A Critique of Canadian Jurisprudence on the Therapeutic Privilege Exception to Informed Consent

*Michael Ralph Hadskis**

The Supreme Court of Canada's landmark decisions in *Hopp v Lepp* and *Reibl v Hughes* furnished a general analytical framework for informed consent actions that remains fully intact today. This article sets its gaze on a specific aspect of the framework, dubbed "therapeutic privilege," that permits physicians to deviate from their general duty to disclose material, treatment-related risks to competent patients. Specifically, the privilege allows information about material risks to be withheld or generalized if physicians believe their patients are "unable to cope" with receiving such information. It is argued that the Supreme Court's terse and vaguely-articulated exception to truth telling disempowers patients by depriving them of their decisional autonomy and undermines the trust relationship that

Les décisions marquantes de la Cour suprême du Canada dans *Hopp c Lepp* et *Reibl c Hughes* ont fourni un cadre analytique général pour les actions en consentement éclairé qui demeure intact aujourd'hui. Cet article fixe son regard sur un aspect spécifique du cadre, sunommé « privilège thérapeutique », qui permet aux médecins de dévier de leur obligation générale de divulger les risques importants relatifs au traitment aux patients compétents. Spécifiquement, le privilège permet l'information sur les risques importants d'être retenue ou généralisée si les médecins croient que leurs patients sont « incapables de faire face » à la réception de telle information. Il est argumenté que l'exception brève et vaguement articulée de la Cour suprême déshabilite les patients en les privant de leur autonomie dé-

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lies at the heart of the physician-patient relationship. In view of these hazards, the article explores the post-*Hopp* and post-*Reibl* jurisprudence to determine how therapeutic privilege has been interpreted and applied by Canadian courts. It finds that the contours of the privilege continue to be ill defined, the Supreme Court's formulation of the privilege has been interpreted by some courts in a manner that is disrespectful of patient autonomy, and no judicial action has been taken to meaningfully narrow the scope of the privilege. While the privilege may be needed in truly exceptional cases, the courts must establish stringent limitations on its application in order to minimize intrusion on patients' right of medical self-determination and reduce the potential harm to the covenant of trust between patients and physicians. Specific recommendations regarding such limitations are provided.

cisionnelle et mine le rapport de confiance qui se trouve au coeur de la relation médecin-patient. À la lumière de ces risques, cet article explore la jurisprudence suite à *Hopp* et *Reibl* pour déterminer comment le privilège thérapeutique a été interprété et appliqué par les cours canadiennes. Il constate que les contours du privilège sont toujours mal définis, la formulation par la Cour suprême du privilège a été interprétée par certaines cours d'une manière qui est irrespectueuse de l'autonomie du patient, et aucune action judiciare n'a été entreprise pour restreindre la portée du privilège. Alors que le privilège est peut-être nécessaire dans des cas véritablement exceptionnels, les cours doivent établir des limites strictes sur son application afin de minimiser l'intrusion sur le droit du patient à l'autodétermination médicale et réduire le préjudice potentiel envers l'engagement de confiance entre patients et médecins. Des recommandations spécifiques concernant ces limites sont fournies.

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Introduction

Patients' right of self-determination requires that they be afforded the opportunity to make informed choices about the medical treatment they will accept or reject. It is axiomatic that such a right can only be meaningfully exercised if patients are properly equipped with relevant information about available treatment options. Only when furnished with this information can it be said that patients are positioned to make choices that accord with their values and beliefs. It is this philosophy that inspired the Supreme Court of Canada's formulation of the common law doctrine of informed consent in the landmark 1980 decisions of *Hopp v Lepp*[1] and *Reibl v Hughes*.[2] The Supreme Court determined that patient autonomy is to be protected[3] through the tort of negligence, by imposing a legal duty of care on physicians to disclose relevant treatment information to patients or, in the event of patients' incapacity, their lawful substitute decision makers. In order to fulfill this duty, physicians must provide their patients with information that a reasonable person in their circumstances would want to know about the recommended treatment and any alternatives to it; this information includes material risks attending the treatment options.[4] Failure to abide by this standard

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1 [1980] 2 SCR 192, 112 DLR (3d) 67 [*Hopp* cited to SCR].

2 [1980] 2 SCR 880, 114 DLR (3d) 1 [*Reibl* cited to SCR].

3 Critiques of the concept of informed consent itself and its ability to advance the interests of patient autonomy are emerging. See e.g. Omri Ben-Shahar & Carl E Schneider, "The Failure of Mandated Disclosure" (2011) 159:647 U Pa L Rev 647 [Ben-Shahar & Schneider, "Failure"]; Robert M Veatch, "Abandoning Informed Consent" (1995) 25:2 The Hastings Center Report 5; Neil C Manson & Onora O'Neill, *Rethinking Informed Consent in Bioethics* (Cambridge: Cambridge University Press, 2007). However, there is no indication that an appetite presently exists within the Canadian judiciary to accept these critiques and completely or substantially forsake the long-standing informed consent framework. Even if such an inclination existed, it is far from clear what regulatory approach could be put in its stead. Ben-Shahar and Schneider concede that they "cannot offer a new panacea to supplant the old one" ("Failure", *supra* note 3 at 746). For these reasons, the present paper does not engage with this literature, but instead offers a jurisprudential analysis that has the more modest goal of identifying an opportunity to reform or clarify a particular aspect of the extant informed consent framework: the therapeutic privilege exception.

4 See Patricia Peppin, "Informed Consent" in Jocelyn Downie, Timothy Caulfield & Colleen M Flood, eds, *Canadian Health Law and Policy*, 4th ed (Markham, Ont: LexisNexis Canada, 2011) 153 at 164.

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exposes physicians to the possibility of a successful negligence action being brought against them by insufficiently informed patients if the undisclosed risks transpire.[5]

The gaze of this paper is set on a problematic aspect of the informed consent framework that creates an exception to physicians' obligation to disclose relevant treatment information to competent patients. This exception, which is commonly referred to as "therapeutic privilege" (TP), permits physicians to withhold or generalize relevant information if a patient is perceived to be unable to cope with receiving such information. Not only does the use of TP disempower patients by depriving them of their decisional autonomy – placing it at odds with more recent Supreme Court jurisprudence in the health care context that places a premium on autonomy[6] – but it also holds the prospect of undermining the trust relationship between physicians and their patients.[7] In view of these hazards, this paper sets out to explore the post-*Hopp* and post-*Reibl* jurisprudence to determine how TP has been interpreted and applied by Canadian courts. Although some academic com-

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5 It should be noted that, even in cases where defendant physicians do not meet the disclosure standard, they may nonetheless escape liability if the plaintiff-patient is unable to prove causation. Comprehensive reviews of Canadian informed consent cases conducted by Professor Gerald B Robertson revealed that plaintiffs' actions are frequently unsuccessful because they cannot establish causation. See "Informed Consent 20 Years Later" (2003) Special Ed Health LJ 153 at 156.

6 See e.g. *AC v Manitoba (Director of Child and Family Services)*, 2009 SCC 30 at paras 39–45, 101–08, [2009] 2 SCR 181 [*AC*]; *Carter v Canada (AG)*, 2015 SCC 5 at paras 64–68, [2015] 1 SCR 331 [*Carter*].

7 In *McInerney v MacDonald*, [1992] 2 SCR 138, 93 DLR (4th) 415 [*McInerney* cited to SCR], the Supreme Court of Canada spoke clearly and forcefully about the importance of the trust relationship between physicians and their patients. The Supreme Court stated: "The physician-patient relationship … gives rise to the physician's duty to make proper disclosure of information to the patient" (*ibid* at para 21). Later in the Court's judgment, it notes why this duty is important: "The ability of a doctor to provide effective treatment is closely related to the level of trust in the relationship" (*ibid* at para 27). While the matter before the Supreme Court involved a physician's failure to disclose medical records to her patient, this case is directly relevant to a discussion of TP, as argued in Part IV of this paper. For a thorough exploration of the link between informed consent and the trust relationship between physicians and patients, see Onora O'Neill, *Autonomy and Trust in Bioethics* (Cambridge: Cambridge University Press, 2002).

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mentary has critiqued the TP exception,[8] a comprehensive exposition of Canadian case law pertaining to this privilege has not been undertaken.

The paper begins by briefly outlining the American approach to TP, as this jurisprudence has played an instrumental role in shaping the Supreme Court of Canada's development of informed consent doctrine, including the TP exception. Next, the Supreme Court's limited guidance on the parameters of the privilege is discussed. This is followed by an analysis of the cases decided after *Hopp* and *Reibl* that address the privilege. The paper ultimately finds that Canadian TP jurisprudence is deficient in as much as it fails to adequately define the bounds of this exception and, in some cases, unduly broadens its scope. While the paper leaves open the possibility that the privilege may be needed in truly exceptional cases, it calls on the courts to establish stringent limitations on its application in order to minimize intrusion on patients' right of medical self-determination and reduce the potential harm to "the covenant of trust between patient and health care provider."[9] Specific limitations that would achieve those ends are set out.

I. THERAPEUTIC PRIVILEGE IN THE UNITED STATES: *CANTERBURY V SPENCE*

The 1972 United States Court of Appeals decision in *Canterbury v Spence*[10] is the leading American case on TP and on informed consent doctrine more generally.[11] The case involved a physician's failure to disclose a

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[8] See e.g. Ellen I Picard & Gerald B Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed (Toronto: Thomson Carswell, 2007) at 148; Margaret A Somerville, "Therapeutic Privilege: Variation on the Theme of Informed Consent" (1984) 12:1 Law Med Health Care 4 at 11.

[9] Philip C Hébert, "Disclosure: Ethical and Policy Considerations" in Newfoundland, *Commission of Injury on Hormone Receptor Testing: "Looking Forward…" Policy Papers*, vol 2 (St. John's: Office of The Queen's Printer, 2009) (Commissioner: Hon Margaret A Cameron) 129 at 138, online: <www.releases.gov.nl.ca/releases/2009/health/Volume2_Looking_Forward_Policy_Papers.pdf>. Although Hébert does not specifically address TP, his report speaks generally about the harms associated with physicians departing from disclosure and truth telling.

[10] 464 F (2d) 772 (DC Cir 1972) [*Canterbury*].

[11] See Kate Hodkinson, "The Need to Know—Therapeutic Privilege: A Way Forward" (2013) 21:2 Health Care Anal 105 at 114; Alan Meisel, "The 'Exceptions'

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one percent risk of paralysis that attended the surgical excision of one of the patient's vertebrae (laminectomy) to correct a ruptured disc that was causing back pain. The surgeon's practice was not to communicate this risk to his patients because such disclosure might deter patients from undergoing needed surgery and possibly produce adverse psychological reactions that could preclude the success of the operation.[12] After addressing the general disclosure requirements under American common law, the court considered exceptions to these requirements, including the privilege physicians have to withhold information for therapeutic reasons:

> The ... 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 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.[13]

After acknowledging the existence of the privilege, the court cautioned that the "physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself."[14] In this regard, it emphasized that the privilege applies only "where the patient's reaction to risk information, as [reasonably] foreseen by the physician, is menacing."[15] On the matter of whether the privilege applied to the facts of the case, the court found that there was no evidence the plaintiff's "emotional makeup was such that con-

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to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking" [1979] 2 Wis L Rev 413 at 462.

12 See *Canterbury*, *supra* note 10 at 778.

13 *Ibid* at 789.

14 *Ibid*.

15 *Ibid*.

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cealment of the risk of paralysis was medically sound."[16] While the focus of the *Canterbury* court was on the possible adverse psychological impact of disclosure, subsequent American jurisprudence has expressly extended the privilege's reach to detrimental effects on patients' physical well-being.[17]

II. Adoption of Therapeutic Privilege by the Supreme Court of Canada

The Supreme Court of Canada has embraced TP as a legal device that can be used by physicians to justify nondisclosure of relevant treatment information but at the same time has offered scant guidance on its dimensions and proper use. In *Hopp* and *Reibl*, the Court referred to *Canterbury* with approval, yet it did so only when discussing what general disclosure standard ought to apply in the consent-to-treatment context.[18] Neither case explicitly discusses the position taken on TP in *Canterbury*. Indeed, the closest *Hopp* gets to possibly hinting at the existence of the privilege is when the Court observes that

> a surgeon has some leeway in assessing the emotional condition of the patient and how the prospect of an operation weighs upon him; the apprehension, if any, of the patient, which may require placating; his reluctance, if any, to submit to an operation, which, if the surgeon honestly believes that the surgery is necessary for the preservation of the patient's life or health, may demand detailed explanation of why it is necessary.[19]

However, acknowledging physicians' leeway to quiet patients' apprehension to undergo an operation and the requirement to provide a detailed explanation of its necessity is far from a clear endorsement of *Canterbury*'s articulation of TP. No guidance is provided in *Hopp* on what measures a physician may take to "placate" a patient who is anxious or otherwise emo-

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16 *Ibid* at 794.

17 See *Pauscher v Iowa Methodist Medical Center*, 408 NW (2d) 355 at 360 (Iowa Sup Ct 1987); *Hook v Rothstein*, 316 SE (2d) 690 at 703 (SC Ct App 1984). For an account of the history of American informed consent law, see Jessica W Berg et al, *Informed Consent: Legal Theory and Practice*, 2nd ed (New York: Oxford University Press, 2001) ch 3.

18 *Hopp*, *supra* note 1 at 208; *Reibl*, *supra* note 2 at 895.

19 *Supra* note 1 at 205.

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tionally affected by the prospect of a particular treatment option. Moreover, the factual circumstances before the Court did not warrant consideration of the applicability of the privilege as there was no suggestion that the patient was unduly apprehensive about the recommended treatment (a laminectomy) or that the defendant surgeon withheld information on the basis of the patient's emotional state.

Somewhat more direction regarding TP is offered in *Reibl*, in which Chief Justice Laskin wrote on behalf of the unanimous Court:

> [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.[20]

The Chief Justice went on to reference, with approval, a passage from an American article addressing the role of medical evidence in nondisclosure cases in view of the *Canterbury* decision.[21] This passage, in part, notes that "if the defendant-physician claims a privilege, expert testimony is needed to show the existence of … the impact upon the patient of risk disclosure where a full disclosure appears medically unwarranted."[22] Thus, it would seem that the Supreme Court of Canada has signaled that the burden is on physicians to establish, with the support of expert evidence, that the full disclosure of material risks is medically contraindicated. Ultimately, the Supreme Court found that the privilege did not apply to the facts of the case before it as "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."[23]

Reibl is exceedingly terse in its treatment of this autonomy-depriving exception and leaves the contours of the privilege poorly defined.[24] Consequently, many critical questions remain unanswered:

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20 *Supra* note 2 at 895.

21 *Ibid*.

22 Linda Babbitt Jaeckel, "New Trends in Informed Consent?" (1975) 54:1 Neb L Rev 66 at 91.

23 *Reibl*, *supra* note 2 at 927.

24 Although there were a few cases decided before *Hopp* and *Reibl* that briefly touched on the concept of TP, they too provided little guidance on the param-

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- Is the privilege to be interpreted narrowly and invoked as a last resort?
- What does "unable to cope with facts relevant" to the recommended treatment actually mean?
- How high does the magnitude and probability of the apprehended harm have to be before the privilege can be invoked?
- Is a physician's concern that disclosure might prompt the patient to forego the recommended treatment a relevant consideration?
- Does the exception apply to elective procedures or non-therapeutic interventions?

The next Part will explore how the Supreme Court's vaguely-formulated exception to informed consent has subsequently been interpreted and applied by lower courts in Canada.

III. JUDICIAL TREATMENT OF THERAPEUTIC PRIVILEGE POST-*HOPP* AND POST-*REIBL*

Since *Hopp* and *Reibl* were decided, 10 Canadian cases have expressly referred to the TP exception in the consent-to-treatment context. Of these,

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eters of the privilege. Moreover, these cases reflect a conception of informed consent that is quite different than that found in *Hopp* and *Reibl*. Specifically, the pre-*Hopp* and pre-*Reibl* cases accorded physicians substantial discretion on the matter of risk disclosure generally and adhered to the reasonable physician standard, not the reasonable patient standard. For these reasons, they provide no assistance in shaping our understanding of TP in Canada. For examples of such pre-*Hopp* and pre-*Reibl* cases, see *Kenny v Lockwood*, [1932] OR 141, 1 DLR 507 at 525 (CA) (the court stated that the disclosure duty on a physician "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"); *Kelly v Hazlett* (1976), 15 OR (2d) 290, 75 DLR (3d) 536 at 565 (H Ct J) [*Kelly*] (the court observed that "the duty to disclose collateral risks inherent in any proposed procedure is substantially a matter of medical judgment … unlike the law in some United States jurisdictions where the duty is based on the notion of what a reasonable patient might be expected to wish to hear in order to make up his mind"); *McLean v Weir*, [1977] 5 WWR 609 at 627, 3 CCLT 87 (BCSC) (the decision indicates that the law permits physicians considerable discretion in deciding whether to communicate information "to a patient which undoubtedly would frighten him to the extent that his treatment would suffer or her would refuse treatment altogether").

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one found that TP does not form part of Canadian consent law. The other nine acknowledge the existence of the exception: two of them found that it justified the physicians' failure to disclose material risks; the remaining seven cases held that the privilege did not apply to the factual circumstances that were before the respective courts. It is worthwhile taking a closer look at these cases as they raise many important issues and concerns pertaining to TP.

A. *Therapeutic privilege found not to form part of Canadian common law*

In the 1991 decision of *Meyer Estate v Rogers*, Justice Maloney of the Ontario Court of Justice found that TP does not form part of Canadian common law;[25] however, the reasons given for this finding lack persuasiveness. The case dealt with an action brought against a radiologist who had injected a patient with a contrast medium as part of a diagnostic procedure to ascertain the cause of the patient's long-standing urinary tract problems.[26] Shortly after this injection, the patient went into respiratory arrest and died as a result of an allergic reaction to the contrast medium.[27] The radiologist admitted that he intentionally withheld information from the patient about the risk of death from contrast media injections, which ranged from 1 in 40,000 to 1 in 100,000.[28] His decision to withhold this information was grounded in the position adopted by the Canadian Association of Radiologists at the time that patients should not be informed of the risk of death because this might induce anxiety, which, in turn, would increase the risk of a contrast media reaction.[29]

Justice Maloney determined that the radiologist's failure to advise of the risk of death from the contrast medium would constitute a breach of the disclosure standard unless it could be shown that Canadian law recognized the TP exception set out in *Canterbury*.[30] In dealing with the issue of whether

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25 (1991), 2 OR (3d) 356 at 366, 78 DLR (4th) 307 (Ct J (Gen Div)) [*Meyer Estate*].

26 See *ibid* at 357.

27 See *ibid* at 358.

28 See *ibid* at 368.

29 See *ibid* at 361.

30 *Ibid* at 362.

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the privilege is alive in Canada, he observed that the Supreme Court in *Reibl* had not "adopted or even approved the therapeutic privilege exception in Canada."[31] He arrived at this opinion, in part, on the belief that the Supreme Court did not appear fully committed to creating such an exception. Justice Maloney stated in this regard:

> One cannot help noticing the hesitancy of Laskin C.J.C.'s 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 [or generalizing the information].[32]

He further noted that the Supreme Court's comments were *obiter dicta*.[33] On this basis, Justice Maloney concluded that TP does not form part of Canadian common law and then added that it should not become part of the law since it "has the potential to 'swallow' the doctor's obligation of disclosure and thus to override the requirement for informed consent."[34]

As noted by Picard and Robertson, it is difficult to sustain the conclusion that TP does not form part of Canadian law.[35] Chief Justice Laskin's use of the word "may" does not necessarily signal that the Supreme Court was equivocating on the exception applying in Canada. Rather, the relevant passage from the judgment can reasonably be construed as general approval of the exception, with the Court's use of the word "may" merely intended to convey that the exception may or may not apply in a given case. Moreover, while the Supreme Court's discussion of TP was *obiter dicta* because its consideration of the privilege was not strictly necessary for the disposition of the particular dispute, it appears nonetheless to be setting out to provide a general analytical framework for future informed consent cases.[36] In any event, as discussed in the next sub-Part, the exception has been

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31 *Ibid* at 364.

32 *Ibid* [emphasis added by Justice Maloney].

33 *Ibid*.

34 *Ibid* at 366.

35 *Supra* note 8 at 174.

36 As established by the Supreme Court of Canada in *R v Henry*, 2005 SCC 76 at para 57, [2005] 3 SCR 609, *obiter dicta* should be accepted as authoritative where the Supreme Court's analysis is obviously intended for guidance.

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acknowledged in all the other Canadian cases that have referenced TP, including the 1981 Ontario Court of Appeal decision of *Videto v Kennedy*[37] that pre-dated *Meyer Estate*. Interestingly, this aspect of *Videto* was not referenced by Justice Maloney.[38]

B. Acknowledgement of therapeutic privilege forming part of Canadian common law

With the exception of *Meyer Estate*, Canadian courts have applied the TP exception or at least acknowledged that it forms part of Canadian common law. Most of these cases have relied on the Ontario Court of Appeal's formulation of the privilege in *Videto* and, in doing so, adopted a serious misinterpretation of *Reibl* by the *Videto* court that offends patient autonomy. Purporting to summarize the main principles of informed consent arising from *Reibl*, *Videto* articulated the privilege in these terms:

> The emotional condition of the patient and the patient's apprehension and reluctance to undergo the operation may in certain cases justify the surgeon in withholding or generalizing information as to which he would otherwise be required to be more specific.[39]

Despite having set out the privilege, the Ontario Court of Appeal decided that the privilege did not come into play on the facts of the case (which involved an elective laparoscopic sterilization) and, in any case, there is no indication that the privilege was even raised by the defendant physician.[40]

Significantly, the *Videto* court interpreted *Reibl* as indicating that a patient's "apprehension and reluctance" to undergo a medical procedure can support a physician's decision to invoke the privilege.[41] However, *Reibl* is

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37 (1981), 33 OR (2d) 497, 125 DLR (3d) 127 (CA) [*Videto* cited to DLR].

38 Justice Maloney only references *Videto* once in his decision and that was in relation to the proposition that the medical profession cannot unilaterally set the standard of disclosure. See *Meyer Estate*, *supra* note 25 at 362.

39 *Supra* note 37 at 133.

40 *Ibid* at 136.

41 *Ibid* at 133.

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entirely silent with respect to such factors. Moreover, this aspect of *Videto* is inconsistent with *Canterbury* since that decision expressly rejected "the paternalistic notion that [a] physician may remain silent simply because divulgence might prompt [their] patient to forego therapy the physician feels the patient really needs."[42] Additionally, one Canadian case has stated that it "is not appropriate for a surgeon to forego a discussion of the risks associated with the surgery because the patient would be 'scared off.'"[43] The inappropriateness of using a patient's apprehension and reluctance as grounds for calling upon the privilege is discussed in more detail in Part IV(C) of this paper.

The following two sub-Parts consider the cases where TP has or has not been found to excuse the respective physicians' failure to lay bare relevant treatment information.

1. Therapeutic privilege found applicable

Two cases, *Puranen v Thomson*[44] and *Hajgato v London Health Association*[45] (decided in 1987 and 1982, respectively), have found that the TP exception excused the physicians' nondisclosure of treatment risks but did so without providing a complete or correct analysis of the privilege. The plaintiff in *Puranen* brought an action against an anaesthetist, Dr. Thomson, alleging that he had failed to warn her, prior to undergoing a Caesarean section, about the 10% chance that an epidural anaesthetic could not be established and that a general anaesthetic would be required. When general anaesthesia is used, there is a 1 in 1,000 risk of experiencing awareness of pain during a Caesarean section.[46] The plaintiff appeared extremely anxious during the pre-surgical consultation with Dr. Thomson and told him that general anaesthetics did not "take" on her.[47] On questioning the plaintiff

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42 *Supra* note 10 at 789.

43 *Bryan v Hicks*, [1993] BCJ No 662 (QL) at para 53, 1993 CarswellBC 1721 (WL Can) (SC), aff'd 10 BCLR (3d) 239, [1995] 10 WWR 145. It should be noted that this case does not make any explicit reference to the TP exception, thus making its relevance arguable.

44 46 Man R (2d) 55, [1987] MJ No 89 (QL) (QB) [*Puranen* cited to Man R].

45 36 OR (2d) 669, [1982] OJ No 2564 (QL) (H Ct J) [*Hajgato* cited to OR].

46 See *Puranen*, *supra* note 44 at para 12.

47 *Ibid* at paras 16, 18.

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about this statement, Dr. Thomson determined that the plaintiff's previous experience with a general anaesthetic had been uneventful.[48] He did not mention the 10% possibility that a general anaesthetic might become necessary because the plaintiff seemed anxious and he did not want to frighten her.[49] Since he did not mention the possible use of a general anaesthetic, he did not tell the plaintiff about the risk of painful awareness.[50] When the Caesarean section was subsequently performed, a general anaesthetic became necessary and the risk of painful awareness materialized.[51] The plaintiff remained awake during the procedure, suffered excruciating pain, and believed she was going to die, but was unable to inform the doctor that she was not anaesthetized.[52]

The Manitoba Court of Queen's Bench quoted the TP passage from *Videto*[53] and then went on to find that Dr. Thomson had not breached the disclosure standard. Specifically, the court stated:

> In the circumstances of this particular case, it is my opinion that Dr. Thomson was not required to inform the plaintiff of the 10% chance that he might be required to use a general anaesthetic nor of the one in a thousand chance that, if he did, the plaintiff might experience painful awareness. It would … have been unwise for Dr. Thomson to have mentioned the chance that a general anaesthetic might have to be used given the plaintiff's apparent, although unfounded, apprehension that it did not "take" on her. Furthermore, given the anxiety of the plaintiff, and the defendant's wish not to frighten her, and given that the risk complained of was so extremely remote – perhaps one in a thousand – and was not physically disabling or life threatening, I do not regard the risk as material, special or unusual so as to require disclosure by Dr. Thomson.[54]

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48 See *ibid*.

49 See *ibid* at para 19.

50 See *ibid*.

51 See *ibid* at para 11.

52 See *ibid*.

53 *Ibid* at para 24, citing *Videto*, *supra* note 37 at 133.

54 *Puranen*, *supra* note 44 at para 25.

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In *Hajgato*, the plaintiff underwent an elective surgical procedure to alleviate pain in her hip.[55] Post-operatively, she suffered from a serious wound infection resulting in severe damage to her hip joint.[56] During pre-operative consultations with her physicians, the plaintiff was told that there was a risk of infection but she was not informed that an infection might result in the destruction of her hip joint.[57] The plaintiff appeared "nervous, apprehensive and frightened in relation to the prospective surgical procedure."[58] She brought an action against her physicians alleging, *inter alia*, negligence in the discharge of their duty of disclosure. The Ontario High Court of Justice referenced *Videto*[59] and went on to find against the plaintiff on the issue of disclosure.[60] On the issue of TP, the court observed:

> While the risk of infection was disclosed to the plaintiff, the possibility of the destruction of the hip joint therefrom was not discussed with her. This was not a risk which in the circumstances, in my view, required disclosure to the plaintiff. While there is no evidence as to the numerical probability of an infection of the severity which occurred, it is common ground that such an infection is some fraction of the total risk of infection of one to two per cent. The emotional condition of the plaintiff and her apprehension in relation to the surgical procedure when weighed against the possibility of the damage from such an infection justified … generalizing the risk of infection to the plaintiff.[61]

Both the *Puranen* and *Hajgato* courts improperly entangle the materiality of risk and TP analyses. Before entertaining whether TP obtains in a given situation, physicians must first inquire whether a risk is material, special, or unusual so as to *ordinarily* require disclosure. This involves considering the likelihood that the given treatment-related risk will unfold and

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55 See *supra* note 45 at 680.

56 See *ibid* at 677.

57 See *ibid* at 678.

58 *Ibid* at 679.

59 *Ibid* at 679–80, citing *Videto*, *supra* note 37 at 133.

60 *Hajgato*, *supra* note 45 at 680.

61 *Ibid* at 680.

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the gravity of harm if it occurs.[62] At this juncture, a patient's level of anxiety and apprehension about the treatment itself and a physician's desire not to frighten the patient are not relevant to whether a particular risk is material or immaterial. Only if a risk is found to be material is it appropriate to deliberate on whether the nondisclosure of such a risk is legally justified under the TP exception by considering factors relevant to that specific determination (e.g., a patient's ability or inability to cope with the receipt of material risk information).

Also noteworthy is the failure of the *Puranen* and *Hajgato* judgments to address the likelihood that the plaintiffs would have experienced harm from the disclosure of the risk information and the possible magnitude of the harm if it had occurred. Nor is there any discussion of the degree of probability and the magnitude of the apprehended harm that a physician must reasonably believe to exist before the privilege can be lawfully invoked. These problematic aspects of *Puranen* and *Hajgato* is discussed below under Part IV(A).

2. Therapeutic privilege found inapplicable

There are seven reported decisions where the courts noted that TP did not apply because there was no indication that the plaintiffs were sufficiently psychologically or physically vulnerable. Five of these cases, *Casey v Provan*,[63] *Stamos v Davies*,[64] *Seney v Crooks*,[65] *Augustine v Lopes*,[66] and *Videto*, summarily dismiss the application of the privilege without any enlightening commentary and will therefore not be elucidated here. The remaining cases, *Pittman Estate v Bain*[67] and *Haughian v Paine*,[68] are worthy of mention as they address what probability of harm associated with risk disclosure is necessary before the privilege is triggered.

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[62] See *Reibl*, *supra* note 2 at 884–85.

[63] (1984), 47 OR (2d) 147, 11 DLR (4th) 708 (H Ct J).

[64] (1985), 52 OR (2d) 10, 21 DLR (4th) 507 (H Ct J) [*Stamos* cited to OR].

[65] [1996] 9 WWR 423, 41 Alta LR (3d) 192 (QB).

[66] 51 ACWS (3d) 733, [1994] OJ No 2646 (QL) (Ct J (Gen Div)).

[67] (1994), 112 DLR (4th) 257, 19 CCLT (2d) 1 (Ont Ct J (Gen Div)) [*Pittman Estate* cited to DLR].

[68] 37 DLR (4th) 624, [1987] 4 WWR 97 (Sask CA) [*Haughian* cited to DLR].

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In *Pittman Estate*, the patient underwent cardiac surgery during which he received an HIV-tainted transfusion.[69] Several years later, the patient's family physician was advised by the hospital in which the surgery had taken place that the transfusion was contaminated with the HIV virus.[70] Despite being so advised, the physician withheld this information from the patient in part because the patient was experiencing ongoing depression.[71] The patient subsequently died of HIV-related pneumonia and a negligence action was commenced against the physician (and others) by the patient's spouse, who had contracted the HIV virus from her husband.[72] The defendant physician argued that his nondisclosure of the tainted blood transfusion fell within the TP exception.[73] The Ontario Court of Justice acknowledged that this privilege can apply in circumstances where a physician has taken "reasonable precautions to ensure the … patient's health is so precarious that such news will undoubtedly trigger an adverse reaction that will cause further unnecessary harm to the patient."[74] However, the court found that the exception did not obtain because the defendant had not taken "sufficient measures to ensure that [the patient's] emotional state precluded his ability to receive bad news."[75]

In the second case of interest, *Haughian*, the defendant neurosurgeon recommended to the plaintiff that he undergo surgery to relieve pain associated with a cervical disc herniation.[76] However, the defendant failed to advise the plaintiff that the procedure carried a risk of 1 in 500 of paralysis, that there was a very small risk of death, that conservative management of the condition was a possibility, and that his condition might improve on its own.[77] It was the defendant's practice not to inform patients of risks that were less than one percent.[78] During the procedure, a piece of surgical gauze

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69 See *supra* note 67 at 265–66.

70 See *ibid* at 266.

71 See *ibid* at 387.

72 See *ibid* at 266.

73 See *ibid* at 399.

74 *Ibid*.

75 *Ibid* at 400.

76 See *supra* note 68 at 627.

77 See *ibid* at 639–40.

78 See *ibid* at 640.

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interfered with the plaintiff's spinal cord, causing paralysis.[79] A follow-up procedure was performed to remove the gauze and the plaintiff recovered from the paralysis.[80] However, the plaintiff "changed from a healthy, normal person to a person with the movements of an old man" and developed certain psychological problems.[81]

The Saskatchewan Court of Appeal referred to the TP passage from *Videto*[82] and then went on to adopt Lord Scarman's dissenting opinion in the English decision of *Sidaway v Board of Governors of the Bethlem Royal Hospital*[83] "as a lucid exposition of how the doctrine [of informed consent] should operate."[84] In *Sidaway*, Lord Scarman determined that TP enables a physician to "avoid liability for failure to warn of material risk"[85] if "on a reasonable assessment of [the] patient's condition [the physician] takes the view that a warning would be detrimental to [the] patient's health."[86] Interestingly, Lord Scarman's articulation of TP is, in turn, heavily inspired by *Canterbury*, which he cites with approval and interprets as having put forth a threshold of "*serious* threat of psychological detriment to the patient" if TP is to be invoked.[87] On the facts, the Saskatchewan Court of Appeal found that the 1 in 500 risk of paralysis was a material risk and that the TP exception did not apply.[88] Regarding the latter finding, the court stated that there "was no suggestion that disclosure would have unduly frightened the [plaintiff], caused him psychological harm or deterred him from taking treatment essential to his health."[89]

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79 See *ibid* at 628.

80 See *ibid*.

81 *Ibid*.

82 *Ibid* at 636–37, citing *Videto*, *supra* note 37 at 133.

83 [1985] UKHL 1, [1985] 1 All ER 643 [*Sidaway* cited to All ER].

84 *Haughian*, *supra* note 68 at 637.

85 *Supra* note 83 at 654.

86 *Ibid* at 655.

87 *Ibid* at 653, citing *Canterbury*, *supra* note 10 [emphasis added].

88 *Haughian*, *supra* note 68 at 643–44.

89 *Ibid* at 644.

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IV. Proposed Limitations on the Application of Therapeutic Privilege

A compelling need exists for stringent limitations to be placed on the invocation of the TP exception to informed consent. Justice Maloney's observation in *Meyer Estate* that TP has the potential to "'swallow' the doctor's obligation of disclosure and thus to override the requirement for informed consent"[90] has considerable merit. It opens the door to physician paternalism by granting judicial license to manipulate relevant treatment information in a manner that may result in patients accepting treatment they may otherwise reject. In such instances, the physician essentially becomes the *de facto* decision maker. Not only is this an affront to patients' right to medical self-determination – a right that has been repeatedly emphasized by the Supreme Court of Canada in cases post-dating *Hopp* and *Reibl*[91] – but it also carries with it a real potential to undermine patients' trust and confidence in the medical profession.[92] Being left to wonder during and after consultations with one's physicians whether they are intentionally withholding or generalizing material risk information does little to build a solid foundation of trust. In view of these hazards, future TP jurisprudence should explicitly adopt the limitations detailed below respecting physicians' use of the privilege.

A. *A significant likelihood that risk disclosure would have a substantial, prolonged adverse effect must exist*

Most of the Canadian TP cases are entirely silent on both the degree of probability and the magnitude of the apprehended harm that a physician must reasonably believe to exist before the privilege can be lawfully invoked. This may stem from *Reibl*'s failure to provide guidance respecting such thresholds. However, direction on the appropriate level of probability and gravity of harm may be garnered from *McInerney v MacDonald*,[93] a Supreme Court of Canada decision rendered 12 years after *Reibl* and dealing with the issue of patients' general right to access their medical records.

[90] *Supra* note 25 at 366.

[91] *AC*, *supra* note 6; *Carter*, *supra* note 6; *Ciarlariello v Schacter*, [1993] 2 SCR 119, 100 DLR (4th) 609; *Starson v Swayze*, 2003 SCC 32, [2003] 1 SCR 722 [*Starson*].

[92] See Meisel, *supra* note 11 at 469.

[93] *Supra* note 7.

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According to the Court, physicians may withhold patients' medical records if they reasonably believe access to this information may harm their patients' health.[94] While it was observed that patients' well-being must be balanced against their right to self-determination, the Court made clear that patients are to have access to their medical records "in all but a small number of circumstances."[95] Recognition of the paramount importance of patient autonomy led to the adoption of a high burden that physicians must meet before they can withhold medical records from their patients: this information must be disclosed to "a patient unless there is a *significant* likelihood of a *substantial* adverse effect on the physical, mental or emotional health of the patient."[96]

The same policy considerations that inspired the *McInerney* thresholds of "significant" likelihood of harm and "substantial" adverse effects to the patient if the harm unfolded have equal purchase to the application of the TP exception in the informed consent context. It should be added that concerns about transient adverse effects ought to be regarded as insufficient to trigger the privilege. For instance, if a physician reasonably believes disclosure of risk information will have a substantial psychological impact on a patient but this adverse effect is not expected to be prolonged, the physician cannot call upon the privilege.[97]

There is no indication in *Puranen* and *Hajgato* of the thresholds the respective courts applied. On the face of the evidence outlined in both judgments, it is not clear that the physicians implicated in those cases would

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[94] *Ibid* at 154–55. In *Wong v Grant Mitchell Law Corp*, 2015 MBQB 88 at para 137, 318 Man R (2d) 79, a medical records access case from the Manitoba Court of Queen's Bench, the court considered *McInerney* to have confirmed the existence of "therapeutic privilege" in Canada, contrary to the holding in *Meyer Estate*, *supra* note 25 at 366.

[95] *McInerney*, *supra* note 7 at 158.

[96] *Ibid* [emphasis added].

[97] Incidentally, in *Mustapha v Culligan of Canada Ltd*, 2008 SCC 27 at para 9, [2008] 2 SCR 114, the Supreme Court of Canada determined that negligently inflicted psychological injuries need to be "serious and prolonged" in order to be compensable under tort law. It noted that transient psychological distress does not meet this threshold. Recently, the Supreme Court confirmed this position in *Saadati v Moorhead*, 2017 SCC 28 at para 37, [2017] 1 SCR 543.

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have met a threshold as high as the one set out in *McInerney*. In *Puranen*, the defendant physician was concerned about risk disclosure increasing the plaintiff's anxiety and frightening her. Similarly, the plaintiff in *Hajgato* was described as being "nervous, apprehensive and frightened" during pre-operative consultations. There is no indication in these cases that there was a significant likelihood of a substantial, prolonged adverse effect on the plaintiff's physical, mental, or emotional health. It is commonplace for patients to be nervous, apprehensive, and frightened prior to an operation. Such emotional states, by themselves, do not justify a physician's use of the privilege. Perhaps the plaintiffs in *Puranen* and *Hajgato* were nervous and frightened to such an extreme extent that it was reasonable to believe full risk disclosure was significantly likely to have a substantial, prolonged adverse effect on them, but this is not apparent from the courts' judgments. Indeed, in view of evidence that risk disclosure does not necessarily increase anxiety but, in some cases, actually reduces it and has other positive effects, such as the development of a trusting relationship with one's physician,[98] the necessity of employing the privilege must be demonstrably justified.

Pittman Estate did speak to the probability of harm that must exist. Specifically, a physician must show that the material risk information will *undoubtedly* cause harm to the patient. This high threshold exceeds *McInerney*'s "significant likelihood" requirement by a considerable margin. Requiring physicians to believe, with certainty, that harm will attend risk disclosure may be an unrealistic threshold. Few things are certain in life and a person's psychological reaction to risk information may well not be one of them. Thus, the *McInerney* threshold may be viewed by other courts as being more pragmatic. Support for the *McInerney* threshold can be found in *Haughian*, where the court, drawing upon Lord Scarman's judgment in *Sidaway*, acknowledged that the risk of harm arising from risk disclosure must be "serious." While the *McInerney* threshold is somewhat more specific, *Haughian* sets out a threshold that is not inconsistent with it.

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[98] See e.g. DD Kerrigan et al, "Who's Afraid of Informed Consent?" (1993) 306:6873 Br Med J 298 at 300; Melina Gattellari et al, "When the Treatment Goal Is Not Cure: Are Cancer Patients Equipped to Make Informed Decisions?" (2002) 20:2 J Clin Oncol 503 at 511; BM Stanley, DJ Walters & GJ Maddern, "Informed Consent: How Much Information Is Enough?" (1998) 68:11 Aust NZJ Surg 788 at 790; Andrew Luck et al, "Effects of Video Information on Precolonoscopy Anxiety and Knowledge: A Randomised Trial" (1999) 354:9195 Lancet 2032 at 2034; Hébert, *supra* note 9 at 140.

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B. Therapeutic privilege can only be invoked as a last resort

None of the TP jurisprudence establishes a requirement for physicians to take all reasonable measures to put patients in a position where they can safely receive risk information. As well, no mention is made of the defendant physicians taking any such steps in these cases. Given the pitfalls of TP (i.e., deprivation of decisional autonomy and the possibility of undermining the trust between physicians and patients), it would be appropriate to make the privilege one of last resort by requiring that it only be invoked if (1) no reasonable measures can be undertaken in the circumstances to place patients in a position where they can safely receive the information or (2) such measures were taken but failed to achieve their objective. Reasonable measures may, where feasible, include affording patients more time to absorb the initial treatment information, allowing them to come to grips with the prospect of undergoing the treatment before the risk information of concern is communicated to them.[99] Patients may also be encouraged to take advantage of any available emotional supports, such as having a close family member present when discussing treatment information or, where reasonably accessible, having a mental health professional guide the delivery of the material risk information.[100]

C. Potential dissuasion from undergoing treatment is not to be considered

Many of the TP cases have adopted *Videto*'s specious interpretation of *Reibl* that a patient's apprehension and reluctance to undergo a medical procedure can be used as a justification to rely on the privilege. In both *Puranen*

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[99] See Meisel, *supra* note 11 at 466–67. The author argues that, "where the need for medical care is not urgent, the therapeutic privilege should rarely, if ever, be invoked" (*ibid* at 466). He notes that, where treatment can be safely delayed, the patient should be given more time for their emotional upset to de-escalate so that they can make the treatment decision (*ibid* at 467).

[100] See Hébert, *supra* note 9 at 139. The author states:

> Even if telling the truth does have some negative consequences, this does not in itself warrant nondisclosure. It is important to break bad news carefully and considerately: in person, sitting down, in a comfortable setting, with a trusted professional, prepared for emotion, ready to answer questions, having all the time needed, and being knowledgeable about the next steps. The news may be brutal for a patient, the telling of it need not be (*ibid*).

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and *Hajgato*, the respective courts expressly countenanced the defendant physicians' decision to not disclose the risk information on the basis of the patients' apprehension. However, important policy considerations strongly militate against allowing a patient's apprehension and reluctance to be one of the factors that can trigger the privilege. Physicians would be permitted to manipulate the disclosure of risk information so that patients, despite their apprehension and reluctance, ultimately decide to undergo treatment that their physicians believe is in their best interests. This is highly offensive to patient autonomy and is reminiscent of concerns respecting paternalism that were expressed by the Supreme Court of Canada in *Starson v Swayze*[101] in the context of capacity assessments for persons with mental disabilities. According to *Starson*, if a person is capable of understanding and appreciating[102] information relevant to the treatment choice to be made, they are "fully entitled to make a decision that … reasonable persons … may perceive as foolish."[103] The *Starson* Court went on to note that it is improper for capacity assessors to allow their own conceptions of a patient's best interests to influence their findings of incapacity.[104]

By analogy, if a capable patient's emotional state causes them to be so unduly apprehensive and reluctant to receive physician-recommended treatment that they may choose to forego the treatment if fully informed about its attendant material risks, they should be entitled to make that (foolish) decision.[105] In such instances, a physician's belief about the unreasonable-

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[101] *Supra* note 91.

[102] The Supreme Court was called upon to define the words "understanding" and "appreciating" in the context of section 4(1) of the *Health Care Consent Act, 1996*, SO 1996, c 2, Schedule A. According to the Court, "understanding" requires that a person "must be capable of intellectually processing the information as it applies to his or her treatment, including its potential benefits and drawbacks" (*Starson*, *supra* note 91 at para 16). "Appreciating" involves the ability of an individual to "weigh or judge and thus evaluate the foreseeable consequences of accepting or refusing treatment" (*ibid* at para 17). These words have been ascribed the same meaning in the context of capacity assessments in other Canadian jurisdictions.

[103] *Supra* note 91 at para 112.

[104] *Ibid*.

[105] The same position was taken by the Ontario Court of Appeal in *Fleming v Reid* (1991), 4 OR (3d) 74 at 85, 82 DLR (4th) 298, where the court stated: "The fact that serious risks or consequences may result from a refusal of medical

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ness of the decision is irrelevant and cannot be used to support a finding that the privilege applies. If, on the other hand, the physician believes their patient's emotional state is such that they are incapable of understanding or appreciating the material risk information, then the physician is mandated to seek and obtain the consent of their patient's legally recognized substitute decision maker. Simply withholding or generalizing the material risk information from incompetent patients and not taking steps to secure the consent of their appropriate substitute decision maker is unlawful.[106]

D. Therapeutic privilege only applies to therapeutic and non-elective medical interventions

In *Hajgato*, the surgical procedure on the plaintiff's hip was, as remarked by the court, elective. Nonetheless, the court found that the defendant's use of the privilege was appropriate. This raises the issue of whether it is proper to invoke the privilege in the context of elective medical interventions. It is well settled in Canadian common law that the scope of risk disclosure is higher when "elective"[107] procedures are involved.[108] One legal academic has convincingly argued that there is little room for TP when the medical intervention can be characterized as being elective[109] and the Ontario High Court of Justice in *Stamos* took the same position.[110] Nor should TP be considered justified in the context of non-therapeutic procedures, including

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treatment does not vitiate the right of medical self-determination." See also *Malette v Shulman* (1990), 72 OR (2d) 417 at 424, 67 DLR (4th) 321, in which the Ontario Court of Appeal observed that "people must have the right to make choices that accord with their own values, regardless of how unwise or foolish those choices may appear to others."

106 See Picard & Robertson, *supra* note 8 at 79.

107 Professor Somerville states that a medical intervention is elective if "there is a real choice in terms of its therapeutic necessity whether to have or forego it" (*supra* note 8 at 8).

108 See Allen M Linden & Bruce Feldthusen, *Canadian Tort Law*, 10th ed (Toronto: LexisNexis Canada, 2015) at 196.

109 Somerville, *supra* note 8 at 8, 10.

110 *Supra* note 64 at 24. The court in *Stamos* dealt with an action against a defendant surgeon who, during a lung biopsy, injured the plaintiff's spleen (see *ibid* at 11). The defendant had not disclosed the risk of such an injury to the plaintiff

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those that form part of human biomedical research protocols. Support for this view can be found in *Halushka v University of Saskatchewan*, where the Saskatchewan Court of Appeal, in a case involving a serious injury sustained by a research subject in a non-therapeutic biomedical study, stated:

> There can be no exceptions to the ordinary requirements of disclosure in the case of research as there may well be in ordinary medical practice. The researcher does not have to balance the probable effect of lack of treatment against the risk involved in the treatment itself. The example of risks being properly hidden from a patient when it is important that he should not worry can have no application in the field of research.[111]

Conclusion

The TP exception to informed consent has formed part of Canadian common law for over 35 years. Throughout its reasonably long history, the parameters of the privilege have remained ill defined, thus leaving the door wide open for undue intrusions on patient autonomy and possible erosion of the trust relationship between physicians and their patients. For these reasons, courts that are tasked with dealing with TP in future cases ought to explicitly establish stringent limitations on its use. These limitations should make the privilege available only as a last resort and only in circumstances where physicians reasonably believe the disclosure of therapy-related risk information to competent patients would carry a significant likelihood of having a substantial and prolonged adverse effect on them. The possibility that a patient might be deterred from undergoing the recommended treatment

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during the pre-operative consultation process (see *ibid* at 17). On the issue of TP, Justice Krever stated:

> I do not think that it can be fairly held that the obviously apprehensive and anxious state of the plaintiff justified withholding from him any information which, but for that state, he would have been required … to specify. The procedure, after all, was not life-saving; it was elective (*ibid* at 24).

A similar position was also taken in *Kelly*, *supra* note 24 at 565.

[111] (1965), 53 DLR (2d) 436 at 444, 52 WWR 608 (Sask CA). This aspect of *Halushka* is discussed in Michael Hadskis, "The Regulation of Human Biomedical Research in Canada" in Downie, Caulfield & Flood, *supra* note 4, 437 at 471.

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if the risk information is disclosed should not be considered. Moreover, the privilege should not apply to elective medical procedures and non-therapeutic interventions. Strict adherence to these limitations may well mean that TP could only be invoked in the most unusual of circumstances and that these circumstances may never actually materialize. This is entirely appropriate given the privilege's inherent dangers.

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