Telling the Truth? Disclosure, Therapeutic Privilege and Intersexuality in Children

Anne Côté

*Sometimes...the best medicine might still be a comforting lie.*
- John D. Lantos, “Should We Always Tell Children the Truth?”

*In no other realm in medicine do doctors regularly argue for active, nearly wholesale deception.*
- Alice Domurat Dreger, “A History of Intersexuality: From the Age of Gonads to the Age of Consent”

Introduction

Family physicians, pediatricians, and geneticists meet a variety of young patients at various stages of the maturing process. As clinicians are privy to information about their patients that may be disturbing, they develop knowledge about human nature and decide, often along with parents, the appropriate level of information for different children and adolescents. And while it may be possible in a clinical sense to delineate the differing stages of understanding of a particular patient, the law may not always recognize these incremental changes. The law insists with few exceptions that those capable of consenting to treatment deserve the disclosure of appropriate information. This ensures that it is the capable patient and not the physician who is making treatment decisions.

One possible exception to the notion that disclosure is necessary for capable patients is termed the “therapeutic privilege.” It provides a way around the requirement that capable patients ought to have full disclosure in order to be able to fully and voluntarily consent to treatment. At times, information regarding a procedure or regarding the patient’s condition is in fact considered to be a potential danger to the patient’s well being. With this exception to the disclosure requirement it is thought that doctors can avoid conflict with the most fundamental portion of the Hippocratic Oath: “do no harm.” In order to protect the patient, some clinicians think it best to withhold or generalize certain disturbing information thought to pose an actual threat to the patient. And some clinicians no doubt feel that there could

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1 Anne Côté is a third-year law student at the University of Alberta, Edmonton, Alberta. This paper was awarded the 2000 Lieberman prize in Law & Medicine.

1 A. Meisel, “The `Exceptions’ to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking” (1979) Wis. L. Rev. 413 at 460 n. 153.
be nothing more disturbing to a child or an adolescent to discover something anomalous about the nature of their sexual anatomical being. Sex and gender are so central to our culture that these concepts are thought to touch the very core of our social and personal identity.\(^2\) And while some sexual differentiation disorders are detected in a child long before there is a question of his/her capacity to consent, others may not be detected until adolescence or beyond.\(^3\) Therefore, when a geneticist\(^4\) discovers that a child has inherited androgen insensitivity syndrome, for instance, or when a family physician determines that an adolescent has a pseudohermaphroditic condition, the clinician may no doubt be wary of passing along this most sensitive information. The temptation to resort to an exception such as the therapeutic privilege may be overwhelming when considering the fear of harm to the young patient’s development and psyche.\(^5\) It is precisely the nature and the consequences of that fear that will be developed further here.

The suitability of using the therapeutic privilege exception in this area of clinical practice is the subject of this study. While the fear of harm on the part of physicians may be genuine, it is perhaps an unexamined fear. A confusion between capacity to consent and the harm caused by informing children may be operational in this conflict and hence the notion of capacity will be further examined. Finally, the remedies for an unjustified withholding of information will be addressed. But first, in order to lay out the discussion in its proper theoretical framework, the discussion must turn to the reasons for disclosure in the medical context.

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\(^1\) However, we are still often unable to articulate our deeply held beliefs about these issues, for talking about gender can be like “a fish talking about water”: J. Lober, *Paradoxes of Gender* (New Haven, Conn.: Yale University Press, 1994) at 13, quoted in R.A. Crouch, “Betwixt and Between: The Past and Future of Intersexuality” (1998) 9:4 J. Clinical Ethics 372 at 372.

\(^2\) Even a condition diagnosed just after a child’s birth may have treatment and other repercussions that continue into adolescence and adulthood. “Intersex” and “intersexuality” will be used as blanket terms for various conditions involving abnormalities of a child’s sex. For a discussion of the variety of intersex conditions such as androgen insensitivity syndrome (AIS) and pseudohermaphroditism, see B.E. Wilson & W.G. Reiner, “Management of Intersex: A Shifting Paradigm” (1998) 9:4 J. Clinical Ethics 360.

\(^3\) Although there may be a question as to who is the geneticist’s patient when an entire family consults with a geneticist, it will be assumed for the sake of brevity and simplicity throughout that geneticists owe the same duties to their individual patients that other physicians do.

\(^4\) Early surgical intervention was often accompanied by a stern warning to parents that any disclosure to children might interfere with the success of the adoption of the chosen sex and gender identity: Wilson and Reiner, *supra* note 3 at 363. This deception is approved of in A. Natarajan, “Medical Ethics and Truth Telling in the Case of Androgen Insensitivity Syndrome” (1996) 154:4 C.M.A.J. 568. This “older model” of treatment is now creating a great deal of controversy; see E.G. Howe, “Intersexuality: What Should Careproviders Do Now?” (1998) 9:4 J. Clinical Ethics 337 at 338.
Informed Consent and the Need for Disclosure

The doctrine of informed consent begins with the notion of autonomy. In discarding the paternalistic approach to decision making, it is now assumed that it ought to be the patient who decides what is done with his/her body and not the doctor. The notion of autonomous decision-making is meant to prevent others from using the individual as a mere means to an end, as Kant’s dictum prescribes. Autonomy is meant to encompass the ethical protection of individual interest in making decisions about the body and in preserving in law the fundamental respect of persons. Therefore, individual autonomy is “fundamental to the common law” and is the “basis for disclosure.”

In order to pass the mantle of decision-making from the physician to the patient, sufficient information must be disclosed. To say that a patient has consented indicates that she or he has been informed of the basic nature of the procedure and that the patient has assented. If this procedure is then performed as indicated, there can be no liability for battery. However, for this to be an informed consent (and hence not negligence), sufficient information must be provided as to the risks associated with the procedure. Truly informed consent will ensure that the patient’s right to autonomous decision-making is enforced.

However, many physicians have resisted this doctrine as being a “myth, a fiction, an unattainable goal, or a snare to entrap physicians.” When compiled, the list of complaints levelled against informed consent is long:

It wastes valuable time that could be spent in rendering treatment to the ill, in part because patients do not understand what they are told and in part because they do not want to be informed; it undermines the trust which patients need to reposit in their doctors if they are to be successfully treated; and it requires disclosure of information about the possibility of the risks of induced treatment or failure of the treatment that may lead to a psychologically self-fulfilling prophecy. In addition, the goal of disclosure of information to patients—that they may make their own choice about treatment—is illusory because disclosure can

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(and indeed usually will) be made by the physician in such a way as to assure that the patient agrees to the treatment. Also, some patients have their minds made up before they acquire the kind of information that the informed consent doctrine requires that they receive, and the receipt of this information does not change their decision. For other patients, the disclosure of information needlessly frightens them, possibly to the extent that they refuse necessary treatment.¹³

Therefore, rather than viewing informed consent as a means of ensuring that patients are themselves able to decide on their treatment, it has often been viewed as merely a legal requirement — and an irritating and unproductive requirement at that. However, it is really more a process of negotiation, of education and collaboration,¹⁴ than it is the “lifeless piece of paper”¹⁵ implied by some (ab)using consent forms. The information provided should not be meant as a transparent attempt at “getting” patients to consent, but rather it is there to aid the patient in deciding, not to aid the doctor in persuading.¹⁶

Not surprisingly, however, given the fact that the distinction between informed consent (the ethical doctrine) and informed consent (the legal requirement) is often blurred or missed altogether. Physicians viewing informed consent as risk management¹⁷ want the law to provide “a clear and predictable legal framework.”¹⁸ While the law may sometimes oblige by laying out “minimally acceptable” standards,¹⁹ more often it is unclear where the exact boundaries are drawn around the legal doctrine, and of course, when those boundaries will change to raise the standard:

This dearth of information [about the standard] frustrates medical practitioners, who tend to see the law as a stable system of clear rules that, if followed, will lead to avoidance of liability. The definition of standard encourages this belief: the term refers to a statement of expected behavior that one may follow to avoid litigation and liability. Such a belief, while understandable, is nonetheless a misconception; the law is neither stable nor clear. Today’s conduct may conform perfectly

¹³Meisel, supra note 1 at 415-16.
¹⁴Piper, supra note 12 at 308.
¹⁵E. Picard & G. Robertson, Legal Liability of Doctors and Hospitals in Canada, 3rd ed. (Scarborough, Ont.: Carswell, 1996) at 111.
¹⁸Manitoba Law Reform Commission, Minor’s Consent in Health Care (Winnipeg: L.R.C., 1995) at 31 [hereafter M.L.R.C.].
¹⁹Lantos, supra note 17 at 83-84.
to yesterday’s judicial decisions, yet still give rise to liability in tomorrow’s courts.\textsuperscript{20}

Physicians, therefore, must look to the spirit of legal standards and decisions, not merely to their minimal application. Informed consent serves not only to inform patients of the risks and benefits of particular procedures, but it works to create a collaborative partnership between doctors and patients. This, if embraced, can work for the benefit of both parties.\textsuperscript{21} However, if it is only grudgingly followed, physicians may be caught explaining today’s conduct in tomorrow’s court. Or, as is human nature, they may search for legitimate exceptions to the rule that they are not comfortable applying. One such exception is the therapeutic privilege.

**The Therapeutic Privilege: Its Nature and Its Limitations**

The therapeutic privilege is an exception to the general requirement of informed consent. If a physician feels that disclosure of certain information will lead to the harm or suffering of the patient, she or he is said to be free to withhold this information.\textsuperscript{22} Information can be withheld if it is countertherapeutic, dysfunctional, or distorting for the particular patient in question.\textsuperscript{23} This doctrine is traced back to the American case of *Canterbury v. Spence*,\textsuperscript{24} where it is declared that if information is “menacing” to a patient, it need not be disclosed.\textsuperscript{25} The exception is raised where “a direct conflict…arises between the doctor’s medico-ethical duty to health and his legal-ethical duty to inform.”\textsuperscript{26} This is based on the “assumption that the physician cares not only for the patient’s physiological health but for his psychological and moral well-being” as well.\textsuperscript{27}

While the therapeutic privilege has been termed “an American exception” by one Canadian court,\textsuperscript{28} its existence north of the border has nevertheless been alluded to by the Supreme Court of Canada. In *Reibl v. Hughes*, Laskin C.J.C. (as he then was) states that “it may be the case that a particular patient may, because of

\textsuperscript{20}Piper, supra note 12 at 301.
\textsuperscript{21}Allowing patients to decide has the obvious benefit of relieving the doctor of ethical and moral responsibility for choosing. As well, increased communication between doctor and patient may actually serve to discourage patient lawsuits: Shultz, *supra* note 6 at 296.
\textsuperscript{23}Dickens, *supra* note 16 at 137.
\textsuperscript{24}464 F.2d 772 (D.C. Cir 1972). The duty to disclose was also delineated in *Natanson v. Kline*, 350 P.2d 1093 (Kan. 1960); although Katz traces the therapeutic privilege doctrine back to a Dr. H. Smith, *supra* note 6 at 155.
emotional factors, be unable to cope with facts relevant to recommend 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.” In response to this statement, Maloney J. in Meyer Estate v. Rogers has nevertheless declared that the therapeutic privilege has no place in Canadian law. Maloney J. states that because Chief Justice Laskin’s comments were obiter, and because of the “hesitancy of Laskin C.J.C.’s tone,” “the Supreme Court of Canada has not, in Reibl, adopted or even approved the therapeutic privilege exception in Canada.” However, even given this strong statement, this does not indicate the death of the exception in Canada.

The following year, the Supreme Court of Canada, in McInerney v. MacDonald, again stated that information can be withheld from a patient if it is not in the patient’s best interest to receive it. However, the Ontario Court of Appeal has held that the exception does not apply in the case of elective surgery. This limit may not apply in Alberta as the therapeutic privilege exception has been codified in the Health Information Act, which provides:

11(1) A custodian may refuse to disclose health information to an applicant

(a) if the disclosure could reasonably be expected

(i) to result in immediate and grave harm to the applicant’s mental or physical health or safety

Therefore, while many commentators have called for its elimination, the therapeutic privilege remains a part of Canadian law.

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32 Supra note 28 at 314.
33 R. Urman, B. Dickens & C. Harrison, “Pediatric Health Care Physicians’ and Surgeons’ Views of Ontario’s Health Care Consent Legislation” (1996) 4 Health L.J. 135 at n. 20 states that the Meyer decision “resulted from an incorrect reading of the law, is not binding, and is unlikely to be followed in future cases.”
36 L.B. Andrews, “Informed Consent Statutes and The Decisionmaking Process” (1984) 5 J. Legal Med. 163 at 215, feels that these situations could be covered under incapacity or the emergency exception. Meisel, supra note 1 at 467-68 feels that it could be covered under incompetency or waiver. van Oosten, supra note 26 at 36, feels that it could be covered under necessity.
It is not clear how severe the imagined effect on the patient must be in order to withhold information. The Canterbury decision indicates that the impact of the information must be that it would impede rational decision-making. However, it is not made clear how being upset would impede rational decision-making, or in what circumstances this would be the case. Dickens suggests that the harm expected must be severe if not actually pathological. Once again, this is not entirely a clarified explanation: were this the only explanation of the privilege, it would leave much up to the discretion of the doctor. Van Oosten describes six instances where disclosure is restricted:

a) where disclosure would endanger the patient’s life or affect physical or mental health
b) where disclosure might prevent rational decision making because the information is confusing or frightening
c) where disclosure causes such anxiety and distress that it might jeopardise the outcome of the intervention
d) where the patient is moribund and disclosure would be inhuman
e) where the risks of disclosure are as much as or more serious than that of intervention, or
f) where disclosure would seriously prejudice third parties.

Excluding the final category, the first five categories explore only the severity or source of harm to the patient. However, without a definition of “serious,” even a detailed list such as this one leaves much to the discretion of the physician.

What is certain, however, is that this harm cannot be merely trivial, nor can the “harm” be that a patient may refuse beneficial treatment if informed. The therapeutic privilege must not be invoked because the patient will make an “inappropriate” choice. It is clear both ethically and in Canadian jurisprudence that autonomous individuals are permitted to make “wrong” or “bad” choices for “[i]f there is a single characteristic that symbolizes “autonomy,” it is the freedom to make bad, or unreasonable, decisions.” If this were not the case, there would be no need for the doctrine of informed consent at all, for the doctor’s reasonable medical decisions could be held to stand in for those of the patient, or the patient could merely be handed a list of pre-classified “reasonable” alternatives from which to choose. This scenario would obviously make a mockery of the idea of respect for persons and for bodily integrity.
There is also a concern that the therapeutic privilege exception may be overused because physicians are anxious to avoid dealing with patients who become upset. The notion of clinical distance is taught to medical students, while empathy or understanding may be ignored or actively discouraged because of its effect on clinical distance.\textsuperscript{42} Therefore, many physicians may feel, as do many familiar with Western Philosophy’s traditional concentration on rationality, that emotions are “bad,” or not scientific, or unpredictable.\textsuperscript{43} Therefore, physicians may well overestimate the degree to which patients find information troublesome.\textsuperscript{44} As well, physicians may have an “ill-perceived conception of psychic injury” that is supposed to follow an upsetting disclosure\textsuperscript{45} and may hence equate upset with harm. Finally, because of a lack of appreciation for the useful informational content of emotions, and a lack of training regarding patients’ emotional states, some physicians may overlook the positive aspects of disclosure.\textsuperscript{46} Because the uninformed patient may actually imagine a situation to be worse than it is,\textsuperscript{47} disclosure may ease fears about a procedure. Thus sensitive disclosure of information may actually help a patient from becoming overwhelmed, and may actually prevent psychological harm.\textsuperscript{48}

What is not directly addressed in the literature or case law, however, is the issue of whether or not a diagnosis (as opposed to risks of a procedure) can be withheld from a patient because it is feared that its disclosure will cause harm.\textsuperscript{49} Physicians may rely on the fact that they need not disclose to children or adolescents diagnoses about their genetic or biological sexual status because this information would be terribly upsetting to the child. On the one hand, it is arguable that a patient is at least as likely to become upset at this type of information as upon hearing about a proposed treatment. On the other hand, this is precisely the sort of information for which a patient goes to a physician. One would have to imagine a situation where the diagnosis itself would cause harm to the child (for instance in the case of a suicidal child). However, if the physician relies on a pre-existing mental condition to invoke the privilege, she or he confuses the use of the exception

\textsuperscript{42}J. Connelly, “Emotions, Ethics, and Decisions in Primary Care” (1998) 9:3 J. Clinical Ethics 225 at 230.
\textsuperscript{43}Ibid. at 229.
\textsuperscript{44}Andrews, supra note 35 at 214.
\textsuperscript{45}Ibid. at 212.
\textsuperscript{46}For a discussion of the positive benefit of emotions in the context of the clinical relationship, see Connelly, supra note 42.
\textsuperscript{48}Andrews, ibid. at 166.
\textsuperscript{49}van Oosten, supra note 26 at 37-38 does allow for this possibility but does not discuss the issue at length.
with the doctrine of incapacity. This confusion may cause the overuse and misapplication of the exception. To apply the exception to the withholding of a diagnosis, there needs to be a clear indication that the child will be seriously harmed by the provision of the diagnosis itself (not by a pre-existing condition that would lead to a finding of incapacity).\(^\text{50}\)

In order to ensure that the therapeutic privilege exception is not misused by overzealous physicians, there are a number of limitations placed on it. The first of these is that the burden of proof (a “heavy” burden\(^\text{51}\)) rests on the doctor.\(^\text{52}\) The doctor must show that this nondisclosure was in the best interest of the patient.\(^\text{53}\) This should be done by balancing the situations described above by van Oosten, as well as by acknowledging that a patient may be as harmed by undermining their self-determination as by disclosing the information in question.\(^\text{54}\) As well, if the information is directly solicited by the patient, the therapeutic privilege exception should not ordinarily be advanced.\(^\text{55}\) However, if the information would still pose a tremendous threat to the patient, the privilege may still be found to apply. It is arguable but by no means certain that upsetting a treatment regime would be such a harm. In fact, the McInerney case involved a direct request for a patient file which, following the judgment, would not preclude the use of the therapeutic privilege exception. Were the question more specific than a general request for information, however, a court may see this in a different light. Given that the Supreme Court of Canada and many commentators are wary that the exception, if allowed too often, could swallow the disclosure obligation altogether,\(^\text{56}\) caution in its application would no doubt be the rule.

Another limitation placed on the exception may well escape the notice of many clinicians. Merely because information disclosed \textit{in toto} may be upsetting does not preclude \textit{all} disclosure. Not only must the clinician assess whether or not there may be less upsetting ways of disclosing the information,\(^\text{57}\) it may be presented in a way that is more generalized than for the average patient.\(^\text{58}\) This may be particularly useful when dealing with children and adolescents. Age-appropriate disclosure may be more difficult or time-consuming but ought to be seriously considered before resort may be had to the therapeutic privilege exception. Urman \textit{et al.} even suggest that there ought not to be a total withholding of information, but

\(^{50}\text{See infra the section below dealing with capacity.}\)
\(^{51}\text{Dickens, supra note 16 at 137.}\)
\(^{52}\text{McInerney, supra note 32 at 427.}\)
\(^{53}\text{Ibid.}\)
\(^{54}\text{Meisel, supra note 1 at 469.}\)
\(^{55}\text{van Oosten, supra note 26 at 33. This is in direct opposition to the clinical and patient experience of the intersex individuals: even direct questions were and are often ignored for fear of upsetting the treatment regime: supra note 5.}\)
\(^{56}\text{The exception should not readily apply: McInerney, supra note 32 at 429. See also Piper, supra note 12 at 302.}\)
\(^{57}\text{Dickens, supra note 16 at 139.}\)
\(^{58}\text{Reibl, supra note 11 at 13.}\)
that at least the basic character of the procedure proposed and its inevitable consequences must be disclosed. Again, children may be able to accept simplified explanations of proposed treatments. As well, the upset caused to the patient should abate over time and disclosure and/or treatment should be delayed when possible.

Another limitation placed on the exception is that it may be required (and most certainly would be required in the case of children) that, if the exception were invoked, the disclosure must be made to a close relative (most likely parents or guardians in the case of children and adolescents). This disclosure to a relative first ought to be made in order to assess whether this disclosure would in fact be harmful to the child, and whether there might be a way to minimize this harm. Therefore parents themselves may be asked to tell children of the genetic or biological sexual abnormality (and any ensuing treatment), in age-appropriate language. Conversely, parents may tell physicians of an easier means of informing the child or may suggest a less upsetting location or time to make this disclosure. If parents are willing to inform children or adolescents in the above manner, there is no real conflict (assuming that the privilege has been properly applied in the first place). Where conflict may arise, however, is when there is no consensus between a physician and parents about disclosure of this information to children or adolescents.

In part, the law has already developed a means of addressing the issue of the proper relationship between children, parents, and physicians in the area of children’s capacity to consent. It is to this topic that the discussion will now turn.

**Children’s Capacity**

Although several provinces have legislated an age or a test for children’s capacity, the remainder of the provinces (Alberta included) have left the determination up to common law principles. The law once looked to indicia of maturity in a child in order to determine that an emancipated minor could consent to treatment. The modern formulation of the test, however, is a cognitive one: can this child understand and decide about the treatment and does she or he appreciate the reasonably foreseeable consequences thereof? This is a subjective and functional determination that is made with regard to the child’s age, intelligence, and experience. Because this test is subjective, the capacity to consent will vary

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59 Supra note 31 at para. 33.
60 Meisel, supra note 1 at 466-67. The exception may not be used for elective procedures: see Videto, supra note 33.
61 Including New Brunswick and Ontario. See J.M. Gilmour, “Minors” in Downie & Caulfield, supra note 16 at 179.
62 Picard & Robertson, supra note 15 at 71-72.
63 Such as marriage or pregnancy. See M.L.R.C., supra note 18 at 4-5.
64 Gilmour, supra note 61 at 180.
65 Urmian, et al., supra note 31 at para. 2.
from child to child and even from procedure to procedure for the child in question.\textsuperscript{66} Therefore, a more complex treatment will require the child to have a greater ability to understand.\textsuperscript{67}

However, as a decision of the Alberta Court of Appeal has indicated, the ability to understand the treatment need not include an understanding of its ethical or moral background.\textsuperscript{68} In that case, it was determined that a child can consent to an abortion if she understands the physical consequences of the procedure.\textsuperscript{69} Therefore, simply because a child or adolescent may not understand all of the social ramifications of his/her intersexuality, this does not preclude him or her from consenting to a procedure regarding the physical aspects of this diagnosis, provided that they understand the physical consequences. This reading of the law may make parents and physicians understandably uneasy.\textsuperscript{70} However, the advantage of the subjective maturity rule is also its disadvantage: theoretically, the discretion of individual assessment leads both to fair decisions in each case and to uncertainty as to the general application of the rule.\textsuperscript{71}

Just as the therapeutic privilege exception cannot be invoked merely because the physician disagrees with a patient’s decision, so too is it inappropriate to decide that a child is incapable merely because the child’s decision is viewed as "wrong."\textsuperscript{72} Children also need the protection from the paternalistic application of medical treatment and hence the acceptance of competent decisions places a limit on paternalism.\textsuperscript{73} Conversely, the law must also recognize that the development of maturity (even with adults) is "a moving target."\textsuperscript{74} Of course, this statement is even more applicable to adolescents. This does not mean, however, that physicians must assume that adolescents are incapable, as the Wren case aptly shows. And just as upset does not necessarily translate into harm for the purposes of the therapeutic privilege exception, the emotional changes or instability of adolescence do not necessarily translate into incapacity.

\textsuperscript{66} Picard & Robertson, supra note 15 at 73.
\textsuperscript{68} C.(J.S.) v. Wren (1987), 35 D.L.R. (4th) 419. Although the court at 421 did note that it may be the doctor’s duty to discuss these matters with the patient.
\textsuperscript{69} Ibid. at 421.
\textsuperscript{69} The unease with the autonomy of children has caused some to call for a retention of the ‘welfare principle’ that states that children can only consent to treatments which are in their best interest: Gilmour, supra note 61 at 186-87. However, this would make the exercise of autonomy useless. Giving someone autonomy only when they agree with your position is hardly autonomy at all.
\textsuperscript{70} M.L.R.C., supra note 18 at 32.
\textsuperscript{73} Gilmour, supra note 61 at 185.
Even given the above, the low common law threshold for children’s capacity has not apparently been translated into clinical practice.\textsuperscript{75} In reality, children are rarely consulted about their care.\textsuperscript{76} In a study done by Urman, Dickens and Harrison, 14 out of 15 physicians still obtained the consent of parents, unless adolescents attended at a clinic by themselves.\textsuperscript{77} As well, 10 out of 15 of the physicians stated that disclosure was often more complete to parents than to children.\textsuperscript{78} This lack of respect or understanding of children’s capacity to consent is likely linked either to clinicians’ reluctance to accept children’s autonomy, or to a fear that borderline cases will result in liability.\textsuperscript{79} When in doubt, many physicians will involve parents in decision-making about their children. As well, parents are often unwilling to accept the lessening of their authority that accompanies their child’s increased maturity,\textsuperscript{80} and may exert influence over physicians who feel that they owe a duty to parents as well as to their young patients.

When parents are automatically consulted about their capable children, physicians may be breaching the child’s right to confidentiality. It must not be forgotten that it is the child not the parent who is the patient and who is owed the duties that can lead to liability. When the child is not capable, the duty is not held by the parent, but is merely exercised by the parent on the child’s behalf.\textsuperscript{81} Therefore, while it may seem a common sense approach to involve parents in such complex and potentially devastating disclosures such as that of a genetic or biological intersexuality, if the child has the capacity to consent on his/her own behalf, automatic disclosure to a parent without a child’s consent would in fact breach a child’s right to medical confidentiality.

Therefore, the law of capacity calls for a clear decision about whether a patient is capable of consent. There is no halfway point for mature children — capacity is an all-or-nothing state.\textsuperscript{82} Physicians must determine whether a child is capable of consenting to treatment decisions regarding the diagnosis at hand. Of course a physician is free to ask a capable child whether she or he would like to have his/her parents informed about the diagnosis, but physicians ought not to assume that parents are automatically owed this information. And as shown above, even a situation as potentially disturbing as that involving intersexuality must not automatically involve disclosure to parents. Capable children must be allowed to make their own healthcare decisions without interference by well-meaning parents or physicians.

\textsuperscript{1}Certainly not in the case of intersexuality: supra note 5.
\textsuperscript{2}McCall & Robertson, supra note 67 at 166.
\textsuperscript{3}Supra note 31 at para. 12.
\textsuperscript{4}Even if the children were considered capable: ibid. at para. 15.
\textsuperscript{5}Picard & Robertson, supra note 15 at 74-75.
\textsuperscript{6}M.L.R.C., supra note 18 at 31.
\textsuperscript{7}Because the parent is assumed to be in the best position to determine what is in the best interest of the child: R.(R.) v. Children’s Aid Society of Metropolitan Toronto, [1995] 1 S.C.R. 315; Gilmour, supra note 61 at 180-81.
\textsuperscript{8}Caulfield & Knoppers, supra note 72 at para. 4.
And just as the therapeutic privilege exception ought not to become the front for this well-intentioned interference, so too incapacity must not merely be a “policy shortcut.” If abortion is not out of the reach of capable children, surely information relating to other sensitive topics such as a diagnosis of intersexuality must not be artificially placed out of their reach. Clinicians must understand that, although the provision of this information to children may make parents uncomfortable, this is the right of the capable child under the law as it is now formulated. Discomfort on the part of parents or physicians must not allow for the confusion of pre-existing legal categories. A child is capable if she or he understands the nature and consequences of a particular treatment. And information regarding that treatment, and certainly regarding the diagnosis itself, must only be withheld if it is reasonably certain to cause serious harm to the child. Though physicians and parents may wish to insert other considerations into these scenarios, neither category should be confused for the other, nor should they be used to circumvent rights given to capable children.

Potential Liability for Misuse of the Therapeutic Privilege/Capacity Doctrines

As expounded above, the purpose of informing patients and of obtaining their consent is in order to prevent unwanted interference with the bodily integrity as this would constitute a battery. In order to preserve the right to self-determination, consent must be obtained before any contact occurs. Absent consent, “any unauthorized physical interference with a person, whether or not that interference causes injury,” is a battery that is actionable under tort law. No special exception is made for medical treatment; all touching, whether direct or indirect, must be consented to, or the person doing the touching is liable for a battery.

Any non-consensual medical touching may be a battery, even if this treatment is in the best interest of the patient. In *Malette*, for example, the patient’s life was possibly saved by the blood transfusion given, but this did not prevent the doctor’s liability for the tortious act. Consequently, a physician is responsible not only for any injury or damage caused by the treatment, but for all of its direct consequences as well. This may include emotional harm, because, while physical harm is additionally compensable, it is not necessary to show actual physical injury in order to prove a battery. This action is also beneficial to the plaintiff, as the onus rests

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84*Malette, supra* note 9.
86Direct touching would involve, for example, surgery, whereas indirect touching might involve something such as the provision of a medication.
87Nelson, *supra* note 85 at 114. This is unlike a negligence action that only allows compensation for foreseeable harm.
with the doctor to prove that there was consent to the medical procedure in question.88

Liability for battery could possibly be applicable in the case of a physician’s withholding of a diagnosis of intersexuality from a capable child or adolescent. If the child was not found to be capable, consent from a parent or guardian would suffice and there would be no liability for battery. Conversely, if the child were capable, the physician must obtain the child’s consent or any touching would constitute a battery. However, the mere withholding of a diagnosis without any further treatment or touching would not constitute battery. Possibly, the instance where the diagnosis was withheld but the treatment itself was otherwise explained and consent was sought would not constitute a battery.89 The most likely instance where the withholding of information would be considered a battery is that of a physician withholding diagnostic information from a competent child and performing a procedure or treatment without consent or explanation. For instance, this might occur if the physician explained that the treatment was “routine,” or “for the patient’s good.” If a physician lies to a patient in order to obtain consent, this is also battery, as fraud vitiates consent.90 Patients, including competent children, must be informed of the nature and consequences of the treatment or its application will amount to battery.

The only issue that would then remain for the court to decide, if battery were proven, would be the issue of damages. While in Malette the plaintiff received an award of $20,000 even though the treatment was said to have saved her life, this amount may well be deceiving. That case involved the patient’s highly believable emotional distress upon receiving a treatment that she was not only strongly opposed to, but that was in fact contrary to her religious beliefs. The damage to her dignity may well be greater than would occur to the typical plaintiff in her situation. Therefore, while injuries to a plaintiff’s emotional being or to his/her dignity are actionable, the ensuing damages may well be minimal.91 Of course, any physical injury that results from the treatment, even if it is competently administered by the physician, will be compensated in an award for damages.

88Or to prove that there was an emergency which did not allow sufficient time to obtain consent.
89Unless it was found that one could not consent to a treatment without knowing of the diagnosis because this would not indicate an understanding of the consequences of treatment.
90Nelson, supra note 85 at 110.
91The defendant’s lawyer unsuccessfully argued before the Court of Appeal that because the treatment was performed in good faith and was therefore merely a technical battery, the damages ought to be merely nominal. This argument was rejected because the Court felt that the damages “cannot be said to be beyond the range of damages appropriate to a tortious interference of this nature,” supra note 9 at 339.
Another cause of tortious liability open in this situation is a negligence action alleging lack of informed consent.\footnote{As well, not involving a child in discussions about treatment outcomes may arguably be negligent because the child’s input is necessary to track the success of the adopted gender identity: see Wilson & Reiner, supra note 3 at 365-66.} Because a physician must give sufficient information to a patient regarding the consequences and material risks of the proposed treatment, any insufficiency in the amount of information proffered may be determined by the court to be insufficient. However, because of the confusion regarding the concepts of capacity and the therapeutic privilege exception, physicians may be tempted not to inform children or adolescents of the information necessary for an autonomous decision. Physicians cannot avoid a discussion of the risks of a procedure or treatment unless they are also invoking the therapeutic privilege for this, as well as for the diagnosis. And of course this would require the same strict analysis as required for the invoking of the privilege regarding the diagnosis. Physicians already uncomfortable with the necessity of disclosing information regarding intersexuality may be tempted to withhold further information about treatment or its risks. This temptation must be avoided if there is to be no fear of a negligence suit.

As well, it is arguable that consent to a treatment cannot be truly informed if the nature of the diagnosis calling for the procedure is not fully explained. It is conceivable that a patient who does not understand the reason for the treatment cannot consent to it.\footnote{See note 89 above.} Or, if this is not the case, it is also arguable that not knowing of a diagnosis means that informed consent is not possible. Physicians have the duty to inform their patients of the alternatives to the treatment being offered,\footnote{Picard & Robertson, supra note 15 at 130. Even if this requirement were narrowly defined, it would apply nonetheless if the diagnosis or much of the information about the treatment were withheld.} something not possible if the diagnosis or the treatment itself is not explained. Patients not told of their diagnosis of intersexuality cannot get counseling, cannot join peer support groups, and certainly cannot research their conditions further or obtain a second opinion as to treatment.\footnote{Dreger, supra note 47 at 352.}

The disadvantage to a plaintiff arguing a negligence claim is that it is much harder to prove this claim than it is to prove a battery claim. Not only is the onus of proof on the plaintiff as opposed to on the physician, the plaintiff must prove that but for the lack of disclosure, the injury in question would not have occurred. Essentially, this means that the plaintiff must prove that, if they had been fully informed, they would not have consented to the treatment. The standard of proof is a modified objective one: what would the reasonably prudent person in the plaintiff’s position and circumstances have done?\footnote{Reibl, supra note 11 at 15.} The injury need not be caused by the item not disclosed.\footnote{Hopp v. Lepp (1980), 112 D.L.R. (3d) 67 (S.C.C.) at 78.} However the injury in a negligence suit must be
reasonably foreseeable. Causation is notoriously difficult to prove in negligence suits. This is in part due to the fact that courts will accept as evidence that reasonable patients trust their doctors, and therefore that most patients do as their physicians instruct. There is no indication that the situation of intersexuality would be any different in this regard.

Another disadvantage of a negligence claim is that, unlike a claim for battery, there is no claim without actual injury reasonably foreseeable by the clinician. Such injury need not be physical; psychiatric injury may also be compensated. As well, the injury may be the child’s worsening condition or that the failure to inform prevented the family seeking other treatment or counseling. However, it must be cautioned that a mere loss of a chance to improve the child’s health is not actionable: the treatment must be proven on a balance of probabilities to have offered an improvement. In the case of an intersex child, it is arguable that a child’s emotional health may worsen if the condition is in some way apparent to the child but is not addressed. It is also arguable that, much as religion was inviolable and sacrosanct in Malette, sexual identity is equally inviolable to a patient, and certainly to an adolescent. Therefore, any unwanted interference with a capable adolescent’s biological sexual identity may cause compensable psychological injury. However, the more tenuous the connection between the injury and the clinician’s actions, the less foreseeable are the injuries, and the less likely it is that a court will award damages.

Another possible action against a clinician is an action for breach of the duty of confidentiality. Much as patient integrity and autonomy must be encouraged and protected in the realm of medical decision-making, so too do these ideals lead to the need for confidentiality. As well, confidentiality is required to maintain the integrity of the doctor-patient relationship and to encourage the complete honesty and trust of the patient. The Supreme Court of Canada in McInerney found that medical confidentiality is almost inviolate: it is absolute unless there is a paramount

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98 This is a question of remoteness: Picard & Robertson, supra note 15 at 161.
99 Most plaintiffs in negligence suits fail: ibid. at 162.
100 Ibid. at 164.
101 Unless it were accepted that the current furor surrounding the treatment of intersexuality was likely to indicate that a patient would not consent to treatment. However, see Arndt v. Smith (1997), 148 D.L.R. (4th) 48 (S.C.C.). This decision has been criticized: Nelson & Caulfield, supra note 41.
102 A.M. Linden & L.N. Klar, Canadian Tort Law, 10th ed. (Toronto: Butterworths, 1994) at 429 ff.
103 The law of tort will not compensate a mere loss of chance: Picard & Robertson, supra note 15 at 166.
104 Not only is intersexuality said to cause shame in the patients in question, “[t]hese individuals report that this shame was further exacerbated by doctors withholding information, which implied that their condition was too shameful to discuss”: Howe, supra note 5 at 338. This is not surprising, given the fact that it is “hard not to know something is wrong when doctors keep examining your genitals”: Dreger, supra note 47 at 352.
105 There may be an action under contract law or under provincial privacy legislation: see M. Marshall & B. von Tigerstrom, “Confidentiality and Disclosure of Health Information” in Downie & Caulfield, supra note 16 at 158. As well, there may be sanctions by a clinician’s professional body. For the sake of brevity these will not be addressed further.
106 Ibid. at 344.
Physicians have a fiduciary obligation to preserve the confidentiality of their patients’ health information. Physicians must act with utmost good faith and loyalty toward their patients, and this includes a duty to preserve their confidences. Even a well-meaning breach such as that of the unsolicited inclusion of parents in the decision-making process would be actionable at common law. There may be an action for a breach of fiduciary duty in the case of the disclosure of intersex diagnosis or treatment options.

However, the common law is arguably overwritten following the passage of the new Health Information Act in Alberta. This Act provides that

35(1) A custodian may disclose individually identifying diagnostic, treatment and care information without the consent of the individual who is the subject of the information

... (b) to a person who is responsible for providing continuing treatment and care to the individual,

(c) to family members of the individual or to another person with whom the individual is believed to have a close personal relationship, if the information is given in general terms and concerns the presence, location, condition, diagnosis, progress and prognosis of the individual on the day on which the information is disclosed and the disclosure is not contrary to the express request of the individual,

(d) where an individual is injured, ill or deceased, so that family members of the individual or another person with whom the
individual is believed to have a close personal relationship or a friend of the individual can be contacted, if the disclosure is not contrary to the express request of the individual,

... 

(n) if that individual lacks the mental capacity to provide a consent and, in the opinion of the custodian, disclosure is in the best interests of the individual.

Therefore, a physician could disclose information to a parent or guardian of even a capable child without his or her consent, unless this was expressly disallowed by the patient. Under this Act, it would certainly be permitted to “go over a child’s head” before the child were given the opportunity to expressly disallow this conduct. Although the interpretation of this provision remains to be seen, this Act may well preclude any true recognition of a capable child’s right to medical confidentiality.

**Conclusion**

While a capable child may well be owed various legal and ethical duties by the clinicians involved in diagnosing and treating intersex conditions, in the long run, the legal remedies provided for their protection appear ill-suited to the task. Legislation may override duties of caregivers as surely as abuses of capacity and consent doctrines override the autonomy of children and adolescents. Fundamentally, intersex children are often deprived of choice by the medical profession and by parents, both because of a “discomfort” with intersexuality, and because of confusion or suspicion of legal doctrines.

Clinicians must be cognizant of the rights of patients not merely because they fear liability repercussions, but because they are willing to work with patients as equals in the decision-making process. Physicians understand more of the physiological workings of the body but they cannot be said to be more competent to make decisions affecting something as fundamental to personhood as a patient’s sex. Ultimately, it is the capable patient (whether child or adult) who must make such a decision. Respect for patient autonomy calls for nothing less.

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111Dreger, *supra* note 47 at 352.