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Nili Karako-Eyal*

I. INTRODUCTION

More than two decades have passed since the publication of one of the most salient articles ever written on the subject of informed consent: "From Informed Consent to Patient Choice: A New Protected Interest."[1] In this article, Marjorie Shultz, argued that a patient's right to autonomy[2] should be

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1. Marjorie Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219 (1985).

2. The "patient's right to autonomy" is a very complex concept. Although discussion of this term—its origin and meaning—exceeds the boundaries of this paper, a short clarification and its relation to other terms, principles and ideas is provided here. The term "patient's right to autonomy" refers to the patient's right to decide whether to undergo the proposed treatment, choose another treatment or refuse any treatment whatsoever. This decision should be intentional, freely accepted and based on relevant information. This right may be confined under special circumstances, i.e., medical emergency or incompetence. For a discussion of the conditions for an autonomy decision see, e.g., RUTH R. FADEN & TOM L. BEUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT 238 (1986). The right to autonomy has several dimensions. First, it expresses philosophical theories—such as those developed by Kant, Berlin and Mill—having the principles of autonomy and liberty as their subjects. For a general description of these theories see, e.g., ALASDAIR MACLEAN AUTONOMY, INFORMED CONSENT AND MEDICAL LAW–A RATIONAL CHALLENGE

recognized and respected as a distinct and separate legal interest.[3] Her approach diverged from the prevailing U.S. position, according to which protection of this interest derived from defense of the interest in a person's physical well-being or physical security.[4]

Three decisions handed down since that article's publication, the first by Australia's Supreme Court, the second by the British House of Lords, and the third by Israel's Supreme Court—*Chappel*,[5] *Chester*,[6] and *Ali Daaka*,[7] respectively—raise the question of whether Shultz's approach has, in fact, been incorporated, either in whole or in part, into Anglo-America law beyond the United States.[8]

9–22 (2009). Hence, the right to autonomy has some characteristics in common with these philosophical theories such as the absence of controlling influences exercised by others. *See* ONORA O'NEILL, AUTONOMY AND TRUST IN BIOETHICS 23, 28 (2002). Second, autonomy is a fundamental principle in medical ethics. It relates to physicians' ethical obligation to respect their patients' wishes and provide assistance in arriving at autonomous decisions. *See* TOM L. BEUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 125 (4th ed. 1994). Third, it represents the rationale behind the legal doctrine of informed consent. According to this doctrine, adopted by American law in the mid-twentieth century, informed consent, as a pre-condition for the performance of any medical treatment, requires the patient to make an autonomous decision as to whether to undergo treatment. A doctor who treats a patient without respecting her right to autonomy—that is, without receiving her informed consent—can be charged with the tort of battery or negligence. *See, e.g.,* Maclean, *supra* note 2, at 190. The term "informed consent" was first used by an American court. *See* Salgo v. Stanford, 317 P.2d 170, 181 (1957) and is effectively identical to an autonomous decision to undergo medical treatment. Also related to the informed consent doctrine is the legal term "dignitary tort." This term was suggested by legal scholars who believed that the law should recognize a new tort for the purpose of protecting the patient's right to autonomy per se. *See infra* note 31.

3. *See generally* Shultz, *supra* note 1.

4. *Id.* at 219.

5. Chappel v. Hart (1998) 195 C.L.R. 232, *available at* http://www.austlii.edu.au/au/cases/cth/HCA/1998/55.html.

6. Chester v. Afshar, [2004] UKHL 41, [2005] 1 A.C. 134 (U.K.).

7. CA 2781/93 Ali Daaka v. Carmel Hosp., Haifa [1999] IsrSC 53(4) 526.

8. Israeli law has long since adopted the doctrine of informed consent as promulgated in Anglo-American law. Like Anglo-American courts, Israeli courts recognize the duty to obtain a patient's consent and to provide her with information. *See Ali Daaka*, [1999] IsrSC at 543–52, 564, 589; CA 434/94 Berman v. Moore Inst. for Med. Info., Ltd. [1997] IsrSC 51(4) 205, 212–14. They also accept the "reasonable patient" test when establishing the boundaries of the physician's duty to inform the

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In this article, I argue that although each of the decisions accords with Shultz's suggestion that the interest protected in informed consent cases should be the patient's right to autonomy, as distinct from physical well-being or physical security, none of these decisions fully reflects the position that a patient's right to autonomy is a separate interest. Hence, none of these decisions accepts the idea that interference with the right to autonomy is in itself a harm that entitles plaintiffs to compensation. In addition, I argue that the main cause for American unwillingness and, perhaps, inability to adopt this idea is rooted in the characteristics of the tort of negligence, a cause of action available to patients claiming breach of the duty of disclosure. I further argue that Shultz's thesis should be reconsidered. I argue that recognition of the right to autonomy as a separate interest is insufficient; in its place, the courts should recognize a new cause of action: interference with the right to autonomy. In addition, elaboration of this argument entails analysis of the issue of compensation to be awarded for interference with the right to autonomy. To support my argument, I analyze *Rees*,[9] an additional decision handed down by the British House of Lords.

There are seven parts to this paper. In the first part (Section II), following the introduction, I present Shultz's thesis. The second part (Section III) begins with a description

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patient. *See* Patient's Rights Act, 1996, S.H. 327. Patients arguing a breach of the duty of disclosure can claim a cause of action under the tort of negligence. Patients wishing to claim physical injury suffered as a result of the medical treatment must prove *injury causation* and *decision causation*. That is, the medical procedure is a "but-for" cause of the physical injury, and the patient would have refused the proposed procedure if the relevant information had been disclosed. If, in addition to that cause of action, a patient wishes to claim that her consent to the treatment was never given, she can claim a cause of action under the tort of assault, so long as the respective treatment entailed physical force. *See Ali Daaka*, [1999] IsrSC at 543–52, 564, 589; *Berman*, [1997] IsrSC at 205, 212–14. In 1996 Israel passed its Patient's Rights Act, which anchored the doctrine of informed consent in comprehensive legislation. Patient's Rights Act, 1996, S.H. 327. The law introduced no changes in the causes of action available to the patient prior to the law's enactment, but it did add a new cause of action: breach of statutory duty. *Id.* at ch. 9. Developments in the doctrine of informed consent in Israeli law thus can contribute to the discussion of the doctrine's evolution in Anglo-American law.

9. Rees v. Darlington Mem'l Hosp. NHS Trust, [2003] UKHL 52, [2004] 1 A.C. 309 (U.K), *available at* http://www.bailii.org/uk/cases/UKHL/2003/52.html.

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of the court rulings in the *Chappel* and the *Chester* cases, followed by a critical analysis of these decisions. Here I comment on whether the courts treated the patient's right to autonomy as a separate interest, as Shultz has suggested. In the analysis, I attempt to identify the reasons for the positions taken by the courts. The third part of the paper (Section IV) deals with the question of what the courts should have done in both cases. I claim that the courts should have recognized a new head of damage—interference with the patient's right to autonomy. I support my conclusions by referring to considerations of efficient deterrence, administrative costs and legal coherence. In the fourth part of the paper (Section V), I discuss the *Ali Daaka* decision, in which Israel's Supreme Court ruled that interference with a patient's right to autonomy is a designated damage. In the fifth part (Section VI) I claim that although Israel's Supreme Court took an important step forward in this ruling, that step was imperfect. My comments focus on the subjective approach taken by the court and how it affected assessment of the compensation. The critical analysis of the decision is supplemented with the suggestion that adoption of an objective approach to compensation would have been preferable. In the sixth part (Section VII) of the paper, I examine whether the objective approach was adopted in the *Rees* case. A discussion of two versions of the objective approach—the objective-proprietary approach and the objective-tariff approach—ends this part. The paper's seventh part (Section VIII) concludes with a summary of my thesis.

II. SHULTZ'S THESIS: AUTONOMY AS A NEW PROTECTED INTEREST

Shultz offered a critical analysis of contemporary law.[10] She argued that although the law recognizes the importance of the patient's right to autonomy, this right is not recognized as a separate interest, worthy of protection in and of itself.[11] The right to autonomy, to date, has been awarded protection only as a byproduct of two other different and separate legal interests: the right to physical security (an interest protected by the tort of assault) and the right to physical well-being (an

10. Shultz, *supra* note 1, at 220–56.
11. *Id.* at 219–20.

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interest protected by the tort of negligence).[12] Shultz contended that this doctrinal structure has led to lacunae in the legal protection given the right to autonomy, and to a good degree of juridical incoherence.[13]

In substantiating her argument that there are gaps in the legal protection of the right to autonomy, Shultz provided a series of examples: the confines placed on the physician's duty to obtain patient consent and to fully inform her about invasive medical treatments;[14] the adoption of a professional standard as the measure determining the scope of disclosure rather than adoption of the "reasonable patient" test, which more appropriately reflects the interest requiring protection;[15] the adoption of an objective test to determine causation as opposed to the autonomy protective test, that is, a subjective test that reflects consideration of the patient's right to make autonomous decisions;[16] and the difficulty of obtaining compensation for some categories of injury irrespective of the clear presence of injury.[17] The solution to these holes and lack of protection is found, Shultz continued, in the legal recognition of the patient's right to autonomy as a distinct and separate legal interest.[18]

Shultz further argued that her approach would do more than provide full and comprehensive protection of the patient's right to autonomy; it also would align with the legal stance taken in other branches of law, such as the constitutional protection of the right to privacy;[19] the defense provided by civil law to other intangible interests (i.e., one's right to a reputation and the right to freedom from emotional anguish)[20] and the imposition of broad disclosure obligations on all parties to a contract as well as on manufacturers (i.e., the duty to disclose potential dangers in a product or property).[21]

The proposed approach, Shultz stated, also would respond to the characteristics of the medical system—that is, the

12. *Id.* at 219.
13. *See id.* at 248–56.
14. *Id.* at 232–41.
15. *Id.* at 241–48.
16. *Id.* at 248–49.
17. *Id.* at 251–52.
18. *Id.* at 276–81.
19. *Id.* at 277–78.
20. *Id.* at 278–79.
21. *Id.* at 279–81.

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presence of conflicts of interest as well as values dividing physicians from patients,[22] and the lack of medical certainty, a factor that introduces considerable opportunities for discretionary choice with respect to medical treatment.[23] This situation justifies the transfer of decision-making authority to the patient on the one hand, and recognition of the patient's right to choose as a separate legal interest on the other.[24]

When expanding upon her thesis, Schultz challenges the allegations that recognition of this new legal interest will cause harm to the patient's health,[25] raise medical costs,[26] unreasonably expand the physician's liability, or cause damage to the physician's status as a result of turning him into a technical purveyor of information. Recognition of an independent interest in patient autonomy, so she claims, would not broaden physicians' liability, especially since the more that patients are informed and participate in decision making, the less the likelihood that they will file a claim.[27] As to the fear of damaging the physician's status, Shultz contends that this fear is baseless since the doctor remains the responsible advisor to the patient.[28]

Shultz is willing to recognize a new head of damage—interference with the right to autonomy. From her perspective, not only is the patient's right to autonomy to be recognized as an interest separate and independent from the interests of physical well-being and physical security, any interference with the exercise of this right is to be considered sufficient to award the patient compensation even if that interference does not result in physical injury.[29]

Before continuing, I would like to comment about my

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22. *Id.* at 272–75.

23. *Id.* at 270–72. This argument requires some explanation. Shultz argues that medical uncertainty destroys the possibility of a single correct answer, leaving many answers in competition with one another. In this situation, choosing among alternative courses implicates the patient's individual characterizes. Conflicts of interest, as well as values separating physicians from patients, undermine the doctor's claim to authority and intensify the patient's right to autonomy. *Id.*

24. *See id.* at 276.

25. *Id.* at 292–95.

26. *Id.* at 295–96

27. *Id.* at 296–97.

28. *Id.* at 297–98.

29. *Id.* at 290–91.

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choice of Shultz's article and the decision to review her ideas at this point of time.

Shultz is not the only scholar who has adopted this approach. Others also have argued that separate protection should be given to the patient's right to autonomy so that any interference with this right will entitle the plaintiff to compensation.[30]

Yet Shultz's thesis is no doubt the most comprehensive of them all. As a result, her article is often mentioned as a prominent paper in the legal literature dealing with the issue of dignitary torts. For these reasons, I have chosen Shultz's thesis as the opening for my discussion

Indeed twenty-five years have passed since the publication of Shultz's article. During those years, the doctrine of informed consent has been revised.[31] Yet, I believe that Shultz's critique continues to be applicable inasmuch as no changes have been made in American law regarding the interest protected. A review of the non-U.S. cases, handed down in the last decade, returned my attention to Shultz's thesis and its continued if not greater relevance. I believe that these cases require a new observation of Shultz's thesis and of American law. My article offers such observation.

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30. *See, e.g.*, JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 69–70, 79 (1984); JOHN G. FLEMING, THE LAW OF TORTS 122–23 (9th ed. 1998); Alan Meisel, *A 'Dignitary Tort' as a Bridge Between The Idea of Informed Consent and The Law of Informed Consent*, *in* MEDICINE AND THE LAW 157–58, 163–64 (Bernand M. Dickens ed., 1993); Joseph Goldstein, *For Harold Lasswell: Some Reflections on Human Dignity, Entrapment, Informed Consent, and the Plea Bargain*, 84 YALE L.J. 683, 691 (1975); Jay Katz, *Informed Consent—A Fairy Tale? Law's Vision*, 39 U. PITT. L. REV. 137, 160–62 & n. 76 (1977); Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 365–67 (1999); Nancy Levit, *Ethereal Torts*, 61 GEO. WASH. L. REV. 136, 188–90 (1992); Grant H. Morris, *Dissing Disclosure: Just What the Doctor Ordered*, 44 ARIZ. L. REV. 313, 330 (2002); Aaron D. Twerski & Neil B. Cohen, *Informed Decision Making and the Law of Torts: The Myth of Justiciable Causation*, 1998 U. ILL. L. REV. 607, 609, 616, 649, 651–52, 665.

31. Most of these revisions concern the duty of disclosure. For a description of this changes see e.g., MICHAEL A. JONES, MEDICAL NEGLIGENCE 652–74 (4th ed. 2008).

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III. THE *CHAPPEL* AND *CHESTER* DECISIONS

A. THE *CHAPPEL* DECISION

The facts of *Chappel*, ultimately decided by the Supreme Court of Australia, are quite simple. The plaintiff, Mrs. Hart, underwent surgery at the hands of the defendant, Dr. Chappel, for the purpose of resolving a medical condition in her throat.[32] The defendant had not warned the plaintiff of the mild risk of damage to her vocal cords that was inherent in the procedure, even though the plaintiff had articulated an interest in the risks posed by the procedure, especially with reference to her voice.[33] Though the surgery was performed with reasonable skill, this risk was realized and the plaintiff, left with a damaged voice, was forced to leave her place of employment.[34]

At the time that the surgery was performed, it was treated by the doctor as an elective procedure.[35] The plaintiff's medical condition, however, was "relentlessly progressive."[36] Hence, had she not undergone the procedure then, she eventually would have had to undergo the procedure anyway, which was considered to be the sole remedy available for her complaint.[37] Accordingly, the court decided that even had the plaintiff been informed of the mild risk of injury to her voice as a result of the procedure, the surgery would eventually have been performed.[38] Moreover, the risk to her voice was associated with procedures of this type, irrespective of when they were performed and the identity of the surgeon.[39]

The plaintiff argued that had the defendant informed her of the risk inherent in the procedure, she would not have acquiesced to his performance of the surgery at that time.[40] The court accepted as credible the plaintiff's argument that she would have sought another opinion and would have selected a

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32. Chappel v. Hart (1998) 195 C.L.R. 232, 233, *available at* http://www.austlii.edu.au/au/cases/cth/HCA/1998/55.html.
33. *Id.*
34. *Id.* at 253.
35. *Id.*
36. *Id.* at 237.
37. *Id.*
38. *Id.* at 239–240, 258.
39. *Id.* at 239–41.
40. *Id.* at 233.

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more experienced surgeon to perform the surgery.[41] The plaintiff further argued that considering the fact that the defendant had reneged on his duty to disclose the respective risk, however mild it was thought to be, he should be required to pay damages for injuring her voice based on the tort of negligence and breach of contract.[42] Although the charge of negligence, based upon the breach of duty of disclosure, aroused no debate,[43] the issue of causation raised serious difficulties.

The source of the difficulty rested on the fact that the plaintiff's medical condition was expected to deteriorate and that her condition could be treated solely by this procedure.[44] Therefore, as the plaintiff herself admitted, even if the risk inherent in the surgery had been disclosed, she would have agreed to undergo the surgery at some point.[45] Moreover, the risk of injury was inherent in the procedure; the plaintiff would therefore have been exposed to that risk whenever the surgery was performed.[46]

Three of the sitting judges ruled in favor of the plaintiff; they stated that she had proved causation.[47] Justice Gaudron grounded her individual opinion in four fundamental arguments. First, the defendant was required to fulfill his duty of disclosure to the plaintiff and inform her, in detail, of the foreseeable risk inherent in the procedure.[48] The defendant had ignored his duty, and the said risk did indeed materialize; hence, his breach of this duty could be considered to have

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41. *Id.*

42. *Id.* at 235.

43. The court's ruling in the first instance determined that the defendant had breached the duty of disclosure with respect to the plaintiff and thus had been negligent. *Id.* at 254. The parties did not appeal the court's decision in this matter. *Id.* at 254–55. For a discussion of the court's ruling with respect to the duty of disclosure imposed on physicians, see Ian Freckelton, *The New Duty to Warn*, [1999] ALT. L.J. 4, *available at* http://www.austlii.edu.au/au/journals/AltLJ/1999/4.html; Owen Bradfield, *At the Heart of* Chappel v Hart*: A Warning About Warning!*, http://www.alsa.asn.au/files/acj/2000/chappel_hart.html (last visited Mar. 10, 2009).

44. *Chappel*, 195 C.L.R. at 237.

45. *Id.* at 258.

46. *Id.*

47. *Id.* at 239, 260, 278. For an analysis of the judges' decisions in this case see, e.g., Peter Cane, *A Warning About Causation*, 115 L.Q. REV. 21 (1999).

48. *Chappel*, 195 C.L.R. at 238–39.

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either caused or contributed to the damage unless some legal rule or legal consideration could justify a different conclusion.[49] Second, no sufficient reason could be identified that might justify an alternative decision. The damage the plaintiff suffered was not only exposure to risk; it also entailed the physical injury suffered de facto.[50] Moreover, even if the plaintiff did take it upon herself to face the risk inherent in the procedure at some future date, she was nonetheless unprepared to do so at the time the defendant had performed the surgery.[51] Third, had the defendant informed the plaintiff of the risk, she might not have submitted to the surgery at that time.[52] Therefore, considering the low probability of the risk, she may very well not have suffered the physical injury at all, and the defendant's breach of the duty of disclosure could be considered a contributing factor to the injury suffered.[53] Fourth, although the risk was independent of the time of the procedure's performance and the identity of the surgeon, the probability of realizing that risk would have declined had the surgery been performed by a more experienced and skilled surgeon.[54]

Contrary to his colleague, Justice Gummow did not base his opinion on the assumption that the procedure's performance by another, more skilled and experienced surgeon would have reduced the risk inherent in the procedure.[55] This divergence, however, did not prevent him from concurring with Justice Gaudron that the plaintiff had, indeed, established causation.[56] At the core of his opinion is an approach stating that the issue of causation requires reference to the scope and purpose of the relevant legal rule.[57] In cases like *Chappel* responses to the question of causation therefore relates to the substance and purpose of the duty of disclosure, a duty derived from the patient's right to make a decision about whether to accept a proposed treatment. The purpose of this

49. *Id.*
50. *Id.* at 239–40.
51. *Id.*
52. *Id.* at 240.
53. *Id.*
54. *Id.* at 241.
55. *See id.* at 260–62 (Gummow, J., concurring).
56. *Id.* at 260.
57. *Id.* at 255–57.

duty is to enable the patient to make informed decisions on the basis of relevant information.[58] Justice Gummow further stressed that the materialized risk, which was at the root of the plaintiff's injury, is the same risk that should have been revealed to her by force of the duty of disclosure as well as the rationale behind that duty's existence.[59] An additional consideration was the fact that the risk of injury to her voice was especially meaningful to the plaintiff, as demonstrated by her research into the subject.[60] Given these circumstances, the judge was persuaded that it would be unjust to discharge the defendant of his responsibility to pay damages on the basis of some hypothetical scenario regarding how events would have unfolded had the plaintiff undergone the procedure at another time and at the hands of another surgeon.[61] Given the facts indicating that if the surgery had been performed at another time and by a more expert surgeon the risk to the plaintiff would have declined considerably (a fact indicating that the "but for" test applied), Justice Gummow concluded that the plaintiff had proven causation.[62]

Positioning himself between the approaches taken by the two other members of the majority, Justice Kirby, also ruled in favor of the plaintiff.[63] He argued that the common-sense approach to causation supported a decision in favor of awarding compensation to the plaintiff, as did the substance and purpose of the duties violated in this case: the duty of disclosure and the duty to respond to all questions honestly.[64] Even though these duties impose heavy burdens on physicians, they are integral to the law; it is therefore fitting that infringements of those duties will invite legal consequences.[65] Justice Kirby was convinced that this was especially true in the current case. The plaintiff had clearly expressed her fears, and had the defendant responded to those fears, it is decidedly possible that the plaintiff would not have undergone the procedure at the given date and would not have suffered the respective injuries—especially considering the

58. *Id.* at 256–57.
59. *Id.* at 257–58.
60. *Id.* at 257.
61. *Id.* at 262.
62. *Id.* at 256–57, 260–262.
63. *Id.* at 276–79 (Kirby, J., concurring).
64. *Id.* at 276.
65. *Id.* at 277.

rarity of the risk and her contention that she would have turned to a more skilled and experienced physician.[66] In consideration of all the circumstances, Justice Kirby was convinced that the damage in this case was caused, not by unrelated intervening problems, but solely by the physician's failure to inform the patient.[67] Hence, as the defendant had not complied with the burden of persuasion[68] regarding causation, Justice Kirby ruled in favor of the plaintiff.[69]

B. THE *CHESTER* DECISION

The factual basis of *Chester*, a case decided by the British House of Lords, closely resembles that of *Chappel*. In this case the plaintiff had been suffering severe back pain.[70] The defendant, a neurosurgeon to whom the plaintiff had turned for counseling, recommended that the defendant undergo surgery.[71] Three days later, the surgery was performed with the plaintiff's agreement.[72] Although the procedure was performed with reasonable skill, the plaintiff suffered considerable damage to her nervous system in the course of the surgery and was left partially paralyzed.[73] The risk of such injury was anticipated in one percent to two percent of the cases.[74] Claiming the tort of negligence, the plaintiff argued that the defendant had failed to warn her of the risk.[75] The plaintiff also stated that had she been given the risk information, she would have first sought another opinion before agreeing to performance of the procedure at that time.[76] Nevertheless, the court did not rule (and was not requested to rule) on whether the plaintiff would have undergone the

66. *Id.* at 277–78.
67. *Id.* at 278.
68. In Australian law as in American law, the onus to prove causation is on the plaintiff. *Id.* at 270. Yet, Justice Kirby ruled that once the plaintiff demonstrates that a breach of duty had accrued, closely followed by damage, a prima facie casual connection is established. In this case, the burden of proof would be shifted to the defendant. *Id.* at 273.
69. *Id.* at 278–79.
70. Chester v. Afshar [2004] UKHL 41, [2005] 1 A.C. 134, 140 (U.K.).
71. *Id.*
72. *Id.* at 142.
73. *Id.* at 140.
74. *Id.*
75. *Id.* at 138.
76. *Id.* at 141.

surgery at all, or whether there was any way to reduce the risk of injury.[77] However, the court did rule that the risk remained constant, independent of when the procedure was performed and independent of the identity of the surgeon.[78] In other words, the court found that the plaintiff was exposed to the identical risk—in terms of the probability of its materialization and its nature—even if the surgery had been performed on a different day or by a more experienced surgeon.

Similar to the *Chappel* case, the question of negligence raised no obstacles in *Chester*,[79] and the debate centered on the question of causation. Because the plaintiff was unable to establish that she would have completely avoided undergoing the surgery, and because her entire argument revolved around her deferral of the procedure, though deferral that would not have altered the risk inherent in the procedure, the question of causation arose.[80]

The three judges submitting the majority opinion—Lord Steyn, Lord Hope, and Lord Walker—were persuaded that the plaintiff had proven causation.[81] Although some minor differences can be found in their separate opinions, the following arguments were common to all three.

First, establishment of causation is an issue pertaining to legal policy.[82] Hence, when establishing causation and thus assigning legal liability, identification of the correlated rights and duties of both parties, as well as of the relevant legal interests, is required.[83] The protected interest in *Chester* was the right of every adult to make a medical decision having the

77. *Id.* at 140–41.

78. *Id.* at 141.

79. The court in the first instance ruled that the defendant had breached the duty of disclosure owed to the plaintiff and was thus negligent. This decision was not appealed. *Id.* at 148. For a discussion of the court's ruling with respect to the duty of disclosure as imposed on physicians, see David Meyers, Chester v. Afshar*: Sayonara, Sub Silentio,*Sidaway*?*, *in* FIRST DO NO HARM: LAW, ETHICS AND HEALTHCARE 255 (Sheila A.M. McLean ed., 2006).

80. *Chester*, [2005] 1 A.C. at 141.

81. *See id.* at 134.

82. *See, e.g.*, *id.* at 139, 146, 158, 162–63.

83. *See., e.g.*, *id.* at 162–63 (Hope, J., concurring) ("The function of the law is to enable rights to be vindicated and to provide remedies when duties have been breached. Unless this is done the duty is a hollow one, stripped of all practical force and devoid of all content.").

potential to influence her life, which is a basic right.[84] The physician's duty was to avoid providing any treatment without first receiving the patient's informed consent. The physician's duty fulfilled two purposes: the first, prevention of realization of risks that the patient is not prepared to take upon herself; the second, showing the appropriate respect and concern for the patient's right to autonomy and dignity.[85]

Second, the risk materialized was the same risk about which the defendant was to warn the plaintiff.[86] Had the defendant not failed to warn the plaintiff of the possible danger of injury, she would have delayed the procedure, the injury would not have taken place when it did, and the probability that the injury would have been suffered on another occasion would have been lowered.[87]

Third, considerations of policy and corrective justice supported vindication of the patient's right to autonomy and to dignity, and thus a slight departure from the traditional rules of causation.[88] This slight departure was expressed in the court's decision that causation had been proven despite the fact that, in light of the circumstances of the case—the plaintiff could not avoid the surgery and the risk was inherent in the procedure—there were doubts as to whether the "but-for" test had been established. In the current case, the court continued, the defendant owed duty of disclosure to the patient and the duty was breached, and the resulting harm fell within the sphere of the duty.[89] Assignment of theoretical meaning and practical relevance to the duty imposed on physicians and to the patient's right to autonomy thus demanded that the defendant compensate the plaintiff for the injuries suffered.[90]

C. A CRITICAL ANALYSIS OF THE *CHAPPEL* AND *CHESTER*

84. *See, e.g.*, *id.* at 162.

85. *Id.* at 138–39, 142, 144, 148–49, 164. This aspect of the decision, that is, the idea that the foundations of the duty of disclosure rest on the patient's right to autonomy, is also mentioned in later decisions. *See, e.g.*, Khalid v. Barnet & Chase Farm Hosp. NHS Trust, [2007] EWHC 664 (QB) (U.K.), ¶¶ 63–67, *available at* http://www.bailii.org/ew/cases/EWHC/QB/2007/644.html.

86. *See Chester*, [2005] 1 A.C. at 164 (Walker, J., concurring).

87. *Id.* at 165.

88. *Id.* at 162–63.

89. *Id.* at 163.

90. *Id.*

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DECISIONS

A superficial reading of the decisions gives the impression that the courts adopted Shultz's thesis in both cases. By placing the patient's right to autonomy at the center of their deliberations, the courts diverged from traditional rules of causation, and ruled in favor of the plaintiffs. Each decision recognized the importance of the right to autonomy as well as autonomy as an interest to be considered when ruling on whether there was causation. This position motivated the courts to devise a creative solution enabling them to award compensation to plaintiffs who had suffered interference with their right to autonomy thus eliminating or alleviating the difficulty of proving causation. Especially important are the courts' rulings stating that the correct approach to be taken in cases of this type involves correcting the injustice done in the form of interference with the plaintiffs' right to autonomy. The judges were thus persuaded that any other approach would not contribute to credible judicial policy nor serve the interests of corrective justice.[91]

Yet a careful review of the decisions soon reveals the cracks in this initial impression. What first appears to be the courts' adoption of the Shultz thesis quickly evaporates. Although both decisions appear to give considerable weight to the right to autonomy in judicial rulings, and even though the courts' objective was to protect this right, the interest protected was, in fact, the patient's right to physical well-being rather than to autonomy. Moreover, the degree to which these decisions granted any protection to the patient's right to autonomy per se was only partial. In the following, I explain

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91. In her article, Shultz herself dealt with how the issue of causation would be affected by the thesis she had suggested. Shultz, *supra* note 1, at 286–91. She was confident that adoption of her position would lead to amelioration of strict rules of causation through rejection of the balance of probabilities test and adoption of the probability (proportional) test. *Id.* According to the latter test, the court is to assess the probability that a patient would have chosen an alternative therapy had there not been any interference with her right to autonomy. *Id.* at 287. The patient would then be entitled to compensation on the basis of this assessment. *Id.* The advantage of the probability test lies in its power to prevent rejection of claims based on the argument that the plaintiff had not complied with the burden of proof—according to the balance of probabilities test—that her decision would have been different had her right to autonomy not suffered interference. *Id.* Such a phenomenon is common in claims based on the doctrine of informed consent. *See id.* at 286–87.

why.

First, the courts in both *Chester* and *Chappel* ruled that compensation was to be awarded to the plaintiffs for the physical injuries they had suffered as a result of the treatment received despite the absence of causality between the breach of the duty of disclosure and the injury sustained or, at the very least, the presence of serious doubt regarding the existence of such causality.[92] Although both courts portrayed their rulings as easing the traditional rules of causation, the fact is that they did not modify these rules but, in effect, sought causation where it was nonexistent.[93]

We can conclude from the considerations voiced, as reported above, that resting at the heart of the majorities' decisions in both cases was the assumption that had violation of the duty of disclosure not occurred, the plaintiffs would not have suffered any physical injury because they would have delayed the procedure and because of the rarity of the subsequent attendant risk.[94] This line of reasoning enabled the judges to "temper" the traditional rules of causation and to base their ruling in favor of the plaintiffs on legal policy considerations.

This assumption, however, was inherently false. The probability that some medical risk, however small, will materialize remains constant irrespective of the timing of a

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92. *See* Chappel v. Hart (1998) 195 C.L.R. 232, 242–44, *available at* http://www.austlii.edu.au/au/cases/cth/HCA/1998/55.html; *Chester*, [2005] 1 A.C. at 162–63.

93. *See Chappel*, 195 C.L.R. at 255–57; *Chester*, [2005] 1 A.C. at 162–63. Criticism of these decisions in this vein was expressed by numerous legal scholars. *See, e.g.*, Kumaralingam Amirthalingam, *Medical Non-Disclosure, Causation and Autonomy*, 118 L.Q. REV. 540, 542 (2002); Bradfield, *supra* note 43; *see supra* text accompanying notes 57–66; Jeremy Clarke, *Causation in* Chappel v. Hart*: Common Sense or Coincidence?*, 6 J.L. & MED. 335, 346–47 (1999); Charles Foster, *It Should Be, Therefore It Is*, 154 NEW L.J. 1644, 1644–45 (2004); Tony Honoré, *Medical Non-Disclosure, Causation and Risk:* Chappel v. Hart, 7 TORTS L.J. 1, 7–8 (1999); Marc Stauch, *Taking the Consequences for Failure to Warn of Medical Risks*, 63 MOD. L. REV. 261, 266–67 (2000); Stephen M. Waddams, *Causation, Physicians and Disclosure of Risks*, 7 TORT L. REV. 5, 6 (1999).

94. As we have seen, this assumption also stood at the heart of Justice Gaudron's decision in *Chappel*, as well as Justice Kirby's, which was likewise based on the argument that the performance of the procedure by a more competent surgeon might have reduced the inherent risk. *See Chappel*, 195 C.L.R. at 242, 277.

procedure. The example of a game of roulette, as Justice Hoffman noted in *Chester*, provides a good demonstration of this flaw: if the probability that the number seven would come up in a roulette game is one to thirty-seven, this probability remains the same even if the gambler leaves the casino without placing a bet and returns later to bet once more.[95]

Hence, the assumption that transmission of information to the plaintiffs would have led them to defer their respective surgeries and thereby prevent the physical injury they suffered is fallacious. It was therefore erroneous to conclude that breach of the duty of disclosure was a "but for" cause of the plaintiffs' injuries. Such injuries were likely to have been suffered, with the same probability, whenever the procedure was performed.[96]

The sole assumption warranting the conclusion that non-disclosure had caused the injuries suffered by the plaintiffs was that had the surgery been performed by a different, more experienced and skilled surgeon, the risk inherent in the procedure would have been reduced.[97] Yet this argument was not raised by the plaintiff in the *Chester* case and so became irrelevant to the court's decision. Although the argument was raised in *Chappel*, only one of the sitting judges—Justice Gaudron—based her ruling on these grounds.[98] Justice Kirby mentioned such a possibility but was insufficiently clear about its factual aspects.[99] Furthermore, however much Justice Kirby might have found this argument acceptable, it represented only one in a range of his considerations and was certainly not the main reason for his decision.[100] The third member of the majority, Justice Gummow, totally ignored this argument.[101]

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95. *Chester*, [2005] 1 A.C. at 147 (Hoffman, J., dissenting).

96. For more on this argument, see IAN FRECKELTON & DANUTA MENDELSON, CAUSATION IN LAW AND MEDICINE 394 (2002).

97. For more on this argument, see *id.* at 394.

98. *Chappel*, 195 C.L.R. at 241–42.

99. *Id.* at 277–78 (Kirby, J., concurring).

100. *See id.* at 276.

101. *Id.* at 255–63. For a similar description of the judges' approaches concerning this factual issue, see Stauch, *supra* note 93, at 265–67. For a more extreme approach stating that all the judges in the majority would have ruled in favor of the existence of causation, even if the probability of the risk materializing had been identical under the hands of a more skilled and experienced surgeon, see FRECKELTON & MENDELSON, *supra* note 96, at 395–96. By contrast, in a later decision reached by Justice

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Given the assumption that even if the surgery had been performed at another time and by a different surgeon the attendant risk would have remained similar, we have no choice but to conclude that the plaintiffs were unable to prove that but for infringement of the duty of disclosure, they would not have suffered any damage. In other words, we find it difficult to avoid the conclusion that causation was not substantiated or, at the very least, that its existence was in serious doubt.[102]

Yet the *Chappel* and *Chester* courts both chose to compensate the plaintiffs for the physical injury suffered. Like their predecessors, they applied the doctrine of informed consent as alternative grounds for awarding compensation for physical injuries;[103] only now the awards were made in cases arousing serious doubt regarding causation.

Interestingly, both the *Chappel* and *Chester* courts chose to base their decisions on the significance of the right to

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Gummow, he described the rulings of the two other judges in the *Chappel* majority—Justices Gaudron and Kirby—as having been based on the assumption that the risk would have declined had the surgeon been more skilled and experienced. *See* Rosenberg v. Percival (2001) 205 C.L.R. 434, 464 (Austl.), *available at* http://www.austlii.edu.au/au/cases/cth/HCA/2001/18.html. John Gunson developed an interesting opinion in this regard, specifically, that although the plaintiff succeeded in proving that the probability of risk would have declined had a more skillful and experienced surgeon performed the procedure, her argument would still have been insufficient to prove causation. This was so in absence of evidence that the harm suffered had resulted from the increased risk to which she was exposed as opposed to the risk inherent in the procedure. *See* John Gunson, *Turbulent Causal Waters: The High Court, Causation and Medical Negligence*, 9 TORT L. REV. 53, 77 (2001).

102. Most judges in the minority opinions of these cases came to the same conclusion. *See, e.g.*, *Chappel*, 195 C.L.R. at 286–87; *Chester*, [2005] 1 A.C. at 147.

103. The main and immediate purpose of the doctrine of informed consent had been the extension of physicians' liability in addition to the guarantee of compensation to a far greater number of patients who had suffered injury in the wake of medical treatment. This phenomenon represented part of a more general trend toward ensuring appropriate compensation to a larger number of injured parties and the broadening of liability to entities known to take advantage of the distribution of damage. For more on this argument and a description of the development of informed consent, see Alan Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 51 (1977); IZHAK ENGLARD, THE PHILOSOPHY OF TORT LAW 161–63 (1993); Gerald Robertson, *Informed Consent to Medical Treatment*, 97 L.Q. REV. 102, 109–12 (1981).

autonomy and on their aspirations to endow that right with the appropriate protection as well as with practical force. Yet this firm, rational basis for the decisions totally contradicts the cases' final outcomes. Instead of identifying the actual injury suffered by the plaintiffs—interference with the right to autonomy— and awarding the plaintiffs compensation for this damage, the courts chose to award compensation for their physical injuries even though neither plaintiff was able to prove, as required, causation between the non-disclosure and the harm suffered.[104]

Another interesting observation is that the *Chappel* court was also offered a theory—the theory of loss of chance—that might have led to awarding compensation for the injury to the plaintiff's right to autonomy. This theory was suggested by the defendant, who argued that the injury suffered by the plaintiff was not physical but, rather, the lost chance of having the surgery performed by another physician and at a different time.[105] Although the defendant's objective in proposing this argument was to deny the plaintiff any compensation, based on the contention that the lost chance had no value, the court could have accepted the notion and awarded compensation based on interference with the plaintiff's autonomy,[106] as I now

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104. It is worth mentioning in this regard the approach taken by Justice Hoffman in *Chester*. Justice Hoffman was persuaded that the plaintiff had not proven causation. *Chester*, [2005] 1 A.C. at 147. Nevertheless, given the fact that the plaintiff's right to autonomy had suffered interference, he considered ruling in favor of a modest *solatium*. *Id.* He himself expressed no enthusiasm regarding this possibility, whether due to the difficulty of determining the appropriate amount of compensation, or whether due to the fact that the high costs of the proceedings made tort law an inappropriate vehicle for allocating damages in such cases. *Id.* The idea of awarding the plaintiff a sum of money in the form of a *solatium* in cases where the right of autonomy had been abrogated but where there was no possibility of proving causation was raised in a later ruling. The idea was briefly discussed by the court but rejected for procedural reasons. Review of statements made by the court indicates that the idea was considered radical, which induced the court to act with circumspection. *See, e.g.*, SEM v. Mid Yorkshire Hosps., [2005] EWHC (QB), B3, [59]–[60], *available at* http://www.bailii.org/ew/cases/EWHC/QB/2005/B3.html.

105. *Chappel*, 195 C.L.R. at 237–38.

106. The defendant claimed that because the injury suffered by the plaintiff was the lost chance of undergoing the surgery at a different time and with another surgeon, and because the risk inherent in the procedure had remained constant irrespective of when it was performed or the surgeon's identity, the lost chance lacked any value. *Id.* This argument raises the question of how to assess compensation for a lost chance, an

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make clear.

The right to autonomy refers to the right to make decisions that reflect the values and preferences of the decision-maker.[107] In order to realize this right, the decision-maker has to receive all the information she considers relevant. Transmission of partial information undermines the prospect that the decision-maker's choice will reflect her values and preferences, and thus her right to autonomy.

Returning to *Chappel*, it follows that a close connection can be established between the award of compensation to the plaintiff for her lost chance that the surgery would be performed at another time and by a different surgeon, choices that more accurately reflect her preferences, and the award of compensation for the interference with her right to autonomy. Hence, the court was given, in effect, an opportunity to develop a liability theory centered on the right to autonomy as opposed to the interest in physical well-being. It appears, however, that the court rejected the theory of lost chance[108] without pursuing development of the alternative idea, as I have suggested.

The approach adopted by the courts, that is, their focus on the physical injury suffered by the two plaintiffs, together with their avoidance of the fact that the real damage suffered was interference with their right to autonomy, was elaborated not only in their final decisions but in the substantiating arguments as well. As we shall soon see, this reasoning had undesirable outcomes—the extension of only partial protection

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issue discussed later with reference to assessment of compensation for interference with the right to autonomy. We can venture here that the conclusion reached by the defendant was not inescapable, and that a different theory regarding the assessment of compensation would have allowed award of compensation under these conditions as well.

107. *See* Shultz, *supra* note 1, at 220.

108. Rejection of the theory of lost chance rested on several considerations: That the injury actually suffered was a physical injury, that no duty was imposed upon the physician to provide the plaintiff with an opportunity for the procedure to be performed by a more skilled surgeon, and that he was not required to refer her to a more skilled surgeon. *See Chappel*, 195 C.L.R. at 237–38, 88. Furthermore, recognition of the lost chance as an injury demanding compensation is constrained by the difficulty of making a reasonable assessment of the damage. *See id.* at 274–75, 78. Finally, from a procedural prospective, the plaintiff demanded compensation for her physical injury and not for the lost chance. *Id.* at 278–79.

to the right to autonomy.

Considerable stress was placed in both *Chappel* and *Chester* on the fact that the risk against which the defendants were to warn the plaintiffs had materialized in the form of physical injury.[109] In effect, it was the chain of events beginning with the breach of disclosure and concluding in realization of physical injury that made it inconceivable, according to the judges in the majority, to free the defendants of liability and to deny the plaintiffs any compensation.[110] As stated, the judges in the majority held that such outcomes contradict corrective justice, and threaten to empty the duty of disclosure of its meaning.

Yet these considerations, however intuitive and rational they may appear to be, are problematic. In both cases it was agreed by the courts that the inherent risk to the plaintiffs was mild. In fact, in *Chappel*, the said risk was described as rare.[111] Moreover, the courts in both cases stressed that had the two plaintiffs undergone the surgery at a later date, it was quite likely that they would not have been harmed.[112] The injury's realization was therefore a matter of bad luck, with a low probability of transpiring. Yet, the breach of the duty of disclosure, like the injury to the plaintiffs' right to autonomy, would have remained effectively the same whether or not the risks had materialized. Nevertheless, the courts' line of argument implied that had the risk not materialized, the plaintiffs would not have been entitled to any compensation for the infringement to their right to autonomy. If this analysis is correct, protection of the right to autonomy rested, in both cases, on the realization of risk and its associated physical injury.[113] Hence, the legal protection given to the right of autonomy was limited to cases marked by these two characteristics: realization of the said risk and the existence of physical injury.

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109. *See, e.g.*, *Chester*, [2005] 1 A.C. at 163; *Chappel*, 195 C.L.R. at 238.

110. These facts were stressed by all the judges in the majority in both cases as central to their decision to digress from traditional rules of causation. *See Chappel*, 195 C.L.R. at 239–40, 260, 276–77; *Chester*, [2005] 1 A.C. at 146, 163, 165–66.

111. *Chappel*, 195 C.L.R. at 242, 267.

112. *Id.*; *Chester*, [2005] 1 A.C. at 142.

113. Substantiation of this argument can be found, for example, in Justice Kirby's reasoning in *Chappel*, 195 C.L.R. at 271–72.

There is little doubt that linking the plaintiffs' right to compensation to the realization of risk and the suffering of physical injury appeared natural in the circumstances of *Chappel* and *Chester*. Both plaintiffs had been harmed, and both claimed compensation on the basis of those injuries. A different but related question concerns whether the linking of the right to compensation to the realization of risk and the experience of physical injury, the result of which was only partial protection of the right to autonomy, is necessary and justified. As I will later argue, the response to this question should be in the negative.

The approach taken by the courts in the two decisions—that is, disregard of the fact that the real damage sustained by the plaintiffs was interference with their right to autonomy—was expressed in connection with another issue. In both decisions, the judges accepted the contention that had the plaintiffs been fully informed about the procedure's risk, they would have delayed the surgery.[114] This position lies at the core of the conclusion that had the defendants fully informed them of the risks, the plaintiffs would presumably not have suffered any injury.[115] At the same time, the judges agreed that if the evidence had indicated that the plaintiffs would not have postponed the time of the surgery but allowed it to be performed as agreed, it would be impossible to award them compensation.[116] Although this conclusion may be justified with respect to the plaintiffs' physical injuries, it cannot be accepted so far as it relates to the injury to their right to autonomy.

I argue here that in the wake of the breach of the duty of disclosure, the plaintiffs' right to autonomy was abridged, irrespective of whether they would have postponed the surgery or not. However, because the courts focused on the physical injury sustained by the plaintiffs rather than on the

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114. *Chappel*, 195 C.L.R. at 254; *Chester*, [2005] 1 A.C. at 141.

115. *Chappel*, 195 C.L.R. at 237; *Chester*, [2005] 1 A.C. at 141.

116. *Chappel*, 195 C.L.R. at 237, 260, 273; *Chester*, [2005] 1 A.C. at 141–42, 144, 154. Literature concurs with this position. *See, e.g.*, JONATHAN HERRING, MEDICAL LAW AND ETHICS 105–06 (2006). This rule was also applied in a later decision in which the plaintiffs based their position on *Chester*. *See* SEM v. Mid Yorkshire Hosps., [2005] EWHC (QB), B3, [36], *available at* http://www.bailii.org/ew/cases/EWHC/QB/2005/B3.html.

interference with their right to autonomy, the right to compensation became subject to a decision different from the one made by the patient, a condition that circumscribed the protection given to the right of autonomy.

Another interesting question relates to why the courts chose to focus on the physical injury suffered, a choice that bound protection of the right to autonomy with evidence of physical injury as well as to the decision of causation. In other words: why were the courts unprepared to adopt the notion that the damage suffered by the plaintiffs for which they were due compensation was interference with their right to autonomy?

The simplest response rests on the circumstances of the cases presented before the court, which I reiterate. As a result of medical treatment meant to improve their condition, the two plaintiffs suffered considerable physical injury.[117] Yet, when it was ruled that their medical treatment had not been delivered negligently, it became impossible to award them compensation on theory of negligent treatment.[118] At the same time, the plaintiffs were denied information on the risk inherent in the proposed surgery, a risk that came to fruition in these cases causing severe and permanent damage.[119] Moreover, the plaintiff in *Chappel* had thoroughly investigated the risk to her voice were she to undergo the procedure and had expressed fears regarding the very injury she eventually suffered;[120] the plaintiff in *Chester* had expressed a preference for avoiding the surgery altogether if the procedure was not essential.[121] The courts certainly found it difficult to deny the plaintiffs' claims; had they done so, it would have left the plaintiffs bereft of compensation for the injuries suffered. The desire to compensate the plaintiffs for their physical injuries, together with the defendants' breach of duty of disclosure, led the courts to link together two separate objectives: compensation for the plaintiffs' physical injury and protection of their right to autonomy.

Yet analysis of the courts' approach indicates a deeper explanation for their decision, one rooted in the doctrine of

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117. *Chappel*, 195 C.L.R. at 253; *Chester*, [2005] 1 A.C. at 150.
118. *Chappel*, 195 C.L.R. at 266. *Chester*, [2005] 1 A.C. at 142.
119. *Chappel*, 195 C.L.R. at 237; *Chester*, [2005] 1 A.C. at 142.
120. *Chappel*, 195 C.L.R. at 257.
121. *Chester*, [2005] 1 A.C. at 140.

informed consent and the characteristics of the cause of action presented by the plaintiffs, i.e., the tort of negligence.

As already noted, the primary and immediate objective for elaboration of the doctrine of informed consent was expansion of physicians' liability and guaranteeing that compensation would be awarded to a much greater number of patients harmed as a result of medical treatment, especially those who were unable to associate the cause of their injuries with negligent medical treatment.[122] Indeed, from the outset, the doctrine of informed consent was presented as resting on the right to autonomy.[123] The courts, however, continued to focus on compensation to the patients for their physical injuries. It should come as no surprise, then, that the courts continued in this vein in the *Chappel* and *Chester* cases.

The award of compensation for the physical injuries suffered by the plaintiffs—as opposed to interference with the right to autonomy—is likewise closely related to the characteristics of the cause of action presented by the plaintiffs, the tort of negligence. The existence of some "injury" represents one cornerstone of the tort of negligence and an initial condition for assigning liability.[124] Indeed, with time, this tort's objectives were broadened beyond protection of the interest in physical well-being to the recognition of the injured party's right to compensation for other injuries, such as pure economic injury and pure mental anguish;[125] yet all of these injuries are considered tangible injuries. Furthermore, with respect to medical accidents, the tort of negligence has historically focused on the award of compensation to the patient for the physical, that is, tangible injury suffered.[126] It could therefore be expected that a similar approach, stressing the physical injuries the plaintiffs suffered but disregarding the real harm done to their right to autonomy, should be adopted

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122. *See* Meisel, *supra* note 103, at 52, 56–60, 63–77; ENGLARD, *supra* note 103; Robertson, *supra* note 103.

123. *See, e.g.*, Salgo v. Leland Stanford Jr. University Board of Trustees, 317 P.2d 170, 181 (Cal. Ct. App. 1957); Cobbs v. Grant, 502 P.2d 1, 9–10 (Cal. 1972); Natanson v. Kline, 350 P.2d 1093, 1104 (Kan. 1960).

124. *See* SIMON DEAKIN ET AL., MARKESINIS AND DEAKIN'S TORT LAW 113 (6th ed. 2008).

125. *Id.* at 139–142, 157–99.

126. ENGLARD, *supra* note 103, at 163–64.

in the *Chappel* and *Chester* decisions.

Several scholars, especially Shultz, have repeatedly argued that a major weakness of the tort of negligence in relation to the doctrine of informed consent is the presentation of proof of physical or some other tangible injury as a precondition for awarding compensation.[127] Due to this focus, the true damage suffered by the patient, i.e., interference with her right to autonomy, has been ignored.[128]

IV. WHAT SHOULD THE COURTS HAVE DONE IN CHAPPEL AND CHESTER? — A NEWLY IDENTIFIED HEAD OF DAMAGE

As can be deduced from the previous critical analysis of the *Chappel* and the *Chester* rulings, I do not concur with the approach applied by the courts in either case. What, then, would I have recommended they do? I suggest that in the first stage, the court should have avoided awarding compensation for the physical injuries suffered. In the absence of causation, there was no reason to award compensation for such injuries.[129] As to the second stage, I believe that the courts should have recognized the existence of a new head of

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127. *See, e.g.*, Shultz, *supra* note 1, at 232–41; *see also* ENGLARD, *supra* note 103, at 164; EMILY JACKSON, MEDICAL LAW—TEXT, CASES AND MATERIALS 300, 302, 304 (2006); KATZ, *supra* note 30; Roger Crisp, *Medical Negligence, Assault, Informed Consent, and Autonomy*, 17 J.L. & SOC'Y 77, 80–81 (1990); Meisel, *supra* note 103, at 132–33; Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 925, 936 (1994); Twerski & Cohen, *supra* note 30, at 616, 620.

128. *See* Shultz, *supra* note 1, at 251–53.

129. This argument should be distinguished so far as it relates to *Chappel*. In that case, if the plaintiff had been able to establish that had the defendant transmitted the information about the attendant risk of the surgery she would have been able to turn to a more skilled and experienced surgeon; that performance of the surgery by such a surgeon would have significantly reduced the related risk; and that realization of that risk resulted from the heightened risk to which she was exposed, the court could have ruled that the requirements of causation had been met, making it possible to award her compensation for the physical injury. However, as we have seen, only one of the three judges in the majority based his decision on this fact-based premise. For an argument in this spirit, see Kenyon Mason & Douglas Brodie, Bolam, Bolam—*Wherefore Art Thou* Bolam*?*, 9 EDINBURGH L. REV. 298, 305 (2005). For a different approach, according to which the court was to compensate the plaintiff for the physical injury suffered despite the absence of causation, see Honoré, *supra* note 93.

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damage—interference with the right to autonomy.[130]

According to this new approach, when a patient's right to autonomy suffers interference by a breach of the duty of disclosure or some other method (i.e., her ability to make decisions of her own free will is undermined), that patient suffers an injury for which she is entitled to compensation. This injury is experienced concurrent with the breach of the duty of disclosure, and its remedy is unrelated to the realization of the risk inherent in the respective procedure and the existence of physical injury. Moreover, remedy for this injury is not subject to proof of a different decision that might have been made by the patient. Proof of a breach of the duty of disclosure necessarily entails proof of causation between the breach of that duty and the damage claimed by the patient, that is, interference with her right to autonomy. Of course, if the patient is able to prove that interference with her right to autonomy caused physical injury, she will be eligible for remedy for this injury as well. In any case, no remedy is to be awarded in the absence of proof of causation between the interference with her right to autonomy and the physical injury.

A number of arguments support the correctness of recognizing this new tort, namely, the interference with the right to autonomy. Because Shultz has provided some of the relevant considerations in her article, I present those arguments yet to be elaborated.

A. ADOPTION OF THIS NEW HEAD OF DAMAGE IS COMMENSURATE WITH THE PATIENT'S RIGHT TO AUTONOMY

Acknowledgement of this right and, it follows, *bona fide* expression of its salience, requires its recognition as an independent and distinctive value warranting remedy. Such

130. Support for this approach can be found in the literature. *See* Mason & Brodie, *supra* note 129, at 305–06; Waddams, *supra* note 93, at 7. For a similar approach according to which the courts were to rule in favor of providing remedy for the non-pecuniary damage suffered due to the breach of the duty of disclosure, see, e.g., Foster, *supra* note 93, at 1645; Edward Levey, *Taking the Scalpel to Compensation*, L. SOC'Y GAZETTE, Dec. 2, 2004, at 37. Nevertheless, as we shall see, the approach I suggest is different, because it treats interference with the right to autonomy as a separate head of damage and not as a derivation of non-pecuniary damages.

remedy is to be awarded in cases of interference with the right to autonomy (as opposed to injury to the interest of physical security) and should not be subject to the realization of any risk or proof of decision causation. The legal designation of interference with the right to autonomy as a separate compensable injury would convey indispensable normative confirmation of this approach, which carries an important message for patients as well as physicians.[131]

It is interesting to note that in the *Chester* decision, Lord Hope, one of the judges in the majority, noted that recognition of the duty to compensate a patient whose right to autonomy was infringed has a powerful symbolic and galvanizing role in the creation of a more substantive right to autonomy for patients.[132] However, the normative statement that eventually emerged under the court's aegis did not transmit the promised symbolic message.

B. THIS RULE'S ADOPTION WILL INTRODUCE COHERENCE

Award of compensation to a patient for a physical injury suffered in the absence of causation, together with conditioning that compensation on the realization of a risk as well as the establishment of decision causation, introduces vertical as well as horizontal incoherence.[133] That is, vertical incoherence is created between the legal rules—the duty to ask for the patient's consent as well as the duty of disclosure—and the theoretical basis of those rules, specifically, the patient's right to autonomy. Furthermore, internal (horizontal) incoherence is introduced among the legal rules themselves by

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131. Twerski & Cohen, *supra* note 30, at 665; Emily Jackson, *'Informed Consent' to Medical Treatment and the Impotence of Tort*, *in* FIRST DO NO HARM: LAW, ETHICS AND HEALTHCARE 273, 284 (Shelia A.M. McLean ed., 2006); Levit, *supra* note 30, at 174, 188–90.

132. Chester v. Afshar, [2004] UKHL 41, [2005] 1 A.C. 134, 162–63 (U.K.).

133. According to coherence theories of law, the question of whether the legal rule is coherent with former legal rules or legal principles is relevant when dealing with the issue of validity or "correctness" of legal rules or decisions. Furthermore, coherence considerations should be part of legal reasoning because this is the best way to identify the correct legal solution. There are different classifications of theories of coherence; one of which differentiates between vertical coherence and horizontal coherence. For a discussion on the nature of vertical coherence see, e.g., NEIL MACCORMICK, LEGAL REASONING AND LEGAL THEORY 106–07, 152 (1978); as to horizontal coherence, see, e.g., LON L. FULLER, THE MORALITY OF LAW 41–42, 65–66 (rev. ed. 1969).

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inappropriately distinguishing between different defendants.

If the patient's right to autonomy rests at the foundations of a legal settlement, any interference with that right should entitle the patient to compensation even if the risk inherent in the respective treatment was not realized and the patient suffered no physical injury. Moreover, compensation is due even if the patient's decision would not have been different had there been no breach of the duty of disclosure. Interference with the patient's right to autonomy materializes with the breach of the duty of disclosure, independent of any physical injury or establishment of any other course of action. In addition, if the patient's right to autonomy rests at the foundation of physicians' basic duties to their patients, then breach of those duties should entitle patients to compensation for the interference itself rather than for the physical injury caused by the medical treatment but not by the interference with the right to autonomy.

Moreover, stipulating patient rights to compensation on the realization of risk or proof of an alternative decision introduces a distinction between plaintiffs who suffered a physical injury and can prove the possibility of an alternative decision, which entitles them to compensation, and plaintiffs who did not suffer a physical injury or are unable to prove the possibility of an alternate decision, and who are thus not entitled to compensation. Such prejudice is inappropriate when recognizing the fact that both experienced interference with their right to autonomy and that the latter may have suffered damage to her right, which is equal to if not more severe than the damage suffered by the former.[134]

Recognition of the interference with the patient's right to autonomy as a distinct compensable injury, bounded neither by the realization of risk nor evidence of decision causation, mitigates incoherence by expressing the notion that the patient's right to compensation becomes palpable upon the breach of any of the physician's duties, and that the true injury suffered by the patient in such cases is the interference with her right to autonomy.[135]

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134. Regarding the vertical incoherence created by the rule adopted in the *Chester* decision, see JACKSON & POWELL ON PROFESSIONAL LIABILITY 1013 (John L. Powell et al. eds., 6th ed. 2007).

135. ENGLARD, *supra* note 103, at 166; Roger B. Dworkin, *Getting What*

It is interesting to note that the issue of horizontal coherence was mentioned by Lord Hope, one of the judges in the *Chester* case. The judge stated that the duty of disclosure imposed on the defendant, resting as it does on the patient's right to autonomy, is unaffected by any decision the plaintiff might have made had she received all the information about the inherent risk.[136] Considerations of vertical coherence can also be found in the remainder of his opinion. According to Justice Lord Hope, denial of compensation to patients who are unable to candidly state that they would have definitely refused the medical treatment and can only prove they would have deferred the treatment in order to consult with other professionals, represents discrimination.[137] The duty to transmit information about all the risks inherent in a procedure to a patient who finds it difficult to make a decision and would prefer to postpone treatment is identical to the duty toward a patient capable of proving that she would refuse the treatment at any time.[138] Yet, despite the weight given to considerations of coherence, the decision reflected a lack of horizontal as well as vertical coherence.

C. ADOPTION OF THIS NEW RULE IS CONSISTENT WITH CONSIDERATIONS OF DETERRENCE

Award of compensation to patients for physical injuries suffered, despite the absence of causation between the interference with their right to autonomy and the said injuries, indicates application of a rule according to which physicians are liable for all the harm suffered by patients in the wake of medical treatment, including those injuries for which they are not guilty. Alternatively, restricting a patient's right to compensation to those cases where they can establish physical injury as a result of the physician's breach of some duty toward his patients indicates adoption of a rule relieving physicians of liability in two situations: first, where the patient did not suffer any physical injury as a result of the treatment;

We Should from Doctors: Rethinking Patient Autonomy and the Doctor-Patient Relationship, 13 HEALTH MATRIX 235, 247 (2003); Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 364–65 (1999); Twerski & Cohen, *supra* note 30, at 608, 616.

136. *Chester*, [2005] 1 A.C. at 154.

137. *Id.* at 162.

138. *Id.*

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second, where the patient suffered personal injury but was unable to establish decision causation.

These rules do not accord with the aspiration to achieve efficient deterrence. In order to do so, the economic burden caused by harmful activity, which is to precisely equal the social costs incurred due to that harmful activity, must be internalized by the appropriate party.[139] Put simply, a rule that imposes social costs on a damager even if the respective costs were not caused by his harmful activity is likely to initiate over-deterrence.[140] Alternatively, a rule that frees a damager of liability in cases where his harmful activity incurred some social cost can be expected to precipitate under-deterrence.[141]

It follows that a rule that allows imposition of liability on physicians for the physical injuries suffered by their patients as a result of medical treatment even in the absence of causation between the interference with the right to autonomy and those injuries, is expected to induce over-deterrence. And the contrary: a rule that relieves doctors of liability in cases where they breached one of their duties and thus interfered with their patients right to autonomy, based on the grounds that the patient did not suffer personal injury or is unable to prove the "decision causation" can be expected to induce under-deterrence.[142]

Recognition of interference with the right of autonomy as a compensable injury is expected to prevent award of compensation to patients, despite the absence of causation,[143] at the same time that it will avoid conditioning entitlement to compensation on the existence of physical injury or proof of

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139. *See, e.g.*, ROBERT COOTER & THOMAS ULEN, LAW & ECONOMICS 383–84 (5th ed. 2008).

140. *Id.*

141. *Id.*

142. Damage to the doctrine's effectiveness regarding deterrence is expected to arise especially in cases where it is difficult to distinguish between outcomes originating in medical treatment and outcomes originating in the natural development of a disease, where the patient's medical condition requires treatment, and where the risk inherent in alternative procedures is identical.

143. This argument is based on the assumption that if we recognize the interference with the right to autonomy as a new head of damage, there will no longer be any need to impose liability on the perpetrator of the physical injury suffered by the patient despite the absence of causation in order to assign normative relevance to the patient's right to autonomy.

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decision causation. In other words, recognition of this new head of damage increases the probability that the damager will be obliged to pay the social costs of his harmful activity. It follows that this approach is congruent with the interests of deterrence.

It is interesting to note that in the *Chester* case, the court thought it worthwhile to assign practical meaning and relevance to the duties imposed on physicians as well as to the patient's right to autonomy. It was clear to them that protecting such interests requires imposition of liability on the defendant for the respective injuries.[144] Although we may initially interpret their statements as expressions of the court's aspiration to achieve deterrence, we soon realize that an inefficient rule was nonetheless adopted.

D. ADOPTION OF THIS RULE COMPLIES WITH THE INTERESTS OF CORRECTIVE JUSTICE[145]

One of the elements characterizing tort law in general and corrective justice in particular is correlativity. Correlativity is expressed, among other things, in the fact that the defendant's harmful actions caused injury to the plaintiff on the one hand, and in the imposition of liability on the defendant to correct the damage through the award of compensation commensurate with the injury on the other hand.[146]

Considerations of corrective justice therefore demand that if the equality between the parties—patient and physician—was abrogated as a result of the physician's harmful action, the physician will be liable for the patient's injury, expressed as the interference with her right to autonomy. Adoption of a rule imposing liability on the physician for the physical injuries resulting from medical treatment but not from interference with the patient's right to autonomy or, alternatively, adoption of a rule releasing the physician of liability for the injuries for which he is culpable (interference with the patient's right to autonomy), contradicts the outcomes required by corrective justice.

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144. Chester v. Afshar, [2004] UKHL 41, [2005] 1 A.C. 134, 146, 150–59, 162–63, 166 (U.K.).

145. For support of this argument, see Levit, *supra* note 30, at 189–90.

146. Jules L. Coleman, *The Practice of Corrective Justice*, 37 ARIZ. L. REV. 15, 26–27 (1995); Ernest J. Weinrib, *Correlativity, Personality, and the Emerging Consensus on Corrective Justice*, 2 THEORETICAL INQUIRIES IN L. 107, 110, 116 (2001).

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As we have seen, considerations of justice, especially of corrective justice, were major factors in the two decisions cited. It was unthinkable to the courts that the defendants' breach of the duty of disclosure and interference with the plaintiffs' right to autonomy should have no legal response. Yet, despite the correctness of these views, the decisions' outcomes fully contradicted the stated intentions. The interference with the plaintiffs' right to autonomy indeed justified a legal response as expressed in the defendants' liability but, contrary to the rulings in the cases, not for the physical injuries suffered by the plaintiffs as they were not in fact caused by the breach of the duty of disclosure. A more appropriate application of the principles of corrective justice would have required making the defendants liable for the injury caused to the plaintiffs' right to autonomy.

E. RECOGNITION OF INTERFERENCE WITH THE RIGHT TO AUTONOMY AS A COMPENSABLE DAMAGE COMPLIES WITH THE LAW'S EVOLUTION

One of the central arguments upon which Shultz based her thesis was the fact that provision of protection to the right to autonomy, and thus the interest in choice, represents a natural extension of developments in constitutional and civil law.[147] There is no need to repeat this argument, which was extensively elaborated in her article. I would nevertheless like to add to this reasoning.

Protection from interference with personal autonomy and dignity underlines recent recognition of remedy for the misuse of private information in the form of a new tort, that of invasion of privacy in New Zealand,[148] and as a further stage in the development of breach of confidence in England.[149]

These recent developments reinforce the contention that recognition of the right to autonomy as a separate interest, the interference with which entitles the patient to compensation, is to be found in common law. Moreover, if the law is prepared to protect the right to autonomy with respect to the misuse of private information, it is right and proper that the same

147. Shultz, *supra* note 1, at 276–81.

148. *See* Hosking v. Runting, [2005] 1 N.Z.L.R. 1, 8 (C.A.).

149. Campbell v. MGN Ltd., [2004] UKHL 22, [2004] 2 A.C. 457, 464–66 (appeal taken from Eng.) (U.K.).

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protection should be extended to instances where it is most needed: cases of interference with the right of a person to make an informed decision regarding the medical treatment that she is to receive.

Despite the presence of these weighty reasons supporting creation of the proposed new head of damage, one cannot ignore two of the arguments raised against the introduction of such a rule: the fear of over-deterrence and the fear of incurring excessive administrative costs. Each will be discussed separately.

1. The Fear of Over-deterrence

According to this argument, the legal rule recognizing interference with the right to autonomy as a compensable damage could motivate physicians to practice defensive medicine. In other words, in the absence of the duty to establish physical injury or decision causation, the scope of medical liability is likely to expand, meaning that this legal rule may instigate over-deterrence.

In-depth review of this argument leads, I believe, to the conclusion that it is inadequate as justification for a rule that would waive a physician's liability for this damage.

First of all, the *Chappel* and *Chester* decisions indicate that, surprisingly, we can expect adoption of this new head of damage to prevent over-deterrence. As we have seen, the courts in both cases awarded compensation to the plaintiffs for their physical injuries, despite the absence of traditional causation, because they felt that the interference with the right to autonomy deserved a legal response.[150] These decisions, which allowed the imposition on the defendants of the social costs (i.e., the patients' physical injuries) not caused by the defendants' harmful activities (i.e., the breach of duty of disclosure) can be expected to instigate over-deterrence. Recognition of the new damage (i.e., interference with the right to autonomy) will prevent such situations. The courts will now be able to give direct normative expression of the importance of the right to autonomy by awarding compensation to patients for interference with that right without recourse to a substitute in the guise of compensation for physical injury. Such a step

150. *See* Chappel v. Hart (1998) 195 C.L.R. 232, 239, *available at* http://www.austlii.edu.au/au/cases/cth/HCA/1998/55.html; Chester v. Afshar, [2004] UKHL 41, [2005] 1 A.C. 134, 146 (U.K.).

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will enable imposition of the true social costs of harmful practices on the defendants and consequently facilitate efficient deterrence.

Second, we should remember that not all additional investments in precautionary measures by the damager represent over-deterrence. Only those investments in means of deterrence entailing costs beyond the expected loss represent over-deterrence. Hence, the additional investments in precautionary measures,[151] to be anticipated in the wake of recognition of the new head of damage, might not necessarily reflect over-deterrence. On the contrary, considering the fact that a rule that releases physicians of their liability for interference with the patient's rights to autonomy (due to the absence of injury or decision causation) induces under-deterrence, the assignment of liability for that interference will result in internalization of the social costs incurred by physicians' actions, a step likely to conclude in efficient deterrence.

Third, even though creation of the new head of damage is expected to enhance physicians' liability and extend that liability to cases where patients did not suffer any physical injury or could not establish decision causation, the new rule is not expected to magnify those duties flowing from the doctrine of informed consent. Patients requesting compensation for interference with their right to autonomy will still be forced to establish a breach of duty. It follows that the rule's effect on the scope of medical liability will thus be more limited than anticipated. Consequently, as far as the phenomenon of over-deterrence is linked to the scope of liability that physicians themselves take into account, we can conclude that recognition of this new head of damage as compensable cannot be expected to dramatically intensify the danger of over-deterrence.

2. The Fear of High Administrative Costs

This argument states that a legal rule recognizing

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151. In the field of informed consent, additional investment in precautionary measures will be expressed in additional time devoted to disclosing information to patients, additional staff (i.e., social service workers) interacting with patients, longer consent forms and additional documentation of informed consent.

interference with the right to autonomy as a compensable damage will add to the population of injured parties claiming a cause of action; the subsequent growth in the number of petitions presented will overwhelm the courts and escalate the accompanying administrative costs. But here, as well, detailed examination of the argument leads to the conclusion that it is insufficient to justify adoption of a contrary rule that releases physicians of their liability for interference with this right.

First, in a large proportion of cases, the new rule will not provide the plaintiff with a cause of action previously unavailable. This will be the case in situations like the ones dealt with in *Chappel* and *Chester*. The two decisions have already expanded the population of plaintiffs by recognizing entitlement to compensation even in cases where heavy doubt remained regarding causation. Recognition of the new head of damage, then, is not expected to further enlarge the number of plaintiffs belonging to this category; rather, it will simply enable more accurate depiction of the respective injury.

Second, victims' presentation of claims represents an essential feature of the tort's internalization mechanism and hence a precondition to the achievement of efficient deterrence.[152] The presentation of more claims, even if it induces higher administrative costs, might then indicate the need for just such an internalization mechanism and, it follows, a necessary condition for achieving economic efficiency.[153] Here we should also mention that the contrary rule releasing physicians of liability for interference with their patient's right to autonomy when physical injury or decision causation are absent is expected to deter patients unable to prove physical injury under such conditions from presenting their claims. Even though the result is likely to be a reduction in administrative costs, this contrary rule, because it inevitably undermines the effect of deterrence embodied in the doctrine of

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152. RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW 192 (7th ed. 2007).

153. It is appropriate to recall here the approach taken by Calabresi, stating that the desirable objective of tort law is the eventual reduction of the total costs of accidents, not the prevention of specific types of costs. Hence, if efficient deterrence can be achieved only by means of additional administrative costs, and if such an act can be expected to reduce total accidental costs, additional administrative costs do not represent a negative but, rather, a necessarily positive phenomenon, one that is commensurate with the interests of economic efficiency. *See* GUIDO CALABRESI, THE COSTS OF ACCIDENTS: A LEGAL AND ECONOMIC ANALYSIS 29–30 (1970).

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informed consent, reduces economic efficiency. It follows that the very recognition of this damage (i.e., interference with the right to autonomy) as compensable may induce higher administrative costs; however, it will, at the same time, improve deterrence and thus reduce the number of cases of interference with this right. In other words, the expected administrative costs may be worthwhile and a more efficient outcome from the perspective of accident costs may be expected.

Third, as the literature shows, the rate of claims submitted by patients suffering from medical negligence is low.[154] This finding, when added to the fact that the compensation awarded for interference with the right to autonomy can be expected to be lower than that awarded for physical injury, indicates that the anxiety over inundation with claims and increasing administrative costs may be unrealistic.[155]

Fourth, incentives favoring the presentation of claims can be expected to be influenced not only by the proposed new legal rule, but also by other legal rules associated with the doctrine of informed consent. Thus, after adoption of the new rule, patients requesting compensation will still face the burden of providing proof of the said breach of duty. This task is far from simple due to evidential difficulties as well as the stipulations of the legal rules defining the physician's duties. It appears, then, that recognition of interference with the right of autonomy as a compensable damage will not significantly improve a plaintiff's prospects for successful adjudication of her claim. Hence, we can expect that the incentives encouraging plaintiffs to present negligence claims against physicians will continue to be limited by the informed consent doctrine's other rules.

Fifth, the previously mentioned incentives to present

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154. *See* Edward A. Dauer, *When the Law Gets in the Way: The Dissonant Link of Deterrence and Compensation in the Law of Medical Practice*, 28 CAP. U. L. REV. 293, 297 (2000) (citing HARVARD MEDICAL PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK 11-4 (1990)); Geoffrey C. Rapp, *Doctors, Duties, Death and Data: A Critical Review of the Empirical Literature on Medical Malpractice and Tort Reform*, 26 N. ILL. U. L. REV. 439, 449 (2006).

155. For support of this argument, see COOTER & ULEN, *supra* note 139, at 379–80.

claims, and thus inflate administrative costs, can be influenced with the appropriate rules. For instance, limiting the amounts to be awarded for interference with the right to autonomy is expected to dissuade patients whose sense of injury to their right to autonomy is not sufficiently strong from presenting their claims given the time and effort demanded for managing legal proceedings.

The conclusion demanded from this discussion is, therefore, that recognition of the new head of damage of interference with the patient's autonomy is the correct step to take. Israel's Supreme Court took that position in the innovative *Ali Daaka* decision.[156]

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156. CA 2781/93 Ali Daaka v. Carmel Hosp., Haifa [1999] IsrSC 53(4) 526. A comprehensive survey of decisions and the literature on English, Australian, Canadian and American law indicates that in cases where the claimed cause of action was absence of informed consent, the court did not recognize interference with the right to autonomy as a compensable tort. The courts ruled that the victim was entitled to compensation only if she could establish that she had suffered physical injury as a result of a breach of the declared duty. *See* JESSICA W. BERG ET AL., INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 138–142 (2d ed. 2001); HERRING, *supra* note 116, at 104; JACKSON, *supra* note 127, at 290; Sheldon F. Kurtz, *The Law of Informed Consent: From "Doctor is Right" to "Patient Has Rights,"* 50 SYRACUSE L. REV. 1243, 1245 (2000); Laurel R. Hanson, Note, *Informed Consent and the Scope of a Physician's Duty of Disclosure*, 77 N. DAK. L. REV. 71, 76 (2001). Indeed, as we shall see, the English House of Lords recognized interference with the right to autonomy as a compensable damage in the *Rees* decision; however, the specific incident dealt with a case of negligent sterilization and not a breach of informed consent. Rees v. Darlington Mem'l Hosp. NHS Trust, [2003] UKHL 52, [2004] 1 A.C. 309, 313, 349 (U.K), *available at* http://www.bailii.org/uk/cases/UKHL/2003/52.html. Therefore, the Israeli Supreme Court is a pioneer in this respect. It is also important to note that several decisions have adopted the approach that a patient is entitled to compensation for the mental anguish suffered as a result of the breach of the duty of informed consent even if she is unable to prove physical injury as a result of the breach. However, the compensation was awarded for tangible mental anguish (e.g., anxiety regarding future personal injury or trauma as a result of disclosure), not for interference with the patient's right to autonomy. *See, e.g.*, Doe v. Noe, 690 N.E.2d 1012, 1020–21 (Ill. App. Ct. 1997); Jones v. Howard Univ., Inc., 589 A.2d 419, 422–25 (D.C. 1991); Faya v. Almaraz, 620 A.2d 327, 337, 339 (Md. 1993); K.A.C. v. Benson, 527 N.W.2d 553, 559–62 (Minn. 1995); Snider v. Henniger, [1992] 96 D.L.R. (4th) 367, 374–75 (Can.); Lachambre v. Nair, [1989] 2 W.W.R. 749, 763 (Can.); Smith v. Barking, Havering and Brentwood Health Authority, (1994) 5 Med. L.R. 285, 288, 291–292; Note, *Goorkani v. Tayside Health Board*, 1991 S.L.T. 94, 95–96. Obviously, the patient who bases her cause of action on the tort of assault can obtain compensation even if she is unable to prove that she suffered physical injury as a result of the interference with her right to autonomy. *See*

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V. THE ALI DAAKA DECISION

In this case, the patient, although hospitalized in order to undergo surgery on her left leg, underwent surgery on her right shoulder for the purpose of performing a biopsy given fears of a malignancy. The decision to operate on her shoulder was made by the attending physicians proximate to the surgery. Hence, although the plaintiff had signed a consent form regarding the surgery on her leg on the day of her hospitalization, she was informed of the need to undergo a procedure on her shoulder only on the day of the operation. Her signature on the consent form regarding the latter procedure was obtained while she was lying on the operating table, under the influence of anesthetizing drugs, without being informed about the risks inherent in the procedure. As a result of the surgery the plaintiff suffered damage to her shoulder. She filed a claim based on the tort of negligence while arguing that she had not transmitted any valid consent to the procedure.

The court ruled that acquisition of the plaintiff's consent under such circumstances, that is, without informing her of the attendant risks, represented negligence on the part of the defendants.[157] Nevertheless, the judges in the majority were convinced that the plaintiff had not proven causation between the negligence and the consequent injury. It accordingly ruled that the plaintiff was not entitled to compensation for the physical injury suffered following the surgery on her shoulder.[158] After this decision was handed down, the court addressed the question of whether it was possible to award the plaintiff compensation for the non-pecuniary damage caused as a result of the defendants' interference with her right to autonomy. Following detailed, intensive discussion, the judges

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Meisel, *supra* note 103, at 74–75. However, a patient can claim the tort of assault only if she can substantiate that she did not consent to the treatment or that no information was transmitted regarding the nature of the treatment. *See* MICHAEL A. JONES, MEDICAL NEGLIGENCE 522 (3d ed. 2003); Canterbury v. Spence, 464 F.2d 772, 782–83 (D.C. Cir. 1972); Reibl v. Hughes, [1980] 114 D.L.R. (3d) 1, 10–11 (Can.); Rogers v. Whitaker, [1992] 175 C.L.R. 479, 490 (Can.). Moreover, in the absence of tangible injury, the patient will be awarded nominal damages rather than compensatory damages. *See* HARVEY MCGREGOR, MCGREGOR ON DAMAGES 360 (17th ed. 2003).

157. *Ali Daaka*, [1999] IsrSC 53(4) at 550, 563, 587.

158. *Id.* at 564–70.

in the majority responded positively,[159] basing their conclusions on three considerations.

A. INTERFERENCE WITH A PATIENT'S RIGHT TO AUTONOMY CAN BE DEFINED AS A "DAMAGE" ACCORDING TO THE TORT ACT

This statement demands clarification. In Israeli law, the tort of negligence is elaborated in the Civil Wrongs Ordinance.[160] In Israeli law, the foundations of this tort are identical to those in Anglo-American law, and require existence of some damage.[161] Accordingly, in order for the plaintiff to claim the tort of negligence, she must prove that the injury represents "damage" as defined in the Civil Wrongs Ordinance, paragraph two, that is: "loss of life, or loss of, or detriment to, any property, comfort, bodily welfare, reputation or other similar loss or detriment."[162] The court in *Ali Daaka* ruled that injury to one's feelings as a result of interference with her basic right to autonomy constitutes an injury to her well-being and thus represents "damage" as defined in the Ordinance.[163]

B. RECOGNITION OF INTERFERENCE WITH THE RIGHT TO AUTONOMY AS A COMPENSABLE DAMAGE IS COMPATIBLE WITH LEGAL POLICY

Influenced by its awareness that a person's right to autonomy is an elemental component of the Israeli legal system as well as the fact that exercise of this right has special significance in the context of medical treatment, the court ruled that not only should physicians anticipate the damage associated with that right's interference as a factual issue, they should also anticipate it as a matter of legal policy. The court mentioned four fundamental considerations to support its conclusion. First, the existence of trust and close ties between patient and doctor, in addition to the patient being in the first circle of risk, indicates proximity between those providing treatment and the patient.[164] Second, given that the physician enjoys an absolute advantage over the patient with respect to the pertinent knowledge, and given his ability to take the

159. *Id.* at 581, 616.
160. Civil Wrongs Ordinance (New Version), 1972, 2 LSI(NV) 5 (Isr.).
161. *Id.* at 6.
162. Civil Wrongs Ordinance (New Version), 1972, 2 LSI(NV) at 5.
163. *Ali Daaka*, [1999] IsrSC 53(4) at 574–75.
164. *Id.* at 576.

measures necessary to prevent interference with the patient's right to autonomy, it appears that the physician is in a superior position to prevent the respective damage. Recognition of this injury as compensable is therefore likely to contribute to the prevention of the stated damage and thus is justified.[165] Third, provision of treatment without the patient's informed consent represents a breach of the physician's contractual duty to act in a skilled and reasonable manner when providing treatment.

The patient is therefore entitled to enjoy the right to compensation for the non-pecuniary damage caused by that breach, which is similar in nature to the damage caused by interference with a patient's right to autonomy. The aspiration not to inappropriately distinguish between contractual claims and tort claims thus justifies recognition of the respective injury as compensable within the framework of tort law.[166] Finally, acceptance of the argument that the patient has a right to select the medical treatment most suitable for her requires determination of a "price" to be attached to the injury to her dignity, expressed in the performance of medical procedures without first obtaining her informed consent.[167]

C. THE STANDARD ARGUMENTS RAISED AGAINST RECOGNITION OF THIS NEW HEAD OF DAMAGE—SUCH AS THE ANXIETY REGARDING "MEDICAL DEFENSIVENESS," THE FEAR OF HIGH ADMINISTRATIVE COSTS AND THE ABSENCE OF AN INJURY APPROPRIATE FOR COMPENSATION—DO NOT JUSTIFY NEGATION OF THE INJURED PARTY'S RIGHT TO COMPENSATION FOR INTERFERENCE WITH HER RIGHT TO AUTONOMY[168]

Further to its conclusion that interference with the right to autonomy represents a compensable damage, the court in this case expressed its opinion that this category of compensation is not to be treated as a proxy for compensation for the physical injury suffered due to the said interference. The damage to the patient's right to autonomy, it reiterated, is separate and distinct from the damage of physical injury, compensation for which is supplemental to the compensation

165. *Id.* at 576–77.
166. *Id.* at 580.
167. *Id.* at 581.
168. *See id.* at 577–79.

awarded for the patient's physical injury.[169]

These considerations led the court to conclude that the plaintiff was entitled to compensation for the non-pecuniary outcomes of the interference with her right to autonomy. After evaluating the damage incurred, it awarded her compensation of NIS 15,000.[170]

VI. A CRITICAL ANALYSIS OF THE ALI DAAKA DECISION AND THE PROPOSED NEW APPROACH

There is no doubt that the *Ali Daaka* ruling quite considerably meets the requirements of Shultz's vision, although careful review of the decision indicates that some gaps remain. This conclusion flows from an analysis of the principles determined with respect to how compensation for the new damage of interference with the right to autonomy is to be assessed.

The crux of the approach adopted by the court is that the compensation is to be assessed according to the non-pecuniary-subjective-tangible outcomes of the interference with the patient's right to autonomy. That is, according to the degree to which her feelings and sensitivities were wounded[171] (hereinafter, the subjective approach).

In assessing compensation for the wounding of the patient's feelings and sensitivities as a result of interference with her right to autonomy, the following factors must be considered. How severe is the breach of informed consent?[172] For example, the more meaningful the information not transmitted to the patient, the greater the severity of the interference with her right to autonomy, hence, the larger is the compensation to be awarded.[173] How important is the decision to the patient? As the decision's importance grows, so does the interference with her participation in decision making

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169. *Id.* at 581–82, 618.

170. An amount valued at about $4,500. (This amount was calculated based on the current exchange rate, which is about NIS 4.2 to $1) The *Ali Daaka* ruling has been implemented by Israeli courts in numerous decisions since it was handed down. Review of the decisions indicates that in the majority of cases, the amount of the compensation ranged between NIS 15,000 and NIS 50,000, that is, between about $4,500 and about $15,000.

171. *Ali Daaka*, [1999] IsrSC 53(4) at 583–84, 618–19, 621, 623.

172. *Id.* at 583, 620.

173. *Id.* at 583.

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and, consequently, so does the damage to her right to autonomy. The likelihood that she will be entitled to greater compensation increases in tandem.[174]

What is the effect of the interference on the patient's decision? If the information not transmitted might have changed her attitude regarding the medical treatment, we can assume that the damage was greater and that she will be entitled to more compensation.[175] What is the patient's attitude toward transmission of medical information? That is, if the patient delegated decision-making to the physician and requested no details about her medical condition, we can assume that she suffered no harm from the interference.[176] What were the results of the treatment? For instance, the fact that the treatment succeeded even though it was performed without the patient's informed consent is likely to reduce the compensation considerably.[177]

The foregoing list is only partial.[178] The court also added general guidelines, advocating that the courts adopt a balanced attitude. On the one hand, the court was requested to recall that the cause of action entailed damage to a basic right and thus demanded determination of appropriate as opposed to symbolic compensation. On the other hand, the court was to restrain itself and avoid the award of exaggerated compensation.[179]

Finally, it is interesting to note that even though the court adopted the approach entailing assessment of compensation according to the non-pecuniary-subjective-tangible outcomes of the interference with the patient's right to autonomy, it also deemed it appropriate to disengage that compensation from dependence on the patient's submission of detailed evidence regarding the extent of damage suffered. In such cases of general injury, the court was likely to award, under the appropriate circumstances, some pecuniary compensation even in the absence of detailed proof of tangible harm. The underlying reasoning for this statement is that the existence

174. *Id.*
175. *Id.* at 620.
176. *Id.* at 620–21.
177. *Id.* at 621.
178. *Id.* at 583.
179. *Id.*

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and severity of the injury was due to the very interference with the patient's right to autonomy; hence, the court is able to assess compensation after considering all the known factors of the case.[180]

Several conclusions can be deduced from the principles adopted by the court. First, to award compensation, there must be proof of subjective and tangible outcomes—such as wounded feelings—subsequent to the interference with the patient's right to autonomy. Closely related is denial of the victim's right to compensation from the damagers if, for one reason or another, the victim is unaware of this interference and is therefore unable to feel the emotional consequences of the injury. Included in this category are persons who died during medical treatment, or immediately afterwards, without learning that they had suffered interference with their right to autonomy; persons who remained unconscious following treatment and are not expected to regain consciousness and who are therefore unaware of the interference or exhibit no emotional responses such as sorrow or mental anguish in its wake; and persons who, as a result of medical treatment, have suffered cognitive loss and are unaware of their surroundings. Patients of this type are not entitled to compensation for the interference with their right to autonomy even though the interference with their right is likely to be equal or perhaps greater in severity than that suffered by patients who are able to feel its outcomes.

Second, application of this approach is expected to conclude in award of considerably low compensation, particularly in two types of cases: cases in which the medical treatment succeeded and did not cause the patient any physical injury;[181] and cases where decision causation cannot be proved.[182] We are able to assume in these two instances, given the absence of other evidence, that the patient's feelings were only mildly wounded, either because the treatment succeeded and the patient suffered no physical injury, or because the patient would not have made a different decision even in the absence of any interference with her right to autonomy.

It follows that the approach adopted by the court is likely

180. *Id.* at 583.
181. *Id.* at 621.
182. *Id.* at 620.

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to culminate in the award of low compensation in exactly those cases where the new head of damage is most pertinent, that is, cases where the plaintiffs cannot prove physical injury or decision causation. This, indeed, describes the circumstances in the *Ali Daaka* case, where the court ruled that decision causation had not been substantiated. The compensation awarded to the plaintiff was a mere NIS 15,000 despite the fact that her right to autonomy had been most grossly interfered with.

The court failed to fully grant sufficient weight to the patient's right to autonomy. It is difficult to deny that the amount of compensation awarded to the plaintiff reflects the importance society attaches to the interest damaged.[183] Denial of the right to compensation for interference with a patient's right to autonomy or the award of meager compensation for that interference, despite the extreme interference suffered, does not accord with the idea that the right to autonomy is an interest to be protected.

Nor does the ruling in the *Ali Daaka* case accord with considerations of deterrence or corrective justice. These require, as we have seen, a stipulation declaring that the perpetrator is to be charged for the damage he caused. Whoever interferes with a patient's right to autonomy is to carry the social cost of the harm, whether or not the patient is aware of the outcomes of the interference, whether or not she suffered physical injury, and whether or not she can or cannot prove decision causation.

Finally, the subjective approach does not abide by standards of coherence. Not only does it not comply with the patient's right to autonomy and thus creates horizontal incoherence, it also introduces an inappropriate distinction between victims based on the level of their awareness regarding the interference with their right to autonomy in addition to their ability to provide evidence of tangible injury as well as decision causation.[184] By following that path, the

183. Donna Benedek, *Non-Pecuniary Damages: Defined, Assessed and Capped*, 32 REVUE JURIDQUE THEMIS 607, 615 (1998).

184. Concurrently, an inappropriate distinction will be made between perpetrators. Thus, for example, a distinction will arise between perpetrators whose victims are able to feel the non-pecuniary injury subsequent to the interference with their right to autonomy, and who are thus obligated to compensate those victims, and perpetrators whose

subjective approach is shown to also create vertical incoherence.[185]

How can we explain the court's failure to fully implement the Shultz vision in the *Ali Daaka* case? Similar to the *Chappel* and *Chester* cases, the Israeli court's decision in *Ali Daaka* was influenced by the approach stating that a patient who suffered from interference with her right to autonomy is to be awarded compensation only if she suffered tangible injuries. Although the court in *Ali Daaka* was prepared to compensate the plaintiff for the very fact of the interference with her right to autonomy, it demanded that the plaintiff establish a tangible injury in the form of wounded feelings. Adoption of this approach, which specifies that compensation be awarded only to patients suffering tangible damage, is related, as we have seen, to the use of the tort of negligence as a cause of action.

An examination of the shortcomings of the approach adopted in the *Ali Daaka* case raises the question of which approach the court should have adopted. Shultz contends that in cases of this type—that is, cases where the plaintiff is unable to prove that she suffered personal injury as a result of the interference with her right to autonomy—the court should award her compensation in the form of a global amount whose value is to be determined according to one of two criteria: either a fixed amount above a nominal sum or an amount determined by the jury in consideration of all the circumstances of the case.[186] Nevertheless, it is difficult to derive a comprehensive theory of compensation from Shultz's position. I will now attempt to present such a theory.

I believe that the court should have adopted an objective-proprietary approach regarding the damage from interference with the patient's right to autonomy. According to this approach, a victim's life, her physical integrity, her ability to enjoy the amenities of living, her freedom from pain and

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victims are unable to do so and are thus free of the same obligation. This distinction is inappropriate when considering the possibility that the two perpetrators caused identical damage in the nature and severity of their interference, performed the same actions and committed the same omissions. It follows that this approach introduces dual incoherence.

185. For an argument similar in spirit against the personal-subjective approach, see Kyle R. Crowe, *The Semantical Bifurcation of Noneconomic Loss: Should Hedonic Damage Be Recognized Independently of Pain and Suffering Damage?*, 75 IOWA L. REV. 1275, 1290–91 (1990).

186. Shultz, *supra* note 1, at 290–91 & n.13.

suffering, and thus her right to autonomy, are all personal properties having value, like a home and its chattel. To deny a patient "property" of this sort implies denial of something for which she enjoys "proprietary rights." Each such "property" has a "value" that requires compensation for its loss or damage, even if the victim is subjectively unaware of the damage and its outcomes, and even if she feels no pain or suffering in the injury's wake.[187]

When following this approach, compensation is assessed by determining the value of the right of autonomy as an amount expressing the right's objective value to society on the one hand, and ascertaining the magnitude of the interference with that right on the other.[188] The magnitude of the interference with the right to autonomy is assessed according to all the circumstances of the case,[189] including the type and scope of information kept from the patient,[190] the importance of the decision to the patient,[191] and the number as well as characteristics of available alternative treatments.[192] In contrast, the intensity of the wounded feelings felt by the patient because of the interference with her right to autonomy will not be considered a contributing factor and will thus be excluded from the compensation assessment. At the same time, I do not deny the possibility of awarding the patient additional compensation for her mental anguish. However, the

187. Comment, *Nonpecuniary Damages for Comatose Tort Victims*, 61 GEO. L.J. 1547, 1548–49 (1973); Benedek, *supra* note 183, at 619–20; Graeme Mew, *Damages—Personal Injuries—Non-Pecuniary Damages—Unaware Plaintiff and the Functional Approach*, 64 CAN. BAR REV. 562, 563–64 (1986); A.I. Ogus, *Damages for Lost Amenities: For a Foot, a Feeling or a Function?*, 35 MOD. L. REV. 1, 2 (1972).

188. The value of the right of autonomy to society will obviously be identical in every case coming before the court. Differences in the compensation awarded will be determined by the distinctive circumstances of the injury.

189. *See* Ogus, *supra* note 187, at 2–3.

190. Thus, the greater the amount of information denied the patient and the more relevant that information to making a decision, the more severe the interference with the patient's right to autonomy.

191. That is, the more important the decision is to the patient and the greater the expectation that its implications will be meaningful to her, the more severe the interference with her right to autonomy.

192. On the approach stating that the greater the number of alternative treatments available to the patient and the greater the difference between those alternatives, the greater the interference with the patient's right to autonomy, see Twerski & Cohen, *supra* note 30, at 658–59.

award of compensation to the plaintiff should not depend on the establishment of tangible-subjective damage.

In determining the "objective" value of the right to autonomy, the court should be swayed by that right's centrality in law and in society. That is, the court is to recognize this right as having more than symbolic value. It thus means that the type of compensation suggested by this approach is to be neither symbolic nor nominal, as is compensation for the tort of assault, but the compensation should still be fitting.[193] At the same time, the courts should abstain from being excessive in the amounts awarded.[194] The purpose of recognizing the new head of damage is not to "punish" the perpetrator. We should therefore avoid enshrouding compensation with an aura of "retribution," an act that might eventually induce over-deterrence.[195]

Adoption of this approach can be supported on several grounds. First, as stated, it resists the assessment of compensation at a level commensurate with the patient's wounded feelings. Hence, application of this approach is not expected to deny the right to compensation to victims who, for whatever reason, are unable to sense distress or mental anguish as a result of the interference with their right to autonomy.

Second, because compensation will not be assessed according to the non-pecuniary outcomes of the interference with the right to autonomy, we can expect less weight to be given to factors such as the treatment's successful outcomes and whether the plaintiff was able to prove decision causation. Adoption of this approach can therefore be expected to prevent the award of low compensation to victims only because the treatment was occasionally successful or because it was assumed that the patient would have agreed to undergo that treatment in any case.

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193. I therefore reject the approach implied by Justice Hoffman in the *Chester* decision, according to which the plaintiff is to be awarded a meager sum for the interference with the right to autonomy. *See supra* note 104.

194. As we have seen, this approach was adopted by the Court in the *Ali Daaka* case. *See* CA 2781/93 Ali Daaka v. Carmel Hosp., Haifa [1999] IsrSC 53(4) 526, 583.

195. Were we to attempt to translate these principles into tangible amounts, the minimal sum would be NIS 50,000 (about $15,000) and the maximum NIS 300,000 (about $80,000).

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Third, given that this approach is based on objective criteria, it minimizes the difficulties attached to the assessment of compensation raised by the approaches based on estimating the damage to the victim's well-being.[196] The accompanying administrative costs will therefore be much lower.

Fourth, because the amount of compensation to be awarded will be fitting as opposed to symbolic, this approach is expected to provide appropriate incentives for the presentation of claims involving interference with the right to autonomy even if this was the sole injury the patient suffered.

Fifth, the objective approach is not foreign to Anglo-American law; it has been recognized with respect to such non-pecuniary damages as loss of the amenities of life and of bereavement.[197]

After examining the attributes of the objective-proprietary approach, I should note that I am not ignoring a potential criticism, specifically, the difficulty of assessing compensation within its framework. The source of this difficulty lies in the nature of the respective "property," the patient's right to autonomy, which has no market value. In addition, in the absence of any other standard for determining the value of this property and the degree of harm suffered, we can anticipate that compensation will be awarded in arbitrary amounts.

Even though this is clearly a substantive argument, it remains insufficient to justify rejection of the proposed approach because similar difficulties arise when applying the subjective approach. According to the subjective approach, the court is to assess the degree of damage inflicted on the victim's well-being as a result of the negligence in question in addition to quantifying the pecuniary worth of that damage. In the case of interference with a patient's right to autonomy, the court is required to assess the non-pecuniary-subjective outcome of the injury in the form of wounded feelings as well as assigning them a value. This task is particularly complex due to the absence of objective standards for measuring the

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196. This difficulty is inherent in the personal-subjective approach. *See* Joseph H. King, Jr., *Pain and Suffering, Noneconomic Damages, and the Goals of Tort Law*, 57 SMU L. REV. 163, 178–79 (2004); Comment, *supra* note 187, at 1553.

197. *See. e.g.*, DEAKIN ET AL., *supra* note 124, at 1002, 1004.

said damage, that is, we lack objective standards for assessing how much well-being was lost as a result of the negligent action and for quantifying the pecuniary worth of that loss.[198] Considerable arbitrariness will therefore characterize the compensation assessment from the subjective approach as well.[199] It follows that the consideration of arbitrariness, in itself, cannot justify rejection of the objective approach. The choice between the subjective approach and the objective approach should, therefore, rest on other considerations as discussed previously. As I have shown, these considerations lead to the conclusion that the objective approach is the desirable one.

In concluding this section I would like to devote a few words to the possibility of assessing compensation according to the theory of loss of chance. As we have seen, this theory was rejected in the form presented by the plaintiff in the *Chappel* case.[200] We have also seen that this theory can be interpreted to allow the award of compensation for the very interference with the patient's right to autonomy by presenting the chance lost as the probability of the victim making a decision that reflects her true wishes and values. If this interpretation is correct, why do I reject this theory and retain my preference for the objective-proprietary approach?

My position rests on the *Chappel* decision, which illustrates the problems of applying the theory of loss of chance. This theory invites the jurist to evaluate the probability of events transpiring differently from the actual events. Such a request risks shifting attention away from the interference with the right to autonomy to the lost chance of receiving treatment different from that given to the plaintiff and to outcomes different from those suffered.

As stated, the *Chappel* decision faithfully demonstrates these issues. The defendant argued that the plaintiff's injury was actually the lost chance of the surgery being performed later and by a different surgeon.[201] He would later argue that

198. *See* King, Jr., *supra* note 196; Comment, *supra* note 187, at 1553.

199. Regarding the arbitrariness inherent in the evaluation of compensation for non-pecuniary damages suffered by the victim, see PETER CANE, ATIYAH'S ACCIDENTS, COMPENSATION AND THE LAW 162, 167 (7th ed. 2006); King, Jr., *supra* note 196, at 179–80.

200. Chappel v. Hart (1998) 195 C.L.R. 232, 236, 278, *available at* http://www.austlii.edu.au/au/cases/cth/HCA/1998/55.html.

201. *Id.* at 237–38.

due to the fact that the risk inherent in the procedure was identical irrespective of the date of the surgery and the identity of the surgeon, the chance lost by the plaintiff would be of minimal value.[202] Clearly, the defendant had ignored the fact that the plaintiff had lost the prospect of making a decision that reflected her desire to postpone the surgery, to select a different surgeon, and to consider the very desirability of performing the surgery at that time, a prospect having value in isolation of the risks inherent in each of the options before her. Adoption of the objective-proprietary approach avoids such a difficulty because it perceives the right to autonomy per se as property, and thus as having independent worth.

An additional problem with the theory of loss of chance is the fact that it requires assessment of the of the victim's lost chance. If the damage suffered is treated as the loss of the victim's chance of making a decision that reflects her values and wishes, this approach raises the question of what proportion of this chance was indeed lost. This question cannot be answered until responses are received regarding two other questions. First, what is the probability that the patient's decision would reflect her values and wishes had there not been a breach of disclosure? Second, to what degree did the breach of the duty of disclosure affect this probability? Given that a large number of factors are likely to influence the patient's decision, and given that some of them might contribute to a situation where the patient's decision might not reflect her values and wishes irrespective of any breach of the duty of disclosure, providing an answer to this question is an intricate if not impossible mission. This intricacy represents a further consideration supporting adoption of the objective-proprietary approach to the assessment of compensation.

VII. REES V. DARLINGTON MEMORIAL HOSPITAL NHS TRUST—IS THIS WHAT WE HAD HOPED FOR?

The *Rees* decision is not a case of informed consent.[203] Its subject is a negligent case of sterilization that concluded in the

202. *Id.*

203. Rees v. Darlington Mem'l Hosp. NHS Trust, [2003] UKHL 52, [2004] 1 A.C. 309, 309 (U.K), *available at* http://www.bailii.org/uk/cases/UKHL/2003/52.html.

birth of a healthy baby.[204] Nevertheless, the decision handed down by the House of Lords has implications for the current discussion.

The plaintiff in the *Rees* case suffered from serious health problems.[205] Because she felt she would be unable to care for a child properly, she requested sterilization.[206] She subsequently turned to a physician who was employed by the defendant while making clear her decision not to conceive.[207] The sterilization was imperfectly performed; the plaintiff later became pregnant and gave birth to a normal, healthy child.[208] She then filed a petition for remuneration for the cost of raising a child given her special circumstances. The House of Lords, in a majority of four to three, ruled that the plaintiff should not be awarded compensation for the full cost of raising her unplanned child,[209] although they did award her a conventional sum of £15,000.[210]

The judges in the majority were convinced that the fairness of a rule that denies a plaintiff, the victim of a legal tort, any compensation exclusive of remuneration of the costs incurred by pregnancy and birth is doubtful.[211] The court believed they should not ignore the real damage caused the parents, especially the mother, under these circumstances. Due to another's negligence, she was denied the opportunity to live the life that she wanted and had chosen.[212] The plaintiff, they continued, had suffered damage to a meaningful aspect of her right to autonomy—the right to plan and limit the size of her family.[213] This right is a significant human right, one that requires legal protection in the form of compensation for the unique interference with the mother's right to autonomy. The House of Lords supported the approach proposed by Lord Millet in *Mcfarlane v. Tayside Health Board*,[214] according to

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204. *Id.*
205. *Id.*
206. *Id.*
207. *Id.*
208. *Id.*
209. *Id.* at 316, 319, 348–49, 354–55.
210. *Id.* at 356.
211. *Id.* at 316–17.
212. *Id.* at 317.
213. *Id.* at 317, 319, 349, 356.
214. McFarlane v. Tayside Health Board, [2000] 2 A.C. 59, 114 (H.L.) (appeal taken from Scot.) (U.K.).

which a conventional sum should be awarded to plaintiffs in such cases.[215] The amount of compensation set in *Rees*, the stated £15,000,[216] was not the product of calculation and was not compensatory, the court stressed; its purpose was to express the tort suffered by the plaintiff and the interference with her right to autonomy.[217]

As stated, the *Rees* decision does not involve a breach of the duty of informed consent; rather, it is a case of medical malpractice. Moreover, we can explain the court's decision by referring to the exceptional, convoluted issue at hand—award of compensation to parents for the cost of raising a healthy child. Nevertheless, the decision does provide important support for my thesis. First, the House of Lords accepted the idea that interference with a person's right to autonomy represents a separate damage that entitles the injured party to compensation even in the absence of tangible damage. Second, by adopting the objective approach for assessing compensation, the House rejected the subjective approach taken by the court in the *Ali Daaka* case. As conceptualized in *Rees*, compensation expressed the injustice done to the victim, not to her feelings.

In consideration of the fact that a person's right to autonomy plays a crucial role in the context of medical treatment, the decision in the *Rees* case is likely to persuade other courts to recognize interference with the right to autonomy as a compensable damage in the context of the doctrine of informed consent.

Nevertheless, one significant feature does separate the approach adopted in the *Rees* case and my own. As we have seen, the amount of compensation to be awarded when applying the objective-proprietary approach is expected to fluctuate in conjunction with the unique circumstances of each case of interference. Yet, in *Rees*, the House of Lords adopted a tariff approach. In contrast to the objective-proprietary approach that assigns a monetary value to the victim's loss based on the particular circumstances of the case,

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215. *Rees*, [2004] 1 A.C. at 317 (citing *McFarlane*, [2000] 2 A.C. at 114).

216. This award is higher than that offered by Lord Millet in the *McFarlane* decision, which amounted to only £5,000, based on the argument that expression should be given to the wrong done as well as to achieve some degree of justice. *Id.*

217. *Rees*, [2004] 1 A.C. at 316–37, 319, 349–50, 356.

the tariff approach assigns a uniform and permanent monetary value to all instances of interference.[218] Accordingly, a standard "price," known in advance, is to be attached to this interference, making it unnecessary for the court to make a case-by-case determination of the correct damage or its outcomes.[219]

It therefore appears that while we can expect these two approaches to prevent the difficulties inherent in the subjective approach (i.e., the unjustified denial of compensation to selected types of victims and the award of small amounts of compensation in cases where the victim did not suffer tangible damage or is unable to prove decision causation), they remain distinct in everything touching upon assessment of the compensation. The question remaining before us pertains to which of these approaches is preferable in cases of interference with the right to autonomy.

The advantage of the tariff approach is embodied in its simplicity. When following this approach, the court is not required to determine the severity of the interference. Compensation is limited to awards in stipulated amounts. Hence, the tariff approach has two major advantages: first, lower administrative costs;[220] second, certainty regarding the anticipated amount of compensation. Due to this certainty, one can expect a rise in the number of compromises and thus a reduction in the number of petitions and, eventually, administrative cost savings.[221]

Despite these advantages, I believe it unwarranted to prefer the tariff approach to the objective-proprietary approach when determining compensation in the wake of interference with the right to autonomy. As some of the judges party to the *Rees* decision noted, the tariff approach is quite arbitrary.[222] Its application is likely to conclude in the award of an invariable amount of compensation, as stipulated by law, to all victims, without differentiating between the circumstances or the severity of the interference.

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218. *See* Alan J. Weisbard, *Informed Consent: The Law's Uneasy Compromise With Ethical Theory*, 65 NEB. L. REV. 749, 763 (1986).

219. *Id.* For an argument that this approach influenced the judges in the *Chappel* case, see Waddams, *supra* note 93, at 7.

220. *See* Ogus, *supra* note 187, at 12–13.

221. *See* CANE, *supra* note 199, at 167; King, Jr. *supra* note 196, at 196–97; Waddams, *supra* note 93, at 7–8.

222. *Rees*, [2004] 1 A.C. at 319, 335.

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Given that, several disadvantages can be attributed to the tariff approach. To begin with, perpetrators will be charged with compensating victims in amounts either above or below the value of the actual damage they caused, practices that are likely to induce over- or under-deterrence. In addition, because some victims will be awarded compensation above the value of the damage they suffered and others compensation below that value, this approach's application is expected to distort the incentives encouraging patients to file for damages. That is, some patients will be dissuaded from filling petitions by inadequate incentives, whereas others will be stimulated by exaggerated incentives, with the attendant implications of under- or over-deterrence and rising administrative costs. Lastly, this approach does not accord with considerations of corrective justice, which require charging the perpetrator for compensation that accurately reflects the harm caused.

The objective-proprietary approach therefore remains the preferable approach. No doubt this approach is characterized by some degree of arbitrariness as well because the respective "property" is the "patient's right to autonomy," a good lacking any market value. And so, in the absence of any other standard for evaluating this property and the amount of damage done, we can expect the compensation awarded to be arbitrary, with all the negative implications. Yet, because this approach encourages consideration of the circumstances of the interference and the degree of damage done, this approach better equips us to express the severity of the interference while differentiating between diverse victims and perpetrators. The comparative level of inherent arbitrariness appears, then, to be lower.

VIII. THE THESIS – SUMMARY

Now, after traveling the long road that began with Shultz's excellent article and ended with a review of the innovative decision handed down by the House of Lords in the *Rees* case, I can summarize the main points of my thesis.

First, the law should recognize a new head of damage of interference with the right to autonomy. Under this heading, a patient who has suffered interference with her right to autonomy will be eligible for compensation regardless of whether she suffered a physical injury as a result of medical

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treatment and whether she can establish decision causation. Nevertheless, there is nothing in this new head of damage to prevent such a plaintiff from also receiving compensation for the tangible injuries she suffered. In other words, compensation for interference with the right to autonomy will not replace compensation for physical injury suffered by the victim as a result of that interference; it can only supplement it.[223]

Second, assessment of the amount of compensation to be awarded for the damage of interference with right to autonomy is to be conducted according to the objective-propriety approach. Assessment of compensation is therefore to be based on the damage suffered to the victim's "property" (i.e., her right to autonomy), rather than any injured feelings. Entitlement to compensation is thus independent of the plaintiff's awareness of the interference with this right. Treatment success and absence of decision causation represent only two of a set of factors to be considered by the court when assigning the amount of compensation to be awarded. Furthermore, the amount of compensation will be determined according to the value of the right to autonomy on the one hand, and the circumstances of the said interference on the other, a strategy that will introduce variety in the amount of compensation to be awarded in each case. The principle guiding this assessment of compensation would be assignment of an appropriate rather than a symbolic amount.

Third, legislation should make available a new and independent cause of action for patients claiming interference with their right to autonomy. This cause of action can be attached to standing legislation dealing with patients' rights or

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223. As we have seen, this is the position taken by the court in the *Ali Daaka* case. *See supra* note 169 and accompanying text. I adopt the same position. The question of whether we should limit the patient's right to compensation to the damage of interference with his right to autonomy, or compensate her for the physical injuries she suffered as well, goes beyond the scope of this article because it raises issues different from those discussed here. I will limit myself to noting that some scholars are convinced that in the majority of cases exhibiting the absence of informed consent, the patient should not receive compensation for the physical injury suffered as a result of interference with her right to autonomy and that we should limit the right to compensation to the damage of interference with that right. *See, e.g.*, Twerski & Cohen, *supra* note 30, at 609, 648, 662; Jackson, *supra* note 131.

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introduced into legislation dealing with physicians' liability; on the basis of such laws, patients will be able to obtain compensation for any of the injuries suffered or for all of them, i.e., the interference with the right to autonomy as well as the other tangible injuries suffered as a result.

It is important to note that the *Rees* decision indicates the possibility of introducing rules such as I have suggested regarding the damage of interference with the right to autonomy and its compensation under the heading of the tort of negligence. Although such steps are possible, they require awareness of the necessity and willingness to distance ourselves from the characteristics of the tort of negligence and its traditional role with respect to claims of medical malpractice. However, it is doubtful whether the courts are amenable to doing so, or are even aware of the need to do so. These constraints are indicated by the fact that even in the *Chester* decision, handed down after the *Rees* decision, the House of Lords made little use of the solution offered in the *Rees* decision. The court in the *Chester* decision could have followed the *Rees* decision and ruled that the plaintiff was not entitled to compensation for the physical injury she had suffered in the absence of causation, but that she was entitled to compensation for the interference with her right to autonomy. As we have seen, the court did not follow this path but focused, for reasons described previously, solely on the physical injury suffered.

It appears, then, that the legal approach most appropriate is creation of a new and independent legal framework for the protection of patients' right to autonomy.

The Shultz's article, together with the *Chappel*, *Chester*, *Ali Daaka* and *Rees* decisions, represent important milestones in the development of the doctrine of informed consent, and the recognition of the right to autonomy as an independent interest having legal salience. Nevertheless, despite the long road traveled by the law, it has still not reached its destination. My proposal represents, I am convinced, an important step toward completion of this journey.