or she is suffering from incurable cancer, without depriving the patient of hope. Maintaining optimism within the context of realism can be achieved by being honest, compassionate and life affirming, and by avoiding pessimism. The doctor can, for instance, relate the probability outcome to the patient whilst at the same time making it clear that, although statistics provide us with information about the prognosis of certain classes of patients, there is no certainty about the outcome for any given patient.

5.4.11 Is the likelihood of fatality a ground for invoking the therapeutic privilege?
Finally, I submit that the likelihood of fatality is not per se a ground for invoking therapeutic privilege, neither is the doctor’s perception of what—in terms of his or her own value system—would be human or inhuman. In other words, it is submitted that a fatal prognosis does not

277 Cassileth, Lusk, Miller, Brown & Miller 1985: 1555. Echoing the sentiments of Fox (Fox 1978 “Premorbid psychological factors as related to cancer incidence” Journal Behavioral Medicine 45 and Fox 1983: 17), they state that such investigations frequently involve populations that are not clinically homogeneous and often fail to control for potentially confounding factors. Occasionally causation is confused with correlation. Some studies claim a direct and overly simplistic causal link. The authors caution that if psychosocial factors have a role in causing or influencing the course of malignant disease under some circumstances and in some persons, it is likely that such factors represent only one link in a very long causal chain.


280 Schain 1990: 931.

281 Schain 1990: 931.
present a different category of instances under which the therapeutic privilege may be warranted, but that the possibility of harm to the patient’s mental or physical well-being that may result in consequence of the disclosure must be weighed against his or her interests in learning the bad news.\textsuperscript{282} In this context, the following remarks are apposite:\textsuperscript{283}

\begin{quote}
It is indisputable that most people suffer anguish when they learn that they have a fatal disease which is likely to kill them. Far less obvious is that such information causes more harm than good, for against the anguish must be set such benefits as: relief of uncertainty (many such people already suspect that something is seriously wrong); the possibility of informed reflection and discussion about the likely course of events; the opportunity to take stock, mend bridges, make farewells, arrange affairs and even help family and friends to come to terms with their loved one’s impending death; the avoidance of the extensive web of deceit in which an initially limited medical (or family) decision to deceive often results – deceit which may supplant a lifetime’s mutual trust; and finally the amelioration of the process of dying which honest preparation for death may achieve.\textsuperscript{284}
\end{quote}

5.5 WHERE THE PATIENT IS MORIBUND AND DISCLOSURE OF THE TRUTH WOULD BE INHUMAN\textsuperscript{285}

It has been argued that therapeutic privilege applies where the patient is moribund and disclosure of the truth would be inhuman.\textsuperscript{286} Although Tempel is sometimes quoted\textsuperscript{287} in support of allowing the therapeutic privilege for the reason mentioned, his argument actually amounts to a recognition of the senselessness of clinging to the truth where the patient, who is at death’s door, is no longer in a state to make decisions.\textsuperscript{288}

\\textsuperscript{282} See eg Rosner 1974: 1468, 1469.
\textsuperscript{283} Editorial 1982: 115.
\textsuperscript{284} An example of how the withholding of the diagnosis of cancer can necessitate other lies (which may eventually result in a “web of deceit”) is to be found in Siebert 1982: 230.
\textsuperscript{286} Van Oosten 1991b: 33.
\textsuperscript{288} Tempel 1980: 614. It is therefore submitted that Van Oosten incorrectly relies on Tempel for his statement that the therapeutic privilege is applicable where the patient is moribund and disclosure of the truth about the intervention proposed would be inhuman.
Brenner recommends that a comprehensive disclosure be inadmissible in the borderland between life and death. He argues that it is inhumane to inform a dying patient on the extent to which a certain measure of treatment can marginally shorten or lengthen his or her lifespan. This goes also for the administration of analgesics that in effect marginally shortens life expectancy. The doctor may not raise the patient’s fear of death by pointing to the “dangerousness” of the treatment, he says. Brenner sees this as a ground for invoking the therapeutic privilege quite apart from that based on the patient’s inability to make (rational) decisions, as appears from his remark that dying patients are often in any case not in a position to make a decision.

Although it is certainly undesirable to shower a moribund patient with upsetting information, doctors should not be allowed to escape their duty to inform by merely allowing a fatal disease to run its course without taking the time to divulge such information as would in the anticipated course of illness and treatment become necessary for the patient in making treatment decisions. It is submitted that the doctor who had adequate opportunity to inform the patient prior to the patient’s becoming moribund, and failed to do so, should not be allowed to escape liability by relying on therapeutic privilege.

5.6 WHERE DISCLOSURE WILL SERIOUSLY PREJUDICE THIRD PARTIES

Some authors argue that the therapeutic privilege should be allowed where disclosure will seriously prejudice third parties, such as relatives. It is submitted that, since the therapeutic privilege aims at freeing doctors from their duty to inform in circumstances where such a duty conflicts with their medico-ethical obligation to do no harm to their patients, it should not be allowed in such cases. Any special defence of “therapeutic necessity” should also be ruled

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292 Van Oosten 1991b: 40 n 5 also believes that the therapeutic-privilege defence cannot apply under these circumstances.

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out. Therapeutic considerations do not enter the picture here. In these cases, the characteristic feature of situations of therapeutic non-disclosure – namely that the interest protected and the interest infringed vest in the same person – is absent.

5.7 PSYCHIATRY AND INFORMATION WITHOUT AN OBJECTIVE SCIENTIFIC BASIS

It is sometimes argued that special rules apply in the case of psychiatry and psychotherapy or that the need to withhold information from the patient is a particularly delicate issue in the matter of treatments for mental illnesses, or in the case of research treatment in the field of psychiatry, or the trial of psychopharmacological medicines. The following examples appear in the literature on the topic: where medical records contain the (subjective) interpretation of certain psychological tests in which the interpreter for instance draws the conclusion that the patient has suicidal or homosexual tendencies and the patient wants access to such records, where a depressed patient’s despair would be reinforced by the information that the antidepressive effect of a drug sets in in only 60 to 70 percent of cases, where a patient with florid depressive schizophrenic symptoms would decline urgently indicated neuroleptic therapy if informed of the

293 To what extent this can be claimed under necessity, will be left unanswered, since it falls outside the ambit of the current investigation.

294 See fn.s 45–49 and the accompanying text supra, chapter 4.


296 Purtilo & Haddad 1996: 44.

297 Which Giesen 1981: 203 defines as “treating a sick person with new methods and means for at least primarily (if not purely) therapeutical purposes; some authors call this the field of therapeutic experiments”.


301 Helmchen & Müller-Oerlinghausen 1975 “Ethische und juristische Schwierigkeiten bei der Effizienzprüfung psychiatrischer Therapieverfahren” Der Nervenarzt 397 400.
side-effects, where the therapist believes that a favourable outcome can be attained only by keeping certain information from the patient; the non-disclosure of the possibility of agranulocytosis prior to antidepressive pharmacotherapy; the non-disclosure of the possibility of intercurrent suicidality or psychotic exacerbation before starting analytic psychotherapy, and the non-disclosure of the possibility of symptom displacement before starting behaviour therapy.

Psychiatry is sometimes singled out as a field which is given to the therapeutic privilege because of the higher likelihood that revealing certain information pertaining to psychiatric treatment will be detrimental to the patient’s care and treatment. However, a more fundamental rationale for singling out psychiatry is to be found in the highly subjective nature of the patient-therapist relationship. In this regard, three judgments by the Bundesgerichtshof provide interesting material in which a line of progression can be observed. Originally the Bundesgerichtshof acknowledged that a patient’s right of inspection of his or her medical records does not extend to inspection of information of a subjective nature that does not have any basis in natural science. In the second case, the Bundesgerichtshof seems to have singled out psychiatry as a field where therapeutic considerations, together with certain other considerations, might militate against affording patients access to their medical records. In the last of these three cases, psychiatry was again singled out, and the court accepted that therapeutic reservations alone can suffice to limit the patient’s right of access to his or her medical records.

303 Purtilo & Haddad 1996: 44.
305 Helmchen & Müller-Oerlinghausen 1975: 400.
308 See eg Giesen 1988a: 382.
In the first of these cases,\textsuperscript{309} in which psychiatric treatment was not involved, the Bundesgerichtshof recognised that, in principle, patients have a right to inspection of their medical records. The court however limited this right\textsuperscript{310} to records of findings that have an objective scientific basis, as well as facts relating to treatment of the patient.\textsuperscript{311} Although a patient may indirectly learn of an unfavourable prognosis through insight into objective findings, the awareness of which may worsen his or her condition, cause him or her to give up hope or even lead to a physical or psychological breakdown, such adverse reactions must be put up with in the interest of the patient’s right to self-determination.\textsuperscript{312} The court added that it could not be denied that there can be exceptional cases where the doctor may withhold certain information (or findings) from a patient for therapeutic reasons, and remarked \textit{obiter} that these exceptional cases should be narrowly circumscribed in the interest of patient self-determination.\textsuperscript{313} However, the court felt that the case at hand did not call for a more detailed exposition of the topic, and left it at that.\textsuperscript{314}

The court went on to explain\textsuperscript{315} that, in addition to scientifically objective findings and facts pertaining to the treatment of the patient, medical records may contain information of a more personal and subjective nature. It is hard to imagine medical activity without any personal engagement of doctor and patient. The personal engagement of the doctor is, to a greater or lesser extent, intrinsic to every field of activity within the medical profession, and is not peculiar to the fields of psychiatry and psychotherapy where the focus lies on exerting influence on the patient’s mind. This personal engagement may, and usually does, also find expression in the doctor’s notes concerning treatment. Medical records often quite appropriately contain information that must be withheld from the patient because it is emotionally coloured and

\textsuperscript{309} BGH 23.11.1982 VI ZR 222/79 BGHZ 85 327.

\textsuperscript{310} At 334.

\textsuperscript{311} "Naturwissenschaftlich objektivierbare Befunde und ... Behandlungsfakten, die die Person des Patienten betreffen".

\textsuperscript{312} At 333.

\textsuperscript{313} At 333.

\textsuperscript{314} See also 337–338.

\textsuperscript{315} At 335–336.
comprises of subjective evaluations. One of the reasons the court mentioned for doubting the desirability of providing full information is that disclosure may result in therapeutically unwanted effects.\textsuperscript{316}

In the second case,\textsuperscript{317} the plaintiff who had been diagnosed as suffering from endogenous psychosis,\textsuperscript{318} schizophrenia, and paranoid-hallucinatory syndrome\textsuperscript{319} and had been treated in the psychiatric clinic of the defendant-university, wished to look at the medical records that had been kept on his case. The medical records contained statements by relatives of the plaintiff who had been consulted by the doctors. At the instigation of the plaintiff, all involved relatives had given their consent to the inspection of the medical records. The plaintiff had further freed all doctors form their duty to maintain confidentiality.

The plaintiff alleged that he needed the medical records for the purpose of writing a dissertation and to develop a better understanding of his illness.

The defendant argued that it is therapeutically unjustifiable to allow the patient to see his records and that such inspection would unreasonably affect the personal interests of the relatives that have been consulted as well as the doctors involved.\textsuperscript{320}

Both inferior courts had granted the claim in full. The Bundesgerichtshof, in dismissing the claim, raised a number of interesting issues. The court mentioned that already in the case of \textit{BGH 23.11.1982 VI ZR 222/79 BGHZ 85 327} the patient’s right to inspection of his or her medical records had been affirmed. Yet, the court said that in the last-mentioned case the Senat had limited this right to inspect one’s medical records to “physikalisch objektivierte Befunde” and

\begin{itemize}
\item \textsuperscript{316} See 337–338.
\item \textsuperscript{317} \textit{BGH 23.11.1982 VI ZR 177/81 BGHZ 85 339}.
\item \textsuperscript{318} “Endogene Psychose”.
\item \textsuperscript{319} “Paranoid-halluzinatorisches Syndrom”.
\item \textsuperscript{320} At 340.
\end{itemize}
reports on treatment measures such as operations and medication. \(^{321}\) Whereas the Senat stressed in \(BGH\ 23.11.1982\ VI ZR 222/79\ BGHZ 85 327\) that the personal nature of the doctor-patient relationship, which involves the doctor’s own persona, is not peculiar to the fields of psychiatry and psychotherapy, but is, to a greater or lesser extent, intrinsic to every field of activity within the medical profession, \(^{322}\) it now interprets that case to have said that “für dieses Einsichtsrecht ausserhalb der somatischen Behandlung, also insbesondere da, wo wie in Psychiatrie und Psychotherapie die für notwendig erachtete Einflussnahme auf die geistig-seelische Person des Patienten den Schwerpunkt des Vertragsgegenstandes und damit der Behandlung bildet, vielfach anderes gelten kann”. \(^{323}\) This holds not only because therapeutic reservations could carry special weight even after the illness has abated, but above all also because the personal involvement of the doctor and third parties can play a special role, and elements of subjective assessment may come to the fore. \(^{324}\) Later in the judgment the court took the view that the clinical records regarding psychiatric treatment typically contain notes against the disclosure of which very serious reservations may exist so that the decision whether or not to disclose such information must be left up to the treating doctor. \(^{325}\)

The reasons advanced by the court for setting apart cases falling outside the sphere of somatic treatment, can be analysed as follows:

(i) therapeutic reservations
(ii) personal involvement of the doctor
(iii) personal involvement of third parties
(iv) elements of subjective assessment.

The court made it clear that (ii)–(iv) outweigh (i) in importance. In fact, the significance of (i) is greatly undermined in the very next sentence in which the court emphasised that in so far as the

\(^{321}\) At 342.

\(^{322}\) See fn 315 and the accompanying text \textit{supra}.

\(^{323}\) At 342.

\(^{324}\) At 342.

\(^{325}\) At 343.

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patient is capable of making rational decisions he or she must be afforded the right to self-injury to a certain extent.\textsuperscript{326} Unfortunately, the court did not expand upon the extent of the right to self-injury which persons who are capable of making rational decisions should be afforded in the absence of (ii)–(iv).

Although the plaintiff was pursuing a legitimate interest when he claimed the right to inspection of the medical records for the purpose of writing a dissertation, he could not be allowed access to information that was not generally accessible and that should be withheld from him in order to protect the interests of both the doctor and any third parties.\textsuperscript{327} There might be situations in which legitimate medical reservations may exist against the patient's being allowed access to his or her medical records, and this is nowhere more apparent than in the field of psychiatry. Here, the medical records inevitably contain information that cannot be verified by the natural sciences. The reason for considering such reservations as legitimate is to be found in the personal engagement of doctor and patient which is not merely accidental but in fact essential to psychiatric treatment. The personal engagement of doctor and patient finds its clear expression within psychoanalysis in the phenomena of transference ("Übertragung")\textsuperscript{328} and countertransference ("Gegenübertragung").\textsuperscript{329} However, the same could be said to be true to a lesser degree for all other forms of treatment through psychological influence.\textsuperscript{330}

\textsuperscript{326} At 342.

\textsuperscript{327} At 343.

\textsuperscript{328} Kaplan & Sadock 1998 *Synopsis of psychiatry: Behavioral sciences / Clinical psychiatry* (8th ed) 6 define transference as follows: "Transference is generally defined as the set of expectations, beliefs, and emotional responses that a patient brings to the doctor-patient relationship. Transference reflects not necessarily who a doctor is or how a doctor acts in reality but, rather, what persistent experiences a patient has had with other important authority figures throughout life."

\textsuperscript{329} Kaplan & Sadock 1998: 7–8 define "countertransference" as follows: "Just as patients bring transference attitudes to doctor-patient relationships, doctors themselves often have countertransference reactions to their patients. Countertransference may take the form of negative feelings that are disruptive to the doctor-patient relationship but may also encompass disproportionately positive, idealizing, or even eroticized reactions. Just as patients have expectations — such as competence, lack of exploitation, objectivity, comfort, and relief — physicians often have unconscious or unspoken expectations of patients. Most commonly, physicians think of patients as good when their expressed severity of symptoms correlates with an overtly diagnosable biological disorder, when they are compliant and generally do not challenge the treatment, when they are emotionally controlled, and when they are grateful. If these expectations are not met, physicians may blame patients and experience them as unlikable, untreatable, or bad."

\textsuperscript{330} At 344.
The Bundesgerichtshof was of the opinion that, in the area of psychiatric treatment, the concern of the doctor that inspection of the medical records by the patient may have therapeutically unfavourable effects was at any rate not far-fetched.\textsuperscript{331} The court did not dispute that there are (non-prevailing) schools of thought that hold a different opinion.\textsuperscript{332} However, the court assessed the situation from the viewpoint of the particular doctor involved (who, like any doctor that would raise the defence of therapeutic privilege, would most likely – if not inevitably – adhere to the prevailing school). A doctor who, in accordance with the traditional approach which also happened to be the predominant one at the time, proceeded on the understanding that the patient would not be able to enforce access to his or her medical records, cannot be expected to reveal such records against his or her therapeutic convictions.\textsuperscript{333}

In the third case, \textit{BGH 6.12.1988 VI ZR 76/88 BGHZ 106 146}, the patient, who had undergone psychiatric treatment in the defendant-hospital as an in-patient for two periods of two months each, required to be entrusted with photocopies of the medical records pertaining to his treatment during the said periods. At first, the defendant had declared its willingness to comply with the request under the condition that the plaintiff first inspected the medical records in the presence of a doctor. However, after renewed in-patient treatment of the plaintiff, again for two periods of two months each, the defendant was no longer willing to grant the request for fear that the plaintiff’s condition might deteriorate. Later, the hospital renewed its offer of inspection of the medical records in the presence of a doctor, but refused, on therapeutic grounds,\textsuperscript{334} the plaintiff’s request for the handing over of photocopies of the medical records.\textsuperscript{335}

The Landgericht dismissed the claim. The appeal to the Oberlandesgericht was likewise dismissed, as was the appeal to the Bundesgerichtshof.

\begin{itemize}
\item \textsuperscript{331} At 344.
\item \textsuperscript{332} At 344.
\item \textsuperscript{333} At 344–345.
\item \textsuperscript{334} Cf \textit{BGH 6.12.1988 VI ZR 76/88 BGHZ 106 146 148}.
\item \textsuperscript{335} At 147.
\end{itemize}
The Bundesgerichtshof reaffirmed that, flowing from the right to self-determination and dignity, patients have a fundamental right of inspection of their medical records without having to show a specific legal interest.\footnote{At 148.} This right must be limited considerably when it comes to psychiatric treatment, even in the case of the patient who had recovered in the mean time and who was no longer under psychiatric treatment.\footnote{At 148.} The basis for this limitation is to be found in the nature of the psychiatric therapeutic relationship which demands that the doctor’s notes be withheld from the patient, not only in the interest of the doctor and third parties, but, to a much greater extent than is the case in other therapeutic areas, also in the interest of the patient himself or herself.\footnote{At 148.} The court made it clear that therapeutic reservations alone can, and in this case, do, suffice.\footnote{At 148.}

The court rejected the contention that, in view of the high premium put on self-determination, it cannot be justified to attach so much importance to the therapeutic aim of psychiatric treatment as to refuse the release of information contained in the medical records where it would jeopardise the realisation of such an aim.\footnote{At 148.} In particular, the claim that therapeutic contra-indication cannot be attributed a greater weight when dealing with the right of inspection of medical records pertaining to psychiatric treatment as opposed to other treatments did not impress the court.\footnote{At 148.} Psychiatry and psychotherapy are fields in which patients’ right to inspection of their medical records can be severely restricted more often than in other therapeutic relationships, not only on account of the personal interest of the doctor and third parties in having a say in the decision whether or not to disclose the medical records, flowing from their personal engagement as a formative component of therapy, but also on account of therapeutic considerations. Allowing the patient access to the medical records and records kept of his or her discussions with the doctor, can have serious implications for the patient’s health. Only if there is concrete reason to fear that
insight into the medical records may have specific negative effects on the patient’s psychological health, may the doctor be justified in refusing access.\textsuperscript{342}

The court was of the opinion that it is for the doctor to decide whether or not therapeutic reservations against unlimited disclosure of medical records exist. It follows from the same considerations that justify the withholding of medical records from the patient that the doctor need not go into details to justify his or her decision before the plaintiff or the judiciary.\textsuperscript{343} All the same, it must be discernible that the doctor made his or her decision in a responsible manner and in full acknowledgement of the patient’s – also the mentally ill patient’s – fundamentally owed right to information on his or her medical history,\textsuperscript{344} and a mere assertion by the doctor that therapeutic reservations militate against the disclosure of the medical records cannot suffice.\textsuperscript{345}

\textit{In casu}, the defendant set forth the following: the course of the illness had run in phases and this necessitated several periods of hospitalisation; the plaintiff was inclined to paranoia; and the psychotic illness of the plaintiff might return should he learn the full content of his medical records.\textsuperscript{346} This information was sufficient to convince the court that the plaintiff should be denied access to his medical records.

5.8 THE withholding of INFORMATION IN ORDER TO ATTAIN OR MAINTAIN the PLACEBO EFFECT

According to Brenner the duty to inform falls away in the patient’s interest where the doctor is of the opinion that the patient’s complaints can be attributed to psychological disturbances and a placebo is used for therapeutic or diagnostic reasons.\textsuperscript{347} The placebo serves to establish if the complaints reported by the patient are in fact existent or whether they disappear as a result of pure

\begin{itemize}
  \item \textsuperscript{342} At 149.
  \item \textsuperscript{343} At 150.
  \item \textsuperscript{344} At 150.
  \item \textsuperscript{345} At 151.
  \item \textsuperscript{346} At 151.
  \item \textsuperscript{347} Brenner 1983: 39.
\end{itemize}

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auto-suggestion after administration of the placebo. It further serves to determine whether a specific drug is well tolerated or whether reported side-effects disappear as soon as the drug is replaced by a placebo.\textsuperscript{348} In the case of such medically indicated measures, informing the patient would call into question the effect of the placebo trial. Consequently, it is not in the patient’s interest to be informed.\textsuperscript{349}

Giesen makes a valuable distinction between the use of placebos for the purpose of diagnosis and therapy, and the use of placebos for the purpose or comparison and experimentation.\textsuperscript{350} If pharmacologically inactive substances are administered to facilitate diagnosis by enabling the doctor to distinguish whether or not the patient’s complaint is imaginary, we are dealing with pure therapeutical treatment. In such cases, the patient is not an object of comparison, and, therefore, not an object of scientific experimentation. Giesen is of the opinion that, in such cases, the patient is in fact being treated therapeutically, albeit not in the way he or she supposes. Informing the patient of the fact that the drug he or she has received is inactive will destroy the diagnostic purpose. For this reason, Giesen argues, where placebos are used for the purpose of diagnosis and therapy, the doctor need not inform the patient of the fact that he is treated with pharmacologically inactive substances if withholding such information proves to be necessary from a diagnostic and therapeutic point of view. The burden of proving that the applied procedure was necessary and the diagnostic purpose would have been destroyed should rest on the doctor.\textsuperscript{351}

\begin{footnotes}

\footnote{348} Brenner 1983: 39.

\footnote{349} Brenner 1983: 39.

\footnote{350} Giesen 1981: 227–228.

\footnote{351} On the use of placebos in general, see Kohlhaas 1964 “Ärztliche Pflichten bei Verabreichung neuer Arzneimittel (Versuchspräparate bzw. noch nicht registrierte Medikamente)” Münchener Medizinische Wochenschrift 2281 2287–2288. See also Welz 1998: 14 who points out that the assumption that the deception involved in administering placebos is justified in the interests of the patient’s well-being is unacceptable to proponents of the ethics of discursive decision-making because of the manipulation involved.

\end{footnotes}
CHAPTER 6
THE IMPORTANCE OF IMPROVING THE QUALITY OF COMMUNICATION

It has been contended that it is not so much a question of whether information that holds potential prejudice for the patient should be divulged, but of how the information is to be communicated, or better still, to be shared.\(^1\) This places the responsibility on doctors to devise ways and means of breaking bad news to patients without causing them undue harm;\(^2\) to involve them in the decision-making process, instead of creating excuses for making decisions on their behalf "in their best interest".\(^3\) Overcoming the problem of avoiding harm through disclosure does not necessarily demand the withholding of information, but rather calls for the development of a duty to inform patients carefully and tactfully.\(^4\) The doctor should be sensitive and empathetic and should tailor

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the information for the particular patient, heeding his or her special fears and emotional state.\textsuperscript{5} Of course, this is easier said than done, and it is acknowledged that there is an acute need to explore the effects of nuances of communication in the context of informed consent decisions so that doctors have guidance about how to present information most fairly,\textsuperscript{6} and that further research is needed to determine how cognitive barriers to rational decision-making affect the legal concept of informed consent.\textsuperscript{7} While admitting that there are difficulties inherent in the concept of informed consent and that the origin of the therapeutic privilege is to be found in a real dilemma,\textsuperscript{8} Burchell\textsuperscript{9} poses that the answer lies not in rejecting the concept of informed consent, but in improving the necessary communication skills needed in the doctor-patient relationship. Through developing communication skills, the medical profession can indeed cut down on complaints and litigation in a proactive way, and with added spin offs.\textsuperscript{10}

Despite evidence of the importance of good communication and emotional support,\textsuperscript{11} doctors have been found lacking in this area.\textsuperscript{12} Poor communication is a common cause of complaints and

\begin{itemize}
\item[8] Viz, that if the doctors provide patients with too little information they will hold themselves open to liability, and if they advise them of every risk, real and remote alike, the patients may be frightened off having an operation which may clearly be in their interests.
\item[10] Ley 1988 Communicating with patients: Improving communication, satisfaction and compliance xiii–xiv mentions the following possible benefits of improved communication: (i) greater patient satisfaction; (ii) better patient co-operation with treatment regimens; (iii) reduced anxiety and distress; (iv) quicker recovery from surgery; (v) shorter lengths of stay in hospital. It is worth noting that both better patient co-operation and shorter hospital stays can save a great deal of money.
\item[12] Corney 1991 “The need for better communication and emotional support” in Corney (ed) Developing communication and counselling skills in medicine 3 8; Simpson, Buckman, Stewart, Maguire, Lipkin,
a major factor in medico-legal cases.\textsuperscript{13} It has even been argued that the realisation of self-determination may be hampered if the focus of informed consent rests on informing patients of certain risks, instead of promoting the quality of communication between patient and doctor.\textsuperscript{14} If doctors lack in communication skills, it is partly attributable to the lack of (or insufficient, or ineffective) communication skills training on the medical curriculum.\textsuperscript{15} One of the reasons Buckman\textsuperscript{16} identifies as being responsible for doctors’ finding it difficult to break bad news, is the lack of being taught how to do it properly.\textsuperscript{17} The need for communication skills training even

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\textsuperscript{13} Harden 1996: 275; Fallowfield 1996: 28; Simpson, Buckman, Stewart, Maguire, Lipkin, Novack & Till 1991: 1385; Buckman 1992: 9; Myerscough (ed) 1989 *Talking with patients: A basic clinical skill* 1; Corney 1991: 3 (who adds that dissatisfaction is also a major factor why some patients choose other forms of help and treatment, such as alternative medicine); Chuang & Man 1983 “Informed consent – ethical considerations” *Medicine and Law* 19 24–25; Lankton, Batchelder & Ominsny 1977 “Emotional responses to detailed risk disclosure for anesthesia, a prospective, randomized study” *Anesthesiology* 294 295; Patterson 1985 “The therapeutic justification for withholding medical information: What you don’t know can’t hurt you, or can it?” *Nebraska Law Review* 721 743–744. See also Ley 1988 1–13.

\textsuperscript{14} Weisbord 1986 “Informed consent: The law’s uneasy compromise with ethical theory” *Nebraska Law Review* 749 757.

\textsuperscript{15} Corney 1991: 8. See also Loge, Kaasa & Hytten 1997: 882.


\textsuperscript{17} Cf Leenen & Gevers 1985 “Netherlands” in Deutsch & Schreiber (eds) *Medical responsibility in Western Europe: Research study of the European Science Foundation* 412 432 where it is argued that, although communication with the patient is not always easy, legally one may require the doctor to be sufficiently skilled to communicate bad news to the patient. Communication skills training, it is argued, should be part of the normal training of doctors. Positive results have been achieved through various programs and courses – see eg Knox & Thomson 1989 “Breaking bad news: Medical undergraduate communication skills teaching and learning” *Medical Education* 258; Hulsman, Ros, Jasssen & Winnubst 1997 “INTERACT-CANCER: The development and evaluation of a computer-assisted course on communication skills for medical specialists in oncology" *Patient Education and Counseling* 129.
received recognition in *Battersby v Tottman.* Although many still believe that communication skills cannot be taught, research appears to prove the opposite.

Tactful, sensitive communication (albeit through a psychiatrist, social worker, minister of religion, family member or friend) can provide the alternative to withholding information where only a diagnosis or prognosis is to be communicated, or where informed consent is required for an intervention which is factually but not temporally urgent (in other words where no real emergency is present). Since a lack of time is often advanced as the reason for withholding information – for it is said that proper sensitive communication must heed the patient’s readiness to learn the news – and time is not of the essence in the above-mentioned instances, the problem could be overcome by delay, just as one would postpone an operation under anaesthesia on account of a patient’s having the flu. Of course, if any information could be communicated in a way which would avoid the adverse consequences feared from disclosure, that must be done.

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18 37 SASR 1985 524 537, Zelling J suggesting that medical students must be trained in communication skills.


21 Rotenberg 1997 “To inform or not to inform – a decision with psycho-biological implication” *Medicine and Law* 49 51 advises that when a doctor informs a patient about the true nature of a serious disease, the information should be supported with psychotherapy. He proposes a model whereby the patient must be made aware that the outcome of the disease depends on his/her own behaviour, and the doctor, together with mental health workers and the patient’s family must provide an opportunity for search activity.


24 Schain 1990 “Physician-patient communication about breast cancer: A challenge for the 1990’s” *Surgical Clinics of North America* 917 929–930 says that, as a general rule, a moderate amount of information should be revealed, whereupon the patient’s desire to know more must be assessed. The patient’s response style, personality profile, and emotional state should be assessed. If the patient becomes overwhelmed, painfully anxious, and too confused to act responsibly, doctor and patient should agree to take more time to review the circumstances and impose a brief delay. Pellegrino 1992 “Is truth telling to the patient a cultural artifact?” *Journal of the American Medical Association* 1734 1735 correctly remarks that the amount, manner, and timing of truth-telling or truth-withholding are crucial factors for which there is no ready formula.
CHAPTER 7
DOCUMENTATION

The doctor would be well-advised to document conversations with the patient when making use of the therapeutic privilege.\(^1\) Notes should be kept of the doctor’s observations of the patient, the information disclosed, the information withheld and the reasons for withholding the information. This should be done prior to the therapeutic intervention.\(^2\) Rosoff advises that the doctor specifically document the patient’s high susceptibility to anxiety (which in his opinion, should be well above the norm for the doctor to have a basis for relying on therapeutic privilege).\(^3\) The doctor’s observation should be confirmed by another doctor\(^4\) and/or relative or close friend of the patient,\(^5\) and this too should be entered in the patient’s treatment record. If the doctor’s decision

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2 Abbuhl & Gerkeng 1975: 224. See eg Patrick v Sedwick Alaska 391 P 2d 453 458–459. In this case the doctor’s chart notes indicated that the patient was a “nervous and apprehensive person”. The patient objected to the report on the basis that the report was self-serving, because it was not made immediately after the operation but a day later and possibly after the first post-operative conversation between the two parties. However, the court could not find that the admission of the report was prejudicial to the patient-plaintiff, because there was no jury to mislead and the plaintiff did not direct the court’s attention to anything in the report itself that was prejudicial.

3 Rosoff 1981 Informed consent 55. See also Roach, Younger, Conner & Cartwright 1994 Medical records and the law (2nd ed) 225.


to withhold information is confirmed, this should also be entered in the patient’s record. Documentation can later serve as an indication of good faith⁶ and as a valuable aide-mémoire. Moreover, it may help the doctor in rebutting an allegation of recent fabrication.⁷

⁶ Abbuhi & Gerking 1975: 224.

⁷ Schmidt 1990 Bewysreg (3rd ed) 372–374. Earle 1995 “Informed consent: Is there room for the reasonable patient in South African law?” The South African Law Journal 629 631. See also 3.5–3.7 supra. Shaw 1986: 877–878 remarks that, in German law, unless the doctor enters the decision not to disclose as well as the reasons for not disclosing in the patient’s medical records, it will be presumed that there was a wrongful failure to disclose.
CHAPTER 8
CONCLUSIONS AND SUBMISSIONS

Beneficence has been a guiding principle in medical practice for a very long time. It had been argued that information may be withheld from a patient in the patient’s (medical) interest long before a legal duty to disclose was placed on the doctor. A growing acknowledgement of the importance of truth-telling as an ethical principle brought a concomitant tension between the principles of truthfulness and beneficence. This tension acquired legal significance with the advent and recognition of the doctor’s duty to inform and the doctrine of informed consent. Realising that situations might occur in which the disclosure of information may cause the patient harm, a need was identified to recognise an exception to the doctor’s duty to disclose where fulfilling such duty would violate the doctor’s “primary” duty to do no harm – hence the birth of the concept of therapeutic privilege.

Once it is accepted that this conflict of duties provides the rationale for acknowledging a defence of therapeutic necessity, it follows that therapeutic privilege cannot be invoked to protect the interests of third parties.

It also follows that the widely-used practice of defining the defence of therapeutic privilege, or of setting its parameters, with reference to the harm that could lawfully be avoided under such defence, is not only of limited use, but over-exposes one side of the conflict and allows the other side to fade into obscurity. The harm that could result from disclosure represents one side of the conflict only. Exercising the privilege inevitably brings about an infringement of the patient’s right to self-determination. Resolution inevitably lies in weighing the harm that may follow upon disclosure against the harm that may follow upon non-disclosure. The recognition of self-determination as a cornerstone of the doctrine of informed consent implies that the patient, and not the doctor, is in the best position to judge his or her own interests. Recognition of the therapeutic privilege implies that a patient’s decision may lawfully be substituted by the doctor’s “objective” decision. The problem is that the doctor more often than not lacks the necessary knowledge of the patient’s non-medical needs to be able to make an objective decision. Where a patient’s right to self-determination is compromised, the patient’s best interests can no longer

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be guaranteed as defined by himself or herself. This is perhaps the most important consideration calling for the restriction of the ambit of the therapeutic-privilege defence.

The therapeutic privilege has received a great deal of attention – albeit often superficially – in medico-legal literature. The decision to withhold information is made at an extremely low level of transparency. Together, these two factors may open the possibility for a potential overuse. If faced with the dilemma of deciding which of the two duties should prevail in a particular instance, these two factors may contribute to the doctor’s deciding to err on the safe side and to withhold information. There exists a real need to specify the particular circumstances under which therapeutic privilege can be justified. Patients who make a decision believing it to be based on all material facts, where in fact it is not, are left in a weaker position to assert their own values than those whose values are openly disregarded by the doctor.

Reasons for limiting the operation of the therapeutic privilege include:

- the fact that therapeutic privilege represents a departure from the general principle of patient self-determination which is the cornerstone of the informed consent doctrine
- the fact that a decision to withhold information may necessitate other deceptions
- adoption of a too permissive attitude towards therapeutic privilege may lead to the weakening of the relationship of trust that exists between doctor and patient
- the potential for abuse
- the fact that it may afford the doctor an easy defence to manufacture after the fact and may shield negligence
- the fact that it may legitimise the doctor’s natural disinclination towards being a bearer of bad news (where the motivation to withhold the truth from patients originates from the doctor’s unwillingness to be the bearer of bad news, one would expect the temptation to withhold the truth to increase with the grimness of the information; it stands to reason that this poses a serious threat to the self-determination of the patient)
- it may result in the deterioration of health standards and concomitant costs for society if patients were to avoid or delay consulting doctors for fear that their non-medical needs might be disregarded.
When a doctor decides to withhold information from a patient, he or she must consider the possibility that the patient may get to know the truth despite his or her efforts to protect the patient therefrom, since this could cause the patient greater harm than that which the doctor sought to avoid in the first place. Attempts must be made to minimise the possibility that the patient finds out in any case. There must be relative certainty that the patient is unlikely to find out — which, in the case of an undisclosed risk, also means that the possibility of its materialising must be relatively small.

The therapeutic privilege has been criticised on the basis that the medical profession lacks the expertise to predict (or at least is susceptible to a high error rate in assessing) whether disclosure of certain information to a particular patient will have a positive or negative therapeutic effect, or no therapeutic effect at all. It should only be allowed where the doctor possesses some expertise in predicting the effect of disclosure of information on patients.

Evidence is mounting that the medical assumption underlying the therapeutic privilege is false. There is some evidence that questions the assumption that telling patients the truth may result in the refusal of necessary treatment and in non-compliance with the therapeutic regimen prescribed. There is also some evidence that risk disclosure does not even raise patients’ level of anxiety. On the other hand, the evidence upon which the idea that disclosure may harm is built, appears somewhat unimpressive and rather anecdotal. Of course it is difficult to generalise and the effect of specific information should be a matter of empirical research. Further research on the effect that information may have on patients’ psychological and physical well-being (and specifically their level of despondency and depression) can greatly contribute to a just and equitable therapeutic-privilege dispensation.

There are ample examples to be found in case law to demonstrate the effect that non-disclosure of a diagnosis or non-disclosure of the fact that the doctor suspects a certain serious condition can have on a patient’s health. It is submitted that if the doctor has good reason to believe that the disclosure of such information might cause the patient harm, the information may be withheld as long as the doctor can ensure that the patient undergoes an indicated intervention or has his or her health monitored as the case may be. Disclosure should be made if it is necessary in order to
safeguard the patient’s medical interests. The same goes for risks associated with treatment. The Battersby case demonstrates that non-disclosure can saddle the doctor with the burden of ensuring that the patient does not suffer the ill-effects associated with treatment of which he or she has not been made aware. If the doctor withholds self-determination information from a patient, the latter’s ability to take responsibility for his or her own health in the light of the insights of medical science is weakened. Furthermore, it must be borne in mind that, although the disclosure of a diagnosis or a prognosis (eg in the case of a terminal disease) does not always serve the purpose of protecting a patient’s health, it may nevertheless enable a person to come to terms with inescapable reality and may have implications for various other non-medical issues.

The term “therapeutic privilege” should not be understood to mean that doctors may use their professional discretion in deciding whether or not to disclose information that may have a detrimental effect on the patient’s health, since a professional discretion to withhold information is inconsistent with a legal duty to disclose information. The therapeutic privilege must not be seen as a medical instrument that merely serves the ultimate goal of therapy. This defence limits the legal duty to comply with the requirements of informed consent, and is a legal defence. The term “therapeutic justification” is a more accurate description, but it is believed that the term “therapeutic privilege” has taken root so firmly that it appears unlikely that it will be supplanted by any other term.

This raises the question whether the therapeutic privilege should be a separate and independent defence or whether any of the other well-known defences – especially necessity or negotiorum gestio – is suited to cater for therapeutic non-disclosure cases. It is concluded that negotiorum gestio does not cater for these situations because this defence requires that the patient must not be capable of giving his or her consent at the time of the intervention. The argument that negotiorum gestio does not enter the picture in the context of therapeutic non-disclosure because it does not operate as a ground of justification where medical treatment is administered against the patient’s will is rejected in view of the judgment in Castell v De Greef. Although necessity contains no requirement which would exclude it from operating as a defence in the typical case of therapeutic non-disclosure, it is submitted that this defence is not eminently suitable to cover such cases, because of the lack of protection afforded to the patient’s autonomy in terms of its
requirements. The therapeutic privilege should be a separate and independent legal defence which should require all the elements of the defence of necessity. In addition, it should contain some of the safeguards afforded to the patient by the requirements of the defence of negotiorum gestio so that therapeutic privilege is out of the question if: (i) medical treatment is administered against the patient’s will; (ii) the doctor has reason to believe (or knows) that the patient will refuse to undergo an intended intervention once properly informed. In contradistinction to negotiorum gestio, there should be no objection to the use of therapeutic privilege to justify an omission to inform (or a subsequent intervention) where the patient would in any event have consented if he or she had been informed.

Three of the requirements for the defence of necessity can be employed to limit the ambit of the defence of therapeutic privilege, namely: (i) the requirement of the existence of an emergency; (ii) the requirement that the conduct must be the only reasonable means of escaping the danger; and (iii) the requirement of proportionality. The first of these requirements implies that the doctor can rely on necessity or the independent and separate defence of therapeutic privilege submitted above only if the proffered intervention is both indicated and temporally urgent. Where this is the case, the doctor may inform the patient of the existence of certain unidentified risks the disclosure of which may cause him or her harm. It can then be left to the patient to determine how much additional information he or she should like to hear. If the patient waives the right to receive the information the subsequent medical intervention is lawful. The second of these requirements implies that the doctor must consider the possibility of alternative forms of treatment. Where the disclosure of, for example, risks associated with a certain urgently indicated intervention may cause a patient harm, and alternative forms of treatment exist which are not associated with the risks the disclosure of which may cause the patient harm, the patient should be advised of such alternatives. If it is to be expected that an indicated but not temporally urgent intervention will in due course become temporally urgent, and the threat of harm to the patient through disclosure is feared as a result of a pre-existing mental state (eg depression or anxiety), the doctor should treat or have treated the mental condition. Tactful, compassionate communication can sometimes provide an alternative to non-disclosure. The requirement of proportionality implies that the interest sacrificed must not be more valuable than the interest protected. The weighing-up process can be very difficult because the interests involved differ in nature. The high value placed
on patient autonomy in South African law must be borne in mind when balancing the interests endangered with the interests protected.

In the dissertation a categorisation of the divergent definitions of therapeutic privilege has been attempted and certain conclusions and submissions have been made in respect of these specific categories. They will not be repeated here in full and the following remarks will suffice. One of the most frequently mentioned effects sought to be avoided under the therapeutic privilege is anxiety. Although it is often said that the disclosure of all possible risks attached to a medical intervention or medication may cause the patient anxiety, it must be borne in mind that the law does not require such a comprehensive disclosure. In my opinion it is conceivable that unfavourable information may cause a patient some anxiety, but the causing of moderate anxiety is sometimes an unavoidable detrimental effect which must be accepted in the interest of the individual’s right to self-determination. Such anxiety may indeed influence a patient in his or her decision to undergo a particular intervention, and rightly so. Justification for withholding information is also often sought in the secondary effects that anxiety may have. It is submitted that the patient’s emotional state and physical condition are very important factors to be taken into consideration when deciding whether or not to withhold information, since patients vary in their needs, their resources, and their ability to integrate threatening information. Not every patient has the constitution to cope with the truth. Moreover, rigid adherence to a uniform style of disclosure for all patients may not achieve the objective of effective communication. The possible advantage of sparing the patient anxiety by withholding information must be set off against the possibility that withholding information may produce anxiety. In fact, withholding information may even produce more anxiety than disclosing it would produce. If the disclosure of information may lead to serious and not merely transient injury to a patient’s health or threaten the patient’s life, the therapeutic privilege can be upheld. Specifically, if disclosure would hold, or increase, the risk of suicide, for instance in the case of a severely depressed patient, information may be withheld. In the light of evidence suggesting that persons who commit suicide are often ambivalent about their death and often suffer from clinically recognisable illnesses with favourable prognoses, and bearing in mind that the decision to take one’s life is irreversible once successfully
executed, it would be reasonable and justifiable to withhold information that may create or increase the risk of suicide. If the fear exists that suicide may follow upon disclosure, the doctor should consider the possibility of referring the patient for psychiatric evaluation and/or treatment.

Although some courts and authors would restrict the harm lawfully to be avoided under the therapeutic privilege to psychological harm, this restriction seems to me to be without any merit.

The frequently-made suggestion that therapeutic privilege is applicable where disclosure may be detrimental to the patient’s best interests bears witness to an attitude of “doctor knows best”. Doctors are likely to view their patients’ best interests as defined by medical practice. To make a true assessment of the patient’s best interests, the doctor needs to possess knowledge of the patient’s non-medical needs and interests. As a result of a tendency towards a more depersonalised doctor-patient relationship (especially medical specialist-patient relationship), this is not likely to be the case.

As has already been stated, non-disclosure cannot be justified by a claim that compliance with the requirements of informed consent may lead to refusal of an intervention. It is submitted that the stance taken in Castell v De Grief is correct. Where a doctor fears that a patient may refuse to undergo an indicated intervention once informed, the doctor may emphasise the need to undergo the treatment. If the information does indeed frighten the patient into refusing the intervention, the doctor may decide to attempt to address any psychological factors such as fear, anxiety, depression or denial which might have influenced the patient’s decision. If the patient refuses an intervention and it can be established that the patient’s refusal is attributable to an inability to make any rational decision, the rules relating to incompetent patients should apply. It would be very difficult to show beforehand that information could result in a patient’s becoming unable to make a rational decision. Because of the inherent fallibility in predicting what the effect of disclosure would be on the patient’s ability to make rational decisions, and the certainty of undermining self-determination by withholding material information, non-disclosure should not be permitted on account of the fear that a patient would possibly become unable to make a rational decision once properly informed.

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The suggestion that the therapeutic privilege should apply where disclosure might prevent the patient from coming to a rational decision by confusing him or her with technicalities, cannot be accepted. The purpose of informed consent is to elucidate, not to confuse. The withholding of information which has the tendency to confuse the patient therefore cannot constitute an exception to the rule of informed consent, but is in fact dictated by (or a necessary implication of) the rule.

There can be no general rule in terms of which information – especially information relating to the diagnosis and prognosis of a serious or (potentially) fatal illness – may be withheld from seriously ill or dying individuals. Several factors require that honest disclosure should be the rule in most cases: the very significance of such information for patient self-determination; the likelihood that attempts to shield patients from the truth will be futile; the fact that patients who discover the truth about their disease despite efforts to conceal the truth may find themselves in isolation, unable to share their concerns and fears; the fact that the withholding of information may lead to inadequate or inappropriate medical care; the relief of uncertainty which may follow on disclosure of the truth; and the fact that the doctor’s own emotional reluctance, embarrassment, fears, uneasiness and anxieties to confront the patient with the truth may make it very difficult for the doctor to be objective when deciding whether or not to disclose such information. Special care should be taken not to expose seriously ill or dying children to the practice of deception and the distrust that it creates. Children are particularly vulnerable to such practices because their perceptiveness is often underestimated.

Although it is undesirable to shower a moribund patient with upsetting information, doctors should not be allowed to escape their duty to inform by merely allowing a fatal disease to run its course without taking the time to divulge such information as would in the anticipated course of illness and treatment become necessary for the patient in making treatment decisions.

It must be recognised that special considerations may apply in the case of psychiatry and psychotherapy because of the highly subjective nature of the psychiatrist-patient relationship, and because psychiatrists may be better able to predict the effect that information may have on patients.
It is submitted that, where a placebo is used for therapeutic or diagnostic purposes, the patient need not be informed of the fact that he or she is treated with a medically inactive substance.

All things considered, there would be very little room for the application of the defence of therapeutic privilege if the suggestions above were to be followed. What can be done to ameliorate the dilemma doctors sometimes find themselves in when faced with the task of breaking bad news? It is submitted that the emphasis should be shifted from “what to tell the patient” to “how to tell the patient” and “when to tell the patient”. Improving the quality of communication, especially through the development of communication skills, could go a long way in overcoming the problem of avoiding harm through disclosure. Communication should be tuned in to the emotional state, fears and needs of the particular patient. Research shows that the common belief that communication skills cannot be taught is incorrect. Communication skills training should fulfill its rightful place on the medical curriculum.

A doctor who decides to withhold information from a patient should keep notes on the information disclosed and the information withheld. The reasons for withholding the information should also be documented, and, specifically, mention should be made of the patient’s emotional and physical state. If possible, the doctor should have his or her observations of the patient and his or her decision to withhold information confirmed by another doctor or someone who knows the patient better than he or she does.
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