

**Abstract:** Therapeutic privilege is conceived as a defence to a negligence claim available to a medical practitioner, where the negligence alleged is a failure to warn. It affords a practitioner an opportunity to prove that the failure to warn was because of a belief that disclosure of a material risk would prove damaging to a patient. Since its endorsement by the High Court in 1992, the concept has received scant judicial attention. This article explains why. The legal landscape has changed and in terms of establishing normative causation, the nature of the duty to warn and its underlying policy provides supports a judgement strongly in favour of patient autonomy. Given the legal commitment to patient autonomy, together with the wider protection that a mentally competent patient has an absolute right to decide whether or not to undergo medical treatment, the concept of therapeutic privilege is redundant. Against an established claim in negligence, therapeutic privilege is no defence.

**Keywords:** negligence, duty to warn, material risk, breach, causation of damage, defence, therapeutic privilege, patient autonomy, medical treatment, consent.

## Therapeutic privilege is no defence

### Contents

Introduction .....	1
Juristic development .....	3
<i>Canterbury v Spence</i> 464 F.2d 772 (D.C. Cir. 1972) .....	3
<i>F v R</i> (1983) 33 SASR 189 .....	4
<i>Reibl v Hughes</i> (1980) 114 D.L.R. (3d).....	5
<i>Sidaway v Bethlem Royal Hospital Governors and others</i> [1985] 2 WLR 480.....	5
The scope of therapeutic privilege.....	6
Occasions when there is no work to do .....	7
The duty to warn must be engaged.....	8
Emergency or Necessity.....	8
The duty is to warn of material risks .....	9
The non-disclosure of the material risk must have been reasonable .....	10
Patient autonomy.....	11
Waiver.....	11
The magnitude of risk and its likelihood.....	13
In the circumstances of the particular patient.....	14
What harm would the especially vulnerable patient suffer .....	17

When the act of giving particular information would cause harm .....	17
Causation of damage .....	18
The proactive duty to inform .....	19
Establishing causation of damage .....	19
Factual causation.....	20
Normative causation .....	21
The irrational vulnerable patient .....	22
Conclusion.....	24

## Introduction

It is well established that, in appropriate cases, a medical practitioner has a duty to warn a patient of material risks. The duty extends to disclosure of risks both inherent in the contemplated treatment, and that the treatment may prove ineffective.<sup>1</sup> In the seminal case of *Rogers v Whitaker*,<sup>2</sup> the majority held that the test of materiality encompasses an objective limb and a subjective limb.<sup>3</sup> The objective limb calls for an assessment of what a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it. The subjective limb calls for an assessment of whether the medical practitioner is, or should reasonably be aware, that a particular patient, if warned of the risk, would be likely to attach significant to it.<sup>4</sup> The duty to warn 'is not qualified by any provision to the effect that relevant information may be withheld due to fears that patients aware of it might not make the best decisions for their own treatment and care'.<sup>5</sup> It is, however, qualified by the concept of therapeutic privilege.<sup>6</sup>

To presuppose a duty to warn, breach of that duty and that causation of damage has been established,<sup>7</sup> therapeutic privilege is said to afford a medical practitioner an opportunity to prove that the failure to warn was because he or she reasonably believed that disclosure of a material risk

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<sup>1</sup> *Rogers v Whitaker* (1992) 175 CLR 479 [481] citing *F v R* (1983) 33 SASR 189 [191] (King CJ).

<sup>2</sup> *Rogers v Whitaker* (1992) 175 CLR 479.

<sup>3</sup> *Rogers v Whitaker* (1992) 175 CLR 479 [490].

<sup>4</sup> *Rogers v Whitaker* (1992) 175 CLR 479 [490] (Mason CJ, Brennan, Dawson, Toohey and McHugh, JJ).

<sup>5</sup> *Haylock v Morris* [2006] ACTSC 86 [25]; see also *Canterbury v Spence* 464 F.2d 772 (1972) [789].

<sup>6</sup> *Rogers v Whitaker* (1992) 175 CLR 479 [490].

<sup>7</sup> See *Wallace v Kam* 250 CLR 375 [7].

would prove damaging to a patient.<sup>8</sup> In qualifying a medical practitioner's duty to warn in this way, the High Court carved out a back door for medical paternalism to prevail, albeit in tension with the duty to warn itself. In other words, the concept of therapeutic privilege represents a tension between a medical practitioner's duty to warn a patient of material risks and their ethical obligations of beneficence and non-maleficence<sup>9</sup> in situations where, to so warn a patient, such a warning would probably cause the patient serious harm.<sup>10</sup>

Given that the concept of therapeutic privilege affords a medical practitioner a defence to a claim in negligence, the question is, on what occasion can the defence of therapeutic privilege be successfully deployed by a careful and responsible<sup>11</sup> medical practitioner who has failed to warn a patient of a material risk?<sup>12</sup> Unfortunately, there is very little guidance. The concept of therapeutic privilege has received scant judicial attention,<sup>13</sup> its operation is obscure<sup>14</sup> and its scope is not settled. Although the defence of therapeutic privilege is recognised in jurisdictions worldwide,<sup>15</sup> since its express endorsement in Australia in 1992 the author has been unable to identify a single case where the privilege has been pleaded with success. This article seeks to explain why this is the case.

This article explores the origins and justifications of the privilege to determine its apparent scope. It then proceeds to reduce the concept to three constituent elements, and by way of analysis against the requirements inherent in an established negligence claim, demonstrates that the defence of therapeutic privilege has no work to do. It concludes that therapeutic privilege is no defence to a negligence claim where the negligence alleged is a failure to warn, and that the

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<sup>8</sup> See *Rogers v Whitaker* (1992) 175 CLR 479 [486].

<sup>9</sup> See especially 'Code of Professional Ethics of the American College of Obstetricians and Gynecologists' July 2011 <<https://www.acog.org/-/media/Departments/National-Officer-Nominations-Process/ACOGcode.pdf>>.

<sup>10</sup> *F v R* (1983) 33 SASR 189 [193].

<sup>11</sup> *Chatterson v Gerson* [1981] 1 All ER 257 [265].

<sup>12</sup> See LC Coetzee, 'A critical evaluation of the therapeutic privilege in medical law: some comparative perspectives' (2003) 36(3) *The Comparative and International Law Journal of South Africa* [268]-[288], 271-272 <<https://www.jstor.org/>>.

<sup>13</sup> Rachael Mulheron, 'The defence of therapeutic privilege in Australia' (2003) 11 *Journal of Law and Medicine* [201]-[213], 212.

<sup>14</sup> Rachael Mulheron, 'Has *Montgomery* Administered the Last Rites to Therapeutic Privilege? A Diagnosis and a Prognosis' (2017) 70(1) *Current Legal Problems* [149]-[188], 150.

<sup>15</sup> See, eg., *Montgomery v Lanarkshire Health Board* [2015] 2 WLR 768 [91] (albeit coined the "therapeutic exception"); *Stuart v Camnitz* 774 F 3d 238, 4<sup>th</sup> Circuit (2004) [254]; *Castell v De Greef* 1994 (4) SA 408 (C) [426].

narrow approach to the operation of the privilege described by Gaudron J<sup>16</sup> in *Rogers v Whitaker* is the preferred approach.

## Juristic development

In *Rogers v Whitaker* the High Court endorsed the concept of therapeutic privilege.<sup>17</sup> In doing so, the Court traced its development in the common law drawing on several milestone cases:

*Canterbury v Spence*<sup>18</sup> (United States), *F v R*<sup>19</sup> (Australia) and *Sidaway v Bethlem Royal Hospital Governors*<sup>20</sup> (United Kingdom). Of significance is that, prior to its endorsement in Australia, the formulation of therapeutic privilege was intended to excuse doctors from upsetting patients whose mental health may be harmed by receiving information.

### *Canterbury v Spence* 464 F.2d 772 (D.C. Cir. 1972)

In the United States, *Canterbury v Spence*<sup>21</sup> was a cause of action that came before the United States Court of Appeals in the (then) District of Columbia Circuit. Mr Canterbury's action for damages included a claim that his doctor, Dr Spence, negligently failed to disclose a risk of serious disability inherent in the proposed surgery. The risk materialised. The court below had entered judgment for the Plaintiff. The Court of Appeals reversed that decision and remitted the case for a new trial.

In obiter dictum, the Court described the general rule of disclosure of material risks relating to operations and then anchored two exceptions to it that would outweigh the patient's right to know of the risks inherent in the surgery contemplated by the medical practitioner. The first exception arises in the situation of an emergency when the patient is unconscious or otherwise incapable of consenting. The second exception is the concept of therapeutic privilege.

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 on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient.

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<sup>16</sup> *Rogers v Whitaker* (1992) 175 CLR 479 [494] (Gaudron J).

<sup>17</sup> *Rogers v Whitaker* (1992) 175 CLR 479 [490].

<sup>18</sup> 464 F.2d 772 (D.C. Cir. 1972).

<sup>19</sup> (1983) 33 SASR 189.

<sup>20</sup> [1985] 2 WLR 480.

<sup>21</sup> 464 F.2d 772 (D.C. Cir. 1972) (Wright, Leventhal and Robinson, JJ).

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. (footnotes omitted)<sup>22</sup>

Significantly, this leading formulation of therapeutic privilege was intended to excuse doctors from upsetting patients whose mental health may be harmed by receiving information.<sup>23</sup>

### *F v R* (1983) 33 SASR 189

In Australia, *F v R*<sup>24</sup> was a cause of action that came before the Supreme Court of South Australia on appeal. At trial, the Plaintiff had recovered damages against her medical practitioner. Her action for damages included the claim that her doctor had negligently failed to disclose a risk of failure of the proposed surgery.

In obiter dictum, Chief Justice King traversed the concept of therapeutic privilege.

Considerations of the temperament and health of the patient are clearly important in arriving at a decision as to the imparting of information. 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 be seriously harmed by the information. Justification may also exist for not imparting information when the doctor reasonably judges that the patient's temperament or emotional state is such that he would be unable to make the information a basis for a rational decision.<sup>25</sup>

In delivering his judgement, Chief Justice King relied on a number of authorities including *Canterbury v Spence* and the case of *Reibl v Hughes*.<sup>26</sup>

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<sup>22</sup> *Canterbury v Spence* 464 F.2d 772 (1972) [789]; affirmed in *Crain v Allison* 503 A.2d 556 (D.C. 1982) [563].

<sup>23</sup> See also *Myer Estate v Rogers* 78 D.L.R. (4th) 307 [12] (Maloney J).

<sup>24</sup> (1983) 33 SASR 189.

<sup>25</sup> *F v R* (1983) 33 SASR 189 [193].

<sup>26</sup> (1980) 114 DLR (3d).

### *Reibl v Hughes* (1980) 114 D.L.R. (3d)

In Canada, *Reibl v Hughes*<sup>27</sup> was a cause of action that came before the Supreme Court on appeal on the issue of liability. Mr Reibl's action for damages included a claim that Dr Hughes had negligently failed to disclose the risk of serious harm inherent in the proposed surgery.

In obiter dictum,<sup>28</sup> the Court addressed the concept of therapeutic privilege.

[I]t 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.<sup>29</sup>

Later in the judgement, in discussing the findings of the trial judge, the Court<sup>30</sup> identified a relevant consideration that 'there was no evidence that the plaintiff was emotionally taut or unable to accept disclosure of the grave risk to which he would be exposed by submitting to surgery'.<sup>31</sup>

Of significance is that, as in *Canterbury v Spence*, the formulation of therapeutic privilege<sup>32</sup> was intended to excuse doctors from upsetting patients whose mental health may be harmed by receiving information.<sup>33</sup>

### *Sidaway v Bethlem Royal Hospital Governors and others* [1985] 2 WLR 480

In the United Kingdom, *Sidaway v Bethlem Royal Hospital Governors*<sup>34</sup> was a cause action that came before the House of Lords on appeal from the Court of Appeal. Ms Sidaway's action for damages included a claim that the late Dr Falconer negligently failed to disclose a risk of serious disability inherent in the proposed surgery.

In his dissenting speech, Lord Scarman canvassed the propositions enunciated in *Canterbury v Spence* concluding with the concept of therapeutic privilege.

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<sup>27</sup> (1980) 114 D.L.R. (3d).

<sup>28</sup> See *Myer Estate v Rogers* 78 D.L.R. (4th) 307 [16] (Maloney J).

<sup>29</sup> *Reibl v Hughes* (1980) 114 D.L.R. (3d) [13].

<sup>30</sup> Laskin CJC, Martland, Dickson, Beetz, Estey, McIntyre and Chouinard JJ.

<sup>31</sup> *Reibl v Hughes* (1980) 114 D.L.R. (3d) [34].

<sup>32</sup> The defence of "therapeutic privilege" was later considered and rejected as alien to Canadian law in *Myers Estate v Rogers* 78 DLR (4<sup>th</sup>) 307 [16], [20].

<sup>33</sup> See also *Haughian v Paine* (1987) 37 DLR (4<sup>th</sup>) 624 [644] (Sherstobitoff JA).

<sup>34</sup> [1985] 1 All ER 643.

The doctor, however, has what the court called a 'therapeutic privilege'. This exception enables a doctor to withhold from his patient information as to risk if it can be shown that a reasonable medical assessment of the patient would have indicated to the doctor that disclosure would have posed a serious threat of psychological detriment to the patient.<sup>35</sup>

Significantly, as in *Canterbury v Spence* and *Reibl v Hughes*, the formulation of therapeutic privilege was intended to excuse doctors from upsetting patients whose mental health may be harmed by receiving information. In contrast, returning to Australia, in *F v R* Chief Justice King expanded the formulation of therapeutic privilege to encompass risk of serious mental *or* physical harm. However, it is difficult to conceive any circumstance where the mere disclosure of information might cause serious physical harm (as distinct from physical harm being a secondary consequence of mental harm). As such, this expansion must be regarded as an interpolation.<sup>36</sup>

## The scope of therapeutic privilege

In 1992 the High Court clearly endorsed the concept of therapeutic privilege.<sup>37</sup> In doing so, the court approved the approach of Chief Justice King in *F v R* to determining if a failure to disclose a material risk was justified; however, it did not express a view that therapeutic privilege extended to a risk of physical harm. Rather, it contemplated 'cases where there is a particular danger that the provision of all relevant information will harm an unusually nervous, disturbed or volatile patient'.<sup>38</sup> As such, until this question is squarely before the High Court, authority that the defence of therapeutic privilege extends to physical harm is obiter dictum of an intermediate appellate court. Further, other intermediate appellate courts and trial judges are not bound to follow such a decision if they are convinced that the interpretation is plainly wrong.<sup>39</sup> As such, the scope of therapeutic privilege is not settled.

It is said that therapeutic privilege affords a medical practitioner an opportunity to prove that his or her failure to warn was because he or she reasonably believed that the very act of disclosure of a material risk to a patient would prove damaging,<sup>40</sup> where damage is contemplated to encompass

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<sup>35</sup> *Sidaway v Bethlem Royal Hospital Governors and others* [1985] 2 WLR 480 [493] (Lord Scarman).

<sup>36</sup> See also *Myers Estate v Rogers* 78 DLR (4<sup>th</sup>) 307 [13] (Maloney J).

<sup>37</sup> *Rogers v Whitaker* (1992) 175 CLR 479 [490].

<sup>38</sup> *Rogers v Whitaker* (1992) 175 CLR 479 [490].

<sup>39</sup> See *Farah Constructions Pty Ltd v Say-Dee Pty Ltd* (2007) 230 CLR 89 [151-152].

<sup>40</sup> See *Rogers v Whitaker* (1992) 175 CLR 479 [486].

(at least) serious mental harm<sup>41</sup> or serious physical harm.<sup>42</sup> In addition, justification may also exist when a medical practitioner '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'.<sup>43</sup>

Comparatively, in *Stuart v Camnitz*,<sup>44</sup> the United States Court of Appeals, Fourth Circuit, recognised therapeutic privilege as permitting a medical practitioner 'to decline or at least wait to convey relevant information as part of the informed consent because in their professional judgement, delivering the information to the patient at the particular time would result in serious psychological or physical harm'.<sup>45</sup> In *Montgomery v Lanarkshire Health Board*,<sup>46</sup> the United Kingdom Supreme Court recognised a therapeutic exception that a medical practitioner is 'entitled to withhold from the patient information as to a risk if he reasonably considers that its disclosure would be seriously detrimental to the patient's health'.<sup>47</sup>

However, given the relative lack of judicial commentary, the scope of therapeutic privilege is far from clear<sup>48</sup> and the circumstances in which the defence may apply are likely to be regarded by the courts as rare.<sup>49</sup> The following analysis proceeds to narrow the scope of its potential operation by identifying those occasions when therapeutic privilege has no work to do. For this purpose, the concept of therapeutic privilege is reduced to three elements: a medical practitioner's **reasonable belief** that warning a **particular patient** will cause **serious harm**.

## Occasions when there is no work to do

There are clearly occasions when therapeutic privilege has no work to do because deployment of the defence is beyond its scope. The starting point is that therapeutic privilege is a defence to a

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<sup>41</sup> See also *Tame v New South Wales; Annetts v Australian Stations Pty Ltd* (2002) CLR 317 [7] (Gleeson CJ), [44] (Gaudron J), [285] (Hayne J).

<sup>42</sup> *F v R* (1983) 33 SASR 189 [193].

<sup>43</sup> *F v R* (1983) 33 SASR 189 [193].

<sup>44</sup> 774 F.3d 238 (4th Cir).

<sup>45</sup> *Stuart v Camnitz* 774 F.3d 238 (4<sup>th</sup> Cir) [254].

<sup>46</sup> [2015] 2 WLR 768.

<sup>47</sup> *Montgomery v Lanarkshire Health Board* [2015] 2 WLR 768 [88].

<sup>48</sup> Emma Cave, 'The ill-informed: Consent to medical treatment and the therapeutic exception' (2017) 46(2) *Common Law World Review* [140]-[168], 143.

<sup>49</sup> Ian Freckelton, 'The new duty to warn' (1999) 24(1) *Alternative Law Journal* 17 <<http://www5.austlii.edu.au/au/journals/AltLawJl/1999/4.html>>.

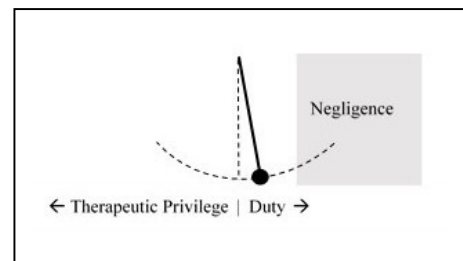


negligence claim that is available to a medical practitioner, where the negligence alleged is a failure to warn.

### The duty to warn must be engaged

The imposition of a duty to warn tells us no more than that the medical practitioner was legally obliged to take care.<sup>50</sup> The duty holds a deterrent potential for medical practitioners against non-disclosure of a material risk, the materialisation of such being unacceptable to the patient.<sup>51</sup> For the defence of therapeutic privilege to have any work to do, the duty to warn must be engaged. To be engaged, the patient must have capacity. Capacity means that the patient is able 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.

Figuratively, the existence of a duty to warn provides impetus for the pendulum of legal responsibility to shift towards negligence being established. In the absence of a duty to warn, therapeutic privilege has no work to do.



**DUTY**

To presuppose a duty to warn, the duty is suspended in circumstances of emergency or necessity.

In the United Kingdom, the view expressed in *Re F (a mental patient: sterilisation)*<sup>52</sup> is that an emergency is a frequent origin of necessity.<sup>53</sup> Thus in circumstances where a patient (or a substitute decision-maker) is unable to consent, the principle of necessity provides justification that, in the patient's best interests, immediate medical treatment should be given to save the life or preserve the health of that patient.<sup>54</sup> Or alternatively—presuming that the patient would consent to the treatment if he or she were capable because it was necessary to save his or her life or preserve his or her health—on the basis of implied consent.<sup>55</sup>

<sup>50</sup> Jane Stapleton, 'Occam's razor reveals an orthodox basis for *Chester v Ashfar*' (2006) 122(Jul) *Law Quarterly Review* [426]-[428], 434-435.

<sup>51</sup> See Stapleton, n 50, 439, 443; See also *Wallace v Kam* 250 CLR 375 [34].

<sup>52</sup> [1990] 2 AC 1 [75] (Lord Goff).

<sup>53</sup> *Re F (a mental patient: sterilisation)* [1990] 2 AC 1 [75] (Lord Goff).

<sup>54</sup> *Re F (a mental patient: sterilisation)* [1990] 2 AC 1 [75].

<sup>55</sup> *Malette v Shulman* (1990) 67 DLR (4<sup>th</sup>) 321 [328-329].

As stated by the majority in *Rogers v Whitaker*, 'except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo it'.<sup>56</sup> If, due to the circumstances of emergency or necessity, there is no opportunity for a patient to make a choice, correspondingly, there is no opportunity for a medical practitioner to warn a patient of material risks.<sup>57</sup> In the absence of an opportunity to warn, no breach of the duty to warn can follow. In the absence of a breach of the duty to warn the defence of therapeutic privilege has no work to do.

### The duty is to warn of material risks

Accepting that a duty to warn is established, the relevant non-disclosure (being the risk the medical practitioner should have warned against) must be a failure to disclose a material risk. In *Rosenberg v Percival*,<sup>58</sup> Justice Gummow put the test of materiality of risk as follows:

(1) In the circumstances of the case, a reasonable person in the patient's position would be likely to attach significance to it (the objective limb); or (2) the medical practitioner was, or should have been, aware that the particular patient would be likely to attach significance to it (the subjective limb).<sup>59</sup>

The remarks of Chief Justice King are apposite to the objective limb of the duty to warn.

The duty extends ... only to matters which might influence the decisions of a reasonable person in the situation of the patient. A risk of harm or of failure might be so slight in relation to the consequences of not undergoing the proposed treatment that no reasonable person would be influenced by it. The duty to disclose does not extend to such a risk.<sup>60</sup>

By way of extreme example in applying the subjective limb, in situations where cancer patients are undergoing high-risk medical procedures (such as bone marrow treatment), Stewart identifies that:

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<sup>56</sup> *Rogers v Whitaker* (1992) 175 CLR 479 [487].

<sup>57</sup> See also David Andrew Ipp, Australian Treasury, *Review of the Law of Negligence: Final Report* (2002) 48-53 ("*Ipp Report*"), 52.

<sup>58</sup> (2001) 205 CLR 434.

<sup>59</sup> *Rosenberg v Percival* (2001) 205 CLR 434 [458].

<sup>60</sup> *F v R* (1983) 33 SASR 189 [192]; see also *Jelicic v Salter* [2003] QSC 103 [34] (Helman J).

In such cases, the choices for patients are stark and it could be argued that the materiality of risk disappears altogether for some. ... Put simply, no risk is material when the only options are treatment or death. The consent is given regardless of the risks involved.<sup>61</sup>

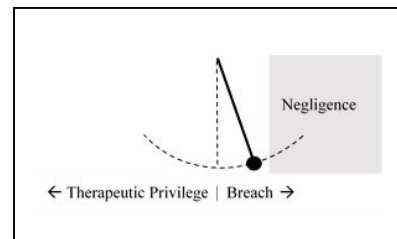
If it is determined that a reasonable person, or the particular patient, would not be likely to attach significance to the risk, the risk is not a material one. If the relevant non-disclosure is a failure to disclose a risk that is immaterial, then no duty to warn arises. In the absence of a duty to warn, the defence of therapeutic privilege has no work to do.

### The non-disclosure of the material risk must have been reasonable

In *F v R*, 'in a manner reminiscent of *Wyong Shire Council v Shirt*',<sup>62,63</sup> Chief Justice King addressed a complex of factors that a medical practitioner must consider in deciding to disclose or advise of a material risk inherent in a proposed procedure. These factors include: the nature of the matter to be disclosed; the nature of the treatment; the patient's desire for information; the characteristics of the patient and the surrounding circumstances.<sup>64</sup> The assessment of whether a medical practitioner's non-disclosure of a material risk is reasonable is an initial enquiry that 'calls for a consideration of the magnitude of the risk and the degree of probability of its occurrence, along with the expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities which the defendant may have'.<sup>65</sup> In the context of medical treatment, the latter point can be described as being balanced against the interest of patient autonomy, which the medical practitioner must sacrifice to avoid the risk of harm.<sup>66</sup>

If the non-disclosure of a material risk was not reasonable, a medical practitioner would breach their duty to warn.

Figuratively, a breach of duty to warn provides further impetus towards negligence being established.



**BREACH**

<sup>61</sup> Cameron Stewart, 'Cracks in the Lintel of Consent', in Ian Freckelton and Kerry Petersen (eds) *Tensions & Traumas in Health Law* (The Federation Press, 2017) 214, 220; see also *Elbourne v Gibbs* [2006] NSWCA 127 [84] (Basten JA).

<sup>62</sup> (1980) 146 CLR 40.

<sup>63</sup> Harold Luntz, *Torts: Cases and Commentary* (LexisNexis Butterworths, 7<sup>th</sup> ed, 2013) 227.

<sup>64</sup> *F v R* (1983) 33 SASR 189 [192-193]; approved in *Rogers v Whitaker* (1992) 175 CLR 479 [488-489].

<sup>65</sup> *Wyong Shire Council v Shirt* (1980) 146 CLR 40 [47] (Mason J).

<sup>66</sup> See, eg, *United States v Carroll Towing Co* 159 F 2d 169 (1947) [173]; see also *Conway v O'Brien* 111 F 2d 611 (1940) [612]; see also *Rosenberg v Percival* (2001) 205 CLR 434 [69] (Gummow J).

## Patient autonomy

The interest of patient autonomy is more than a recognition of the right of a patient to be adequately informed of material risks so as to be able to make a rational choice. It is a recognition of a patient's interest in his or her own physical integrity.<sup>67</sup> A patient's interest in being adequately informed of material risks is an aspect of his or her interest in his or her physical integrity because he or she can act on that information to avoid the risk.<sup>68</sup> No medical treatment is inevitable, and the cost benefit analysis of taking the risk belongs to the patient. The law seeks to protect the patient's physical integrity by ensuring that he or she 'is only subjected to risks that are judged reasonable in the circumstances, where that assessment is entrusted to the appropriately informed [patient themselves]'.<sup>69</sup>

## Waiver

The duty to warn is suspended by a patient waiving their right to be warned of material risks.<sup>70</sup> To presuppose that a patient has been informed in broad terms of the nature of the proposed treatment, and has provided his or her consent,<sup>71</sup> waiver of the right to be warned of material risks accepts that a patient can inform their medical practitioner that he or she consents to the treatment in the absence of the warning that would normally be required.<sup>72</sup> In *F v R* Chief Justice King identified that the extent of the duty to warn 'depends greatly upon the patient's expressed or apparent desire for information'.<sup>73</sup> Gutman identifies the spectrum of patients who do not want to be informed of material risks.

Some patients do not want to know of the risks associated with proposed medical treatment. This may be because they have complete confidence in the doctor and wish to leave medical decisions to professionals. Alternatively, it may be because they are scared about knowing the risks. They do not

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<sup>67</sup> Stapleton, n 50, 443.

<sup>68</sup> Stapleton, n 50, 443.

<sup>69</sup> Stapleton, n 50, 443-444, citing *Chester v Afshar* [2005] 1 AC 134, [18] (Lord Steyn), [28] (Lord Hoffmann), [54]-[55], [86] (Lord Hope), [92] (Lord Walker) and M. Jones, 'A Risky Business' (2005) 13 Tort Law Review 40.

<sup>70</sup> Law Reform Commission of Western Australia, *Informed Consent to Medical Treatment: Processes, Practices and Beliefs*, Report (1992) 12.

<sup>71</sup> *Chatterson v Gerson* [1981] QB 432 [443] (Bristow J).

<sup>72</sup> Law Reform Commission of Western Australia, n 70, 13.

<sup>73</sup> *F v R* (1983) 33 SASR 189 [192], citing *Smith v Auckland* [1965] NZLR 191.

want to be burdened and frightened by the knowledge of the risks associated with the procedure or treatment.<sup>74</sup>

It is accepted that patients have the power to decline information.<sup>75</sup> A patient who (expressly or apparently) conveys a desire not to be given information, regardless of their reasons, is exercising his or her autonomy to not be informed of material risks,<sup>76</sup> 'even though they may be less informed, uninformed or even ill-considered'.<sup>77</sup> Therefore, in applying the subjective limb of the duty to warn in *Rogers v Whitaker*, no risk is material. This is because the particular patient does not attach significance to it.<sup>78</sup> Therefore, the risk is immaterial. As stated above, if the relevant non-disclosure is a failure to disclose an immaterial risk, then no duty to warn arises. In the absence of a duty to warn the defence of therapeutic privilege has no work to do.

However, this line of reasoning does not necessarily follow when applying it to the objective limb of the duty to warn. Although the objective and subjective limbs are described as conceptually discrete, this approach belies the fact that two limbs must operate in tandem. You simply cannot conceptually disregard the objective limb in the face of the subjective limb (and vice versa). As such, there is a logical inconsistency between the objective limb and subjective limb when they are in tension. This is evident when it is assessed by the medical practitioner that (objectively) a reasonable person in the patient's position would be likely to attach significance to the warning; however, in the circumstances, the medical practitioner is aware that (subjectively) the particular patient does not attach significance to it.

Although, *Rogers v Whitaker* clearly establishes a duty to warn (subject to therapeutic privilege), the judgment does not afford a priority to the operation of either limb over the other, and there is no corresponding duty to not warn (subject to therapeutic privilege). On the face of it, in these circumstances the objective limb and the subjective limb are in conflict.

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<sup>74</sup> Judy Gutman, 'The Right Not to Know: Patient Autonomy or Medical Paternalism?' (2000) 7 *Journal of Law and Medicine* [286]-[292], 289-291.

<sup>75</sup> Cave, n 48, 143.

<sup>76</sup> Law Reform Commission of Victoria, *Informed Decisions about Medical Procedures*, Report No 24 (1989) 18.

<sup>77</sup> Stewart, n 61, 219.

<sup>78</sup> See also *Rosenberg v Percival* (2001) 205 CLR 434 [458] (Gummow J).

However, a medical practitioner is not obliged to provide a patient with information in these circumstances. Recently, the Supreme Court in *Montgomery v Lanarkshire Health Board*<sup>79</sup> said:

A person can of course decide that she does not wish to be informed of risks of injury (just as a person may choose to ignore the information leaflet enclosed with her medicine); and a doctor is not obliged to discuss the risks inherent in treatment with a person who makes it clear that she would prefer not to discuss the matter.<sup>80</sup>

Whereas therapeutic privilege provides a defence to a failure to warn, there is no reverse form of therapeutic privilege that sanctions a medical practitioner giving patients ‘information that they do not want if a doctor deems it necessary’.<sup>81</sup> To do so runs counter to patient empowerment<sup>82</sup> and the tenor of the judgment in *Rogers v Whitaker* itself. The tension is therefore resolved in favour of the subjective limb. Although there is a clear presumption in favour of disclosure of information going to material risks, ‘a doctor is not required to inflict on his patients information which they do not seek and do not want’.<sup>83</sup> The presumption is therefore rebuttable. In rebutting the presumption, the objective limb of the duty to warn in *Rogers v Whitaker* is suspended and no breach of the duty to warn can follow. In the absence of a breach of the duty to warn the defence of therapeutic privilege has no work to do.

## The magnitude of risk and its likelihood

Returning to the apparent scope of the defence of therapeutic privilege against a background of where the defence has no work to do. Given the relative lack of judicial commentary, the author suggests that, for the defence be successfully deployed, the magnitude of the risk must be serious<sup>84</sup> and the likelihood of its occurrence must be at least ‘not unlikely to occur’, or there to be ‘a real risk or danger’ of harm.<sup>85</sup> Noting that ‘[t]he concept of a ‘material risk’ is potentially dramatically elastic

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<sup>79</sup> [2015] 2 WLR 768.

<sup>80</sup> *Montgomery v Lanarkshire Health Board* [2015] 2 WLR 768 [85] (Lord Kerr and Lord Reed (with whom Lord Neuberger, Lord Clarke, Lord Wilson and Lord Hodge agree)).

<sup>81</sup> Gutman, n 74, 290.

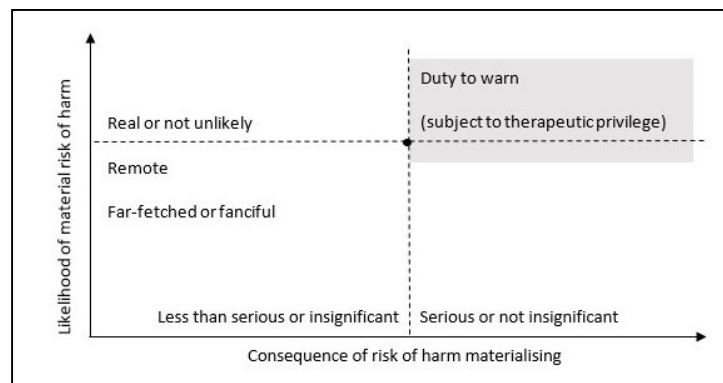
<sup>82</sup> Gutman, n 74, 290.

<sup>83</sup> *F v R* (1983) 33 SASR 189 [193].

<sup>84</sup> See *F v R* (1983) 33 SASR 189 [193]; see also *Montgomery v Lanarkshire Health Board* [2015] 2 WLR 768 [28]; see also *Sidaway v Bethlem Royal Hospital Governors and others* [1985] [1985] 1 All ER 643 [665] (Lord Templeman) cited in *Rogers v Whitaker* (1992) 175 CLR 479 [486].

<sup>85</sup> *Caterson v Commissioner for Railways (NSW)* (1973) 128 CLR 99 [102] (Barwick CJ).

in the context of an especially anxious or emotionally labile patient',<sup>86</sup> the following diagram depicts therapeutic privilege as being conceived as having work to do about the intersection of a real or not unlikely likelihood of serious or not insignificant harm.



**THE SCOPE OF THERAPEUTIC PRIVILEGE**

As the diagram illustrates, the scope of therapeutic privilege is coincident with the medical practitioner's duty to warn a patient of a material risk. Accordingly, therapeutic privilege has potential to 'devour the disclosure rule itself'.<sup>87</sup> Because of this, a court will carefully circumscribe a medical practitioner's privilege to withhold information. The manner in which the defence of therapeutic privilege would be carefully circumscribed is by its application to a particular patient.

### In the circumstances of the particular patient

The defence of therapeutic privilege has no work to do where the failure to warn is borne of general practice. A general practice that warnings are not provided to patients because they are likely to become distressed, or that because acutely ill patients are often unable to adequately understand detailed information, does not approach the duty on a case-by-case basis. Justice Gaudron in *Rogers v Whitaker* stated, the duty to warn 'takes its precise content, in terms of the nature and detail of the information to be provided, from the needs, concerns and circumstances of the patient'.<sup>88</sup> The corollary is that, the defence of therapeutic privilege, in terms of the nature and detail of the information not provided to a patient, is informed in the same way. A case in point is *Di Carlo v Dubois*.<sup>89</sup>

<sup>86</sup> Freckelton, n 49.

<sup>87</sup> *Canterbury v Spence* 464 F.2d 772 (1972) [789].

<sup>88</sup> *Rogers v Whitaker* (1992) 175 CLR 479 [493] (Gaudron J); see also *Montgomery v Lanarkshire Health Board* [2015] 2 WLR 768 [89]; see also Law Reform Committee, Parliament of Victoria, *Legal Liability of Health Service Providers*, (1997), 38.

<sup>89</sup> [2004] QCA 150.

In *Di Carlo v Dubois*<sup>90</sup> the appellant (who was concerned he had a brain tumour) was not warned of the risk of an adverse reaction to a contrast agent prior to a CT scan. The risk materialised. The trial judge had identified a general practice or approach common to all relevant medical witnesses ‘of not giving a warning of a possible life threatening reaction because of the possibility of increasing the anxiety of a patient and perhaps thereby increasing the risk of an adverse reaction’.<sup>91</sup> Although the appeal failed on the issue of causation of damage, Justice McMurdo held that the defence of therapeutic privilege would not have been available. This is because the practice followed by the relevant medical practitioners was not informed by the needs, concerns and circumstances of the individual patient.

The practice which they and others followed in not disclosing this risk was a general one, applied to all patients. It did not involve a consideration of a particular patient’s physical or mental health and the likelihood that his or her health would be seriously harmed by the warning. Nor could it be suggested that in the appellant’s case the warning itself would have seriously harmed his health. And this was not a case where the proposed scan was clearly necessary for the appellant’s health, such that the immediate necessity for the scan could have reasonably justified the withholding of the information; instead, the first respondent followed a practice that required no consideration of whether for a particular patient, the scan was necessary. In my view, this was not an example of the therapeutic privilege and, accordingly, the practice was not in accordance with the duty as defined in *Rogers v Whitaker*.<sup>92</sup>

In the United States, the practice is to require defendant medical practitioners who raise the defence of therapeutic privilege to give evidence ‘that his or her decision to withhold information was based on specific considerations in the individual patient’s case and identify those considerations’.<sup>93</sup> This ensures that the use of the defence is ‘carefully circumscribed’.<sup>94</sup>

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<sup>90</sup> [2004] QCA 150 (7 May 2004).

<sup>91</sup> *Di Carlo v Dubois* [2004] QCA 150 (7 May 2004) [80].

<sup>92</sup> *Di Carlo v Dubois* [2004] QCA 150 (7 May 2004) [81].

<sup>93</sup> *Barcai v Betwee* 98 Haw 470, 50 P 3d 946 (2002), Supreme Court of Hawai’i [948]; see also *AB v Leeds Teaching Hospitals NHS Trust* [2004] EWHC 644 (QB) [237] (albeit described as “therapeutic judgement”).

<sup>94</sup> *Barcai v Betwee* 98 Haw 470, 50 P 3d 946 (2002), Supreme Court of Hawai’i [963] citing *Canterbury v Spence* 464 F.2d 772 (1972) [789].



Some commentators<sup>95</sup> suggest that, in *Rogers v Whitaker*, the court held that the failure to warn may be judged reasonable if 'the provision of all relevant information will harm an unusually nervous, disturbed or volatile patient'.<sup>96</sup> However, this is not what the court said. A closer reading of the judgement reveals that the court identified these cases as exceptions to where, having regard to the patient's apparent capacity to understand, generally speaking 'no special medical skill is involved in disclosing the information, including the risks attending the proposed treatment'.<sup>97</sup> The skill in communicating risks is one matter. Non-disclosure of material risks is another matter entirely. A better approach to describing an unusually nervous, disturbed or volatile patient is to regard them as an especially vulnerable patient.<sup>98</sup> In *Stuart v Camnitz*, the court conceived the privilege as protecting 'the health of particularly vulnerable or fragile patients, and permits the physician to uphold his ethical obligations of benevolence'.<sup>99</sup> This approach requires an analysis of the harm the especially vulnerable patient would suffer.

In 1996 in *Tai v Saxon*,<sup>100</sup> the Supreme Court of Western Australia considered a negligence claim where Dr Tai failed to warn a more than ordinarily anxious patient of a material risk on the basis that he felt that 'to warn her about a remote possibility will just cause more anxiety to her'.<sup>101</sup> Justice Ipp held that:

Harm of this kind could well follow where the objective circumstances are such that it is inevitable that the patient would agree to the proposed procedures. In such a case the disclosure of risks would only add to the level of the patient's anxiety without realistically affording the patient the prospect of alleviating that anxiety by undergoing some other treatment or declining treatment entirely. Examples of this type of situation are where the intended treatment is essential for the preservation or prolongation of life, or possibly where the health of the patient is such that the quality of his or her life is of a very low level and would be transformed by obviously warranted treatment. In circumstances, however, where the proposed treatment is non-essential, and where it is reasonably possible that the patient might exercise a choice to decline to undergo it, an obligation

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<sup>95</sup> Mulherton, n 13, 203; n 14, 171; Danuta Mendelson (ed) 'Operation of Guardianship Laws in the Emergency Ward' (2011) 19 *Journal of Law and Medicine* [13]-[31], 21.

<sup>96</sup> *Rogers v Whitaker* (1992) 175 CLR 479 [490].

<sup>97</sup> *Rogers v Whitaker* (1992) 175 CLR 479 [490].

<sup>98</sup> See Freckelton, n 49, 20.

<sup>99</sup> *Stuart v Camnitz* 774 F.3d 238 (4<sup>th</sup> Cir) [254].

<sup>100</sup> *Tai v Saxon* [1996] SCWAF (unreported, FCWA BC9600521) (8 February 1996).

<sup>101</sup> *Tai v Saxon* [1996] SCWAF (unreported, FCWA BC9600521) (8 February 1996) [12].

which a medical practitioner might otherwise have to disclose the attendant risks cannot be avoided on the grounds that disclosure might make an anxious patient more anxious. That is because the very fact that a patient is anxious may induce him or her not to have the treatment (thereby rendering the risk significant in the *Rogers v Whitaker* sense).<sup>102</sup>

As stated above, no medical treatment is inevitable, and the cost benefit analysis of taking the risk inherent in the proposed treatment belongs to the patient. This means that, although the more than ordinarily anxious patient may be regarded as an especially vulnerable (or fragile) patient, such an occasion does not give rise to the operation of therapeutic privilege.

To identify occasions where a medical practitioner's ethical obligations of beneficence and non-maleficence (justifying non-disclosure of a material risk) can gain traction against the countervailing duty to warn, an examination of when serious harm may be occasioned is needed.

### What harm would the especially vulnerable patient suffer

Conceptually, there are two occasions when an especially vulnerable patient may suffer serious harm. First, by the very act of a medical practitioner giving the patient particular information. Second, when the patient would have chosen not to undergo the treatment (either at all or at a later time)<sup>103</sup> if warned of all material risks inherent in the proposed treatment and, as a result of the treatment, one or more of the risks materialises.<sup>104</sup>

### When the act of giving particular information would cause harm

The first occasion when a vulnerable patient may suffer serious harm is by way of the warning itself. Recalling the dissenting speech of Lord Scarman in *Sidaway v Bethlem Royal Hospital Governors and others*,<sup>105</sup> His Lordship said that therapeutic privilege 'enables a doctor withhold from his patient information as to risk if it can be shown that a reasonable medical assessment of the patient would have indicated to the doctor that disclosure would have posed a serious threat of psychological detriment to the patient.'<sup>106</sup> And recalling the comments of Chief Justice King in *F v R* that a 'doctor is justified in withholding information, and in particular refraining from volunteering

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<sup>102</sup> *Tai v Saxon* [1996] SCWAFB (BC9600521) (8 February 1996) [12]-[13].

<sup>103</sup> Cf *Chapel v Hart* (1998) CLR 232.

<sup>104</sup> *Wallace v Kam* 250 CLR 375 [17]-[20].

<sup>105</sup> [1985] 2 WLR 480 [493].

<sup>106</sup> *Sidaway v Bethlem Royal Hospital Governors and others* [1985] 2 WLR 480 [493].

information, when he judges on reasonable grounds that the patient's health, physical or mental, might be seriously harmed by the information.<sup>107</sup> However, in this circumstance, there is a clear problem with establishing a claim in negligence. This is because, if the giving of the warning itself is to be regarded as the potential cause of harm to the patient, no harm can flow from the warning when the warning is not in fact given. Therefore, causation of damage can never be established.

Although, *Rogers v Whitaker* clearly establishes a duty to warn (subject to therapeutic privilege), there is no corresponding duty to not warn (subject to therapeutic privilege). If therapeutic privilege is said to afford a medical practitioner an opportunity to prove that the failure to warn was because he or she reasonably believed that disclosure of a material risk would prove damaging to a patient, in the absence of causation of damage (this is the gist of negligence), a negligence claim cannot be established. If a negligence claim cannot be established, the defence of therapeutic privilege has no work to do.

### Causation of damage

For the defence of therapeutic privilege to have any work to do in a claim of negligence, there must be a breach of the duty to warn and causation of damage must be established. In such a case: a medical practitioner must negligently fail to warn a patient of a material risk of harm in the contemplated treatment; that the patient (reasonable or actual) would not have proceeded with the treatment if the warning had been given; and the risk of harm materialises despite the exercise of all reasonable care by the medical practitioner in giving the treatment.<sup>108</sup>

In 2002, in the *Review of the Law of Negligence*<sup>109</sup> (the "Ipp Report"), the panel considered the concept of therapeutic privilege in the context of a medical practitioner's duty to inform. In the Ipp Report, the Panel described the duty to warn as a 'proactive duty to inform' and 'reactive duty to inform'<sup>110</sup> in a way that echoes the common law.<sup>111</sup> The proactive duty to inform requires a medical practitioner to give information which he or she considers to be material to the reasonable patient. The reactive duty to inform requires a medical practitioner to give information to a patient

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<sup>107</sup> *F v R* (1983) 33 SASR 189 [193] cited in *Battersby v Tottman* (1985) 37 SASR 524 [527].

<sup>108</sup> Ipp Report, n 57, 112 Fn 12.

<sup>109</sup> Ipp Report, n 57.

<sup>110</sup> Ipp Report, n 57, 48.

<sup>111</sup> *Rogers v Whitaker* (1992) 175 CLR 479 [486]; *F v R* (1983) 33 SASR 189 [193].

in response to their specific concerns or questions, or in response to a particular patient's circumstances.<sup>112</sup>

### The proactive duty to inform

In relation to the proactive duty to inform, the Panel describes therapeutic privilege as a situation in which the duty would not arise.

Where a medical practitioner reasonably believes that the very act of giving particular information to a patient would cause the patient serious physical or mental harm. This is the so-called therapeutic privilege. In this context, the phrase 'serious physical or mental harm' does not include harm likely to be suffered by reason only of a decision not to undergo the treatment in question. If it did, the patient's freedom to choose whether or not to undergo the treatment could be seriously compromised by a decision of the practitioner that the patient did not know what was in his or her own best interests.<sup>113</sup>

However, in relation to the proactive duty to inform,<sup>114</sup> the view that the duty would not arise in the face of therapeutic privilege is not correct. This is because, if it is accepted that therapeutic privilege is a defence to a claim in negligence, it does not prevent the duty to warn from arising in the first place—it does not equate to a countervailing duty to not inform. In the context of the proactive duty to inform, as discussed above, it is establishing causation of damage that is problematic.

### Establishing causation of damage

Noting the importance of defining with some precision the relevant risk it is alleged the medical practitioner should have warned against,<sup>115</sup> a medical practitioner who is found to have breached his or her duty to warn a patient of a material risk is only liable if that breach caused the patient's injury or loss. Recalling in *F v R*, Chief Justice King, in obiter dictum, said that 'a doctor is justified in withholding information ... when he judges on reasonable grounds that the patient's health,

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<sup>112</sup> Tracey Carver and Malcolm K Smith, 'Medical Negligence, Causation and Liability for Non-Disclosure of Risk: A Post-Wallace Framework and Critique' (2014) 37(3) *University of New South Wales Law Journal* [972]-[1018], 973.

<sup>113</sup> Ipp Report, n 57, 51.

<sup>114</sup> The Panel conceded that the application of the therapeutic privilege to the reactive duty to inform raises difficult questions of policy and concluded that the application of these issues should be left to the common law to develop. Ipp Report, n 57, 52.

<sup>115</sup> *Rosenberg v Percival* (2001) 205 CLR 434 [453]-[456], [457] (Gummow J).

physical or mental, might be seriously harmed by the information’.<sup>116</sup> And to also recall that therapeutic privilege is a defence to a claim in negligence, that is, duty, breach and causation of damage has been established, the conclusion that the defence of therapeutic privilege has work to do overlooks the complexity inherent in establishing causation, as illustrated below.

The common law of negligence requires determination of causation for the purpose of attributing legal responsibility. Such a determination inevitably involves two questions: a question of historical fact as to how particular harm occurred; and a normative question as to whether legal responsibility for that particular harm occurring in that way should be attributed to a particular person.<sup>117</sup>

Statutory reform, which is substantially replicated in each State and the Australian Capital Territory, requires these two questions to be kept distinct.<sup>118</sup> This reform reflects a change in the legal landscape since 1992.

### Factual causation

Factual causation asks if the negligence was a necessary condition of the occurrence of the harm.<sup>119</sup> ‘The determination of factual causation ... involves nothing more or less than the application of a “but for” test of causation’.<sup>120</sup> In a case where there has been a breach of the duty to warn, factual causation is established if a patient proves, on the balance of probabilities, that he or she sustained, as a consequence of having chosen to undergo the medical treatment, serious injury that he or she would not have sustained if warned of all material risks.<sup>121</sup> Or in other words, ‘but for’ the medical practitioner’s failure to warn, he or she would not have suffered harm because he or she would not have chosen to undergo the medical treatment. For the defence of therapeutic privilege to have work to do, as a pre-condition to its operation, it must be assumed that factual causation has been established. However, attributing legal responsibility also requires an affirmative answer to the question of normative causation, or scope of liability. That is, given the historical involvement of

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<sup>116</sup> *F v R* (1983) 33 SASR 189 [193].

<sup>117</sup> *Wallace v Kam* 250 CLR 375 [11]: See also Stapleton, n 50, 426.

<sup>118</sup> *Wallace v Kam* 250 CLR 375 [12].

<sup>119</sup> *Civil Liability Act 2002* (NSW) s 5D; *Wrongs Act 1958* (Vic) s 51; *Civil Liability Act 1936* (SA) s 34(1),(3); *Civil Liability Act 2003* (QLD) s 11; *Civil Liability Act 2002* (WA) s 5C; *Civil Liability Act 2002* (Tas) s 13; *Civil Law (Wrongs) Act 2002* (ACT) s 45(1),(3).

<sup>120</sup> *Wallace v Kam* 250 CLR 375 [16], citing *Strong v Woolworths Ltd* (2012) 246 CLR 182 [190]-[191].

<sup>121</sup> See *Wallace v Kam* 250 CLR 375 [17].

the breach, should a particular consequence of the breach be judged to be within the scope of liability for the breach?<sup>122</sup>

### Normative causation

The deterrent potential of the duty to warn is limited by the normative assessment that the consequences of the breach should lie within the scope of liability.<sup>123</sup> Scope of liability asks if it is appropriate for the negligent person's liability to extend to the harm so caused.<sup>124</sup> Accepting that it is not necessarily appropriate for the liability of the medical practitioner to extend to the materialisation of every risk of harm about which it is the duty of the medical practitioner to warn,<sup>125</sup> consideration of a case involving the materialisation of a risk that has caused serious harm requires recourse to the nature of the duty to warn and its underlying policy.<sup>126</sup> In *Wallace v Kam*,<sup>127</sup> the High Court set forth the framework against which a medical practitioner's liability is to be assessed.

The component of the duty of a medical practitioner that ordinarily requires the medical practitioner to inform the patient of material risks of physical injury inherent in a proposed treatment is founded on the underlying common law right of the patient to choose whether or not to undergo a proposed treatment. In imposing that component of the duty, the common law recognises not only the right of the patient to choose but the need for the patient to be adequately informed in order to be able to make that choice rationally. The policy underlying the imposition of that component of the duty is to equip the patient with information relevant to the choice that is the patient's to make.<sup>128</sup> The duty to inform the patient of inherent material risks is imposed to enable the patient to choose whether or not to run those

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<sup>122</sup> Stapleton, n 50, 426.

<sup>123</sup> Stapleton, n 50, 439.

<sup>124</sup> *Civil Liability Act 2002* (NSW) s 5D; *Wrongs Act 1958* (Vic) s 51; *Civil Liability Act 1936* (SA) s 34(1),(3); *Civil Liability Act 2003* (QLD) s 11; *Civil Liability Act 2002* (WA) s 5C; *Civil Liability Act 2002* (Tas) s 13; *Civil Law (Wrongs) Act 2002* (ACT) s 45(1),(3).

<sup>125</sup> *Wallace v Kam* 250 CLR 375 [27]; *Overseas Tankship (UK) Ltd v Morts Dock & Engineering Co Ltd (The "Wagon Mound" (No 1))* [1961] AC 388.

<sup>126</sup> *Wallace v Kam* 250 CLR 375 [36].

<sup>127</sup> 250 CLR 375.

<sup>128</sup> *Wallace v Kam* 250 CLR 375 [8], citing *Rogers v Whitaker* (1992) 175 CLR 479 [486].

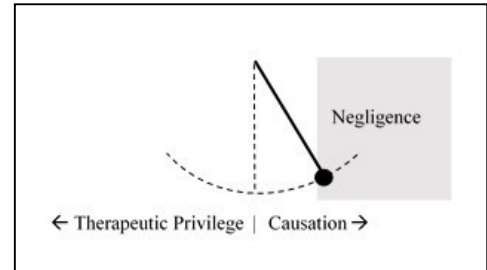
inherent risks and thereby ‘to avoid the occurrence of the particular physical injury the risk of which [the] patient is not prepared to accept’<sup>129</sup>.

Although the judgement is couched in terms of physical injury, it is difficult to conceive of any circumstance where the materialisation of a risk inherent in the proposed therapeutic treatment gives rise to serious mental harm. Regardless, for the defence of therapeutic privilege to have work to do, as a further pre-condition to its deployment, it must be assumed that normative causation has been established. This means that a

normative judgement has been made that the medical practitioner is liable for the consequence of material risks of serious harm that were unacceptable to the uniformed vulnerable patient. Figuratively, the pendulum has swung—negligence has been established.

if it is accepted that therapeutic privilege is a defence to a claim in negligence, the establishment of the claim must precede any possible deployment of the defence. However, to now deploy the defence of therapeutic privilege in the face of established legal responsibility necessarily requires a countervailing normative assessment.

Of the five factors outlined in *F v R* by Chief Justice King, at this point it must be accepted that, given normative causation is established: the nature of the matter should have been disclosed; the nature of the treatment should have been disclosed; the patient desired the information; and the surrounding circumstances have not suspended the duty to warn. To recognise not only the right of the patient to choose, but the need for the patient to be adequately informed to be able to make that choice rationally, it is simply no answer to the normative assessment that there was an ‘absence of opportunity for detached reflection or calm counselling’.<sup>130</sup> The countervailing normative assessment therefore lies in consideration of the patient.



**CAUSATION**

## The irrational vulnerable patient

In *F v R*, Chief Justice King, in obiter dictum, said that justification for a failure to warn may exist when a medical practitioner ‘reasonably judges that a patient’s temperament or emotional state is

<sup>129</sup> *Wallace v Kam* 250 CLR 375 [8], citing *Chester v Afshar* [2005] 1 AC 134 [144].

<sup>130</sup> *F v R* (1983) 33 SASR 189 [193].

such that he would be unable to make the information a basis for a rational decision'.<sup>131</sup> This approach is problematic for two reasons. First, the approach inappropriately imposes a value judgement as to what is assessed as a decision the patient should make, whereas the decision made is rational according to the individual's values system.<sup>132</sup> In light of this the medical profession must respect the individual's choice, unless he or she lacks the legal capacity to decide.<sup>133</sup> Second, the approach assumes that all patients are a rational consumer of health services.<sup>134</sup>

There is a distinction between a patient that is considered vulnerable because of his or her incapacity for rational thought that deprives him or her of the capacity to make decisions in his or her own health interests<sup>135</sup> and a patient with capacity to make treatment decisions that others consider irrational.<sup>136</sup> In regard to the former, the concept of therapeutic privilege has no application. Decisions regarding the treatment of a patient who lacks legal capacity fall either to a substitute decision maker or within the principle of necessity (eg., an emergency). Concerning the latter, Cave identifies the commitment of the common law to upholding 'the right of patients with mental capacity to make treatment decisions that others consider irrational'.<sup>137</sup> In *Re MB (an adult: medical treatment)*<sup>138</sup> [1997] EWCA Civ 3093, Lord Justice Butler-Sloss stated:

A mentally competent patient has an absolute right to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death.<sup>139</sup>

As such, in the face of the normative assessment having established legal responsibility of the medical practitioner, the countervailing normative assessment justifying non-disclosure of a material risk has no real work left to do. Given the pendulum has swung sufficiently to establish legal responsibility, therapeutic privilege, having no real work left to do, is unable to swing the

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<sup>131</sup> *F v R* (1983) 33 SASR 189 [193].

<sup>132</sup> Cave, n 48, 154.

<sup>133</sup> *Montgomery v Lanarkshire Health Board* [2015] 2 WLR 768 [115], citing *St. George's Healthcare NHS Trust v S* [1999] Fam 26.

<sup>134</sup> Stewart, n 61, 220.

<sup>135</sup> Freckelton, n 49.

<sup>136</sup> Cave, n 48, 154.

<sup>137</sup> Cave, n 48, 143.

<sup>138</sup> [1997] EWCA Civ 3093.

<sup>139</sup> *Re MB (An Adult: Medical Treatment)* [1997] EWCA Civ 3093 [17]; see also *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871 [904]-[905] (Lord Templeman); see also *Re T (An Adult)(Consent to Medical Treatment)* [1993] Fam 95 [102] (Lord Donaldson MR).



pendulum back. Therefore, therapeutic privilege is not a defence to a claim in negligence, where the negligence alleged is a failure to warn.

## Conclusion

In *Rogers v Whitaker*, the High Court confirmed that the medical practitioner's duty to warn was subject to the supervision of the Court. In terms of describing the duty to warn, the Court established that a medical practitioner's duty to warn encompasses an objective limb and a subjective limb, qualified by the concept of therapeutic privilege.<sup>140</sup> The concept of therapeutic privilege is widely regarded as a defence to a negligence claim where the negligence alleged is a failure to warn. However, since its endorsement in *Rogers v Whitaker* the concept of therapeutic privilege has received scant judicial attention, its operation is obscure and its scope is not settled. This article explores the origins, justifications and apparent scope of the privilege by identifying those occasions when therapeutic privilege has no work to do. The analysis proceeds by reducing the concept of therapeutic privilege to three elements: a medical practitioner's **reasonable belief** that warning a **particular patient** will cause **serious harm**. The assessment of whether a medical practitioner's non-disclosure of a material risk is reasonable is an enquiry that considers the magnitude of the risk and the likelihood of its occurrence balanced against the interest of patient autonomy. The defence of therapeutic privilege has no work to do if the duty to warn is not engaged—the duty is to warn a competent patient of material risks. A competent patient is able 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. The deployment of the defence of therapeutic privilege can only gain traction if the medical practitioner reasonably believed that the warning would cause serious harm to a particular patient, where the particular patient is regarded as especially vulnerable. For the especially vulnerable patient the concept of therapeutic privilege contemplates serious harm as occurring either in the by the very act of a medical practitioner giving the patient particular information, or when the patient later suffers harm that materialises as a consequence of undergoing the medical treatment that he or she would not have undergone if provided with a warning of the material risks in the first place. However, for the defence of therapeutic privilege to have any work to do in a claim of negligence, there must be a breach of the duty to warn and causation of damage must be established. The analysis

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<sup>140</sup> *Rogers v Whitaker* (1992) 175 CLR 479 [490].

demonstrates that causation cannot be established where a medical practitioner reasonably believes that the very act of giving particular information to a patient would cause the patient serious physical or mental harm. This is because no warning is in fact given—there is no causation of damage. Conversely, where causation is accepted as having been established, the defence of therapeutic privilege requires a countervailing normative assessment based in consideration of the patient temperament or emotional state, where the assessment is that he or she would be unable to make the information a basis for a rational decision. However, this approach is problematic. This is because the approach inappropriately imposes a value judgement as to what is assessed as a decision the patient should make, whereas the decision made is rational according to the individual's values system. Further, the approach assumes that all patients are a rational consumer of health services, whereas the law upholds the absolute right of the mentally competent patient to refuse to consent to medical treatment for any reason, rational or irrational, or for no reason at all. As such, in the face of the normative assessment having established legal responsibility of the medical practitioner, the countervailing normative assessment to justify non-disclosure of a material risk has no real work left to do. Therefore, therapeutic privilege is no defence to a claim in negligence, where the negligence alleged is a failure to warn. The preferred approach is, as Justice Gaudron said in *Rogers v Whitaker*.

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.<sup>141</sup>

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<sup>141</sup> *Rogers v Whitaker* (1992) 175 CLR 479 [494] (Gaudron J) (minority).

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