



**CAN DOCTORS LIE TO THEIR PATIENTS? A CONSTITUTIONAL
INQUIRY INTO THERAPEUTIC PRIVILEGE IN KENYA.**

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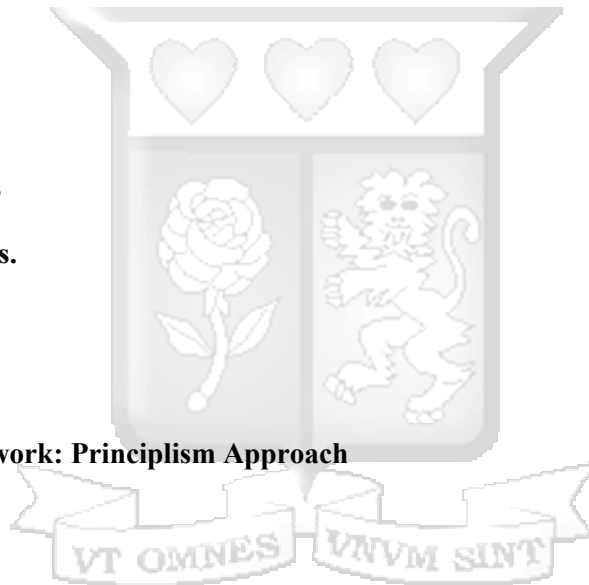
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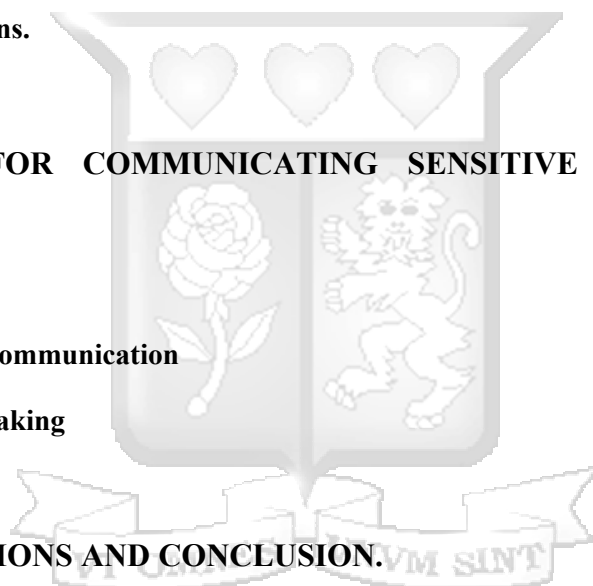
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DECLARATION

I, **LYNN SANAIPEI PARIT**, do hereby declare that this research is my original work and that to the best of my knowledge and belief, it has not been previously, in its entirety or in part, been submitted to any other university for a degree or diploma. Other works cited or referred to are accordingly acknowledged.

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Date:



This dissertation has been submitted for examination with my approval as University Supervisor.

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ABSTRACT

This study focuses on the constitutional validity and the ethical justification of therapeutic privilege within Kenya's healthcare system, focusing on section 8(a) of the Health Act. Therapeutic privilege allows healthcare providers to withhold medical information from patients if disclosure is believed to cause harm. While it is intended to protect vulnerable patients, the study argues that this provision is vague and lacks adequate safeguards, leading to potential violations of patients' constitutional rights, including the right to life (Article 26), health (Article 43), dignity (Article 28), and access to information (Article 35) under the Constitution of Kenya.

The study examines the conflict between medical paternalism and patient autonomy, highlighting the moral necessity of informed consent and based on the principles of justice, autonomy, non-maleficence, and beneficence. Through a comparative analysis of legal practices in the United States and South Africa, the study highlights how other jurisdictions have narrowly defined and strictly regulated the application of therapeutic privilege. The insights are used to critique Kenya's legal position and advocate for legal reform.

The dissertation concludes that the current legal framework inadequately balances patients' rights with clinical discretion and calls for a legislative amendment to section 8 of the Health Act. The proposed reform would introduce procedural safeguards, require justification, and oversight for withholding information, and prioritize transparency and shared decision-making in clinical practice.

LIST OF ABBREVIATIONS

CoK – Constitution of Kenya, 2010

KMPDC - Kenya Medical Practitioners and Dentists Council.

WHO – World Health Organization

UN – United Nations

UN CESCR – United Nations Committee on Economic, Social, and Cultural Rights



LIST OF CASES

Al Hamwi v Johnston and the Northwest London Hospitals [2005], The United Kingdom House of Lords.

Canterbury v Spence [1972], The Supreme Court of United States.

Castelle v De Greef [1994], Constitutional Court of South Africa.

Cobbs v Grant, [1972], The Supreme Court of United States.

Donoghue v Stevenson, [1932], The United Kingdom House of Lords.

Francis Coralie Mullin v The Administrator, Union Territory of Delhi [1981], The Supreme Court of India.

Halushka v. University of Saskatchewan [1965], The Court of Appeal of Saskatchewan.

Hopps vs Lepp [1980], The Supreme Court of Canada.

Lane v Candura [1978], The Supreme Court of the United States.

McInerney v Mcdonald [1992], The Supreme Court of Canada.

Meyers Estate v Rogers, [1991], The Supreme Court of Canada.

Nairobi Law Monthly Company Limited v Kenya Electricity Generating Company & Others [2013] eKLR.

Pittman v Bain, [1994], The Supreme Court of Canada.

P.A.O. & others v. Attorney General [2012] eKLR

Reibl v Hughes [1980], The Supreme Court of Canada.

Sidaway v Board of Governors of the Bethlehem Royal Hospital [1985], The United Kingdom House of Lords.

Starzon v Swayze [2003]. The Supreme Court of Canada.

Teik Huat Tai v Saxon [1996], The Supreme Court of Australia



LIST OF LEGAL INSTRUMENTS

Constitution of Kenya, 2010.

Health Act (Act No.21 of 2017).

Section 6(2), Access of Information Act (No.31 of 2016)

African Charter on Human and Peoples' Rights (1981).

International Covenant on Economic, Social and Cultural Rights (1966).

International Covenant on Civil and Political Rights (1966).



1.0. INTRODUCTION.

1.1. Background

The complex relationship between medical ethics and legal frameworks is especially evident when considering the fine line that separates patient autonomy from healthcare providers' paternalistic behavior. Therapeutic privilege, a doctrine that allows healthcare providers to withhold information from patients, is one such area of tension.¹ This paper aims to delve into the use of therapeutic privilege in Kenya, examining its compatibility with the country's constitutional provisions and ethical considerations. A long-standing medical practice known as therapeutic privilege allows medical professionals to keep information from patients if they thought it would harm them.² The idea that doctors are the best people to decide what information is helpful or harmful to a patient's health because they are experts is the foundation of this intrusive approach. However, the justification for withholding information often rests on subjective assessments and can vary widely between healthcare providers.

The Constitution of Kenya, (herein referred to as CoK) enshrines fundamental human rights, including the right to life, health, and information. These rights are essential for individual autonomy and well-being. The CoK guarantees the right to the highest attainable standard of health, which encompasses access to health services, information, and education.³ Additionally, it guarantees the right to information, empowering individuals to make informed decisions about their lives, including their health.⁴ Furthermore, Article 26 protects the right to life,⁵ as read with Article 25, which is linked to the right to basic healthcare and being able to access accurate health information that is essential for making informed decisions about someone's health and well-being.⁶

¹ Shalak M, Doddapaneni V, and Shariff M, 'The truth, the whole truth, nothing but the truth' Therapeutic privilege 2022 <https://pmc.ncbi.nlm.nih.gov/articles/PMC9733515/> on 11 February 2025.

² Shalak M, Doddapaneni V, and Shariff M, 'The truth, the whole truth, nothing but the truth' Therapeutic privilege 2022 <https://pmc.ncbi.nlm.nih.gov/articles/PMC9733515/> on 11 February 2025.

³ Article 43, *Constitution of Kenya* (2010).

⁴ Article 35, *Constitution of Kenya* (2010).

⁵ Article 26, *Constitution of Kenya* (2010).

⁶ Article 25, *Constitution of Kenya* (2010).

A legal foundation for the practice of medicine and healthcare in Kenya is also provided by the Health Act of Kenya. It includes provisions related to informed consent, confidentiality, and the disclosure of medical data. While the Act does not explicitly address therapeutic privilege, it does outline circumstances under which healthcare providers may withhold information from patients. Section 8 of the Health Act provides that every health care provider shall inform a user of health information or, where the user of the information is a minor or incapacitated, inform the guardian of the user's health status, except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user.⁷ This provision raises questions about the interpretation of “best interests” and the potential for abuse of discretion by healthcare providers.

This provision may undermine their constitutional rights. Healthcare providers may violate Article 35 of the CoK by preventing patients from making informed decisions about their care and treatment. This may also violate Article 28 of the CoK, which protects patients' autonomy and dignity.⁸ Withholding information can jeopardize a patient's right to health by preventing them from making educated decisions about their care and health.⁹ This could accordingly result in death, which goes against the right to life enshrined in the CoK.¹⁰

Cobbs v. Grant established a legal requirement for informed consent in the practice of medicine. It was decided that a doctor has an obligation to tell a patient everything that could influence their choice. The court insisted that the physician’s duty to disclose is not simply a medical standard practice but a fiduciary duty that is imposed by law.¹¹ A doctor owes a patient this duty as a patient is a neighbor to a doctor is law as per the case of *Donoghue v Stevenson*.¹² This means that if information is important to the patient's decision, the doctor is required by law to disclose it.

A doctor was found negligent in the *Pitmann Estate v. Bain* case for failing to disclose to a patient and his spouse that he had contracted HIV from a blood transfusion.¹³ The doctor may have been

⁷ Section 8, *Health Act* (Act No.21 of 2017).

⁸ Article 28, *Constitution of Kenya* (2010).

⁹ Article 43, *Constitution of Kenya* (2010).

¹⁰ Article 26, *Constitution of Kenya* (2010).

¹¹ *Cobbs v Grant*, (1972), The Supreme Court of United States.

¹² *Donoghue v Stevenson*, (1932), The United Kingdom House of Lords.

¹³ *Pitman v Bain* (1994), The Supreme Court of Canada.

worried about the therapeutic privilege, but the court determined that it was not justified. patient's depression. In this instance, the doctor's discretion should have been superseded by the patient's right to know their current health status.

In an effort to reduce the risk of breast cancer, the patient in the South African case of *Castelle v. De Greef* (1994) had a bungled preventative double mastectomy and breast reconstruction. By outlining the potential hazards of the recommended course of therapy, the doctor hoped the patient would change their mind. The doctor has an obligation to warn a patient who is giving their permission to a potentially dangerous therapy because the patient's interest is in getting treatment.¹⁴

These cases unequivocally demonstrate that there is no basis for claiming therapeutic privilege, even in situations where the physician is aware that doing so would cause the patient to refuse payment. In the case of *Teik Huat Tai v Saxon*, the doctor was found negligent for withholding information from a patient that they could potentially get a rectovaginal fistula that could potentially lead to a hysterectomy and then vaginal damage.¹⁵ Because of the patient's depression and anxiety, the doctor invoked the defense of therapeutic privilege. The court decided that this was insufficient justification for hiding such crucial information.

In Kenya, the court reaffirmed the constitutional right to information in health care services, not limited to medical records.¹⁶ Justice H. Ogungi had found Nairobi Women's Hospital to have violated this right when they withheld patients' medical records that included clinical notes, nurses' notes, nursing kadex, consent forms, and theatre operation notes. The court determined that by failing to provide the patient with the information she requested, the hospital had infringed upon her constitutional rights.¹⁷ The court affirmed "the right to information should not be affected by the reason why a patient seeks that information." Both state and non-state actors are held accountable if they do not follow this rule.¹⁸ The decision emphasizes on the connection between the right to health and the right to information, stressing that having access to information is crucial

¹⁴ *Castelle v De Greef* (1994), Constitutional Court of South Africa.

¹⁵ *Teik Huat Tai v Saxon* (1996), The Supreme Court of Australia.

¹⁶ <https://www.kelinkkenya.org/court-reaffirms-the-constitutional-right-to-information-including-to-access-medical-records/#:~:text=Ong'udi%20held%20that%20the,a%20citizen%20seeks%20the%20information.%E2%80%9D> on 21 January 2025.

¹⁷ Article 35, *Constitution of Kenya* (2010).

¹⁸ Section 6(2), *Access of Information Act* (No.31 of 2016)

for good health outcomes. This decision serves as a warning to healthcare facilities, both public and private, that routinely deny patients access to their medical records.

In medical practice, therapeutic privilege should not be permitted under the aforementioned conditions. The 1991 case *Meyers Estate v. Rogers*, in which a patient passed away following an intravenous injection of a contrast agent for a standard radiologic procedure, lends credence to this.¹⁹ The physician had intentionally refused to tell the patient of the plausible risks that could be incurred by the injection. The physician later in court brought about therapeutic privilege as a defense on his part. The court stressed that therapeutic privilege was not supported in their state in any way and provided the justification that granting a doctor the authority to choose whether to reveal critical information to a patient could undermine informed consent. This being a practice that is allowed in Kenya could create a thin line between informed consent and the privilege, hence making it an informal decision that is not backed up by law, and this could result in a lot of harm to patients.

1.2. Problem Statement

Patient autonomy and the concepts of informed consent are compromised by the aforementioned practice, which presents serious ethical and legal issues. While people may argue that it can be used to protect patients from harm. Certain courts have acknowledged the therapeutic privilege of upholding the principle of "*primum non nocere*," or "first do no harm." It could also potentially limit patient autonomy and prevent them from making informed decisions. This can consequently result in suboptimal health outcomes and risks that could lead to death. If physicians fail to disclose the risks because they feel it is in the patient's "best interest" to remain ignorant, patients may grow suspicious of the treatments. This paper aims to show how the above practice is not ethically justifiable and information is information, whether good or bad, and withholding information requires a greater justification than a patient's sensitivity to information.

The CoK protects the rights to information, health, life, and dignity. These rights are interrelated and necessary for personal welfare. Therapeutic privilege undermines all these fundamental rights, therefore making Section 8(a) of the Health Act inconsistent with the CoK. In Kenya, it is critical

¹⁹ *Meyers Estate v Rogers* (1991), The Supreme Court of Canada.

to reconsider the idea and make sure it adheres to all of the aforementioned guidelines. Ethical considerations further challenge the justification of it. A physician who ethically withholds information violates the ethical principles of autonomy, beneficence, and nonmaleficence in addition to their fiduciary duty to act in good faith. The purpose of this essay is to present the moral and legal justifications for providing patients with accurate information.

1.3. Research Questions

1. To what extent is the practice of therapeutic privilege under Section 8(a) of the Health Act compatible with the fundamental rights to life, health, and information in Kenya?
2. How do common law countries, such as the United States, Canada, and South Africa, legally and ethically regulate the practice of therapeutic privilege?
3. What are the best practices for communicating complex medical information to patients while respecting their autonomy and minimizing the potential harms of disclosure?

1.4. Research Objectives.

1. Critically examine the practice of therapeutic privilege under Section 8(a) of the Health Act compatible with the fundamental right to life, health, and information in Kenya.
2. To analyze the legal and ethical frameworks governing therapeutic privilege in common law countries, such as the United States, Canada, and South Africa.
3. Develop recommendations for ethical decision-making regarding the use of therapeutic privilege in clinical practice.

1.5. Hypothesis

The practice of therapeutic privilege as enshrined in Section 8(a) of the Health Act is incompatible with fundamental rights of life, health, and information.²⁰ Due to this legal provision, patients can choose to withhold important medical information, which limits the capacity to make well-informed decisions about their medical care. The research aims to demonstrate the need for the re-evaluation of therapeutic privilege in Kenya, advocating for a patient-centered approach that prioritizes transparency.

1.6. Justification

The study's justification stems from the increasing necessity to guarantee that Kenya's health regulations conform to the fundamental values of accountability, transparency, and human rights protection. However, the incorporation of therapeutic privilege under Section 8(a) of the Health Act creates a legal ambiguity that potentially undermines the constitutional rights as stated above.²¹ A cornerstone of contemporary healthcare is informed consent, which acknowledges patients' right to make treatment decisions after receiving complete and accurate information. By permitting the withholding of information, therapeutic privilege challenges this principle and may contribute to condescending practices that disempower patients.

Kenya's healthcare system provides care for a wide range of people, including vulnerable populations like women, children, people with disabilities, and rural residents. These populations often face barriers to accessing information and healthcare services, which are further exacerbated by legal provisions that limit transparency. The potential misuse or overapplication of therapeutic privilege could put them at a higher risk of experiencing barriers to health care access that eventually disproportionately affect these groups. This study seeks to examine whether Section 8(a) aligns with the constitutional provisions that safeguard patient rights and autonomy.²² By exploring the tension between therapeutic privilege and the Constitution, the research will provide critical insights into how health laws can be reformed to better uphold the rights of individuals while balancing the ethical obligations of healthcare providers. Additionally, it will add to the

²⁰ Section 8, *Health Act* (Act No.21 of 2017).

²¹ Section 8, *Health Act* (Act No.21 of 2017).

²² Section 8, *Health Act* (Act No.21 of 2017).

continuing discussion about patient-centered care and the legal requirements needed to provide healthcare in a fair and open manner. This study is essential to ensuring that Kenya's health legislation aligns with constitutional principles and international best practices. The findings will inform policymakers, fostering a system that respects and upholds the dignity and autonomy of all patients.

1.7. Theoretical Framework: Principlism Approach

To answer an ethical dilemma, some ethicists rely on ethical theories to provide answers to whether something is right or wrong. The ethical theories provide a comprehensive explanation that guides certain moral reasoning and decision-making in complex situations. For instance, proponents of Kantian ethics emphasize the importance of treating every individual with inherent dignity and respect.²³ They argue that moral actions are those based on universal principles or rules that all rational beings can accept and endorse without contradiction. This theory prioritizes consistency, fairness, and respect for autonomy in moral reasoning.

In contrast, consequentialists focus on the outcome of the actions that determine their moral value.²⁴ According to this view, the right course of action is the one that generates the greatest number of positive effects with less harm. The emphasis is on maximizing overall well-being and reducing suffering, with a practical, results-oriented approach to ethics. Virtue ethicists prioritize the cultivation of moral character and personal virtues.²⁵ They contend that ethical actions are those that contribute to the development of good character traits that ultimately lead individuals to live fulfilling and meaningful lives. Rather than outcomes, virtue ethics emphasizes the moral development of individuals.

When making moral decisions, care ethicists take a position that highlights the significance of emotional bonds and interpersonal interactions.²⁶ They argue that morality should center on feelings of care, sympathy, and compassion that we have for others and the responsibilities we hold within our interpersonal relationships. These diverse theories show the importance of moral

²³ <https://1000wordphilosophy.com/2014/06/09/kantian-ethics/> on 21 December 2024

²⁴ <https://1000wordphilosophy.com/2014/05/15/consequentialism/> on 21 December 2024

²⁵ <https://www.britannica.com/topic/virtue-ethics> on 20 November 2024.

²⁶ <https://ethics.org.au/ethics-explainer-ethics-of-care/> on 16 December 2024.

philosophy in offering various ways to approach questions of right and wrong. Each perspective holds different dimensions of human experience and moral reasoning, providing valuable insights into how we navigate ethical dilemmas in our lives. One of the moral philosophies that will be discussed in the paper is principlism.

The application of ethical principles is the focus of the applied ethics approach known as principlism, which is used to address moral dilemmas.²⁷ This approach to ethical decision-making has previously been used in a variety of contexts, owing to its ability to avoid complex theoretical debates in moral philosophy. This ethical framework is rooted in four core principles: justice, autonomy, non-maleficence, and beneficence.²⁸ The idea of autonomy emphasizes the need of respecting patients' autonomy, which goes beyond their capacity to make informed decisions about their own medical care.²⁹ Doctors should empower their patients to make choices that align with their values and beliefs. Withholding information from a patient may jeopardize their autonomy and ability to make informed healthcare decisions.

Modern medical ethics, on the other hand, strongly oppose such paternalistic methods, highlighting the value of making educated decisions and upholding patients' autonomy. Nonetheless, conflicts between these ethical principles still arise. For instance, consider a patient with strict religious beliefs who refuses a simple yet life-saving treatment, such as a blood transfusion. From the perspective of beneficence, medical practitioners might advocate for the transfusion to save the patient's life. However, they may ultimately choose to respect the patient's autonomy, even if it means honoring their decision to refuse treatment, knowing it could lead to their death. Balancing these principles remains one of the most challenging aspects of medical ethics.³⁰

Justice is a principle that requires a fair and equitable distribution of healthcare resources and treatment. It entails treating every patient with dignity and respect, irrespective of their financial or social standing. Therapeutic privilege can lead to discriminatory practices, as it may be used with certain patient populations, such as the elderly, the mentally ill, and those from marginalized

²⁷ Encyclopedia Britannica, 7ed.

²⁸ Childress J and Beauchamp T, *Principles of Biomedical Ethics*, 5th ed, New York: Oxford University Press. (2007) 32.

²⁹ <https://pmc.ncbi.nlm.nih.gov/articles/PMC7923912/> on 4 January 2025..

³⁰ <https://pmc.ncbi.nlm.nih.gov/articles/PMC7923912/> on 4 January 2025.

groups.³¹ As citizens with healthcare rights, they bear unnecessary burdens and do not have equal access to medical resources. However, improving healthcare team training, revising intake procedures, and considering patient experiences can all help to improve access to community resources. And this is all much more just. With all the principles, no single principle takes priority over the other. According to Beauchamp and Childress, ethicists must attempt to strike a balance between the conflicting demands of the cases and the principles when they clash. Beauchamp and Childress argue that the best way to deal with ethical quandaries is to have a critical and inclusive conversation with all parties involved, even though this does not guarantee a particular result.³² Considering the impact of their strategy, they might be correct. Unless it contradicts another principle in every situation, each of the four ethical principles should be viewed as a prima facie duty that must be fulfilled. When faced with such a dilemma, the doctor must assess the conflicting prima facie obligations based on context and substance in order to identify the true duty to the patient.³³

1.8. Literature Review

Informed consent currently mandates that doctors provide "any facts that are necessary to form the basis of the patient's intelligent consent to the proposed treatment." The definition of "facts that are necessary" was then established.³⁴ The diagnosis, the nature and goal of the proposed intervention, the likely risks and benefits of the intervention, alternatives to the proposed intervention, including the risks and benefits of each option, and the repercussions of declining or not intervening must all be disclosed for informed consent to be obtained.³⁵ Therefore, the right to the truth necessitates giving the patient all relevant facts so they can make an informed choice. However, the use of this notion presents significant challenges in practice, irrespective of the interpretation provided.³⁶

³¹ <https://pmc.ncbi.nlm.nih.gov/articles/PMC7923912/> on 4 December 2024.

³² Childress J and Beauchamp T, *Principles of Biomedical Ethics*, 5th ed, New York: Oxford University Press. (2007) 32.

³³ <https://pmc.ncbi.nlm.nih.gov/articles/PMC7923912/> on 4 December 2024.

³⁴ Paterick J, 'Medical informed consent' General consideration for physicians, 2008, [https://www.mayoclinicproceedings.org/article/S0025-6196\(11\)60864-1/fulltext](https://www.mayoclinicproceedings.org/article/S0025-6196(11)60864-1/fulltext) on 2 March 2025.

³⁵ Paterick J, 'Medical informed consent' General consideration for physicians, 2008, [https://www.mayoclinicproceedings.org/article/S0025-6196\(11\)60864-1/fulltext](https://www.mayoclinicproceedings.org/article/S0025-6196(11)60864-1/fulltext) on 2 March 2025.

³⁶ Paterick J, 'Medical informed consent' General consideration for physicians, 2008, [https://www.mayoclinicproceedings.org/article/S0025-6196\(11\)60864-1/fulltext](https://www.mayoclinicproceedings.org/article/S0025-6196(11)60864-1/fulltext) on 2 March 2025

First and foremost, there is some degree of ambiguity surrounding the idea of the "right to the truth". What does the term "truth" mean, particularly considering the reality that medical knowledge and practice are always evolving? When evidence-based medicine is articulated in terms of probabilities rather than absolutes, are we speaking of the "truth"? How can one reconcile the patient's world of truth and hope with probabilities? and anticipations, particularly if the data tend to be "unlikely"? Furthermore, this continuously changing body of research-based evidence only represents what we currently know, whereas fresh studies could readily indicate a more recent "truth."³⁷ Despite undeniable scientific advancements, uncertainty persists in medical practice because of the "incomplete state of medical knowledge" and the difficulties in establishing clinical reasoning. Thus, the nature of the problem, the different ways the clinical picture is presented, the limitations of the patient's story, the numerous biases of the different clinical reasoning strategies, the continuously expanding body of medical knowledge, and the limited nature of human rationality all contribute to the need for medical judgment that seeks the "truth" and the inevitable element of uncertainty in medical decisions.³⁸

Over the years, truth-telling has been reviewed extensively, but few have particularly addressed the difficulties non-ethicists face when implementing it in their day-to-day clinical practice. This paper's focus is on this. Thus, using the informed consent rule, which is based on the autonomy principle, cannot be regarded as a mere formality.³⁹ Whether they relate to the diagnosis, the interventions, or the prognosis, the "necessary facts" are more than just logical information. They are not taken for granted. The "necessary facts" identified by the physician in his scientific field are conveyed to the patient as "information" that might cause him to have various "issues." They are involved in a process where the patient and the doctors have differing perspectives and

³⁷ Zolkefli Y, 'The Ethics of Truthtelling in Healthcare Settings.' *The Malaysian Medical Journal of Sciences*, 2018, <https://pmc.ncbi.nlm.nih.gov/articles/PMC6422557/#:~:text=To%20consent%20to%20any%20health,effective%20decisions%20without%20truthful%20information> 28 February 2025.

³⁸ Zolkefli Y, 'The Ethics of Truthtelling in Healthcare Settings.' *The Malaysian Medical Journal of Sciences*, 2018, <https://pmc.ncbi.nlm.nih.gov/articles/PMC6422557/#:~:text=To%20consent%20to%20any%20health,effective%20decisions%20without%20truthful%20information> 28 February 2025.

³⁹ Kettle M, Informed Consent, Its Origin, Purpose, Problems and Limits, Graduate Thesis and Dissertations Working Paper Number.1523, 2002, <https://digitalcommons.usf.edu/cgi/viewcontent.cgi?article=2522&context=etd> on 19 January 2025.

understandings, and how the "facts" are interpreted is influenced by emotion.⁴⁰ In situations like this, mutual trust is essential to the decision-making process. However, the doctor is sometimes caught between the duty to ensure the patient's well-being by alleviating their suffering and the need to give them information so they may make informed, independent decisions. Therefore, the beneficence principle and the necessity of patient autonomy are at odds.⁴¹

Therapeutic privilege was first recognized by the law in the seminal *Canterbury v. Spence* case, where the plaintiff suffered paraplegia after surgery because his physician had neglected to warn of the possibility of paralysis. By acknowledging that patients can occasionally become so emotionally upset when such information is revealed, leading to irrational decisions, they defended therapeutic privilege. It would be legal to withhold such information if it was thought that the patient would be more negatively affected by the disclosure.⁴² Similarly, Lord Scarman used therapeutic privilege as a defense to avoid disclosing crucial information in situations where the physician feels that doing so would cause more harm in the *Sidaway v. Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* case.⁴³

The question Edwin raises is whether therapeutic privilege is ever warranted. How can patients provide informed consent if they are not fully informed? He clarifies that the informed consent doctrine runs counter to the legal justifications for the therapeutic privilege. He contends that a patient's extreme illness or emotional distress after learning certain information should not be an excuse for lying or withholding information from legally competent patients. Since best interests can vary for a variety of reasons, best interest is a subjective and broad concept that should not be used as a basis for claiming therapeutic privilege. According to him, people occasionally become upset, but this does not imply that their capacity for reasoned decision-making is compromised.⁴⁴

⁴⁰ Zolkefli Y, 'The Ethics of Truth-telling in Healthcare Settings.' *The Malaysian Medical Journal of Sciences*, 2018, <https://pubmed.ncbi.nlm.nih.gov/articles/PMC6422557/#:~:text=To%20consent%20to%20any%20health,effective%20decisions%20without%20truthful%20information> 28 February 2025.

⁴¹ Paterick J, 'Medical informed consent' *General consideration for physicians*, 2008, [https://www.mayoclinicproceedings.org/article/S0025-6196\(11\)60864-1/fulltext](https://www.mayoclinicproceedings.org/article/S0025-6196(11)60864-1/fulltext) on 19 January 2025.

⁴² *Canterbury v Spence* (1972), The Supreme Court of United States.

⁴³ *Sidaway v Board of Governors of the Bethlehem Royal Hospital* (1985), The United Kingdom House of Lords.

⁴⁴ Edwin A, 'Don't lie but don't tell the whole truth' *The Therapeutic privilege—is it ever justified?*, <https://pubmed.ncbi.nlm.nih.gov/articles/PMC2673833/#:~:text=Therapeutic%20privilege,-%E2%80%9CThe%20therapeutic%20privilege&text=If%20disclosure%20of%20certain%20information,is%2C%20however%2C%20not%20acceptable> on 4 December 2024.

He clarifies that although emotional factors are unavoidable and inevitable when a serious illness is involved, this does not imply that they will adversely affect their ability to make logical decisions. According to Cote, doctors tend to overjudge patients because they believe that emotions are negative, unscientific, and unpredictable. They also believe that patients may find information difficult to understand. This school of thought prevents doctors from seeing the benefits of disclosure.⁴⁵ Giving patients sensitive information instead of completely withholding it could be one way for doctors to address this. In the case of *Al Hamwi v Johnston and the Northwest London Hospitals NHS Trust (2005)*, According to Justice Simon, a clinician must always exercise reasonable caution when issuing a warning that is appropriate in terms of its scope, content, and presentation. They must also take action to ensure that the warning is understood.⁴⁶

The ethical justification for the therapeutic privilege argument's failure is provided by Beauchamp and Childress. Doctors often use the moral justification that their privilege is advantageous because it prevents patients from harming themselves. The doctors say they support the ideals of beneficence and non-maleficence rather than violate them. Evidence supports the notion that informing patients about their life-threatening conditions helps them make informed decisions about their lives rather than making them more anxious, afraid, or depressed.⁴⁷ Patients communicate more with staff and family members and have more faith in the care they receive as a result. This is due to the possibility that failing to notify patients could damage their faith in medical professionals.

Healthcare providers cannot always be correct because they tend to withhold information because they do not know how the patient will behave, but rather because they believe they will. Non-disclosure cannot be justified by this uncertainty. By knowing what to anticipate, patients can better prepare for what lies ahead, which puts them in a better position even when treatment options are limited. Edwin also admits that there are instances in which patients are unwilling to learn the

⁴⁵ Edwin A, 'Don't lie but don't tell the whole truth' The Therapeutic privilege—is it ever justified? 2008

⁴⁶ *Al Hamwi v Johnston and the Northwest London Hospitals* (2005), The United Kingdom House of Lords.

⁴⁷ Varkey B, 'Principles of Clinical Ethics and Their Application to Practice': *Medical principles and practice: international journal of the Kuwait University*, Health Science Centre, <https://pmc.ncbi.nlm.nih.gov/articles/PMC7923912/> on 4 November 2024.

truth about their illness. Information rights may be waived by the patient, and it is critical to distinguish between the two.⁴⁸ One way to think of a waiver is as a therapeutic privilege.

According to Coetzee, in the event of a lawsuit alleging a lack of informed consent, this privilege may allow a physician to easily defend themselves and shield negligence. The range is too wide to comprehend where physicians can take precautions. When doctors are unable to accurately diagnose a patient's illness, they may use this privilege as a shield and a way to cover themselves. He clarifies that withholding information can have two possible outcomes. It could potentially lead to unnecessary or experimental treatments. Patients might receive expensive and possibly dangerous treatments—with poor success rates and possible side effects—that they would not choose if they were fully informed. This may lead to needless suffering and resource waste. Additionally, it might deter patients from seeking essential and possibly life-saving medical care. Due to perceived risks and expenses, patients may postpone or decline treatments if they are not aware of how urgent their condition is.⁴⁹

1.9. Methodology

This study will depend on qualitative research that will mostly emanate from a literature search from online databases, and the keywords for the research will be therapeutic privilege, patient autonomy, informed consent, medical ethics, physician-patient communication, truth-telling in medicine, end-of-life care, and mental health. I intend my study to be mainly from secondary sources such as research reports, journal articles, chapters in books, and case law. It also relies on primary sources, such as the Health Act of Kenya. This being the case, the study will be mainly desk-based and will utilize a deductive understanding that establishes premises from which the main claim will be derived.

These textbooks will be analyzed to intrigue discussions on therapeutic privilege. These will include the definition and justification for using therapeutic privilege, the ethical consideration of using therapeutic privilege, the practical guidance on when and how to use therapeutic privilege, and case studies or examples illustrating the concept. The collected data will then be systematically

⁴⁸ Edwin A, 'Don't lie but don't tell the whole truth' The Therapeutic privilege—is it ever justified? 2008

⁴⁹ Coetzee L, A Critical Evaluation of The Therapeutic Privilege in Medical Law: Some Comparative Perspectives, 2003, 11, https://journals.co.za/doi/pdf/10.10520/AJA00104051_128 on 11 November 2024

analyzed using thematic analysis. This involves identifying, analyzing, and interpreting patterns and themes within the data. Content analysis will be used to examine the frequency and nature of discussions on therapeutic privilege within the selected textbooks, and the findings of the textbook analysis will be compared with the ethical guidelines and professional codes of conduct.

As this study aims to rely on existing literature, issues of confidentiality and anonymity will not apply. Proper citation and referencing will be used to credit the work of other researchers and avoid plagiarism. This study will be limited to a review of existing literature and may not capture the full range of perspectives and experiences related to therapeutic privilege. The selection of articles may be subject to inherent biases in the literature search process.

1.10. Chapter Breakdown

Chapter One will serve as the prefatory chapter of this study. It entails, among others, the research questions and objectives, the theoretical framework, and the justification of the study, and on that basis, it will set the stage for the subsequent chapters. Chapter two explores the barriers and best practices surrounding informed consent in the Kenyan healthcare system. It highlights legal provisions such as the Constitution and the Health Act, which guarantee patients the right to information and autonomy. The chapter emphasizes that informed consent must be more than a procedural formality; it should be a meaningful process that upholds patient rights.

Chapter three addresses the core research questions, focusing on whether therapeutic privilege is compatible with patients' constitutional rights. It argues that the broad and vague application of therapeutic privilege under Kenyan law undermines the right to information and informed decision-making. A comparative analysis of legal and ethical perspectives reveals growing support for transparency over paternalism.

Chapter four proposes strategies for ethically and effectively disclosing sensitive information to patients and concludes that effective communication is a better alternative to therapeutic privilege and essential for ethical, patient-centered care. The final chapter will conclude the study and calls for amending Section 8(a) of the Health Act to clearly define and limit therapeutic privilege.

2.0. THE DYNAMIC OF INFORMED CONSENT: BARRIERS AND BEST PRACTICES IN THE KENYAN CONTEXT

2.1. Introduction

The problem with therapeutic privilege starts with the violation of informed consent. Informed consent is limited by therapeutic privilege, which is acceptable in certain situations but problematic when abused. A well-rounded strategy is required in which physicians are held to ethical standards to guarantee that patients' autonomy is upheld while simultaneously shielding them from needless suffering. There is a knowledge asymmetry between patients and healthcare professionals in third-world nations with low literacy rates, like Kenya.

2.2. The Barriers of Inadequate Information and Informed Consent

In Kenya, patients' inability to obtain adequate, pertinent, or easily accessible information is a major obstacle to informed consent. Physicians frequently believe that signing a preprinted consent form or providing a brief verbal explanation meets the ethical and legal requirements for informed consent. However, this practice falls short of ensuring that the patient is genuinely informed. Several studies have demonstrated that the information shared with patients is either incomplete or delivered in a manner that is not conducive to understanding. A study conducted at the University of Benin Teaching Hospital revealed that only 60.9% of id were given an opportunity to inquire further before surgery.⁵⁰ Half of the patients expressed dissatisfaction with the amount of information provided, and some admitted they only signed consent forms to avoid cancellation of their procedures. Similarly, in the Kilifi “Consent Study” by Molyneux, participants often could not distinguish between clinical treatment and research, indicating how crucial and fragile the communication chain is in ensuring proper understanding.⁵¹

Overburdened public healthcare systems in Kenya, where physicians are under pressure to see many patients in a short amount of time, exacerbate the issue. This frequently leads to a hurried consent procedure where thorough justifications are foregone in favor of expediency. Instead of

⁵⁰ Osime O, ‘Current Practices and Medico-Legal Aspects of Informed Consent.’ 2004. East African Medical Journal 81(7): 331-335

⁵¹ Molyneux C, ‘The Myths and misunderstandings of 'informed consent' In: Understanding of Informed Consent in a low-income setting: three case studies for the Kenyan Coast', Social Science and Medicine, 2024 59: 2547-2559.

being a well-considered exception based on the patient's best interests, therapeutic privilege runs the risk of turning into a general justification for non-disclosure when it is used in such circumstances.

2.3. The Influence of Linguistic Diversity on Informed Consent

Kenya is a linguistically diverse country with over 40 indigenous languages and two official languages which are English and Kiswahili. While many patients may understand Kiswahili or English, the level of fluency and literacy varies significantly depending on factors such as education level, geographical location, and socio-economic status.

According to the Belmont Report, informed consent must be presented in a language understandable to the patient, taking into account their intelligence, maturity, and education.⁵² However, as Green points out, many Kenyan healthcare providers speak at the same intellectual level as their peers or use technical medical jargon.⁵³ Patients become alienated as a result of this practice, which makes it harder for them to understand the nature of their illness, the available treatments, or the risks involved.

The issue is made worse when physicians fail to use local language-translated written or visual aids or hire interpreters. Confusion can result from the use of formal or extremely technical language, and patients may give their consent without being fully informed if they feel embarrassed to acknowledge they do not understand. Therefore, the necessity of multilingual consent procedures and patient education materials catered to different literacy levels should be emphasized in best practices. Modules on cultural sensitivity and effective patient communication should also be included in medical education programs.

For informed consent to be valid, understanding is essential and disclosure alone is considered to be insufficient. Though, this is one of the aspects that is least addressed. According to Braddock an evaluation of the patient's comprehension was present in just 2% of observed doctor-patient

⁵² Ethical Principles and Guidelines for the Protection of Human Subjects of Research. <http://www.med.umich.edu/irbmedethics/Belmont/BELMONTR.HTM> on 11 November 2024.

⁵³ Green J, 'Putting the "informed" into "consent": A matter of plain language, 2003 Junior Pediatric Child Health 39:700-703

interactions.⁵⁴ This disparity still exists in Kenya, where comprehension is rarely assessed or verified, particularly in surgical or inpatient settings.

2.4. Best Practices in informed consent: Patient Volition

Volition refers to the patient's ability to make decisions freely, without coercion, manipulation, or undue influence. In the African context, including Kenya, several cultural and structural factors can compromise this autonomy. Regardless of the patient's competence, healthcare decisions are frequently made collectively or deferred to family heads, who are typically men, due to the extended family system and hierarchical social structures. This dynamic frequently compromises the autonomy of women and children, according to Ijsselmuiden & Faden.⁵⁵ Particularly in rural areas where gender roles are more strictly enforced, a capable adult woman may be eclipsed during the consent process by her husband or a male elder.

To safeguard volition, doctors must ensure that patients understand their right to refuse or withdraw consent at any point. Ethical guidelines and hospital policies should clearly stipulate that no treatment should proceed without the patient's active and informed approval, and systems should be in place to monitor compliance. Fundamentally, therapeutic privilege gives doctors the power to decide what information a patient can and cannot handle. Even though the goal is frequently to protect the patient from harm or distress, the patient is deprived what they need make an informed decision. The doctor becomes the gatekeeper of information and decision-making authority in these circumstances.

In Kenya, where power dynamics in healthcare settings are already imbalanced, with doctors being viewed as figures of authority or even unquestionable experts, therapeutic privilege can further suppress the patient's agency. The doctor may withhold important information regarding a diagnosis, prognosis, or treatment risks if they believe that the patient might be "upset" or "confused" by the truth. Therefore, even though the patient's choice is technically "voluntary," it is compromised because they did not have access to all relevant information.

⁵⁴ Braddock C, Fihn S, 'Informed Decision Making in the Outpatient Setting.' *Journal of General Internal Medicine*, 1997, 12:339-345.

⁵⁵ Ijsselmuiden C, 'Research and Informed Consent in Africa - Another Look. In: (Eds), *Health and Human Rights*, Routledge, New York, 1992, 363-379.

2.5. Conclusion

The long-term consequences of such non-disclosure can be detrimental, even if the information is initially kept secret out of concern for the patient's well-being. The patient may experience feelings of betrayal, mistrust, or rage if they later learn that important information was withheld, particularly if the treatment's outcome was unanticipated or subpar. In these situations, the patient might wonder if their consent was coerced or sincere. The integrity of their decision may be retroactively revoked if it turns out that it was based on incomplete or selective information. This undermines not just individual volition but the broader trust in the healthcare system. For example, a patient who is not informed of a terminal diagnosis because the doctor believes it would “distress” them may go on to make life decisions about finances, family, or travel that they would have handled differently had they known the truth. Though they may have technically given “consent” to a treatment plan, the foundation of that consent, free and informed volition, was compromised.

Kenya's Health Act, under Section 8(a), allows for therapeutic privilege but does not provide clear procedural safeguards or limits to its use.⁵⁶ There is no mandatory requirement for documentation, second opinions, or oversight bodies to review the decision to withhold information. As a result, the doctrine is vulnerable to abuse or overuse, particularly in under-resourced hospitals where overworked doctors may invoke privilege not out of careful ethical consideration, but out of expedience. The lack of a robust framework to audit or question the invocation of therapeutic privilege means that even well-intentioned actions can systematically erode patient volition without detection.

Therapeutic privilege places the healthcare provider in a delicate position, balancing the duty to inform with the duty to protect. But in practice, especially in socio-culturally hierarchical systems like Kenya's, this balance often tips in favor of control rather than care. By obscuring information, even for compassionate reasons, doctors may unintentionally reclaim the decision-making power that rightfully belongs to the patient. This weakens free will and sets the stage for a paternalistic

⁵⁶ Section 8(a), *Health Act* (Act No. 21 of 2017).

approach to caregiving. Therapeutic privilege must be applied carefully, openly, and within a clear framework that protects patients' autonomy and well-being to be ethically justified.



3.0. THERAPEUTIC PRIVILEGE: A DISSECTION OF THE PRACTICE OF THERAPEUTIC PRIVILEGE

3.1. The practice of therapeutic privilege under section 8(a) of the Health Act and its compatibility with the right to life, health, and information.

In Kenya, this exception is codified in Section 8(a) of the Health Act.⁵⁷ While the rationale behind therapeutic privilege is ostensibly to protect patients, its application potentially infringes upon the constitutional rights to life,⁵⁸ the highest attainable standard of health,⁵⁹ and the right to information.⁶⁰ In order to make the case that therapeutic privilege's current definition and possible abuse are essentially incompatible with these constitutional guarantees, this paper examines the legal, moral, and practical ramifications of therapeutic privilege in Kenya.

Section 8(a) permits medical professionals to withhold information if they believe it would not be in the patient's best interests, codifies the idea of therapeutic privilege into Kenyan law.⁶¹ The phrase “*best interests*,” in particular, is vague and general, granting medical practitioners a great deal of latitude. Therapeutic privilege makes informed consent, which is otherwise a fundamental component of moral medical practice, exceptional. Respecting patients' autonomy requires informed consent under Kenyan common law and statutory provisions. However, without a clear definition or procedural safeguards, Section 8(a) creates room for arbitrary or paternalistic decisions that may contradict constitutional values.

The CoK establishes the supremacy of the Constitution under Article 2, which mandates that all laws must conform to constitutional standards.⁶² Therefore, Section 8(a) is vulnerable to constitutional scrutiny, especially if it seems to restrict or deprive guaranteed rights.⁶³ Kenyan

⁵⁷ Section 8(a), *Health Act* (Act No. 21 of 2017).

⁵⁸ Article 26, *Constitution of Kenya* (2010).

⁵⁹ Article 43, *Constitution of Kenya* (2010).

⁶⁰ Article 35, *Constitution of Kenya* (2010).

⁶¹ Section 8(a), *Health Act* (Act No. 21 of 2017).

⁶² Article 2, *Constitution of Kenya* (2010).

⁶³ Section 8(a), *Health Act* (Act No. 21 of 2017).

case law has progressively upheld the significance of patient autonomy and information access regarding health. The High Court underlined in *P.A.O. & others v. Attorney General (2012)* that information access is essential to the realization of fundamental freedoms, particularly in the context of healthcare.⁶⁴ Furthermore, the Kenya Medical Practitioners and Dentists Council (KMPDC) Code of Professional Conduct and Discipline emphasizes the duty of full disclosure, suggesting that therapeutic privilege must be an exception, not the norm. The absence of guidelines on the operationalization of Section 8(a) places Kenya at odds with best practices globally.⁶⁵

3.1.1. Best Interests: Right to life

Article 26(1) of the Constitution states that every person has the right to life.⁶⁶ Life, in this context, must be interpreted broadly to include not just the right to exist, but the right to live a dignified life, which includes access to healthcare and information needed to preserve life. Withholding crucial medical information can directly undermine the right to life, especially when it pertains to diagnoses, risks of procedures, or alternatives to treatment. A patient denied knowledge of a life-threatening condition or critical treatment options is effectively denied the opportunity to act in their own interest to preserve life. In the case of *Francis Coralie Mullin v The Administrator, Union Territory of Delhi (1981)*, the Indian Supreme Court interpreted the right to life to include the right to live with dignity, which entails access to health and information.⁶⁷ Kenya's courts have shown signs of adopting similarly expansive interpretations of Article 26.⁶⁸

3.1.2. Best Interests: Right to Best Possible Standard of Health

Every individual in Kenya has the right to the best possible standard of health, including reproductive healthcare.⁶⁹ This right is both procedural and substantive; it includes the ability to make educated decisions regarding one's health in addition to the provision of health services. The World Health Organization (WHO) recognizes informed consent as central to the right to health. According to the United Nations CESCR General Comment No. 14, the right to health

⁶⁴ *P.A.O. & others v. Attorney General (2012)* eKLR .

⁶⁵ Section 8(a), *Health Act (Act No. 21 of 2017)*.

⁶⁶ Article 26 (1), *Constitution of Kenya (2010)*.

⁶⁷ *Francis Coralie Mullin v The Administrator, Union Territory of Delhi (1981)*, The Supreme Court of India.

⁶⁸ Article 26, *Constitution of Kenya (2010)*.

⁶⁹ Article 43 (1)(a), *Constitution of Kenya (2010)*.

encompasses the freedom to access health-related information and to take part in decision-making.⁷⁰ Therapeutic privilege, if misapplied, denies patients the participatory role envisioned under Article 43.⁷¹ In the context of reproductive health, for instance, withholding information about complications, fertility, or treatment options violates the patient's ability to exercise agency.

3.1.3. Best Interests: Right to Access Information

The right to access information held by the state or by any other individual necessary for the exercise or defense of any right or basic freedom is enshrined in Article 35 of the CoK. This right is directly implicated in healthcare, where medical records, diagnostic reports, and prognostic assessments are often solely in the possession of healthcare providers.⁷²

The Constitution does not permit blanket exceptions to this right. As a result, any deviation through therapeutic privilege must pass the proportionality and justifiability test under Article 24, which permits the restriction of rights only in cases that are reasonable and acceptable in a free and democratic society.⁷³ The court in *Nairobi Law Monthly Company Limited v Kenya Electricity Generating Company & Others (2013)* held that the right to information cannot be withheld arbitrarily and must always be subject to judicial oversight.⁷⁴

Medical practice in Kenya is unclear due to the absence of statutory guidance on therapeutic privilege. Anecdotal evidence indicates that, frequently in rural or under-resourced settings with little oversight, information is occasionally withheld from patients without explicit criteria. The High Court upheld the right to information in *P.A.O. & others v. Attorney General (2012)* stressed the need for the state and its representatives to behave openly, especially when it comes to issues pertaining to health and bodily integrity.⁷⁵ Cases involving medical malpractice have also shown cases where avoidable harm resulted from non-disclosure. This calls into question whether the use of therapeutic privilege serves patients or shields doctors from legal action.

⁷⁰ General Comment 14, UN Committee on Economic, Social, and Cultural Rights.

⁷¹ Article 43, *Constitution of Kenya* (2010).

⁷² Article 35, *Constitution of Kenya* (2010).

⁷³ Article 24, *Constitution of Kenya* (2010).

⁷⁴ *Nairobi Law Monthly Company Limited v Kenya Electricity Generating Company & Others* (2013) eKLR.

⁷⁵ *P.A.O. & others v. Attorney General* (2012) eKLR

While therapeutic privilege aims to shield patients from harm, its unregulated use under the Health Act poses a direct threat to constitutionally guaranteed rights. The practice undermines autonomy, risks abuse, and may result in irreparable harm to patients. Aligning Kenya's statutory provisions with constitutional and international obligations requires urgent reform to ensure that the right to life, health, and information is not compromised in the name of protection.

3.2. Exploring the Ethical Implications and Practical Consequences of Therapeutic Privilege on Patient Autonomy, Trust, and Health Outcomes.

As the saying goes, ‘What you don’t know can’t hurt you.’ The lingering question is, can it? As discussed earlier, courts have grounded therapeutic justification on the feeling of anxiety by a patient, but there are also instances where the courts have considered the secondary effects of anxiety on a patient. The courts have accepted non-disclosures where “psychological damage” or “psychosomatic ramifications” were threatened.⁷⁶ Patients may experience anxiety or fear upon hearing about risks, while others may feel empowered to make informed decisions. This variability renders the predictive abilities of physicians inconsistent and unreliable. Therapeutic privilege often assumes that the “rational” decision aligns with the physician’s recommendation. However, patients have the right to prioritize their own values, lifestyle, and preferences over medical advice. This principle is central to informed consent, which seeks to uphold patient autonomy rather than enforce adherence to medical judgments.⁷⁷

A justification for therapeutic privilege is the claim that disclosing risks may increase patient anxiety, potentially leading to stress-related disorders. While this argument seems plausible on the surface, it fails under closer scrutiny. The medical community’s understanding of how anxiety contributes to physical illness is limited since not all patients who experience anxiety develop stress-related illnesses. Coping mechanisms, interpersonal support, and personality traits all influence how individuals respond to stress. There are no established criteria for identifying which

⁷⁶ Patterson G, ‘The Therapeutic Justification for Withholding Medical Information: “What you don’t know can’t hurt you, or can it?”’, 1985, 64.

⁷⁷ Patterson G, ‘The Therapeutic Justification for Withholding Medical Information: “What you don’t know can’t hurt you, or can it?”’, 1985, 64.

patients are more susceptible to stress-induced illnesses. This uncertainty undermines the argument that withholding information is necessary or effective in preventing such outcomes. Courts and medical experts acknowledge the difficulty of linking anxiety to specific diseases. It is nearly impossible to predict which patients will suffer stress-related harm due to disclosure. As one commentator noted, while it is tenable to say that “stress causes illness,” the statement lacks practical significance due to the variability in individual responses.⁷⁸

In *Lane v Candura* (1978), the patient’s refusal of amputation was initially deemed irrational by the trial court, but the appellate court rejected this view. The case underscores that disagreement with medical recommendations does not equate to incompetence or irrationality. Therapeutic privilege based on the assumption that a patient will make a “wrong” decision is therefore unjustified.⁷⁹

The central premise of therapeutic privilege is that a physician may withhold information to protect the patient’s physical well-being. However, this implies that physical health takes precedence over autonomy. This is problematic because autonomy relies on the availability of full and accurate information. Without it, patients are deprived of the ability to make meaningful choices about their own care. In the broader context of tort law, individual autonomy has historically been given priority over physical well-being.

The right to informed consent stems directly from tort principles. Patients have the established right to refuse potentially beneficial treatments, even if such refusal may lead to death. The doctrine of informed consent recognizes the necessity of providing patients with all material information to enable them to make informed decisions about their care. Therapeutic privilege, however, undermines this doctrine by prioritizing physical well-being as determined by the physician rather than the patient’s own values and preferences. The conflict between autonomy and physical well-being extends into constitutional law, particularly the right to privacy.

In Kenya, there is a practice that health care providers disclose a patient's HIV-positive status to third parties, typically caregivers or spouses, without the patient's explicit consent. The healthcare

⁷⁸ Patterson G, ‘The Therapeutic Justification for Withholding Medical Information: “What you don’t know can’t hurt you, or can it?”’, 1985, 64.

⁷⁹ *Lane v Candura* (1978), The Supreme Court of the United States.

providers justify this by arguing that such disclosure is necessary to protect caregivers and facilitate proper care for the patient.⁸⁰ A nurse in Central Province shared an instance where a critically ill patient refused to disclose their HIV status to relatives who were expected to care for them. The nurse disclosed the information to ensure the patient's care needs would be met post-discharge. The disclosure was made under the presumption that the patient's well-being could be jeopardized if caregivers were unaware of the diagnosis and unwilling to provide appropriate care due to a lack of understanding.⁸¹ If doctors can go to the lengths of involving guardians in telling their patient's health status, then withholding information should not be a debatable case. The Kenya national HTC guidelines emphasize consent, confidentiality, and counseling.⁸² Yet, therapeutic privilege is used to justify practices that conflict with these principles.

One of the most significant negative effects of therapeutic privilege is the undermining of patient autonomy. Modern medical ethics prioritize respect for autonomy, emphasizing that patients have the right to make informed decisions about their healthcare. When a healthcare provider exercises therapeutic privilege, they essentially deny the patient the opportunity to understand their condition fully and participate meaningfully in decisions about their treatment. For example, withholding information about a terminal illness because the provider fears the patient might lose hope can rob the patient of the chance to prepare emotionally, make personal or financial arrangements, or pursue meaningful experiences in their remaining time. Such actions not only violate the patient's autonomy but also risk eroding trust in the physician-patient relationship when the omission is eventually discovered.

Therapeutic privilege can also have profound psychological effects on patients. When patients sense that critical information is being withheld or later discover they were not fully informed, they may feel betrayed, disempowered, or anxious. These feelings can outburst existing mental health challenges and create additional emotional burdens. For instance, a patient who learns that their diagnosis was intentionally understated may experience resentment and a sense of helplessness, questioning their healthcare provider's motives and the integrity of the care they received. Furthermore, withholding information can prevent patients from engaging in coping

⁸⁰ <https://www.tandfonline.com/doi/full/10.1080/02664763.2012.755339#d1e351> on 4 November 2024.

⁸¹ <https://www.tandfonline.com/doi/full/10.1080/02664763.2012.755339#d1e351> on 4 November 2024.

⁸² <https://www.tandfonline.com/doi/full/10.1080/02664763.2012.755339#d1e351> on 4 November 2024.

strategies or seeking appropriate psychological support, leaving them ill-prepared to manage their condition.

While therapeutic privilege is often employed with the intention of protecting patients, its negative effects are profound and far-reaching. By undermining patient autonomy, causing psychological harm, exposing providers to legal risks, perpetuating societal inequities, and impeding health literacy, this practice creates more harm than benefit. Examples such as withholding a terminal diagnosis or understating treatment risks illustrate the real-world implications of therapeutic privilege and highlight the importance of prioritizing transparency, respect, and shared decision-making in healthcare. Embracing these principles not only aligns with ethical and legal standards but also fosters a more compassionate and equitable healthcare system.

3.3. Therapeutic Privilege in Common Law Jurisdictions: A Comparative Study of Legal, Ethical, and Practical Dimensions.

3.3.1. The United States of America and Canada

In 1972, the United States Court of Appeal's decision in *Canterbury v Spence* (1972) which is the leading case in therapeutic privilege as discussed previously in the paper.⁸³ The Supreme Court of Canada has embraced this privilege and has used it in the case *Hopps v Lepp* (1980)⁸⁴ and *Reibl v Hughes* (1980).⁸⁵ The legal threshold for invoking therapeutic privilege is high, and Canadian courts have grappled with its proper application. Although it is recognized in Canadian jurisprudence, its application remains controversial. However, Canadian courts have established strict conditions under which therapeutic privilege can be invoked, and these conditions have evolved over time as different cases have contributed to shaping its legal framework.

The legal threshold for invoking therapeutic privilege in Canada is high, and courts have consistently emphasized the importance of respecting patient autonomy. The most significant case in establishing the legal framework for therapeutic privilege is *McInerney v MacDonald* (1992),

⁸³ *Canterbury v Spence* (1972), The Supreme Court of the United States.

⁸⁴ *Hopps vs Lepp* (1980), The Supreme Court of Canada.

⁸⁵ *Reibl v Hughes* (1980), The Supreme Court of Canada.

which stands as a landmark decision in Canadian tort law.⁸⁶ In this case, the Supreme Court of Canada ruled that physicians have a duty to disclose material risks to patients unless there is a strong likelihood that disclosure would cause harm to the patient's physical, mental, or emotional well-being. The decision in *McInerney* emphasized that it is not enough to demonstrate general anxiety or apprehension; instead, the physician must establish that the patient would suffer significant harm if the risks were disclosed.⁸⁷ The *McInerney* ruling set a clear boundary by requiring that therapeutic privilege be applied only when a physician can demonstrate a substantial likelihood that disclosure would harm the patient.⁸⁸ The court stressed that such a decision should not be made lightly, and physicians must balance the patient's right to make informed decisions with the duty to protect their well-being. This threshold is particularly significant because it prevents physicians from arbitrarily withholding information based on their personal beliefs or assumptions about what is best for the patient.

This legal threshold was further reinforced in the *Pittman Estate* case, where the Ontario Court of Appeal reinforced the need for certainty that harm would result from disclosure.⁸⁹ The *Pittman Estate* case clarified that a physician could only rely on therapeutic privilege if the risk of harm from disclosure was not just a possibility but a certainty. This ruling raised the bar for invoking therapeutic privilege, highlighting the necessity for a more stringent standard when balancing the competing interests of informed consent and the physician's duty of care.⁹⁰ Despite these rulings, some scholars argue that the legal threshold for applying therapeutic privilege is still too ambiguous, and more clarity is needed. In particular, the challenge remains in defining what constitutes "substantial harm" and whether it is reasonable to expect that physicians can predict with certainty the emotional reactions of patients to risk information.

A significant issue that arises in the application of therapeutic privilege involves the role of a patient's apprehension or reluctance to undergo treatment. Several courts, including *Puranen* and *Hajgato*, have highlighted the use of therapeutic privilege based on patients' emotional states, such as fear or anxiety, which could potentially lead them to refuse treatment. However, concerns about

⁸⁶ *McInerney v Mcdonald* (1992), The Supreme Court of Canada.

⁸⁷ *McInerney v Mcdonald* (1992), The Supreme Court of Canada.

⁸⁸ *McInerney v Mcdonald* (1992), The Supreme Court of Canada.

⁸⁹ *Pittman v Pittman* (1980), The Court of Appeal of California.

⁹⁰ *Pittman v Pittman* (1980), The Court of Appeal of California.

a patient's reluctance to undergo treatment, while understandable, should not serve as the sole justification for invoking therapeutic privilege.⁹¹

In Puranen and Hajgato, the courts allowed the use of therapeutic privilege in situations where patients' emotional states were an obstacle to their acceptance of treatment.⁹² In these cases, the respective courts acknowledged that physicians might have valid concerns about the emotional toll that disclosing certain risks could have on patients. However, the application of therapeutic privilege in such context risks overstepping the bounds of medical paternalism, as it permits physicians to decide for the patient what information is best to disclose, often in situations where the patient might still be fully capable of understanding the risks involved.

In these cases, the issue of patient autonomy becomes particularly contentious. The patient's right to make an educated decision may be compromised if therapeutic privilege is used in response to the patient's emotional condition and the doctor ends up making the decision for them. Such a practice can be likened to a paternalistic approach, where the physician assumes that the patient is unable to handle the truth and may make decisions that are contrary to their best interests if fully informed.⁹³ This concern is echoed in the *Starson v Swayze (2003)* decision, where the Supreme Court of Canada ruled that individuals who can understand and appreciate the consequences of their decisions are entitled to make choices that others may perceive as foolish or unwise.⁹⁴ In the context of therapeutic privilege, this means that even if a patient's apprehension or reluctance to undergo a medical procedure seems unreasonable, the patient should still have the right to make the final decision about their treatment. A capable patient who is emotionally distressed may still

⁹¹ Hadkis M, A critique of Canadian Jurisprudence on the Therapeutic privilege exception to informed consent, *Mc Journal of Law and Health*, 2018, <https://www.canlii.org/en/commentary/doc/2018CanLIIDocs95#!fragment/BQCwhgziBcwMYgK4DsDWszIQewE4BUBTADwBdoByCgSgBpltTCIBFRQ3AT0otokLC4EbDtyp8BQkAGU8pAELcASgFEAMioBqAQQByAYRW1SYAEbRS2ONWpA> on 14 December 2024

⁹² Hadkis M, A critique of Canadian Jurisprudence on the Therapeutic privilege exception to informed consent, *Mc Journal of Law and Health*, 2018, <https://www.canlii.org/en/commentary/doc/2018CanLIIDocs95#!fragment/BQCwhgziBcwMYgK4DsDWszIQewE4BUBTADwBdoByCgSgBpltTCIBFRQ3AT0otokLC4EbDtyp8BQkAGU8pAELcASgFEAMioBqAQQByAYRW1SYAEbRS2ONWpA> on 14 December 2024

⁹³ Hadkis M, A critique of Canadian Jurisprudence on the Therapeutic privilege exception to informed consent, *Mc Journal of Law and Health*, 2018, <https://www.canlii.org/en/commentary/doc/2018CanLIIDocs95#!fragment/BQCwhgziBcwMYgK4DsDWszIQewE4BUBTADwBdoByCgSgBpltTCIBFRQ3AT0otokLC4EbDtyp8BQkAGU8pAELcASgFEAMioBqAQQByAYRW1SYAEbRS2ONWpA> on 14 December 2024

⁹⁴ *Starson v Swayze* (2003). The Supreme Court of Canada.

be able to understand the risks involved and denying them the opportunity to make their own decision can be seen as a form of medical paternalism that undermines patient autonomy.

The *Starzon v Swayze* (2003) case is crucial in understanding the broader principles of patient autonomy in Canadian law. In *Starzon*, the Supreme Court addressed the issue of capacity and the right of mentally competent individuals to make their own healthcare decisions, even when those decisions may appear irrational.⁹⁵ The court held that a person who can understand the relevant information and appreciating the consequences of their decision should have the right to make that decision, even if it involves refusing treatment that could be in their best interest. This decision has significant implications for the application of therapeutic privilege in situations where a patient is reluctant to undergo treatment due to emotional distress or fear.

The court in *Starzon* emphasized that the perceived wisdom of the decision should not overshadow the individual's right to self-determination. If a capable patient chooses to reject treatment, even after being informed of its risks, the physician should respect that choice, regardless of how "unwise" it may appear.⁹⁶ By analogy, if a patient's emotional state leads them to be reluctant to undergo a treatment, they should still be entitled to make that decision. If the physician believes the patient may make an unwise decision based on emotional distress, the physician should not invoke therapeutic privilege to withhold risk information but rather should consider providing further support or counseling to help the patient come to an informed decision.

The application of therapeutic privilege in elective procedures presents additional challenges. Elective procedures, by definition, involve treatment that is not immediately necessary and allow patients to make a choice about whether to proceed. In such situations, patient autonomy is paramount, and the use of therapeutic privilege should be scrutinized more closely. In the court of *Hajgato*, they allowed the use of therapeutic privilege in the context of an elective surgery, even though elective procedures are typically associated with a higher level of patient choice and autonomy.⁹⁷ The decision in *Hajgato* raised concerns about whether therapeutic privilege should

⁹⁵ *Starzon v Swayze* (2003). The Supreme Court of Canada.

⁹⁶ *Starzon v Swayze* (2003). The Supreme Court of Canada.

⁹⁷ Hadkis M, A critique of Canadian Jurisprudence on the Therapeutic privilege exception to informed consent, *Mc Journal of Law, and Health*, 2018, 11.

be applied in elective situations, where patients can take the time to make an informed decision without the urgency that might justify withholding risk information in emergency situations.

In the case of non-therapeutic operations, including biomedical research, therapeutic privilege ought to be extremely uncommon. The Saskatchewan Court of Appeal addressed the question of informed consent in research settings, where the dangers are frequently higher and the benefits are undetermined.⁹⁸ The court made it clear that in research, the requirements for informed consent should be absolute, and there should be no exceptions, as withholding information would undermine the integrity of the research process. In non-therapeutic medical interventions, there is no direct therapeutic benefit to the patient, making the need for full and transparent disclosure even more critical. The *Halushka* case illustrates that researchers, like physicians, have a duty to fully disclose all material risks to participants in clinical trials or other research activities. Any attempt to withhold risk information under the guise of therapeutic privilege would violate the fundamental principle of informed consent and could compromise the ethical standards of the research.⁹⁹

3.3.2. South Africa

South Africa is well-known for abusing the advantages. A number of important therapeutic privilege tenets are highlighted. First, only in extraordinary situations where the possible harm from disclosure outweighs the need for complete information may non-disclosure or incomplete disclosure be justified. This principal stresses that withholding information should not be a routine practice, but a rare exception based on clear and significant risks. Furthermore, the burden of proof rests with the medical practitioner to demonstrate that the decision to withhold or inadequately disclose information was grounded in sound clinical judgment. This ensures that physicians are accountable for their decisions and must justify their actions with evidence that the withholding of information was necessary for the patient's well-being.

In South Africa information may be withheld if a medical practitioner believes that the patient's emotional or psychological state renders them unable to make a rational decision based on the provided information. This recognizes that some patients, due to their mental or emotional condition, may not be able to process or appropriately react to the full range of risks associated

⁹⁸ *Halushka v. University of Saskatchewan* (1965), The Court of Appeal of Saskatchewan.

⁹⁹ *Halushka v. University of Saskatchewan* (1965), The Court of Appeal of Saskatchewan.

with a treatment. The South African framework stresses the need to balance patient autonomy with medical judgment. While patient autonomy must be protected, the practitioner's clinical expertise should guide decisions to ensure the best possible medical outcome. The doctor can make decisions that are best for the patient while still respecting the patient's right to know what choices they can make about their care.

3.4. Conclusion

One plausible reason for the absence of therapeutic privilege cases in Kenya is the lack of legal precedent or awareness of the issue within the judicial system. Unlike in jurisdictions like Canada or South Africa, where therapeutic privilege has been explicitly addressed in case law, Kenya has not yet seen significant litigation or rulings on this matter. The issue may simply not have come before the courts, and when it does, the legal system might lack sufficient awareness or case law to fully address the nuances involved.

Moreover, the absence of formal case law does not mean that the issue is not present in practice. Many healthcare decisions are made behind closed doors, and disputes related to informed consent or withholding information might be resolved outside of the courtroom, often through informal channels like hospital committees or medical boards. Additionally, there might be limited resources or mechanisms in place to track or report such cases, which leads to a lack of visibility in the public and legal domain. While Section 8(a) of the Health Act in Kenya provides a broad framework for informed consent and the disclosure of information, there is a lack of detailed guidance on the specific conditions under which therapeutic privilege can be applied.¹⁰⁰ The law does not explicitly address the concept of therapeutic privilege, leaving it to the discretion of healthcare providers to determine when it might be necessary to withhold information.

The lack of a clear, codified framework makes it difficult to assess the legality or appropriateness of withholding information in individual cases. Additionally, without robust mechanisms in place to monitor the practice and ensure compliance with ethical standards, medical practitioners might

¹⁰⁰ Section 8(a), *Health Act* (Act No.21 of 2017).

not feel compelled to strictly adhere to the principle of informed consent. As a result, therapeutic privilege may be invoked inappropriately or without sufficient justification.



4.0. STRATEGIES FOR COMMUNICATING SENSITIVE INFORMATION TO PATIENTS

4.1. Introduction

Therapeutic privilege should be used as an exception and not the rule.¹⁰¹ The communication of sensitive medical information to patients is a crucial aspect of medical practice that requires careful navigation to ensure that patients remain well-informed while minimizing potential psychological harm.¹⁰² The ethical principle of therapeutic privilege allows medical professionals to withhold certain information when disclosure is believed to cause significant harm to a patient. However, this principle must be carefully balanced against the fundamental ethical and legal obligation to respect patient autonomy. This chapter explores various strategies and techniques for effectively communicating sensitive medical information while ensuring patient understanding, emotional well-being, and collaborative decision-making. The principles of patient-centered communication, clarity, empathy, and cultural competence serve as the foundation for these strategies. Additionally, the role of shared decision-making is examined to highlight its importance in fostering trust and collaboration between patients and healthcare providers.

4.2. Patient-Centered Communication

A basic strategy that puts the patient at the center of medical conversations is patient-centered communication. The Institute of Medicine describes it as a collaboration between healthcare professionals, patients, and their families that guarantees decisions respect patients' needs, preferences, and desires and gives patients the information and assistance they require to take part in their own treatment, make decisions, and support efforts to improve quality..¹⁰³ By adjusting communication techniques to each patient's unique requirements, preferences, and comprehension levels, this method acknowledges their individuality. An essential aspect of patient-centered communication is active listening, openness, and speaking plainly, where physicians engage in

¹⁰¹ Jahawar K, 'Medical errors: Overcoming challenges',2004, 12.

¹⁰² Jahawar K, 'Medical errors: Overcoming challenges',2004, 12.

¹⁰³ Committee on Quality of Health of Care in America. Crossing the Quality Chasm: A New Health System for the 21st Century. Institute of Medicine, National Academy Press; Washington, DC, USA: 2001.

meaningful dialogue with patients, acknowledging their concerns, emotions, and expectations.¹⁰⁴ Physicians can create a supportive environment where patients feel comfortable discussing their health conditions and treatment options by cultivating an atmosphere of mutual respect and trust. Additionally, the use of open-ended questions encourages patients to express their thoughts and concerns, allowing for a more comprehensive understanding of their perspective and emotional state.¹⁰⁵

Communication is a form of treatment. Clarity in communication is vital when conveying complex medical information to patients. Medical jargon and technical terms can be overwhelming and difficult for patients to understand, potentially leading to confusion and anxiety.¹⁰⁶ A number of detrimental effects, including interrupted care, compromised patient safety, wasteful use of precious resources, dissatisfaction amongst patients and doctors, and often-unnoticed financial repercussions, can result from poor communication. Since written communication is still the most common way for primary care and specialists to communicate, this review can act as a roadmap for future developments in this field.¹⁰⁷ To address this issue, healthcare providers should use plain language and simple explanations, ensuring that patients grasp essential information about their diagnosis, treatment options, and prognosis. Visual aids, such as diagrams and models, can also enhance comprehension by providing a tangible representation of medical concepts.¹⁰⁸ Furthermore, the teach-back method, where patients repeat back the information in their own words, is an effective technique to confirm understanding and reinforce key messages.¹⁰⁹ Ensuring clarity in communication empowers patients to make informed decisions about their health while reducing the likelihood of misinformation and misinterpretation.¹¹⁰

¹⁰⁴ Naughton C.A. 'Patient centered communication',2018, <https://pmc.ncbi.nlm.nih.gov/articles/PMC5874557/#ref-list1> on 13 December 2024

¹⁰⁵ Naughton C.A. 'Patient centered communication',2018,

¹⁰⁶ <https://paradoxmarketing.io/capabilities/knowledge-management/insights/ethical-communication-the-basic-principles/> on 23rd November 2024.

¹⁰⁷ Vermeir P, 'Communication in healthcare: a narrative review of the literature and practical recommendations', *International Journal of Clinical Practice*, 2015, <https://pmc.ncbi.nlm.nih.gov/articles/PMC4758389/#ijcp12686-sec-0025> on 6 November 2024

¹⁰⁸ Naughton C.A. 'Patient centered communication',2018,

¹⁰⁹ Naughton C.A. 'Patient centered communication',2018,

¹¹⁰ Vermeir P, 'Communication in healthcare: a narrative review of the literature and practical recommendations', *International Journal of Clinical Practice*, 2015, on 6 November 2024.

A key component of communicating sensitive medical information is empathy. When delivering difficult news, healthcare providers must approach the conversation with compassion, recognizing the emotional impact that such information may have on the patient. Empathetic communication involves acknowledging the patient's emotions, providing reassurance, and offering support throughout the discussion. Techniques such as maintaining appropriate eye contact, using a calm and soothing tone of voice, and offering words of encouragement can help patients feel heard and valued.¹¹¹ Additionally, providing emotional support resources, such as counseling services or support groups, can further assist patients in coping with distressing medical information.¹¹² By demonstrating empathy, healthcare providers can mitigate the psychological burden associated with receiving sensitive medical news, fostering a more positive patient experience. When receiving treatment, patients who feel empathetic show better outcomes and a greater chance of progress.¹¹³

Another crucial component of successful medical communication, especially in multicultural healthcare environments, is cultural competence. Patients come from various cultural backgrounds, each with unique beliefs, values, and communication preferences that influence their perception of medical information. Healthcare providers must be aware of cultural differences and tailor their communication strategies accordingly. This includes being sensitive to language barriers, religious beliefs, and health literacy levels.¹¹⁴ For patients who have low proficiency in the healthcare provider's first language, the employment of qualified medical interpreters can help ensure proper communication. Additionally, understanding cultural attitudes toward illness, treatment, and end-of-life care enables physicians to deliver information in a manner that aligns with the patient's values and expectations.¹¹⁵ By embracing cultural competence, healthcare providers can build stronger relationships with patients and ensure that medical information is conveyed in a respectful and meaningful way.

¹¹¹ Naughton C.A. 'Patient centered communication, 2018,

¹¹² Moudatsou M, The Role of Empathy in Health and Social Care Professionals, 2020, <https://pmc.ncbi.nlm.nih.gov/articles/PMC7151200/#sec3-healthcare-08-00026> on 30 January 2025.

¹¹³ Moudatsou M, The Role of Empathy in Health and Social Care Professionals, 2020,

¹¹⁴ Stubbe D, 'Practicing cultural competence and cultural humility in the care of diverse patients', *American psychiatric publishing*, 2020, <https://pmc.ncbi.nlm.nih.gov/articles/PMC7011228/> on 24 Jan 2025.

¹¹⁵ Stubbe D, 'Practicing cultural competence and cultural humility in the care of diverse patients', *American psychiatric publishing*, 2020,

4.3. Shared Decision-Making

A cooperative strategy that increases patient involvement in the choice of their medical treatment is called "shared decision-making." This method empowers people to make educated decisions that align with their beliefs and preferences by recognizing patients as active partners in their healthcare journey.¹¹⁶ In the context of communicating sensitive medical information, shared decision-making involves presenting patients with all available treatment options including their risks and benefits and guiding them toward a decision that best suits their individual needs. Doctors are essential in helping to facilitate this process. by providing balanced information, answering questions, and addressing concerns in a transparent and non-directive manner.¹¹⁷ Decision aids, such as pamphlets, videos, and online resources, can further support patients in evaluating their options. Healthcare professionals can empower patients to actively participate in their care and develop a sense of control and confidence in their medical decisions by encouraging shared decision-making.¹¹⁸

4.4. Conclusion

Conclusively, communicating sensitive medical information requires a delicate balance between respecting patient autonomy and minimizing potential harm. Patient-centered communication, clarity, empathy, and cultural competence are essential principles that guide effective communication strategies. Shared decision-making further enhances collaboration between patients and healthcare providers, empowering patients to make informed choices about their health. By implementing these techniques, healthcare professionals can foster trust, improve patient comprehension, and support emotional well-being in the face of challenging medical conversations. While challenges may arise, adaptive communication approaches can help mitigate distress and ensure that patients receive information in a manner that aligns with their needs and preferences. Ultimately, a thoughtful and compassionate approach to medical communication

¹¹⁶ Montori V, Shared decision making as a method of care, *BMJ evidence-based medicine*, 2022, <https://pmc.ncbi.nlm.nih.gov/articles/PMC10423463/> on 2 Dec 2024.

¹¹⁷ Montori V, Shared decision making as a method of care, *BMJ evidence-based medicine*, 2022,

¹¹⁸ Naughton C.A. 'Patient centered communication, 2018,

strengthens the patient-provider relationship and enhances the overall quality of healthcare delivery.



5.0. RECOMMENDATIONS AND CONCLUSION.

5.1. Recommendation

Section 8(a) of the Health Act in Kenya has raised significant concerns regarding its consistency with the Constitution, particularly in relation to patient rights, autonomy, and access to medical information. The idea of therapeutic privilege, which permits doctors to keep information from patients if they feel it might hurt them, may be introduced in this section. Therapeutic privilege is intended to protect patients from needless suffering, but its broad and unclear application increases the risk of misuse and jeopardizes the fundamental protections of individual liberty, dignity, and knowledge. This provision's uncertainty calls for immediate legal review and possible revisions to bring it into compliance with international human rights norms and Kenya's constitutional values.

Potential conflicts with Article 35 of the CoK, which protects the right to access information, are one of the main issues with Section 8(a). For individuals to make educated decisions regarding their health, medical information must be made available. The constitutional right to information access is violated when patients are denied access to pertinent health information, particularly when such information directly impacts their wellbeing. The broad language used in Section 8(a) leaves room for subjective interpretations, allowing healthcare providers to withhold information without clear guidelines on when and how therapeutic privilege should be exercised. This lack of clarity could lead to situations where patients are denied crucial medical details that could impact their treatment decisions and overall health outcomes.

Moreover, Section 8(a) contradicts the highest attainable standard of health right provided in the CoK. This right includes the ability to make informed choices regarding treatment options, risks, and alternative care. Without full disclosure, patients may be deprived of the opportunity to participate actively in their healthcare decisions. This exclusion infringes upon the principle of patient autonomy, which is a cornerstone of ethical medical practice. The section, as currently framed, places excessive discretionary power in the hands of healthcare providers without sufficient checks and balances, thereby eroding patients' rights to self-determination and informed consent.

Another fundamental issue with Section 8(a) is its potential misuse in cases where medical practitioners may withhold information for reasons unrelated to patient welfare. Without strict guidelines and oversight mechanisms, therapeutic privilege could be invoked to shield medical errors, conceal malpractice, or avoid legal liability. The lack of accountability and transparency in such cases could erode public trust in the healthcare system and create an environment where patients feel disempowered. To ensure ethical integrity in medical practice, there must be clear safeguards to prevent the misuse of therapeutic privilege. This necessitates a legislative amendment to provide a more structured and rights-centered approach to withholding medical information.

Given these concerns, it is imperative that Section 8(a) be amended to provide a more balanced approach that respects both patient autonomy and the duty of care of medical practitioners. A revised version of this section should explicitly define the circumstances under which therapeutic privilege may be exercised, ensuring that withholding medical information is an exception rather than the norm. The amendment should establish clear guidelines that require healthcare providers to document and justify the decision to withhold information, subject to oversight by an independent medical ethics board. The updated clause should also require that alternative communication techniques be used to gradually inform the patient while offering the required psychological support in cases where information is withheld.

An appropriate amendment to Section 8(a) could read as follows:

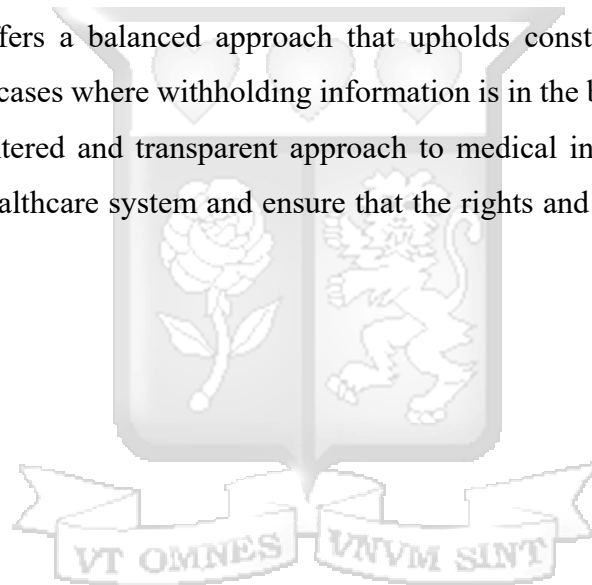
“A healthcare provider may, in exceptional circumstances, withhold specific medical information from a patient if disclosure is reasonably anticipated to cause severe and immediate harm to the patient’s mental or physical health. Such a decision must be based on clear medical evidence, documented, and subject to review by an independent ethics board. In instances where information is withheld, the healthcare provider must explore alternative means to communicate relevant details in a manner that upholds the patient’s dignity and right to informed decision-making.”

This amendment ensures that therapeutic privilege is exercised with transparency, accountability, and respect for patient rights. It shifts the emphasis from discretionary withholding of information to a structured and well-regulated practice that prioritizes patient welfare. The amendment also

improves oversight in the healthcare industry and reduces the possibility of arbitrary application by establishing an independent review mechanism.

5.2. Conclusion

In conclusion, Section 8(a) of the Health Act, in its current form, contravenes various rights enshrined in the CoK. While therapeutic privilege has a place in medical practice, its application must be carefully regulated to prevent abuse and ensure that patients remain active participants in their healthcare decisions. Enhancing patient protection while upholding the ethical obligations of healthcare providers can be achieved by amending Section 8(a) to include explicit guidelines on when and how medical information may be withheld, as well as an oversight mechanism. The proposed amendment offers a balanced approach that upholds constitutional principles while allowing for exceptional cases where withholding information is in the best interest of the patient. Ultimately, a patient-centered and transparent approach to medical information disclosure will strengthen trust in the healthcare system and ensure that the rights and dignity of all patients are safeguarded.



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