Pleading the defence of therapeutic privilege

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Currently the majority of medical negligence claims are based *inter alia* on an allegation that the doctor failed to procure the patient's informed consent. Therapeutic privilege is an important defence to allegations of non- or inadequate disclosure where the circumstances had warranted its invocation.

Any form of medical intervention requires a patient's informed consent unless other grounds of justification exist, such as statutory authority, necessity, authorised administration, authorisation by the court, waiver and therapeutic privilege.[1] A recognised exception to the required consent is the so-called therapeutic privilege whereby a medical practitioner may at his/her discretion withhold information from a patient with regard to the diagnosis or nature of the proposed treatment and the risks involved, when the practitioner is of the opinion that the patient's state of mind is such that full awareness of the gravity and severity of his condition or the drastic nature of the treatment indicated could be therapeutically detrimental to such a degree that his recovery may be prejudiced.[2]

However 'little documentation exists for claims that informing patients is more dangerous to their health than not informing them, particularly when the informing is done in a sensitive and tactful fashion. On the contrary there is much to suggest that therapeutic privilege has been vastly overused as an excuse for not informing patients of acts they are entitled to know.'[3]

The nature of the defence

The defence of therapeutic privilege includes diagnosis and treatment. There is no general duty on a medical practitioner to divulge his diagnosis to the patient unless it is an express or an implied term of the agreement between the medical practitioner and the patient that he or she must be informed of the diagnosis.[4] Failure to disclose a diagnosis to a patient may, however, constitute negligence if necessary and appropriate treatment is not administered timeously because of this.[1]

Where a patient consents to a diagnostic intervention conditional upon disclosure of diagnosis, non-disclosure vitiates prior consent and puts paid to a defence of therapeutic privilege. In cases where information on diagnosis is material to the patient's decision to subject himself to an intervention, there will obviously be a duty to disclose, subject to the medical practitioner's therapeutic privilege. Therapeutic non-disclosure would be especially appropriate where psychiatric illness is diagnosed. The medical practitioner should be under a duty to reveal the diagnosis under circumstances where non-disclosure may cause the patient physical or psychological harm. A therapeutic duty to warn will rule out therapeutic privilege as a defence.

The following instances should be recognised as exceptions or restrictions to the medical practitioner's general duty to disclose in respect of treatment, namely if: (*i*) full disclosure could be life-threatening to the patient or could detrimentally affect his physical or psychological welfare; (*ii*) full disclosure might influence the patient's decision-making to such a degree that it may prevent him from coming to a rational decision; (*iii*) full disclosure would possibly cause such anxiety and distress that it may jeopardise the final outcome of the proposed medical intervention; (*iv*) the patient is moribund and full disclosure would be insensitive or inhuman; (*v*) disclosure could seriously prejudice third parties; or (*vi*) the risks of full disclosure equal or exceed the dangers of the proposed intervention or treatment.[5]

The psychological profile of the patient

The psychological profile of the patient plays the most important role when evaluating the possible consequences of full disclosure on an already compromised patient. The Federal Supreme Court in Germany, for example, recognised just one situation where disclosure may be restricted and that is in the context of psychiatry and psychotherapy, where it was argued that in such circumstances the subjective nature of the patient/therapist relationship militates against disclosure.[6]

Should the clinical assessment of the patient's psychological status on presentation indicate that full disclosure may result in adverse effects, the practitioner is advised to 'test' the patient by initially imparting information of a general nature in a sensitive and compassionate fashion to evaluate the patient's understanding and emotional reaction to these facts. The effects on the patient of the medical history and disclosures of other medical practitioners who are also involved with the treatment or management, are also relevant.

The patient's unusual susceptibility to anxiety should be clinically assessed and clearly recorded in the doctor's medical records. There should be a direct correlation between the nature of the intervention or diagnosis and the extent of the non-disclosure. A more serious diagnosis or intervention should pose a higher risk or threat of psychological or physical harm to the patient and will be an important factor for the court to evaluate when it considers the reasonableness of the non-disclosure. The onus of proving a non-disclosure rests on

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the patient in civil actions and on the state in criminal prosecutions. The defence of therapeutic privilege in civil actions will have to be pleaded and proved by the medical practitioner involved.

The medical practitioner's clinical records

To comply with the ethical guidelines with regard to clinical note keeping and to record the fact that the doctor applied therapeutic privilege, the following should be contemporaneously and carefully documented in the clinical notes: (*i*) details of the patient's history, psychological profile and clinical assessment; (*ii*) the nature of the diagnosis or disease, its course and prognosis; (*iii*) the material risks and/or complications associated with the treatment envisaged and the risks that will remain undisclosed; (*iv*) the extent and reasons for the non-disclosure; and (*v*) the nature of the harm and the detrimental effect that the medical practitioner recognised and sought to avoid.

These records will constitute *prima facie* proof of the medical practitioner's reasons for non-disclosure and could neutralise an allegation or inference that invocation of the exception is an invention employed by the practitioner to escape non-disclosure liability.

The utility of disclosure documents

Van Oosten[7] is of the opinion that consent forms cannot serve as a meaningful substitute for a disclosure conversation. He states that 'a disclosure conversation is better suited than document disclosure to realize the ideal of a so-called therapeutic alliance in health care, which denotes shared decision making between doctor and patient and, hence, a reconciliation and collaboration between the parties.'

When determining whether or not the medical practitioner's non-disclosure was reasonable under the circumstances the court should consider expert medical evidence in respect of the risks and dangers of the particular diagnosis or intervention, the disease or complaint and its prognosis, the testimony of the medical practitioner relating to his clinical assessment of the patient at the time of non-disclosure, his reasons for non-disclosure, and the nature and extent of the non-disclosure. The evidence of the patient relating to the disclosure consultation, the patient's subjective feelings in this regard and expert evidence relating to the patient's psychological profile will also be important. The ultimate question is whether the medical practitioner's conduct conformed to the standard of reasonable care demanded by the law. It is a question for the court to decide and cannot be delegated to the medical profession or a group in the community.[8]

In the Australian case of *Battersby v. Tottman*[9] the court upheld a defence of therapeutic privilege on the grounds that the information as to the risk associated with the intended procedure was withheld because it could actually cause physical or mental harm to the patient. It was found that Dr Tottman understood the patient's mental and emotional condition to be of such a nature that he had to make the decision regarding the proposed therapy on her behalf.

A distinction should be drawn between circumstances in which a decision is made on behalf of the patient because of the patient's mental infirmity, and circumstances in which a medical practitioner withholds information from a patient regarding the attendant risks associated with a proposed intervention so as to facilitate a patient's consent. In the latter case the patient still makes the decision to undergo the intervention although the consent is not 'informed' with regard to the information that was not disclosed. In the former instance the doctor makes the decision on behalf of the patient because the patient lacks the necessary capacity. However, it is submitted that the doctor's therapeutic privilege should also be extended to accommodate circumstances in which a patient becomes so ill or emotionally distraught on disclosure that it may foreclose a rational decision from the patient. The distinction between mental incapacity and emotional instability of this nature may be very fine and aggravate the troublesome nature of the defence.

Recommendations

The following principles are recommended for acceptance and application in the South African context: (*i*) non- or inadequate disclosure can only be justified in exceptional circumstances; (*ii*) there must be a real threat of detriment to a patient's physical or mental health; (*iii*) information may be withheld when the medical practitioner judges the patient's temperament or emotional state to be such as to be unable to make the information the basis of a rational decision; (*iv*) the medical practitioner bears the onus of proving that the non- or inadequate disclosure was based on sound clinical judgment; and (*v*) the legal, ethical and moral principles relating to the medical practitioner's therapeutic privilege should protect patient autonomy without unduly restricting medical judgment, with the object of achieving the best medical result for the patient.

References

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8. Castell v. De Greef 1994 (4) SA 408 C:426 I- 427 B.
9. Battersby v. Tottman (1985) 37 SASR 189.