CA 2781/93

Miassa Ali Daaka

v.

1. Carmel Hospital, Haifa

2. Health Fund of General Association of Workers in Israel

The Supreme Court Sitting as the Court for Civil Appeals

[August 29, 1999]

Before President A. Barak, Deputy President S. Levin, and Justices T. Or, M. Cheshin, T. Strasberg-Cohen, D. Beinisch, I. Englard

Facts: Appellant was admitted to the hospital for an operation on her left leg, and she signed a consent form agreeing to the operation. Two days later, after being placed on the operating table and receiving sedatives in advance of undergoing anesthesia, she was asked to sign a consent form for a biopsy operation on her right shoulder. She did so, and the biopsy was performed and did not reveal malignancy. After being released from the hospital, her shoulder remained stiff. Appellant sued the hospital for negligence, claiming negligence in failing to receive her informed consent, in the decision to conduct the biopsy, and in the treatment she subsequently received. The trial judge dismissed the claim.

Held: The Court granted the appeal through a plurality opinion written by Justice Or, in which President Barak, Deputy President Levin, and Justices Cheshin, Strasberg-Cohen, and Englard concurred. Justice Or held that there was no negligence in the decision to perform the biopsy, they way it was performed, or in the post-operative treatment, but that the hospital was negligent in not receiving Appellant's informed consent to the operation. There was no causal connection, however, between failure to obtain informed consent and the damage caused by the operation, because Appellant would almost certainly have agreed to the operation, had she been informed of its nature and risks. Appellant was not

entitled to recover for her bodily damage, but she was entitled to recover for the violation of autonomy in not obtaining her informed consent, which is a separate head of damage in tort claims. Justice Strasberg-Cohen wrote separately to say that determining a causal connection in a hypothetical situation – e.g. whether Appellant would have agreed to the operation had her informed consent been sought – should be done through the evaluation of chances test, in which a patient may recover proportional damage if the chance that he or she would have agreed to the operation is more than negligible, even if it is not more 50%. Because there was a 50% chance that Appellant would not have consented to the operation, Appellant should be awarded half the physical damages, in addition to compensation for violation of autonomy. Justice Beinisch dissented, holding that Appellant would not have consented to the operation and that she was therefore entitled to full recovery for the bodily injury suffered. Awarding compensation for violation of autonomy should be reserved for rare cases which do not include this one.

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[2] CA 560/84 *Nachman v. Histadrut Health Fund,* IsrSC 40(2) 384.

[3] CA 4384/90 *Vaturi v. Leniado Hospital,* IsrSC 51 (2) 171.

[4] CA 470/87 *Alturi v. State of Israel – Ministry of Health*, IsrSC 47(4) 146.

[5] CA 58/82 *Kantor v. Moseib*, 39(3) 253.

[6] CA 5049/91 *Histadrut Klalit Health Fund v. Rachman,* IsrSC 49 (2) 369.

[7] CA 434/94 *Berman (Minor) v. Moore Institution for Medical Information Ltd,* IsrSC 51(4) 205.

[8] CA 6643/95 *Cohen v. Histadrut Klalit Health Fund*, IsrSC 53 (2) 680.

[9] FHC 7015/94 *Attorney General v. Anonymous*, IsrSC 50 (1) 48.

[10] HCJ 2481/91 *Dayan v. Jerusalem District Commissioner*, IsrSC 48(2) 456

[11] HCJ 693/91 *Efrat v. Director of Population Registry of the Ministry of the Interior*, IsrSC 47(1) 749.

[12] HCJ 7357/95 *Baraki Peta Humphries (Israel) Ltd. v. State of Israel*, IsrSC 50(2) 769.

[13] HCJ 4330/93 *Ganem v. Tel-Aviv District Committee of the Bar Association Committee*, IsrSC 50(4) 221.

[14] CA 5942/92 *Anonymous v. Anonymous*, IsrSC 48(3) 837.

[15] CA 1233/94 *Cohen v. Attorney General* (unreported).

[16] HCJ 50161/96 *Horev v. Minister of Transportation,* IsrSC 51(4) 1; [1997] IsrLR 149.

[17] CA 7155/96 *Anonymous v. Attorney General,* IsrSC 51(4) 160.

[18] LCA 1412/94 *Ein Kerem Medical Association v. Gilad,* IsrSC 49(2) 516.

[19] CA 4837/92 "*Eliyahu" Insurance Company v. Borba,* IsrSC 49(2) 257.

[20] CA 243/83 *Jerusalem Municipality v Gordon,* IsrSC 39(1) 113.

[21] CA 4500/90 *Hershko v. Aurbach,* IsrSC 49(1) 419.

[22] CA 558/84 *Carmeli v. State of Israel,* IsrSC 41(3) 757.

[23] CA 1730/92 *Matzrava v. Matzrava* (unreported).

[24] LCrim 6795/93 *Agadi v. State of Israel,* IsrSC 48(1) 705.

[25] CA 915/91 *State of Israel v. Levi,* IsrSC 48(3) 45.

[26] CA 50/91 *Sabin v. Minister of Health,* IsrSC 47(1) 27.

[27] CA2989/95 *Korantz v. Sapir Medical Center "Meir" Hospital,* IsrSC 51(4) 687.

[28] CA 429/82 *State of Israel v. Sohan,* IsrSC 42(3) 733.

[29] CA 283/89 *Haifa Municipality v. Moskovitz,,* IsrSC 47(2) 193.

[30] CA 37/86 *Levi v. Sherman,* IsrSC 44(4) 446.

[31] CA 2934/93 *Soroka v. Hababu,* IsrSC 50(1) 675.

[32] CA 414/66 *Fishbein v. Douglas Victor Paul by Eastern Insurance Service,* IsrSC 21(2) 453.

[33] CA 591/80 *Chayu v. Ventura,* IsrSC 38(4) 393.

[34] CA 437/73 *Aik (minor) v. Dr. Rosemarin,* IsrSC 29(2) 225.

[35] CA 145/80 *Vaknin v. Beit Shemesh Local Council,* IsrSC 37(1) 113.

[36] FH 24/81 *Honovitz v. Cohen,* IsrSC 38(1) 413.

[37] CA 20/80 *Fleisher v. Laktush,* IsrSC 36(3) 617.

[38] CA 410/83 *Petrolgas Israeli Gas Company (1969) Ltd .v. Kassero* IsrSC 40(1) 505.

[39] CA 231/84 *Histadrut Health Fund v. Fatach* IsrSC 42(3) 312.

[40] CA 679/82 *Netanya Municipality v. Tzukim Hotel Ltd.* (not published).
[41] CA 355/80 *Nathan Anisivmov Ltd v. Tirat Bat Sheva Hotel Ltd*, IsrSC 35(2) 800.

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[44] *Chappel v. Hart* (1998) 72 Aust. L.J. Rep. 1344.
[45] *Salis v. United States* 522 F. Supp. 989 (1981).
[46] *Kramer v. Lewisville Memorial Hosp.* 858 S.W. 2d 397 (1993).
[47] *Falcon v. Memorial Hosp*. 462 N.W. 2d 44 (1990).
[48] *Canterbury v. Spence* 464 F. 2d 772 (1972).
[49] *Hartke v. McKelway* 707 F. 2d 1544 (1983).
[50] *Sard v. Hardy* 379 A. 2d 1014 (1977).
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[52] *Memphis Community School Dist. v. Stachura* 106 S. Ct. 2537 (1986).
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[59] *Chatterton v. Gerson* [1981] 1 All E.R. 257 (Q.B).
[60] *Bolitho v. City and Hackney Health Authority* [1997] 3 W.L.R. 1151 (H.L.).
[61] *Davies v. Taylor* [1972] 3 All E.R. 836 (H.L.).
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[68] *Arndt v. Smith* (1995) 126 D.L.R. (4th) 705.
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[70] *Hopp v. Lepp* (1980) 112 D.L.R. (3rd) 67.
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[114] Restatement 2d, *Torts*.

Appeal against judgment of the Nazareth District Court (Judge G. Ginat) of January 29, 1993 in CC 425/90.

The appeal was allowed in part by the majority, in accordance with the opinion of Justice T. Or

For Appellant – Akiva ben Chaim, Elad Cohen
For Respondents – Ricardo Weiss

JUDGMENT

Justice D. Beinisch

This is an appeal of the judgment of the District Court of Nazareth (Judge G. Ginat) in CF 425/90 of March 29, 1993, which rejected the appellant's claim for damages for physical harm that she sustained as a result of the biopsy performed on her shoulder in the respondents' hospital.

The Facts

1. Appellant is disabled, born in 1959, who since birth has suffered from a deformity in the sole of her left foot. Sometime during 1987, Appellant also began suffering from pains in her right shoulder. After symptomatic treatment failed to help, x-rays were done, followed by bone mapping, resulting in a diagnosis of "diffusive absorption."

On January 5, 1988, Appellant was hospitalized in the "Carmel" hospital – Respondent 1 – for an operation on her left leg. Two days later, on January 7, 1988, Appellant was operated upon and a biopsy was performed on her right shoulder, because of a suspicion of a growth on the shoulder and the need for a clear diagnosis as to the cause of the diffuse absorption, which had shown up in the bone mapping. The change in the operation was apparently the result of the doctor's decision, immediately before the operation, that the finding in the shoulder

necessitated an operation that was more urgent than the operation in the leg.

On the day of hospitalization, Appellant was asked to sign a form recording her consent to an operation on her leg. Two days later, when she was actually on the operating table, having already received sedatives given to patients prior to being taken from the orthopedic ward to the operating theatre, she was asked to sign a consent form for an operation on her shoulder.

The operation did not reveal anything, and after five days of hospitalization, the appellant was released from the hospital and referred for continued treatment in the hospital's outpatient clinic.

After the operation, Appellant's shoulder remained stiff, and the parties agree that she has a disability of 35%. Similarly, it is not disputed that if not for the biopsy, presumably the shoulder would not have become stiff, except that the respondents maintain that the injury is rooted in the appellant's unwillingness to move her shoulder.

On November 30, 1988, Appellant underwent the operation on her leg, and as a result there was a significant improvement in the condition of the leg. At the same time, she underwent manipulation on the shoulder to improve its mobility. On December 28, 1989, Appellant underwent additional manipulation, but to no avail; the shoulder remained stiff.

Appellant filed a claim against the respondents, demanding compensation for the physical harm to her shoulder caused by the operation. Her claim was exclusively based on the grounds of negligence. Appellant claimed that she had been totally unaware of the doctors' intention to operate on her right shoulder, becoming aware of the fact only when coming out of the anesthetic. Appellant further claimed negligence in the medical treatment given to her, both regarding the actual decision to conduct a biopsy and regarding the treatment she received after the biopsy.

The Judgment of the Trial Court

2. The honorable Judge Ginat dismissed the claim of negligence in all its aspects.

Regarding the allegation of negligence in the execution of the biopsy, the judge ruled that even Appellant's expert, whose opinion was the basis of the claim, did not categorically state that there was no justification for conducting a biopsy on the basis of the findings that were before the doctors. In the trial judge's view, this was sufficient grounds for dismissing the allegation of deviation from appropriate professional standards on the part of the treating doctors in their decision to conduct the biopsy.

Regarding Appellant's claim that she never consented to the biopsy operation, the trial judge determined that already prior to her hospitalization, Appellant had been aware of the problem with her shoulder, and that nothing in the evidence substantiated her claim that she was shocked when finding out that her shoulder and not her leg had been operated upon. He further ruled that he had no doubt that at a certain stage during the admission procedure into the hospital, there had been a hitch in the sense that the appellant initially signed a consent form for the operation on her leg, and only at the last moment, just before the biopsy was conducted, was she asked to sign another consent form which included the correct description of the anticipated treatment. In the lower court's view, the aforementioned hitch was insufficient to substantiate the claim that Appellant had not consented to the conduct of the biopsy:

> In these circumstances there is no escaping the conclusion that there was no defect in the decision to conduct the biopsy. I am also of the opinion that the plaintiff consented to the treatment after being explained that it was the appropriate medical treatment…
>
> In these circumstances, given the appellant's total denial of having received any information regarding the anticipated

> treatment for her shoulder, and given my rejection of her denial, I am unwilling to hear an alternative factual allegation from her to the effect that she had received information on the matter but that it was incomplete.

The trial judge further stated that the sole grounds for the action relied upon by Appellant was negligence, and that such claim required proof of the causal connection between the negligence and the damage. Since Appellant had not proved that her shoulder was damaged as a result of breach of the obligation to supply her with information, her claim should be dismissed, even assuming, *arguendo*, that the appellant had not received complete information prior to the biopsy.

Regarding the allegation of negligence in the medical treatment after the operation, the trial judge ruled that there was no foundation for the appellant's claim that different physiotherapeutic treatment would have prevented the damage to her shoulder. The trial judge did not totally endorse the doctors' claim that conceivably a greater degree of effort on the appellant's part would have prevented the damage to her shoulder. Nonetheless, he ruled that absent any claim regarding a defect in the execution of the biopsy, and having dismissed the claim regarding the nature of the physiotherapeutic treatment given to the appellant, it was not possible to establish negligence in the medical treatment, and such negligence could not be inferred from the actual occurrence of the damage itself.

3. In her appeal, Appellant claimed that even if the tort of battery was explicitly claimed in the complaint, the lower court was nonetheless mistaken in its failure to address it, given that the factual components of the tort of battery were fully described in the complaint.

On the merits of the issue, counsel for the appellant contended that the lower court erred in its rejection of Appellant's claim that she had not consented to the operation. He argued that even if prior to the operation, the appellant had suffered from certain medical problems in her shoulder,

this fact by itself did not contradict her claim that she was shocked upon finding out that her shoulder had been operated upon.

In summations, Appellant further claimed that respondents' doctors had been negligent in their actual decision to perform the operation, which was allegedly performed without justification, and that they were negligent in the post surgical treatment. It was further claimed that respondents bear the burden of proving the absence of negligence, under the rule that "the thing speaks for itself" and that the court erred in its failure to apply that rule to the circumstances of the case.

During oral arguments in the appeal, Appellant focused on the question of the absence of consent to the operation on the shoulder. He claimed that in this case, the elements of the tort of battery had been proven, and that the respondents were therefore liable for damage caused to the appellant by the operation, even in the absence of proof of a causal connection regarding the full extent of damage sustained by Appellant. CA 3108/91 *Reibl v. Veigel* (hereinafter: "*Reibl*") [1] (Shamgar, P). He further added that the case law trend to recognize medical treatment given without consent as constituting the tort of battery had been reinforced following the enactment of the Rights of the Patient Law, 1996 (hereinafter: Patient's Rights Law).

Respondents countered by claiming that the appeal addresses issues of fact, not law, in which this court does not generally intervene.

Respondents further asked the Court to reject the claim regarding transferring the burden of proof, arguing that, in any event, they had satisfied this burden by proving that they had not been negligent in the treatment they gave to Appellant, both in the operation itself and the post surgical treatment.

4. We are satisfied that no negligence was proven on the respondents' part regarding the decision to perform the operation on Appellant's shoulder, nor in the treatment given to Appellant in order to overcome the

invalidity caused by the operation, including both the physiotherapy and the additional operations. In this context, there are no grounds for interference with the findings and conclusions of the trial court, grounded in the testimony of the doctors, which it preferred over the medical expert opinion submitted by the appellant.

Nevertheless, the court's conclusion and dismissal of the claim caused us considerable consternation, to the extent that it was based on the absence of the appellant's consent to the operation or on her alternative claim that even if she had given consent, under the particular conditions in which it had been given, it could not be considered "informed consent."

5. Before addressing the legal conclusions dictated by the proven facts, it is necessary to briefly describe the factual picture regarding the circumstances of the dispute over Appellant's consent to the operation on her shoulder.

Appellant suffered from pains in her shoulder during the months preceding the operation. As indicated in the affidavit and examination of Dr. Sharvit, the treating orthopedist, and from notes appearing in the patient's file in the Health Fund during the period preceding the operation, Appellant was sent for a number of tests, including a bone scan. The health file indicates that on November 27, 1987, in view of the scan findings, Dr. Sharvit recommended that the appellant be sent for a biopsy. Until the appellant's actual hospitalization, no date was set for the recommended biopsy.

As described above, the appellant was hospitalized on January 5, 1988 for an operation on her leg, and she also signed a consent form for the operation. The hospital documents, the illness summary and treatment record, submitted as exhibits, indicated that Appellant had been admitted to the hospital for an elective operation on her leg. On January 7, 1988, the operation date, Dr. Antol – the surgeon who operated on Appellant – wrote the following:

> It has become clear that she has been suffering from pains in her right shoulder for half a year; the shoulder was examined (bone scan, x-ray), which indicated Rt. Proximal Humerus Steolitic Lesion. The finding was explained to the patient who agreed to the conduct of a biopsy and at this stage to defer the Triple Arthrodesis.

This note was written by Dr. Antol, who testified that he had informed the appellant of the need for the operation on her shoulder on the morning of the operation, when she was lying on the operating table, after discovering that she had signed a consent form for the operation on her leg.

The trial judge ruled that despite the circumstances under which the information and explanation regarding the intended operation were given to the appellant, immediately before the operation, and not in the customary manner, in view of her existing knowledge of her medical history and previous treatment, she understood the nature of the intended operation. From the judge's findings, it further emerges that had the consent form signed on the operating table been the sole evidence of the appellant's consent, he would not have ruled that the appellant was aware of the anticipated operation. However, the consent that she gave must be considered against the background of the information she possessed prior to her hospitalization.

The trial court examined the question of liability from the perspective of the tort of negligence, according to claims raised by Appellant, because even during the trial at the District Court, the claim of lack of consent was one of the central claims made by the appellant's attorney, and he did not raise the claim of battery.

The following questions therefore arise: If the judge was correct in ruling that the appellant gave her consent to the operation, could it be regarded as "informed consent?"; if not, what is the requisite conclusion with respect to the respondents' liability in tort?

6. The question is therefore whether medical treatment given without the explicit, intelligent consent of the patient, and without knowledge of all the facts regarding the odds and risks of the treatment, is included within the tort of battery. The question has perturbed many researchers and scholars dealing with torts and has also substantially occupied the courts.

Our case law ruled a long time ago that under particular circumstances, this kind of treatment constitutes the tort of battery:

> The problem is whether the prospects and risks involved in the examination were explained to the plaintiff prior to his consent. If explained to him, then his consent is effective and binding and the doctors cannot be impugned with battery or any other tortious act by reason of having performed the examination. If the plaintiff did not receive a complete explanation of the risks, then his consent is meaningless and the examination will be regarded as an act of battery, constituting a tort.

CA 560/84 *Nachman v. Histadrut Health Fund* [2] at 387.

For this reason, according to this rule, compensation must be awarded for damage caused to a patient treated without his having properly consented to the treatment, even absent proof of the breach of the duty of care, and even absent proof of a causal connection between the failure to provide details as legally required and any damage sustained by the patient. *See Reibl* [1] 509-510.

Considerable reservation has been expressed regarding the resort to the tort of battery as a way of classifying medical treatment. *Inter alia*, there is uneasiness in imputing anti-social behavior, tainted by wantonness, to medical treatment that was intended entirely to help the other person:

> It would appear that there are many for whom the use of the term "battery" in the context of medical treatment is both morally and intellectually repugnant. This is a term which is commonly understood as implying anti social behavior – hitting a person in the face, for example. Stigmatizing a doctor as "an attacker" by reason of medical treatment given to the patient creates discomfort, especially for those adopting judicial decisions. This explains their hesitation in regarding the criminal offense of battery, or the tort of battery as an appropriate tool for adjudicating cases in which medical treatment was provided without appropriate disclosure of information regarding risks and alternatives.

A. Shapira, *Haskama Mudaat Letipul Refui – Hadin Hamatzui Veharatzui* [77] at 231.

In his book, *The Philosophy of Tort* [83], Prof. Englard explains that the transition from use of the tort of battery to the doctrine of "informed consent," based on medical negligence, is the result of the discomfort occasioned by imputing doctors with wanton anti-social behavior, when their sole intention was to assist the patient:

> The retreat from the doctrine of battery has been explained by the discomfort of treating doctors, who genuinely care for the well-being of the patient, under a doctrine aimed at sanctioning anti social conduct, usually perpetrated with the worst kind of intentions. Courts were reluctant to stigmatize the physicians with the label of having committed battery, lumping them into the same category as murderers, robbers and bar-room trollers.

Id. at 162.

In her article, "From Informed Consent to Patient Choice: A New Protected Interest" [94], the author M.M. Shultz writes:

> Discomfort with treating doctors under a doctrine aimed at antisocial conduct has prompted most jurisdictions to limit the battery action to those relatively unusual situations where a medical procedure has been carried out without *any* consent, rather than where the consent has merely been insufficiently informed. The modern allegation of battery typically arises when consent to a particular procedure is given and a different or additional procedure carried out.

Id. at 226.

In accordance with this approach, in most states with tort law resembling our own, use of the tort of battery for dealing with medical treatment given without "informed consent" has all but disappeared. Broadly speaking, it is generally accepted that the tort of battery is only resorted to when the patient received no information at all about the type of treatment proposed for him, or was not informed of an inevitable consequence of the treatment, or if the treatment actually provided was substantially different from the treatment of which the patient was informed. Needless to say, the tort of battery will be recognized when the consent was obtained by misrepresentation.

On the other hand, in cases of absence of "informed consent", as opposed to the absence of any consent to medical treatment, the focus in the assessment of tortious liability has moved toward the tort of negligence. In this context, the scholar Prosser writes:

> A rapidly growing form of medical malpractice litigation involves the doctrine of "informed consent", which concerns the duty of the physician or surgeon to inform the patient of the risks involved in treatment or surgery. The earliest cases treated this as a matter of vitiating the consent, so that there was liability for battery. Beginning around 1960 however it began to be recognized that the matter was really one of the

> standard of professional conduct, and so negligence has now generally displaced battery as the basis for liability.

W.L. Prosser, W.P. Keeton, On the Law of Torts [84] at 189 -190.

The distinction between the absence of consent, in which the treatment may be considered as battery and the absence of "informed consent" which is included in the category of the tort of negligence, also ensures the conceptual distinction between "guilt" and "duty," where failure to discharge a duty is substantively related to the tort of negligence.

In England, too, where the tort of battery is still used more extensively than in the United States and Canada, it was ruled that the patient's signature on a consent form affirming that the nature of the operation was explained to the patient is not sufficient, unless he or she actually received a proper explanation of the treatment and its risks. The absence of an explanation regarding the risks of the treatment, as opposed to the absence of an explanation of the substance and nature of the treatment, does not vitiate the consent for purposes of battery, but it does constitute a breach of the doctor's duty, imposing liability for negligence. *See* H. Street, M. Brazier, *On Torts* [85].

This distinction was addressed by Judge Laskin, in his judgment in the Canadian Supreme Court:

> I can appreciate the temptation to say that the genuineness of consent to medical treatment depends on proper disclosure of the risks which it entails, but in my view, unless there has been misrepresentation or fraud to secure consent to the treatment, a failure to disclose the attendant risks, however serious, should go to negligence rather than to battery. Although such a failure relates to an informed choice of submitting to or refusing recommended and appropriate treatment, it arises as the breach of the anterior duty of due care, comparable to the legal

> obligation to the duty of care in carrying out the particular treatment to which the patient has consented. It is not a test of the validity of the consent.

Reibl v. Hughes (1980) [67] at 10-11.

It should be noted that the trend toward applying the tort of negligence to situations of medical treatment given without informed "consent" does not altogether obviate resort to battery in the context of medical treatment. This claim, however, is limited to special cases in which medical treatment was given in the total absence of consent to treatment on the patient's part, or when the patient was not informed of its inevitable result.

The tort of negligence in place of battery in cases of a lack of "informed consent" to medical treatment has gradually become accepted in Israeli case law. In his judgment in CA 4384/40 *Vaturi v. Leniado Hospital* (hereinafter: *Vaturi* [3]), Justice Mazza dealt with the doctor's duty to provide information to the patient regarding the medical treatment, within the framework of the duty of care which is one of the foundations of the tort of negligence:

> The doctor's duty to inform the patient of the information he or she has and its possible consequences derives from the general duty of care which the doctor and the hospital owe to the patient. It is based on our right to know about ourselves. This is an expression of the autonomy of the private will of every person, which expresses our human dignity. *See* CA 1412/94 *Hadassa Medical Association Ein Kerem v. Gilad* at 525 (Barak, J.). The doctor's duty of disclosure is not absolute and does not always extend to all the details of the medical treatment. For example, there is no need to provide the patient with information regarding a remote risk attendant to receiving a vaccination that all people receive, and the necessity of which is not disputed. CA 470/87 *Alturi v. State of Israel – Ministry*

> *of Health* at 153. But where the choice of the medical path or the receipt of medical treatment involves substantial risks, the doctors are obliged (subject to certain exceptions) to provide the patient with the information reasonably required in order to reach an intelligent, informed decision whether or not to choose this particular treatment path, with its attendant risks. *See Sid-away v. Bethlem Royal Hospital Governors* at *655c* (per Lord Scarman); the *Koheri* case, *supra*, at 171. *This at all events is the most minimal parameter of the duty. Its fulfillment by doctors is intended to serve a practical purpose. It constitutes a part of the duty of care imposed upon the doctor in respect of the patient he is treating. If the duty is breached, and the patient suffers damage as a result, the breach may give the patient a right to indemnification based on negligence.*

Vaturi [3] at 182 (emphasis added – D.B.).

In accordance with this evolving approach, and considering the particular circumstances of the case before us, my opinion is that the appellant's case should be dealt with within the framework of the tort of negligence. Resort to the tort of battery for the provision of medical services should be left for those extreme cases in which the medical treatment was given against the patient's will, or cases in which the treatment was substantially different from the treatment to which the patient agreed, or when the patient did not receive any information regarding the nature of the treatment or its inevitable consequence.

On the basis of this distinction, the case before us can be distinguished from the *Reibl* case [1], in which, during the course of the operation, the doctor decided to perform an operation that differed from what had been agreed upon in advance, without such a possibility even having been presented to the patient prior to that time, and without there being any urgency to the matter.

In Appellant's case, the decision to perform the operation was taken by the doctors with the intention of reaching a clear diagnosis, and in order to verify the suspicion of a growth, in view of findings which were discovered in Appellant's shoulder. According to the findings of the lower court, Appellant was aware of the need for this treatment, even though the evidence indicates that until she was brought into the operating ward, she did not think there would be a need to the perform an operation on her shoulder during the duration of this hospitalization.

Under these circumstances, it was necessary to clarify whether the manner in which the appellant was informed and the manner in which her consent was obtained indicate negligent conduct on the doctors' part. This in fact is what the lower court did.

Duty of Care

7. Like the District Court, I too believe that the appellant's case should be examined within the framework of negligence, but my conclusion differs to that of the trial judge. In my opinion, it was proven that the doctors of the hospital were negligent regarding the procedures that preceded the biopsy. Their negligence was expressed in the fact that, in the first place, they did not discharge their obligation to apprise the appellant of the need for a biopsy during the hospitalization in question. The appellant did not receive timely notice of the intention to postpone the operation on her leg, and it was only in the operating room that she received the pertinent details regarding the operation that she was to about to undergo, when she was already sedated and in a state that was inappropriate for making a decision.

For a patient's consent to medical treatment to his or her body to be regarded as "informed consent," the patient must receive appropriate information regarding his or her condition, the nature of the treatment recommended and its purpose, the risks and prospects entailed, and the reasonable alternatives to the treatment proposed. Having the patient sign a consent form is inadequate for the purpose of informed consent. On the

nature of the patient's signature on the consent form for an operation when the patient is in the operating theater or being brought to the theater, Giesen writes that:

> It may be doubtful, indeed, whether such a single act of disclosure will ever suffice if made only shortly before the proposed treatment, such as on the very eve of an operation which has already been scheduled, and the information will undoubtedly come much too late when given to a patient already under sedation, or to a patient on his way to the operating theatre, or to a patient in the anteroom of the operating theatre. "A patient is entitled to have enough time and an environment to enable him or her carefully to consider his or her position."

D. Giesen, *International Medical Malpractice Law* [86] at 393.

Today an entire chapter of the Patient's Rights Law deals with "informed consent." The law does not apply to our case because of the date in which it came into force, but it nonetheless indicates the legislative tendency. Section 3(b) of the law provides that "in order to obtain informed consent, the physician shall give the patient the medical information reasonably required by him in order to decide whether or not to consent to the treatment proposed …"; For this purpose, medical information includes: the nature of the procedure, its purpose, the benefit expected, its risks and prospects, and alternative treatments, all as specified in the law.

Appellant's case does not require discussion of the question of the scope of the duty imposed on the doctor regarding receipt of the patient's "informed consent." As a rule, the question is not simple. Generally, where the operation or treatment is not intended to prevent immediate danger and can be postponed without aggravating the situation, enabling the patient to formulate a decision with the relevant information at his or her disposal, the duty of disclosure becomes broader. Naturally, the

degree of risk entailed by the treatment is also relevant to the duty of disclosure, and clearly there are exceptions which exempt the doctor from giving full and detailed information in certain extraordinary cases. For example, emergency cases that require urgent treatment, or cases in which the expected danger is negligible when contrasted with the treatment's benefit, or when the patient's condition is such that the disclosure itself may be harmful to him or her. These exceptions now find statutory expression in the Patient's Rights Law, but, as stated, they are not relevant to the case at hand. *See* CA 470/87 *Alturi v. State of Israel-Ministry of Health* [4].

The question of whether a duty of care should be established according to the criteria of the reasonable doctor or the expectations of the reasonable patient was deliberated extensively by courts in different countries, but it does not relate to this appeal. Standard hospital practice for orderly signing of a consent form for operation, after explanation of the prospects, risks and alternatives, expresses accepted law regarding "informed consent." The duty of giving the information necessary to obtain informed consent to an operation is a duty imposed upon the doctor and owed to the patient; its violation constitutes a breach of the duty of care, and it therefore constitutes negligence. Hence, a doctor is obliged to provide the patient with the information reasonably necessary for the patient to adopt a decision regarding his or her consent or non-consent to an operation or medical treatment.

In our case, given that the doctors deviated from what was considered by Respondent 1 to be accepted practice, we need not examine the broad question concerning the scope of doctor's duty to give information to the patient. The director of the Orthopedics department in Respondent 1 during the relevant period was Dr. Shweppe. He testified that prior to every operation, it was customary to assemble the entire medical staff and have them meet with the patient, to discuss the case and the anticipated treatment. Dr. Shweppe did not recall whether there had been such a consultation in the appellant's case, but the trial judge saw no reason to assume any deviation from the practice in this particular case. [But in fact

– trans.], absent any medical records, it was for the respondents to discharge the burden of showing that such a consultation was actually conducted. CA 58/82 *Kantor v. Moseib* [5] at 259; CA 5049/91 *Histadrut Klalit Health Fund v. Rachman v. Rachman* [6] at 376. The doctors were unable to recall whether there had been such a consultation. Appellant testified that such consultations had been conducted prior to her previous operations in the hospital, but not prior to the operation on her shoulder. Dr. Antol's memorandum in the patient's chart from the operation day, together with his court testimony on the matter, support the conclusion that the need for a shoulder operation became clear immediately prior to the operation itself, and that the appellant was informed of the need in the circumstances described above, without any prior consultation. Moreover, the operation itself involved inherent dangers, as demonstrated by the fact that the appellant was harmed, even if negligence was not proven regarding the actual performance of the operation and the post-surgical treatment given to Appellant. The existence of this kind of danger clearly explains the duty of complete disclosure to the patient prior to the treatment.

Under those circumstances, the doctors were duty bound to apprise the appellant of the nature and the gravity of their fear that a tumor had developed in her shoulder. They should have explained to her whether there was a real suspicion of a tumor. They should have apprised her of the operation's importance and its urgency. They also should have explained to the appellant that there was a chance that the treatment would cause paralysis.

Having the appellant sign the consent form for the operation at such an advanced stage, as described above, is not accepted practice, and it certainly is not the practice which should be accepted and practiced by doctors for obtaining consent. The possibility intimated to her by the treating doctor in the Health Fund, two months before her hospitalization, that she might require a biopsy, does not constitute a full disclosure of information which is required for the patient in order to adopt a decision

and give informed consent to the conduct of such an operation. *See* CC (PAPP) 88/84 *Assa v. Histadrut Health Fund* [42].

All of the above indicates that Appellant's doctors violated their duty to fully apprise Appellant of the biopsy operation that she was about to undergo, and it was not proven that, under the circumstances, they were exempt from fulfilling their duty as stated. As such, it can be determined that Appellant's doctors violated a duty which is part of the duty of care incumbent upon them as doctors providing medical treatment, and in so doing – they were negligent.

The Causal Connection to the Damage

8. The holding that respondents were negligent in the disclosure of information to the appellant and in the manner in which they obtained her consent to the operation compels an examination of the causal connection between respondents' negligence and the damage caused. The trial judge rejected the appellant's blanket claim that she had no advance knowledge of the shoulder operation and did not consent to it; accordingly, he was not prepared to address her alternative claim regarding the absence of complete information. Even so, the trial judge ruled that:

> Even under the assumption (which I do not share) that the plaintiff did not receive complete information prior to the biopsy, I still have no evidence before me that the damage caused to the plaintiff's shoulder resulted from the violation of Defendant 2's obligation to provide all the relevant information to the plaintiff … I received no evidence that under these or any under conditions the plaintiff would not have consented to the performance of the biopsy. There was no proof of a causal connection between the damage that was caused and the doctors' alleged violation of their duty.

The question is: What issue should be examined by the court when assessing the causal connection, in order to determine the existence of the tort of negligence in cases of absence of "informed consent?"

The question of the causal connection when the damage is not the result of negligent treatment but rather due to the absence of sufficient information for there to have been "informed consent" of the patient is a complex question. Having recognized that this kind of negligent behavior on the doctor's part is a possible cause of damage, the question is therefore whether or not the patient would have willingly accepted the treatment proposed had the patient been fully informed.

Usually in this kind of negligence action, the patient wants compensation for the direct damage caused by the treatment. The damage in the case of absence of "informed consent" is not caused as a result of negligent treatment. It is rather the result of the bare fact of medical intervention, even if it was not done negligently. Under these circumstances, the causal connection is assessed on the basis of the degree of damage to the autonomous will of the patient and the negation of the patient's capacity and ability to prevent the treatment given to him or her. In other words, there must be an assessment of the possibility that the patient would have prevented the treatment had he or she been given the information.

9. States that recognized the grounds of "informed consent" as the breach of a duty that creates the tort of negligence have deliberated the manner of proving the causal connection regarding the damage due to the necessity of retroactively assessing a hypothetical occurrence. *See Arndt v. Smith* (1995) [68] (in Canada); *Salis v. United States* (1981) [45] (in the United States).

In Israel, in a similar case in which the patient did not receive complete details regarding alternative treatments, Justice Mazza wrote the following:

> The causal connection for our purposes does not require a holding in accordance with the accepted causality tests … these tests, which are intended to enable decisions in accordance with the probability indices, are not appropriate for cases in which the court must make a hypothetical assessment of the particular patient's response had the doctors given him or her details in advance regarding the risks and prospects of a particular medical treatment.

Vaturi [3] at 191.

In that case, the court concluded that when proving the existence of a causal connection requires resolution of the theoretical question of "what would the patient have decided had he or she been given the complete information," it is not enough to find that an analysis of the probabilities [i.e. more likely than not – ed.] has failed to show that the patient would have chosen not to receive the treatment. According to that approach, while there is no justification for awarding the injured party full compensation for damages absent sufficient proof of the causal connection, it would be wrong to deny any compensation just because the negligent action of the tortfeasor prevented the patient from proving that the negligence caused his or her damages. Accordingly, the holding in that judgment was that in such a case, an assessment is made of the chance that proper disclosure of the information would have caused the patient to refuse the treatment. The degree of damage owed by the tortfeasor will be determined in accordance with the assessment of the likelihood of refusal.

The proof of the causal connection to the damage in circumstances of failure to disclose details regarding medical treatment is complex and raises a number of problems. Legal scholars have disputed the question of whether to adopt the path of an assessment of likelihood in a case of a hypothetical question concerning "informed consent." See Shultz's article, *supra* [94] at 286-87 and Giesen's book, *supra* [86] at 354-55, both of which endorse the view of assessment of likelihood.

As opposed to the approach of these scholars, the Court has a practical concern regarding the possibility of substantiating a claim in tort with the possibility of compensation, when the causal connection has not been proven at the level of proof normally accepted in a civil trial. The concern is that such a possibility will open the floodgates in other areas too, and thereby lead to a glut of claims and the imposition of an untenable burden on the medical system and on the legal system too. *See Kramer v. Lewisville Memorial Hosp.* (1993) [46] at 406; *Falcon v. Memorial Hosp.* at 64-68.

Personally, my view is that there must be a distinction between proof of negligence in regular negligence cases and proof of negligence when negligence consists of the failure to give informed consent to the treatment. Due to its special character, negligence in the latter category should be determined as a function of the degree of chance, and not in accordance with the balance of probability, provided that this rule is qualified and does not confer entitlement to compensation except in those cases in which it can be determined that there is a significant chance that the patient would not have consented to the treatment.

10. In the case before us, I gave considerable thought to the question of whether a causal connection had been proven between the negligence of the doctors and the hospital in receiving the appellant's consent to the conduct of the examination and the damage that was caused to her. I also examined the possibility of resolving the question of the causal connection in accordance with the method mentioned above, of assessing the likelihood of refusal and not in accordance with the probability balance. After much consideration, I arrived at the conclusion that in present circumstances, I need not decide the question of whether the assessment of likelihood should be established as the proper test for the causal connection in cases of the absence of informed consent. My reason is that the respondents' responsibility for Appellant's damages was proven even in accordance with regular evidentiary tests of balance of probability.

As stated above, the test regarding the existence of a causal connection in a negligence claim occasioned by failure to receive informed consent is, whether the patient would have consented to the treatment had he or she been informed of all the relevant facts. This test is conducted according to the criterion of the reasonable patient under similar circumstances.

We use an objective test of the reasonable patient in order to try to establish the truth regarding the particular patient. Clearly, there is a tremendous practical difficulty in ascertaining the position of the patient at the relevant time, because the question arises only retroactively, at a time when the patient is suffering from the results of the treatment. In numerous judgments, the courts have noted that it is inhuman to expect a person suffering from treatment received to give credible testimony about what he or she would have done at the time of adopting the decision, had he or she been aware of all its possible consequences.

In any event, this difficulty was one of the central considerations that led courts in the United States and Canada to prefer the objective test, adapted to the circumstances, as the criterion for establishing the causal connection. *See Canterbury v. Spense* [48] at 791; *Arndt v. Smith* (1997) [69].

Accordingly, the courts that adopted this criterion also ruled that the injured patient's testimony should not be accorded conclusive weight, even though it is relevant evidence which helps clarify the truth. *See Hartke v. McKelway* [49] at 1551; *Sard v. Hardy* [50] at 1026*; Bernard v. Char* [51] at 670.

In order to determine the probability of whether the patient would have refused the treatment, the court must consider the type of treatment received by the patient and its degree of urgency as opposed to its risks. Within these parameters, it ascertains the patient's probable response according to the criterion of the reasonable patient in similar circumstances. According to this criterion, a causal connection can be

established between the failure to disclose information in violation of the duty of caution and the damage actually caused by the treatment. This objective test does not obviate the need for an assessment relating to the particular patient who has come before the court. The court assesses the degree of damage to the patient's ability to exercise judgment against the background of the conditions and the manner in which the patient received the information and the entirety of data and circumstances relating to the patient's physical and mental condition. Against that background, the court makes a judicial assessment, estimating how the patient might have acted were it not for defendants' violation of their duty. The Canadian court gave the following explanation of the objective test as it relates to the subjective circumstances of the injured patient:

> I think it is the safer course on the issue of causation to consider objectively how far the balance in the risks of surgery or no surgery is in favour of undergoing surgery. The failure of proper disclosure pro and con becomes therefore very material. And so too are any special considerations affecting the particular patient.
>
> ...
>
> The adoption of an objective standard does not mean that the issue of causation is completely in the hands of the surgeon. Merely because medical evidence establishes the reasonableness of a recommended operation does not mean that a reasonable person in the patient's position would necessarily agree to it, if proper disclosure had been made of the risks attendant upon it, balanced by those against it. The patient's particular situation and the degree to which the risks of surgery or no surgery are balanced would reduce the force, on an objective appraisal, of the surgeon's recommendation." Reibl [67] at 16 (Leskin, J.).

This test was cited approvingly by the Canadian Supreme Court in its a recent judgment. *Arndt* [69].

11. The lower court totally rejected the appellant's account regarding her surprise upon discovering that it was her shoulder and not leg that was operated upon, because it assumed that her prior knowledge regarding the necessity of the operation sufficed to negate the defect in the manner of receiving her consent. Having said that, under the circumstances, the previous information was not sufficient to receive the required consent to the treatment given to her, and in the absence of any proof of prior consultation and transmission of information concerning the nature of the treatment and its attendant risks, it was for the court to ascertain how the appellant would have behaved had she received the necessary information under appropriate conditions.

I considered whether the appellant's case should be returned to the lower court, in order for it to deal with the existence of the causal connection and to assess the probability of the appellant's refusal to the operation, had she had all the information. However, I have reached the conclusion that on the basis of the evidence presented by the parties, and in consideration of all the facts before us, it can be determined that the causal connection between the non-disclosure and the damage has been proven.

Respondents did not adduce evidence to substantiate the alleged conclusion that the anticipated risk of the operation was negligible and did not necessitate prior notification to the appellant of its nature. Assuming that the appellant was treated professionally and not negligently, and that the treatment given after the operation was proper, the necessary conclusion is that the disability caused to the appellant was a risk that was endemic to the treatment given to her. In any event, having claimed that the risk of the treatment they gave was not negligent, the respondents bear the burden of proving that the operation was urgent, and that the anticipated danger to the appellant as a result of the operation itself was negligible to a degree that it would not have affected the appellant's decision had she been informed of it.

As stated, such evidence was not submitted. In the special circumstances of this case, there is sufficient grounds for the assumption that a reasonable patient would have preferred to conduct an additional consultation with an expert regarding the need for the examination, in view of its endemic danger, given that the examination itself had previously been postponed, and in view of the fact that, as it became clear in retrospect, the operation was of doubtful necessity.

I am prepared to assume that in an ordinary case in which the examination was intended to ascertain whether a growth had developed, a reasonable patient would have adopted a different approach, especially if there was urgency in early discovery, and absent any alternative method of clarifying the matter.

However, the appellant's case is a special one. She was hospitalized in order to rectify a deformity in her leg, which was the result of a birth defect. Under these circumstances, one may assume that as a woman who was disabled from birth, she would have been particularly wary of the endangering the functioning of her right arm, had she been aware of such a danger.

Furthermore, the concern leading to the operation was apparently, from the outset, not regarded as being of any particular urgency. The appellant waited for the operation for more than two months, and a date for the operation was not actually set until her hospitalization. In their affidavits for the District Court, which were found to be credible, Respondent 1's doctors described the suspicion that led to the decision to perform a biopsy. Dr. Schweppy's affidavit states that "we decided that the results of the rentogen and the bone scan indicated pathological problems, and that in order to obtain a totally clear picture, there was a need for a biopsy, because there was no definitive diagnosis." The treating doctor, Sharvit, stated that "the findings provide concern of the existence of a growth … when I determined in the Lin clinic that there is a suspicion of growth of cartilage."

These comments, viewed together with the other evidence, indicate that the decision to perform a biopsy was not based on an urgent need for an immediate diagnosis.

Considering the degree of negligence involved in the non-disclosure of the information, the way in which the appellant's consent to the operation was obtained, and the particular circumstances of her case, it can be determined that if the appellant had been aware of all the relevant details regarding the nature of the examination and the risks involved, she would not have agreed to the examination at the date and in the manner that it was performed. For this reason, I conclude that there was proof of the causal connection between the non-disclosure of complete information and the damage caused to the appellant from the treatment she received.

12. After writing my judgment, I had the chance to review the comprehensive judgment of my colleague, Justice Or, and I will add my comments regarding its proposed method of compensation.

I wholeheartedly concur with the credo expressed by my colleague regarding the importance of the individual's right to autonomy. I think that in principle there ought to be recognition of the possibility of compensation for the violation of that right, though not necessarily in the context of the doctrine of "informed consent." It appears to be desirable to extend the right of separate compensation for violation of individual autonomy to cases in which a patient was denied the right to decide whether medical treatment would be administered. Still, in the context of non-disclosure of information regarding medical treatment, difficult questions arise when assessing the appropriateness of compensation for this kind of damage, independent of the treatment's results.

13. The critique of the approach allowing compensation for violation of autonomy in the context of non-disclosure of information, irrespective of the consequences of the medical treatment, has two focuses. The first

focus is analytic, concerning the essence of the doctrine of informed consent. The second focus concerns appropriate judicial policy.

Analytically, the doctrine of informed consent is based on the special status granted to the violation of individual autonomy, to the extent that under certain circumstances, such a violation is equivalent to medical negligence, in the sense that it entitles the victim to full compensation for all the consequences of the medical treatment.

When we chose the path of the tort of negligence, we ruled that in cases of failure to disclose information that is relevant and significant about the possible results of the treatment, the doctor's breach of his or her duty to the patient consists of the fact of non-disclosure. The theory of negligence based on non-disclosure of sufficient information to the patient is based on a number of things, one of the most central being the violation of individual autonomy. Remedy for a violation of that kind will be protected even when it is not specified separately as an aspect of the damage. The various components of the "informed consent" doctrine were summed up as follows by the learned P.H. Shuck:

> [I]nformed consent does not simply pursue the contract law goals of individual autonomy, efficiency, and anti-statism; it also advances two related ideas, fault and duty, that pervade and moralize tort law.

Rethinking Informed Consent [95] at 902.

According to supporters of the doctrine of "informed consent", medical negligence in the disclosure of information justifies compensating the patient for the treatment's consequences. The assumption is that *in principle* it is possible to prove the causal connection between the failure to give information and the treatment's consequences. Legal literature indicates that as a rule, those favoring the compensatory approach for violation of individual autonomy in the context of non-disclosure of medical information are also of the view that

in principle there is no recognition of the causal connection between negligence in the disclosure of information and the consequences of the treatment; from their perspective, compensation awarded for violation of autonomy is a substitute for the doctrine of informed consent. As such, it seems that the opinion stating that in the absence of informed consent, compensation can be granted for the violation of individual autonomy, regardless of the consequences of the medical treatment, is consistent with the view of those who dispute the doctrine of informed consent as a part of medical negligence. *See* Prof. Englard's book [83] at 607; A.D. Twerski, N.B. Cohen, *Informed Decision Making and The Law of Torts: The Myth of Justiciable Causation* [96].

Needless to say, the most "blatant" cases of violation of autonomy in medical treatment (for example when the medical treatment is given without the patient having given any consent at all, or where there was absolutely no disclosure of the inevitable result of the treatment) are treated by tort law under the tort of battery. In these extreme cases of non-consent, compensation will be given for the damage in its entirety, even without proof of the causal connection.

The distinction between a blatant violation of autonomy, addressed via the tort of battery, and non-disclosure as a part of medical negligence was dealt with by the Australian Supreme Court in its judgment in *Rogers v. Whitaker* (1992) [43]. In that judgment, the court distinguished the right to autonomy which is protected by the tort of battery from negligence in giving information, which requires a balance between the duty of the treating doctor and the patient's right to receive the relevant information:

> The right of self-determination is an expression which is, perhaps, suitable to cases where the issue is whether a person has agreed to the general surgical procedure or treatment, but is of little assistance in the balancing process that is involved in the determination of whether there has been a breach of the duty of disclosure.

Id. at 52.

The Canadian Supreme Court recently criticized the view that gives the patients' right to decide an independent and separate status from the subject of medical negligence being discussed here:

> The suggestion that loss of choice as such merits compensation is related to the suggestion that failure to advise of risk of medical intervention negates the patient's consent, making the physician's intervention - tortious battery. This Court unanimously rejected this approach in *Reibl v. Hughes*.

Arndt [69] at 62 (McLachlin, J.).

In this context, one can also mention the judgment in *Vaturi*, which emphasizes the complex connection between the duty of the doctor giving medical treatment and patient autonomy. *Id.* at 181-82.

14. In terms of appropriate judicial policy, I think that when dealing with the question of "informed consent," though my colleague's approach is intended to enhance the right to individual autonomy, paradoxically, his approach weakens it. The fear is that this approach will lead to a limitation of the compensation given to the victim of a treatment administered without giving him or her information, and it may even encourage the courts to avoid dealing with the complex question of the causal connection between failure to receive "informed consent" of the patient and the results of the treatment he received. This possibility was raised by Cohen and Twersky in their article in support of the separate claim of damage for the violation of autonomy. Twersky & Cohen [96] at 648.

In considering whether to adopt an approach that makes do with compensation for violation of autonomy, I think that the fear of the victim's compensation being limited to nominal compensation outweighs the benefit of enhancing the autonomy of the individual. On the other

hand, full acceptance of my colleague's approach allows compensation even in cases in which the treatment was successful and the patient satisfied, if it becomes clear that the patient was not initially presented with full details regarding the treatment. It is doubtful whether this result is desirable.

It should be noted that other legal systems similar to our own have not accepted the rule that compensation can be granted by reason of violation of autonomy in the context of non-disclosure of information, regardless of the results of the medical treatment. I was unable to find a single judgment in which the courts awarded compensation exclusively for violation of autonomy, as distinct from compensation awarded for damage caused as a result of the treatment.

It should be emphasized here that a distinction must be made between compensation for violation of autonomy and compensation for shock or mental trauma upon becoming aware of the grave consequences of unexpected treatment, a distinction made in both of the judgments cited in my colleague's opinion. *See Goorkani v. Tayside Health Board* (1991) [66]; *Smith v. Barking Havering & Brentwood Health Authority* (1989) [56].

These judgments are in accordance with the English approach to liability in the absence of "informed consent." As indicated above, the position of English law on the subject of "informed consent" differs from that of other common law countries, and English law has yet to confer it with the same scope as it has in the United States and Canada. *See* I. Kennedy, A Grubb, *Medical Law* [87] at 172-202; R. Nelson-Jones, F. Burton, *Medical Negligence Case Law* [88] at 102.

15. Furthermore, recognition of the violation of individual autonomy as an individual claim of damage, while commendable, is still in its "infancy," and its definition and the way it will be formulated still need to be developed. While tort law grants compensation for non-pecuniary damage, the proposed claim of damage still lacks precise and clear

criteria for its application. Moreover, I find it difficult to accept the analogy proposed by my colleague, namely compensation for violation of constitutional rights. For it is unclear whether the damage for a constitutional tort is evaluated according to the criteria of the tort of negligence. This is a complex question which merits a separate discussion. *See* D. Barak-Erez, Avlot Chukatiot [Constitutional Torts] [73] at 243 and subsequent text. *See also Memphis Community School Dist. v. Stachura* [57] at 2544 – 45.

16. To conclude: It seems that these problems necessitate particular caution when assessing the cases in which compensation may be made for violation of autonomy as an independent tort and whether it should be done in cases of negligent non-disclosure of medical information. We must decide when and according to which criteria the damage will be assessed. In principle, I think that the introduction of this new claim of damage should initially be assessed in the framework of cases in which there was a blatant violation of human dignity and individual autonomy, where that kind of violation constitutes the main focus of the damage. On the other hand, matters that can be classified as medical negligence should generally be assessed within the context of results of the treatment.

In any event, compensation for violation of individual autonomy should not be allowed to undermine the doctrine of informed consent. Accordingly, in my view, compensation for violation of autonomy should only be awarded in rare cases, which I have not deemed it appropriate to define at this stage.

17. In light of my conclusion, were my opinion to win a majority, I would propose that the appeal be accepted and the case returned to the District Court for it to hear evidence regarding the damage caused to the appellant, so that the court can assess the level of compensation for that damage.

Justice T. Or

1. Unfortunately, I cannot concur with the conclusion of my colleague, Justice Beinisch. I will clarify my position below.

2. I accept that the discussion in the district court proceeded on the assumption that the respondents or doctors in their employ were found to be tortuously liable for the tort of negligence and not the tort of assault. Negligence is therefore the only ground we must decide in this appeal.

Within this framework, those responsible for providing medical treatment are obliged to compensate the patient for all bodily damage sustained as a result of the breach of their duty to receive his or her full consent to treatment. In my view, those responsible for giving medical treatment must also compensate the patient for all non-pecuniary damage sustained as a result of the violation of the patient's right to autonomy, if the medical treatment is administered to the patient without his or her informed consent. The first part of my opinion discusses the respondents' obligation to compensate the appellant for her bodily damage. My conclusion, which I will explain shortly, is that there was no proof of the required causal connection between the failure to receive the appellant's informed consent and the bodily damage that she sustained. In the second part of my judgment, I will discuss the obligation to compensate a patient – in our case, the appellant – for non-physical damage sustained due to the violation of patient autonomy in giving medical treatment without the patient's informed consent. I will first deal with the factual background and then discuss the above-mentioned questions.

The Principle Facts and the Dispute

3. I accept the conclusion reached both my colleague, Justice Beinisch, and the District Court that there was no proof of negligence in the actual decision to perform a biopsy on the appellant's shoulder, the manner in which the biopsy was performed, or the appellant's post-operation treatment to address its consequences. These conclusions are well grounded in the District Court's findings, which were based on

evidence that it found reliable. As my colleague explained, there are no grounds for our intervention in these findings.

The claim against the respondents' doctors therefore focuses on their failure to inform the appellant of the risks and the prospects of the biopsy (hereinafter: the biopsy), creating a situation in which the appellant cannot be regarded as having given her "informed consent" to the biopsy. Here, too, I concur with my colleague that this constituted negligence in the way the doctors who treated her received her consent to the biopsy. However, before doing so, I must stress that, under the circumstances, the biopsy was a medical necessity which any reasonable doctor would have performed.

4. The principle facts regarding the biopsy are as detailed below:

(a) As the trial court determined:

> Around the middle of 1987, plaintiff began suffering from constant pain in the right shoulder, by day and by night. When systematic treatment was to no avail, rentogen photos were taken, followed by a bone-mapping. The latter test indicated 'a diffuse absorption' – which is a pathological finding. According to Dr. Eric Sharvit, the orthopedic specialist who treated the plaintiff in Defendant 2's clinic: "I observed an irregularity in the diffuse absorption, cysts and unremitting pains; diffuse absorption is a pathological finding. No absorption can ever be normal. In mapping, the reason always shows up. It may be cancer, an undiagnosed fracture, or an infection. It may also be a growth…. *There was something suspicious that required further clarification.*

And further on:

> According to Dr Eli Sharvit's affidavit of April 22, 1991, he examined the plaintiff's right shoulder on the dates September

> 8, 1987, October 20, 1987, and November 27, 1987. Sharvit stated that *at the end of the examination of November 27, 1987, in the framework of the consultation group, and after everybody had seen her and examined her file, it was unanimously agreed that a biopsy was necessary* (emphasis added – T.O.).

As Dr. Sharvit clarified in his testimony, "there was a concern about a destructive process which would be irreversible." He went on to say that:

> [T]here was no explanation for the absorption evidenced by the bone mapping, and a biopsy was therefore required in order to reach a clear diagnosis.

In addition to the above, the district court accepted Dr. Sharvit's account of events in paragraph 8 of his affidavit:

> In other words, I spoke with the plaintiff and, regarding her shoulder, I explained that she would have to have an operation in order to identify the problem, because the findings provided grounds for suspicion of a growth, and an operation was the only way of clarifying the matter. We had this conversation on October 20, 1997, when I determined that there was a suspected growth of cartilage.

The court also referred to the testimony of Dr. Schweppy, affirming it:

> The head of the Orthopedic Department in Carmel Hospital at the time of plaintiff's hospitalization of the plaintiff was Dr. Yitzhak Isadore Schweppy. Dr. Schweppy testified in court that the bone mapping indicated "an aggravated diffusive absorption near the humerus" and that the technician conducting the bone mapping had written (September 1, 1987) "Nature of absorption unclear. Recommend further examination." According to Schweppy, "the photograph

> indicates a pathological finding and the mapping also shows these signs. The mapping states that there is no unequivocal finding. All of this, in my opinion, necessitates a biopsy.

In view of all this, and since appellant's expert, Prof. Stein, did not explicitly contest the need for a biopsy, the court concluded that it was medically necessary to perform it, and there are no grounds for our intervention in this finding.

(c) Appellant maintained that she had never had problems with her shoulder, that she had never made any complaints in that regard, and that the entire issue of the biopsy came as a total surprise to her. Her version was rejected by the district court in view of the trust it placed in Dr. Sharvit. Relying on examinations performed on the appellant – a photograph of shoulder and mapping of shoulder – the court rightfully concluded that appellant had suffered from shoulder pains and that she was well aware of the "problem" she had with her shoulder.

(d) The court further noted that the appellant almost admitted to having been spoken to regarding the shoulder, prior to the biopsy. It was apparently referring to the following paragraph in her testimony, in which she said:

> Prior to the anesthetic I asked why the operation was on the arm and not on the leg. After they performed the operation I asked them.

Para.12.

In this paragraph she had a slip of tongue, indicating that already prior to the operation she asked "why the operation was on the arm." In other words, she was aware that they were about to operate upon her shoulder. Even so, she immediately "corrected" herself.

At all events, as stated, the entirety of the evidence indicates that the performance of the biopsy was required, as customary in similar cases, to rule out the serious suspicion of it being a cancerous growth.

5. In her judgment, Justice Beinisch explains why the conduct of the operating doctor should be regarded as negligent. I accept that regardless of appellant's general awareness of the need for such an operation, the doctor failed to discharge his duty to explain to the appellant the importance of the operation and its necessity as opposed to its risks, in order to ensure that the appellant's consent would indeed be "informed consent." Prior to the operation there may indeed have been a period of time during which appellant knew that she was about to undergo a biopsy. Nonetheless, the circumstances in which her consent was obtained indicate that she did not give her informed consent. The appellant was initially summoned to the operating room for an operation on her leg. While she was in the operating room, immediately prior to the operation, it was clarified to her that they intended to perform a biopsy on her shoulder, without making the associated risks clear to her, as required. I therefore accept my colleague's conclusion that there was negligence on the part of the treating doctors in their performance of the biopsy without giving the required explanation of its risks.

The district court determined that appellant had given her "informed consent" to the biopsy. It reached this conclusion in reliance, *inter alia*, on the conversation between Dr. Sharvit and appellant in October 1987, about two and a half months before the biopsy. However, the contents of that conversation do not substantiate the court's conclusion. Even if we accept the court's reliance on Dr. Sharvit's testimony, his comments to the appellant regarding the need to perform a biopsy did not constitute an explanation of the risks and prospects of the biopsy as required from a doctor about to perform an operation on a patient. Dr Sharvit's general comments to the appellant were made when she was already on the operating table, awaiting a different operation for which she had been prepared. Clearly, this could not satisfy the requirement of receiving informed consent, as explained by my colleague in her judgment.

So far, I have traversed a long way along the path leading to my colleague's conclusions. Nonetheless, in one matter I cannot concur with her conclusion. I refer to the proof of the causal connection between the doctors' negligence and the bodily damage suffered by the appellant as a result of the biopsy. I do not believe that there was proof of a causal connection between the doctors' negligence and the bodily damage suffered by the appellant as a result of the biopsy. Consequently, my conclusion is that appellant is not entitled to compensation for this damage. On the other hand, it is my view that those responsible for the appellant's treatment must compensate her for the violation of her right to dignity and autonomy, which flows from the doctors' negligence. I will first discuss the question of the causal connection between negligence and the bodily damage.

Appellant's Right to Compensation for Bodily Damage Caused As a Result of the Biopsy – the Causal Connection

6. Where a plaintiff bases a claim on the grounds of medical negligence, he or she bears the burden of proving, *inter alia*, a causal connection between the doctors' negligence and the alleged damage, namely that the negligence caused the damage – that but for the negligence, there would have been no damage. This is the rule for all claims grounded in negligence, including claims in which the tort is imputed to the doctor for negligence in failing to discharge his or her duty of disclosure to the patient prior to receiving consent for treatment. *See* CA 4384/90 [3]; CA 4341/94 *Berman (Minor) v. Moore Institute for Medical Information Ltd* [7]; s*ee also* Shapira [77] at 236. Consequently, it was incumbent upon the appellant to prove that had she received the requisite explanation regarding the biopsy – the importance of the biopsy, compared to its risks – she would not have given her consent to its performance. Should it transpire, however, that even after such an explanation, the appellant would still have agreed to perform the biopsy, it can no longer be said that it was the doctor's failure to receive her "informed consent" that actually caused the damage that occurred as a

result of the biopsy. In other words, in such a case, one cannot say that it was the absence of such consent that caused the damage.

The question is: what would have happened had the appellant actually received all the requisite and relevant explanations regarding the operation and then been asked to give her consent to the biopsy? Upon receiving the information, would she have refused to undergo the biopsy, which would have prevented the damage caused to her by its performance? The answer is not clear:

> There are considerable difficulties in responding to the hypothetical causal question of what would have happened if they had conducted themselves in accordance with the law. The response is necessarily dependent on guesses and conjecture, especially with respect to the question relating to hypothetical human responses.

I. Englard, *Yesodot Haachraut Benezikin*, Dinei Nezikin – Torat Hanezikin Haclallit [74] at 230-39.

The kind of matter being dealt with here poses a particular difficulty: determining whether a patient would have agreed to the operation had he or she possessed all the relevant facts prior to giving consent. In his book, *The Philosophy of Tort Law,* Englard deals with the question in all its complexity, especially in view of the fact that these cases are not normally decided exclusively by logical considerations. *See Id, Informed Consent: The Problem of Autonomy and Compensation* in [74] at 166-67; *see also* CA 4384/90 [3].

Considering the difficulty in answering that question, the Court's response must be based on the evidence submitted and considerations of common sense and life experience.

7. The case before us also raises the issue of whether the answer to the question presented above should be given according to a subjective

criterion, namely, how would the appellant before us have reacted, or alternatively, according to an objective criterion. In other words, how would a reasonable patient have conducted himself or herself in a similar situation. Another possibility is the mixed criterion: how would a reasonable patient in the appellant's position have behaved.

Even though my tendency is towards the subjective criterion, with the objective criterion serving as an auxiliary tool in its application, we need not resolve the issue in this case. The reason is that in my view, under the circumstances of this case, both the subjective and the objective criterion lead to the same unavoidable conclusion. It may be presumed, with an extremely high degree of certainty, that the patient would have actually consented to the biopsy even if all the facts that were relevant for receiving her consent had been presented to her. In my view, the possibility or the chances that she would not have agreed to it are particularly low, if not altogether negligible.

8. In her testimony, Appellant did not address the question of whether she would have agreed to a biopsy had she received an explanation of its urgency, its dangers and its prospects. In court, she categorically denied any conversations with her doctors regarding her shoulder. She even denied ever having complained about pains in her shoulder. The court rightly rejected this testimony, considering the proven facts: Appellant had been asked to undergo examinations which included an x-ray of her shoulder as well as a bone mapping, and these were in fact conducted.

However, even though she denied that the subject of her shoulder and the need for the biopsy were raised at any stage, nothing prevented her from addressing the hypothetical question of her consent to a biopsy. Appellant was given the opportunity to explain whether or not she would have agreed and her reasons for either decision. Had she utilized the opportunity and explained her stance, the court would have subsequently examined the credibility of her position and reasons, as well as their reasonability. The appellant was silent on this point, even though her

particular considerations for not assenting to a biopsy, if she had them, were known only to her.

And so, on this point, the district court correctly said that: “We have no evidence that in these or other circumstances, the plaintiff would not have agreed to the biopsy.”

9. The court cannot speak in the place of the appellant, who was silent on this matter in her testimony. What the court can do is examine the entire complex of circumstances, even without her testimony, and ask whether it indicates that the appellant, as a reasonable person, would have refused the biopsy, had she received an explanation of its need as opposed to its inherent risks. One must assess the likelihood that disclosure of the requisite information would have led the patient to oppose the performance of a biopsy. In deciding this question, the court must consider the type of treatment that the patient received and the degree of its urgency compared with the risks involved and assess the probable response of the patient according to the criterion of how a reasonable patient would have responded in similar circumstances.

This assessment must relate to the time at which the appellant’s agreement was required, in other words, prior to the biopsy, after being presented with all the relevant data and being asked to decide whether or not she agreed to the operation. Clearly, the answer cannot be based on wisdom after the fact, when it was already clear that the concern regarding a cancerous growth had evaporated and that she had been injured as a result of the operation.

10. The circumstances preceding the biopsy were as follows:

(a) Appellant had complained of severe pains in her shoulder, which lead to the conduct of various examinations. The examinations included an x-ray of her shoulder and bone mapping. These two examinations justified further clarifications, due to the possibility of there being a cancerous growth.

As evidenced by experts' testimony, which the court relied upon, additional clarification was to have been conducted by way of a biopsy. In their examinations, the experts were not presented with any proposition to the effect that there were other means for conducting that clarification, means that would have posed less risk than a biopsy, which entailed surgical intervention. Nor was the court presented with any evidence from which it could deduce that a biopsy was not the only reasonable measure to confirm or negate the existence of a cancerous growth on the appellant's shoulder. The circumstances as they were presented to the court indicated the clear necessity of the operation, and any person who cared about his or her health would have given consent, in the absence of extreme unusual circumstances that would have dissuaded the patient from consenting. There was no evidence of such circumstances in this case.

(b) All surgical interventions involve certain dangers. Unfortunately, one of those became reality in the appellant's case. Even so, it is commonplace that the mere existence of an element of danger does not prevent operations or the performance of examinations which are medically necessary. It must be stressed that in our case, no evidence was submitted of any particular risks, beyond the ordinary risks attendant to any surgical intervention, which are involved in the performance of a biopsy. By itself, the fact that the appellant was injured as a result of the operation provides no indication about the nature of the risks that are part of the biopsy performed on the appellant.

(c) My colleague, Justice Beinisch, suggested that had appellant been apprised of the need for the biopsy as opposed to the risks entitled therein, then presumably, like any other any reasonable patient, she would have preferred to receive a second opinion regarding the need for the examination. I do not accept this presumption. As early as October 1987, it had been explained to the appellant that an operation would be necessary in order to examine the problem. Sec. A of Dr. Sharvit's affidavit. Appellant denied that the meeting with Dr. Sharvit ever took place, and we heard nothing from her to indicate that she would have

consulted with an additional expert had the need for a biopsy arisen. In this context, I will mention that Appellant had long been in the treatment of doctors in respondents' orthopedic department, and she would naturally trust them. The same doctors had both recommended and performed other operations on the appellant without her having consulted an additional expert. Furthermore, in view of the proven need to perform a biopsy, it is reasonable to assume that any additional expert would have recommended the same examination. These facts help us understand the testimony of the respondents' experts, upon which the district court saw fit to rely.

11. On the basis of these data, in my opinion, not only was there no proof that Appellant would not have agreed to the biopsy had she been presented with all the information necessary in order to receive her consent, but the circumstances indicate that she would actually have agreed to it. The examination was required in order to ascertain the existence of a serious risk to her health as a result of a cancerous growth, and Appellant had previously put her trust in the respondents' doctors; these factors and all the other circumstances, too, point very clearly in this direction. Like any reasonable person, the appellant would have agreed to it.

Admittedly, despite the fact that at the end of November 1987, the medical team of the Orthopedic Department of the hospital determined that there was a need for a biopsy, it was not actually performed until January 7, 1988. Arguably, in view of the clarification required regarding the shoulder, it would have been appropriate to recommend the performance of the biopsy at an earlier date. The question as to why this didn't happen was not clarified in the district court, because the witnesses were not fully examined on this matter. Even so, when the appellant was brought to undergo the leg operation, the doctors considered the biopsy operation urgent to a degree that gave it priority over the leg operation that the appellant required. This fact indicates a dimension of urgency in the performance of the biopsy.

12. My conclusion that there was no proof of a causal connection between breach of the duty to receive the informed consent of the appellant and the performance of the biopsy is based on considerations similar to those adopted by other courts in the past in rejecting similar claims for compensation for bodily damage in tort actions. I will cite two examples.

In *Smith* [56], an operation was performed on plaintiff's spine. The operation involved a risk factor of a 25% chance that three of the plaintiff's limbs would be paralyzed. Plaintiff was not informed of this risk prior to the operation, and as a result of the operation, she was indeed inflicted with paralysis in three limbs. She subsequently filed suit, demanding compensation for the bodily damage.

Based upon the doctors' testimonies, the court ruled that the doctors were negligent in their failure to inform the patient of this risk. Even so, the action under this head of damage was rejected because it was determined that a causal connection between the omission of failing to inform about the risk of that damage and the damage that was actually caused had not been proven. The court noted that the evidence presented did not indicate any particular factors that might have influenced the plaintiff's subjective position regarding the question of whether to receive the treatment or not. As for specific factors regarding the treatment, the court pointed out, *inter alia*, that failure to treat the patient within a short period of time would have left the plaintiff paralyzed in all the limbs of her body. Furthermore, the danger to which she would have been exposed if the operation had not succeeded would not have been more severe than the danger that she could have expected had she not undergone the operation. On the other hand, had the operation succeeded, it would have postponed the plaintiff's disability for a significant period of time. The court therefore concluded "unhesitatingly" that there was a strong likelihood that the plaintiff would have agreed to undergo the operation even had she received full information and that it was "in the highest degree unlikely" that the plaintiff would have refused to undergo the

operation. Consequently, the court rejected the plaintiff's claim for compensation based on the bodily damage caused to her.

The court acted similarly in *Goorkani* [66]. In that case, a man was treated with a particular medicine for an eye disease from which he suffered. Treatment with this medicine for a period exceeding a few months, at the dosages being given to the plaintiff, involved a high risk of infertility. In spite of the ongoing nature of the treatment, which extended for over a year and a half, plaintiff was not informed of the danger. The treatment solved his problem of vision, but the risk of infertility materialized, culminating in a suit for damages compensation.

The court ruled that in failing to give the information, the doctors breached their duty of care to the plaintiff. Nonetheless, his claim for compensation for bodily damage was rejected in the absence of the causal connection between the breach and the stated damage. In its ruling, the court considered the fact that the treatment was given to the plaintiff during his studies, while he was working towards an engineering degree. At that time, his motivation to complete his studies was particularly strong. As such, the problems regarding his vision caused him severe anxiety and even led to emergency hospitalization for treatment of this problem. Considering the fact that at that time of his life, the plaintiff was also experiencing marital problems, the court's view was that even had he been informed of the danger of infertility, the plaintiff would have taken that risk in order to save his vision. In other words, the path of action chosen by the plaintiff would not have changed, even had the doctors discharged their duty to give him all the relevant information. Plaintiff's claim was therefore rejected under this head of damage, in the absence of a causal connection between the violation and the damage.

I did not cite these two examples in order to prove that that the conclusion in the two aforementioned cases regarding the absence of a causal connection was the necessary conclusion in those cases. I cited them only in order to illustrate that when negligence is proven regarding the failure to receive informed consent for the operation, the court will

not be afraid to determine, on the basis of the facts of the case, that there was no causal connection between the negligence in not receiving informed consent to the operation and the bodily damage caused by the operation.

13. My conclusion is therefore that the appellant is not entitled to compensation for bodily damage caused to her as a result of the biopsy. In view of this result, I need not express my opinion as to what the result would have been, had it been possible to prove that the balance of probability indicated that Appellant would have refused to receive the treatment had she been aware of all the relevant facts. For example, had it been possible to determine that there was a 30% chance that she would have refused to undergo a biopsy, the question might have arisen as to whether to give monetary expression to the loss of that chance, as a result of the breach of the duty to receive the appellant's informed consent to the biopsy. It has been argued that in such a case, the appellant should be entitled to compensation calculated as a function of the degree of probability that she would have refused to perform the biopsy. My colleague, Justice Strasberg-Cohen, adopted this position in her opinion in this case, similar to her position in CA 6643/95 *Cohen v Histadrut Klalit Health Fund* [8] (*see also* Justice Mazza's opinion in CA 4384/190 [3]). In the example that I gave, this would mean that appellant would be entitled to compensation equivalent to 30% of the damage caused as a result of the biopsy.

In view of my conclusion regarding the causal connection, under the facts of this case, I will not express my opinion on the question, and it will remain open, pending deliberation and decision in an appropriate case.

14. This completes our discussion of whether or not Appellant is entitled to compensation for bodily damages, but it does not complete my judgment. The additional question requiring resolution is whether compensation should be awarded to the appellant for the non-bodily damage sustained by her due to the violation of her autonomy, deriving

from the fact that an operation was performed on her body without her having given her informed consent. I will now examine this question.

Introduction – The Right to Autonomy

15. The point of departure for this discussion is the basic recognition that every person has a fundamental right to autonomy. Every individual has the right to decide his or her deeds and wishes in accordance with his or her choices, and to act in accordance with those choices. The right to autonomy is, in the language of that definition, "his or her independence, self-alliance and self contained ability to decide." F. Carnelli, Crisis and Informed Consent: Analysis of a Law-Medicine Malocclusion [97], n.4 at 56. In a similar vein, Justice Cheshin stated that: "the law recognizes the autonomy of the individual to formulate his or her will as he or she considers appropriate, for his or her own 'good'; it is the individual who decides his or her own 'good': his or her 'good' is his or her will, and his or her will is his or her 'good.' A person's 'will,' whether explicit or implied, includes that person's 'good.' A person's 'good' is inseparable from his or her will." FHC 7015/94 *Attorney General v. Anonymous* [9] at 95-96. A person's right to shape his or her life and fate encompasses all the central aspects of his or her life: place of residence, occupation, the people with whom he or she lives, and the content of his or her beliefs. It is a central existential component of the life of every individual in society. It expresses recognition of the value of every individual as a world unto himself or herself. It is essential for the self-determination of every individual, in the sense that the entirety of an individual's choices constitutes his or her personality and life. *See* D. Herman, *The Basis for the Right of Committed Patients to Refused Psycho-tropic Medication* [98].

16. The individual's right to autonomy is not expressed only in the narrow sense of the ability to choose. It also includes another –physical – dimension of the right to autonomy, relating to a person's right to be left alone. HCJ 2481/93 *Dayan v. Commander of Jerusalem District* [10] at 470-72. The import of the right is, *inter alia*, that every person has

freedom from unsolicited non-consensual interference with his of her body. Dworkin made this point when addressing this aspect of individual autonomy:

> It is a physical concept rather than an intellectual one. If you touch me or eavesdrop on me, you have injured my autonomy by invading my space. If you actually do something to change my body, you have injured my autonomy by changing the very constitution of what I am.

R.B. Dworkin, *Medical Law and Ethics in the Post-Autonomy Age* [99] at 733.

17. The recognition of a person's right to autonomy is a basic component of our legal system, as a legal system in a democratic state. R. Gavison, *Esrim Shana Lehilchat Yardor – Hazechut Lehibacher Vilikachei Hahistoria* [78]; HCJ 693/91 *Efrat v. Commissioner of the Population Registry in the Ministry of Interior* (*Efrat*) [11] at 770. It constitutes one of the central expressions of the constitutional right of every person in Israel to dignity, a right anchored in the Basic Law: Human Dignity and Liberty. Indeed, it has already been ruled that one of the expressions of right to dignity is "the freedom of choice of every person as an individual being" and that this reflects the conception that every person … is a world in himself or herself and an end unto himself or herself." HCJ 7357/95 *Baraki Petar and Humphries (Israel) Ltd. v. State of Israel*, (hereinafter, *Baraki Petar and Humphries* [12] at 783-84) (Barak, P.). President Barak further noted that, "The autonomy of individual will is a basic value in our legal system. Today it is anchored in the constitutional protection of human dignity." HCJ 4330/93 *Ganem v. Tel Aviv District Committee of the Bar Association* (*Ganem*) [13] at 233-34. In this context, President Shamgar gave the following explanation of human dignity:

> Human dignity is reflected, *inter alia*, in the ability of a human being as such, to freely form his or her personality at his or her

> own free will, to express ambitions and to choose the means of realizing them, to make his or her own volitional choices, not to be subjected to arbitrary coercion, the right to fair treatment by any authority or any other individual, to benefit from the inherent equality of all human beings …

CA 59942/92 *Anonymous v. Anonymous* [14] at 42.

18. The right to autonomy is "a framework right." 3 A. Barak, Parshanut Bimishpat [Interpretation in Law], Parshanut Chukatit [Constitutional Interpretation] [76] at 357-58. Accordingly, this right served as a basis for deriving numerous specific rights. For example, it was the basis of the right of every person to choose his or her family name (*Efrat* [11]); for the right of the criminally accused not to be present at trial against their will (*Baraki Peta Humphries*, *supra* [12]; it was accorded weight regarding the question of appointing a guardian for another person (CA 1233/94 *Cohen v. Attorney General* [15] paras. 4,5, (Strasberg-Cohen, J.)). It was the basis for the fundamental right of every person to freedom of movement in Israel. HC 5016/96 *Horev v. Transportation Minister* [16] at 59-60 {256-57} (Barak, P.). It was also the basis of a person's right to choose his or her own attorney to represent the person in court. *Ganem*, *supra* [13]. It was also given significant weight regarding the question of whether and to what extent one can recognize the validity of the adoption of an adult person, based on the approach that "In our times, when 'human dignity' is a protected, constitutional right, we must give effect to the individual's desire to concretize his or her own personal being …" CA 7155/96 *Anonymous v. Attorney General* [17] at 175 (Beinisch, J).

19. A person's right to dignity and autonomy are cardinally important in the context of medical treatment. Medical treatment is part of the inner core of a person's right to control his or her life. The impact it may have on a person's lifestyle and quality of life may be direct and often irreversible. Accordingly, the derivative of a person's right to autonomy is the right to receive information regarding the medical treatment he or

she receives in a hospital. LCA 1412/94 *Hadassah Medical Association, Ein Kerem v. Gilad* [18] at 525. In the same vein, it was held that a person may not be pressured, either directly or indirectly, into consenting to an operation on his or her body which he or she does not want by way of reducing the compensation to which he or she is entitled. CA 4837/92 "*Eliyahu" Insurance Company v. Borba* [19]. This expresses the conception that "a medical operation constitutes an assault on a person's body, and a person must retain autonomy over his or her body to decide whether he or she desires such an assault or not." *Id.* at 261. The patient is entitled to refuse treatment, even if its advantages exceed its disadvantages and its prospects outweigh its dangers. The central focus of the decision to perform medical treatment is primarily the patient's rights as a person, especially his or her right to dignity and autonomy, and only to a lesser extent, the medical repercussions of his or her decision. *See* R. Macklin, *Symposium: Law and Psychiatry, Part II: Some Problems in Gaining Informed Consent from Psychiatric Patients* [100] at 349-50. *See also* Justice Mazza's opinion in CA 4384/90 [3] at 181.

The right to autonomy is also the main foundation of the doctrine of informed consent under which, subject to certain exceptions which are not relevant here, no medical procedure can be performed on a person's body unless his or her informed is given. CA 3108/91 [1] at 91. In this context, the rule is that "where the choice of a medical course or the receipt of medical treatment involves substantial risks, doctors are obliged (subject to exceptions) to provide the patient with the information that is reasonably necessary for him or her to reach a personal and informed decision as to whether or not to choose the particular medical treatment and to take the risks involved. CA 4384/90 [3] at 182 (Mazza, J.). The decision concerning medical treatment … "must be an individual decision which first and foremost takes into account the will and choices of the patient himself.." *Id.* Justice Dorner summarized this point well in CA 434/94 [7]:

> The patient is not an object. The patient is a subject who bears the consequences of the risks and chances that the doctor takes

> when choosing the manner of treatment. As such, the patient has the basic right, flowing from the autonomy of the individual, to make an informed decision, i.e. with awareness of the relevant facts, whether to agree to medical treatment being proposed to him or her.

Id. at 212.

20. Parenthetically, it should be noted, in order to provide a complete picture, that in 1996, the Patient's Rights Law was enacted. The purpose of the law is "to establish the rights of a person applying for, or receiving medical treatment and to protect his or her dignity and privacy." Sec. 1. The law prescribes, *inter alia,* a detailed arrangement regulating the subject of the patient's informed consent to medical treatment Sec 13-15. This law does not apply in our case, given that it was enacted after the biopsy was performed on the appellant.

Violation of Autonomy: A Remunerable Damage Under the Tort Ordinance [New Version]

21. Returning to the case before us. As I indicated above, under the circumstances of this case, the duty to receive appellant's informed consent to the biopsy on her shoulder was not discharged. This was a violation of appellant's basic right, as a human being, to dignity and autonomy. Does this fact confer the appellant with a right to compensation, even if the appellant suffered no bodily damage as a result of the failure to receive her informed consent?

The first question to be addressed in this matter is whether or not the damage involved in the harm to the patient's dignity and autonomy is "damage" in the sense of the Tort Ordinance [New Version]. In my view, this question must be answered affirmatively. The term "damage" is defined in Section 2 of the Tort Ordinance [New Version]. The definition is broad, including "loss of life, loss of assets, comfort, bodily welfare or reputation, or detriment thereof, or any other similar loss or detriment."

In the framework of this definition, protection is given to numerous intangible interests. As such, compensation is awarded for non-pecuniary damage, such as pain and suffering, which are part of the bodily damage caused to a victim. The breadth of the definition led to the ruling that any harm to bodily comfort, pain and suffering, even *without* physical expression, even if not accompanied by any bodily damage of any kind, may constitute remunerable damage in a tort action. CA 243/83 *Jerusalem Municipality v. Gordon* [20] at 139 (hereinafter - *Gordon*). In accordance with this approach, the Tort Ordinance [New Version] also protects "the victim's interests in his or her life, comfort, and happiness." *Id.* at 141. Accordingly, the Court ruled that a person harassed by reason of a criminal procedure that originated in the negligent adoption of a mistaken criminal procedure against him is entitled to compensation from the prosecuting authority for that damage. *Id*.

In a series of subsequent judgments, the Court trod a similar path, awarding damages for harming intangible interests of plaintiffs in tort actions. Hence, the Court ruled that the owner of a copyright is entitled to compensation for psychological damage and emotional distress caused by the violation of the right. CA 4500/90 *Herschko v. Aurbach* [21] at 432 (Levin, D.P.). This was also the ruling regarding damage to a person's dignity and freedom occasioned by his coerced and illegal hospitalization in a mental health hospital. CA 558/84 *Carmeli v. State of Israel* (*Carmeli*) [22] at 772 (Netanyahu, J.). Similarly, the Court ruled that the suffering sustained by a woman whose husband divorced her under circumstances of duress constitutes compensable damage. CA 1730/92 *Matzrava v. Matzrava* [23], para. 9 (Goldberg, J.).

The same applies to the violation of a person's dignity and sensibilities which constitute a fundamental head of damages in the tort of assault and in the tort of false imprisonment. *See* H. McGregor, *On Damages* at 1024, 1026.

Against this background, I think that the violation of human dignity and right to autonomy caused by the performance of a medical procedure

on a person without his or her informed consent entitles him or her to compensatory damages under tort law. The illegal harm to a person's sensibilities attendant to the failure to respect the basic right to shape his or her life according to his or her own will constitutes a detriment to that person's welfare and falls within the aforementioned category of "damage." It matters not whether we regard it as damage to "comfort" or "or any other similar loss or detriment" under the definition of the "damage" in section 2 of the Ordinance. We have dealt with the centrality of the right to autonomy in shaping the identity and fate of a person in the society in which we live. The right to autonomy is central to the formulation of a person's identity and fate in our society. It is a crucial component of a person's ability to live as an independent and thinking individual. The inevitable conclusion is that this right is an essential part of a person's interest in "his or her life, comfort, and happiness" (*Gordon* [20] at 122), and its violation may entitle the individual to compensatory damages. As Crisp wrote:

> One's well-being is constituted partly by the very living of one's life oneself, as opposed to having it led for one by others. The fear we have of paternalism does not arise merely from the thought that we know our own interests better than others, but from the high value we put on running our own lives.

R Crisp, *Medical Negligence, Assault, Informed Consent and Autonomy*, [101] at 82.

A person is not an object. Every legally competent person is entitled to have his or her wishes respected by society and its members, in all important matters relating to that individual, provided that he or she does not harm others. LCrim 6795/93 *Agadi v. State of Israel* [24] at 710. It derives from the recognition of a person's intrinsic value and of the fact that all people are free. Violation of this fundamental right, other than by force of legal power or right, seriously vitiates individual welfare, constituting damages for which compensation can be awarded.

Violation of Autonomy, Violation of the Doctor's Duty of Care to the Patient

22. Our affirmative answer to the question of whether the damage discussed entitles its victim to compensation under the Tort Ordinance [New Version] does not terminate the discussion. Where a claim is based on negligence, the victim's right to compensation depends on whether the tortfeasor owes a duty of care to the victim to prevent that damage. Recognition of this obligation is a function of "considerations of legal policy." *Gordon* [20] at 140. *Gordon* ruled that the tort of negligence also encompasses a duty of care for damage which is neither pecuniary nor bodily, caused to persons within the first circle of risk, in other words, the targets of the injurious activity. In this context, Justice Barak ruled that:

> The tort of negligence should provide equal protection to both the victim's interest in his or her body and money and his or her interest in life, comfort and happiness. Non-pecuniary damage should not be regarded as "parasitical," only to be tolerated when ancillary to pecuniary damage. It should be recognized as independent damage, meriting compensation as such. Human dignity, a person's reputation, comfort, and mental well-being are important to proper societal life and must receive the appropriate protection granted to all other pecuniary interests. A person's body and property are no more important than his or her grief.

Gordon [20] at 142.

Application of these considerations in a case of the type at hand tips the scales in favor of recognizing a victim's right to compensation for non-pecuniary damages. The tortfeasor – who was responsible for providing the treatment – is clearly capable of anticipating the damages that will ensue from the violation of the person's basic right to autonomy should the person fail to receive the information necessary to decide

whether or not to undergo the treatment. *See* CA 195/91 *State of Israel v. Levy* [25] at 65-66 (Shamgar, P).

The person responsible for providing treatment and his or her patient are connected by relations of "proximity" within the tort law meaning of the term. This term refers to the component of duty of care, and it relates to "a special connection of different kinds between the tortfeasor and the victim." It serves as "a means of control and supervision over the borders of responsibility by delimiting the "circles of danger." Y. Gilad, *Al Hanachot Avoda, Intuitzia Shiputit Veratzionaliut beKeviat Gidrei Achrayut BeRashlanut* [79] at 322. A particularly close and intimate connection exists between the patient and the person responsible for his treatment in view of the treatment's potentially far-reaching implications for the patient's life and welfare. Against this background it was ruled that the patient-doctor relationship is predicated on a relationship of trust which "is the basis of the patient's readiness to place his or her life, health, and welfare in the doctor's hands." CA 50/91 *Sabin v. Minister of Health* [26] at 34 (Shamgar P.). The patient undergoing a medical procedure is in the primary circle of risk of suffering harm if, prior to that procedure, the patient does not receive all the relevant information. Recognition of the patient's right to compensation will not create broad circles of obligations which we cannot anticipate in advance. Consequently, the proximity requirement derives from the consideration that "according to any consideration of legal policy, there is a (normative) duty to anticipate non-pecuniary damage to a person who happens to fall within the primary circle of danger. In other words the person who was the target of the injurious action." *Gordon* [20] at 142.

Furthermore, the nature of the relationship between the patient and doctor is such that the doctor is in a better position to prevent these kinds of damages. It must be remembered: The doctor enjoys an absolute advantage in knowledge over the patient. As a rule, the patient lacks the tools that would enable him or her to make an independent assessment of the various matters relating to the treatment. The patient does not have the fundamental corpus of knowledge that would enables him or her to

direct questions to the treating doctor about all aspects of the particular medical procedure being considered. In other words, the doctor responsible for the treatment is fully equipped to adopt all measures that are necessary to prevent the damage that may be incurred by the patient due to a failure to provide important information prior to the actual treatment. Recognition of the patient's right to compensation for violation of his autonomy in a case where this duty was breached may also help contribute to the duty actually being fulfilled [in other cases – ed.]. It may be of assistance in preventing situations such as ours, in which the doctors ascribe minimal significance, if any, to the patient's opinion regarding the medical procedure, which in their opinion should be performed on the patient's body.

Rejection of Considerations Against Recognizing the Obligation to Compensate for the Violation of Autonomy

23. Are there any counter-considerations, tipping the scale against recognizing the obligation to compensate for violation of a patient's autonomy?

a) One possible consideration concerns the fear of what is referred to as "defensive medicine." By that I mean the practice of medicine focused on the doctor's protection against potential liability as distinct from the focus on the patient's welfare. *See* the detailed comment of my colleague, Justice Strasberg-Cohen, regarding this concern; CA 2989/95 *Korantz v. Sapir Medical Center – "Meir" Hospital* at 698-99; A. Porat, *Dinei Nezikin: Avlat Harashlanut alpi Pesikato shel Beit Hamishpat Haelyon Minekudat Mabat Theoretit [Tort of Negligence]*, [80] at 37. In our case, this fear would be manifested by providing unnecessary, superfluous information to the patient with the intention of exempting the doctor from possible liability. But in fact, "flooding" the patient with unnecessary information can actually violate the patient's autonomy to the extent that it prevents him or her from exercising effective and meaningful discretion before deciding whether to undergo the medical procedure.

In my opinion, however, this fear should not be accorded significant weight in our case. Irrespective of whether or not we recognize an obligation to compensate for violation of the patient's right to autonomy, it is still the doctor's duty to give the patient all essential information of importance for the patient's decision whether or not to consent to a particular medical procedure. This is the derivate of the doctor's general and concrete duty of care which he owes to the patient, and which today is anchored in the Patient's Right Law.

Our case is not concerned with broadening the existing duty or creating an expanded duty to give the patient information. There are parameters that determine the scope of information that the doctor must give the patient, and we will not broaden them. The obligation to give the patient this information applies, and will continue to apply, only to information of which the patient must be aware in order to decide whether or not to agree to the treatment. The doctor's failure to discharge his or her duty of disclosure to the patient violates the patient's autonomy. The determination that such violation of autonomy creates an additional right to compensation in no way affects the nature or the scope of this duty. The scope and the nature of the information which the doctor must give to the patient continues to be a derivative of the patient's right to decide, on the basis of all the relevant information, whether to agree to the treatment proposed. Even in the legal regime proposed, which recognizes the patient's right to compensation for the mere fact of the violation of his or her autonomy, the patient would not be entitled to any compensation in a situation in which the doctor failed to give the patient information which was not important to the patient's decision.

Furthermore, in the current legal regime, doctors are liable for compensation of patients when there is a causal connection between the violation of the duty to receive the patient's informed consent and the bodily damage caused to the patient. Usually the victim's compensation award for the mere violation of the patient's right to autonomy will be relatively small in relation to compensation for bodily damage. We should remember that we are not dealing with punitive or extraordinary

damages but rather with compensation for harm to an intangible value, usually of restricted scope. *See* para. 27, *infra*. As such, we are not dealing with the broadening of potential professional liability to a degree which could trigger a real fear of widespread adoption of the practice of giving superfluous information to patients. In this context, Englard cites the following statement in his book: "Authoritarianism is deeply embedded in professional practices." *Supra* [83] at 165. These comments, which largely reflect reality, tell us that as a matter of fact, we are still a far cry from the situation in which a patient's autonomy will be violated by being provided with superfluous information. As such, I would not accord significant weight to this consideration.

b) Another risk mentioned in this connection is the danger of high administrative costs due to the court being flooded with claims. Amongst the other factors, there are objective difficulties in adjudicating this kind of tort action, which by definition is vague and intangible. *See* Porat [80] at 389.

The "flooding" claim has been raised on a number of occasions in the past, when the question deliberated was the existence of a duty of care on the part of the different administrative authorities. *See e.g.* CA 429/82 *State of Israel v. Sohan* [28] at 741 (Barak, J); *Gordon*, *supra* [20] at 125. Usually the Court has not accorded significant weight to this claim, and in my opinion, rightly so. Experience indicates that none of the cases in which the claim was raised actually triggered the flooding of which we had been warned, including with regard to the subject of compensation for non-pecuniary damage only. Absent, a firm, factual foundation for this claim, I would therefore avoid according any significant weight to this consideration. Furthermore, we must remember that we are dealing here with substantive law, which concerns the rights of individuals to compensation for a violation of one of their basic rights. Courts exist in order to do justice, and in the words of Justice Netanyahu, discussing periodic compensation payments:

> The principle of the finality of a judgment, whether it protects a party against being unnecessarily disturbed or protects the court against being flooded with applications for repeated adjudication, is indeed an important matter, *but it should not prevail over the primary consideration, which is doing justice between two parties*. CA 283/89 *Haifa Municipality v. Moskovitz* [29] at 727 (emphasis added, T.O).

(c) It was further claimed that that there is no need to recognize a damageable right in cases of the kind before us, because in reality there are numerous patients who do not desire autonomy when receiving medical treatment. For various reasons rooted in the nature of the situation of treatment situation and the nature of the doctor-patient relationship, patients prefer to transfer responsibility for deciding their fate to the doctors treating them. *See* Englard, *supra* [83], at 163-65. Consequently, one cannot say that any damage was incurred by these patients due to the failure to disclose the risks and damages occasioned by the treatment they received.

I lack the tools required for an empirical examination of this proposition. I have serious doubts whether most patients voluntarily waive any significant involvement in the decision making process regarding treatment they are about to receive and have no interest in such involvement. Furthermore, compensation for damage awarded for the violation of the right to autonomy is individually based, taking into consideration the particular circumstances of the case. *See* para. 27, *infra*. Accordingly, there may be cases in which the evidence indicates that the patient's right to autonomy was not violated, despite the failure to comply with the legal duty to receive the patient's informed consent to medical treatment. For example, the patient's particular subjective preferences may lead the court to conclude that there is no justification for granting the patient compensation for violation of that right. Nonetheless, from a conceptual perspective, this does not preclude recognition of statutory remedy for cases in which the evidence indicates a violation of the patient's right to autonomy.

As such, I conclude the reasons for rejecting recognition of a duty to compensate for damages caused by the violation of autonomy do not convince me to change my conclusion that such duty should be recognized.

24. This conclusion is buttressed by an additional consideration. Normally, there is a contractual connection binding the patient, the doctor treating him or her, and the institution in which treatment is given. This contract includes an implicit condition whereby the treatment given to the patient will comply with required standards of expertise and reasonability. Providing treatment without receiving the patient's informed consent to the treatment constitutes a breach of this duty and is therefore a breach of the contractual obligation owed to the patient. *See* CA 3786 *Levi v. Sherman* [30] at 462. That violation may entitle the patient to a remedy, *inter alia*, under section 13 of the Contract Law (Remedies for Breach of Contract), 1970, which provides that "where the breach of contract has caused other than pecuniary damage, the Court may award compensation for that damage at the rate it deems appropriate under the circumstances of the case." Among other things, the provision entitles the victim of such a violation to compensation for "hurt, suffering, disappointment and emotional pain, and perhaps even for loss of pleasure." G. Shalev, Dinei Chozim [Contracts Law] [75] at 586. These damages are essentially similar to damages sustained by the patient due to the violation of his or her autonomy. Recognition of a contractually based compensatory right by reason of those damages provides additional support for the conclusion that there should be recognition of a similar duty in the tort context. There is no rational reason for distinguishing between the grounds for a contractual action and the grounds for an action in tort, where both actions flow from the same set of relations.

Case Law Supporting Recognition of Right to Compensation for the Violation of Autonomy

25. In addition to the aforementioned considerations, I will add that over the last few years, the tendency in case law has been to recognize the patient's right to compensation for damages incurred by reason of the violation of his or her dignity caused by the treating doctor's failure to provide relevant information, even in situations where there was no proof of a causal connection between the bodily damage caused to the patient and the doctor's violation of the duty.

In this context, I refer to *Goorkani* [66], mentioned above in another context. A man received treatment aimed at preventing blindness that was developing due to a sickness from which he was suffering. He was not informed that the treatment was liable to render him infertile. The court determined that there was no proof that the patient's decision would have been different had he been informed of that risk. Even so, the court awarded compensation for the sum of 2,500 pounds sterling by reason of "*the loss of self-esteem*, shock and anger at the discovery of his infertility, together with the frustration and disruption which ignorance and sudden shock of discovery brought to the marital relationship." *Id.* at 24-25 (emphasis added – T.O).

Similarly, in *Smith* [56], also referred to above, the court ruled that there was no proof of a causal connection between the paralysis suffered by plaintiff following her operation and the omission of failing to inform her, prior to the operation, of the 25% risk factor of disability. As stated, the [physical damages – ed.] claim was rejected, but the court still awarded plaintiff the sum of 3,000 pounds sterling for the mental shock she sustained upon becoming aware that she had incurred a severe disability, with no prior warning of the possibility of its occurrence. The court arrived at a similar result in *Lachambra v. Nair* (1989) [57], cited by Edward ([83], n.19 at 172). There, the court ruled that it was not proven – objectively or subjectively - that plaintiff would have not agreed to the performance of the proposed medical procedure, even had he been given all the relevant information. But despite the absence of proof that the tort had caused pecuniary damage, plaintiff was awarded

compensation for the sum of $5000, in view of the breach of the patient's right to receive all the relevant information prior to the medical treatment.

Summing up this point, these judgments evidence a trend which is in conformity with my own conclusion: recognition of the duty to compensate for the mere violation of a person's autonomy.

26. This concludes my discussion of the patient's right to compensation for violation of autonomy occasioned by the breach of the duty to receive his informed consent to medical treatment. My conclusion is that there should be recognition of a duty to compensate the patient for this violation. Indeed, if we take a serious attitude to the patient's right to choose whether and what kind of medical treatment he or she is to receive, then our ruling should be that there is "a price" for the very fact that his or her dignity was harmed because medical treatment was performed on the patient's body without receiving the patient's informed consent. *See* M.R. Fluck, *The Due Process of Dying* [102] at 141. In her book, Barak-Erez made this point too, arguing that "if tort law purports to protect interests which the legal system considers important, then in accordance with contemporary thinking, the time has come to extend the protection of these laws to individual rights." [73] at 157.

Violation of Autonomy in Addition to Bodily Damage Caused by Negligence in Medical Treatment

27. At this point. we must relate to the concern mentioned by my colleague, Justice Beinisch, that recognition of the patient's right to compensation for the violation of his or her autonomy may paradoxically lead to "a limitation of the compensation given to the victim of a treatment, being content with nominal compensation…" in view of the danger that the courts will avoid "dealing with the complex question of the causal connection".

These comments rest on the assumption, with which I concur, that as a matter of principle, violation of autonomy and bodily damage constitute

two distinct torts, one being *supplementary* to another and not *instead of* the other. Compensation for violation of autonomy does not replace compensation for bodily damage. It is supplementary thereto, and attempts to place the injured party as near as possible to his or her original position by way of pecuniary compensation.

Indeed, there are numerous cases in which the claim for compensation occasioned by violation of autonomy will not be the main remedy requested, and the claim will focus on the patient's right to compensation for bodily damage caused by reason of medical treatment performed without the his or her informed consent. In that framework, the examination required is not limited to ascertaining whether or not there was a breach of the duty to provide the patient with all information required to decide whether not to undergo the treatment. The parties and the court, too, must also decide upon the causal connection between the breach of the duty and the damage actually caused. Indeed, in numerous cases both the evidence and legal argumentation focus primarily on this last question. A question arises as to whether this situation provides cause for concern that the court will take the "easy" path. In other words, the court is liable to determine that there was no casual connection between the breach of the duty and damage caused, even in the absence of any substantive justification for its determination. It could choose this path of action in the knowledge that the patient also has a right to some compensation for violation of his autonomy.

I think that the question ought to be answered in the negative. In my opinion, trial judges deserve credit in the form of the assumption that they will not diminish the substantive rights of a patient to whom remunerable damage was caused as a result of receiving medical treatment without his informed consent. Nor should one forget that judgments in these matters are subject to appeal. Inadequate reasoning for the determination was that there no proof of casual connection between the violation of the duty and the damage that was caused will not stand up to judicial review. Neither is it amiss to mention that in the two English cases mentioned above, which determined that there was no casual connection between the

violation of the duty and the actual damage, there was, *inter alia*, a ruling of compensation for the violation of autonomy and a detailed judicial discussion of the question of the casual connection. Neither of the judgments evidence any sign of an attempt to "avoid" dealing with this complicated question.

In sum, there does not appear to be any substantial foundation for my colleague's concern. As such, my conclusion is that there ought to be recognition of the tort of violation of right to autonomy as an independent tort under which compensation is awarded to a patient, where there was a breach of the duty to provide him or her with necessary information.

The Extent of the Damage in the Violation to the Right to Autonomy – Generally and in Our Case

28. Having ruled that there is a duty to compensate for damages sustained as a result of violation of autonomy, I will now examine the question of proving the damage and its scope. Naturally, matters relating to the proof and the extent of damage are determined in accordance with the particular data in each individual case and the evidence submitted in court. The substantive criterion for generally determining the amount of compensation to which the victim is entitled is the criterion of restoring the situation to its original [*ex ante* – ed.] state. This criterion is an individual one. It requires an individual assessment of the gravity of the harm caused to the specific victim. *See* CA 2934/93 *Soroka v. Hababu* [31] at 692.

In cases of the kind under discussion, the damage is expressed primarily in the plaintiff's psychological and emotional response to the fact that medical treatment was performed on the patient's body without his or her informed consent and the fact that risks materialized of which the patient was not informed prior to agreeing to the treatment *See* Englard at 164. In assessing the amount of compensation for the damage, there is importance to the severity of the breach of the duty to receive the patient's informed consent prior to performing the treatment. Failure to

provide any manner of significant information concerning the procedure about to be performed is generally more serious than failure to provide part of the substantive information.

Similarly, the graver the danger of which the patient was not informed in terms of possible injury, and the greater the likelihood of it materializing, the more serious the violation of patient autonomy. In other words, there is a proportional relationship between the gravity of the decision from the patient's perspective, the gravity attaching to a denial of his or her effective involvement in the decision-making process, and the gravity of the violation of the right to autonomy. Thus, to the extent that the potential damage is greater, so too, greater importance attaches to the duty of informing the patient of the potential danger, which in turn impacts on the severity of the violation of the duty and the actual damage caused to the patient by that omission.

Clearly, these guidelines are only general. By definition, the damage in this kind of case involves a predominantly subjective aspect, giving rise to inevitable difficulties in assessing it. Ultimately, the sum of compensation in each particular case, similar to compensation for other non-pecuniary damages, is a matter of judicial discretion, and it is thus determined by making an evaluation based on all the relevant circumstances and the impression of the court. The court must therefore adopt a balanced approach. It should give the appropriate weight to the fact that basic human rights were violated, which dictates an award of appropriate compensation as opposed to a symbolic compensation. On the other hand, considering the difficulties inherent in the procedure of accessing the damage, judicial restraint is required, and exaggerated compensation awards should be avoided/ *See Alexander v Home Office* [58] at 122, which adopted a similar approach.

Summing up this point, Barak-Erez's comments are relevant, with the necessary changes, for assessing damage in the case of violation of an abstract constitutional right:

> Compensation will be based on an assessment of the degree of offense to the individual's sensibilities, against the background of the particular circumstances. In view of the essence of this kind of violation of rights, one cannot expect accurate proof of damage, as with the proof required for consequential damages, whether physical or economic. This kind of proof is not possible, given that there is no criterion for general, non-pathological feelings of insult and grief. Courts will have to make an assessment based on the circumstances and also based on the judges' life experience. The compensation will not be symbolic. It will be based on the assumption the damage was caused….
>
> On the other hand, one can not diverge from principles of tort by awarding compensation which is unrelated to the concrete violation and its circumstances. The sum of compensation cannot and should not reflect the universal value of the right … In the area of torts, compensation is determined according to the damage suffered by the plaintiff himself or herself, and not according to the value of his or her rights from the perspective of another person".

[73] at 276-77.

Precision is required here. These comments were made in the context of a general thesis, advocating recognition of the citizen's right to compensation when an authority illegally violates his constitutional right. The question is an important one, concerning judicial recognition of the existence of "constitutional torts," but it does not arise in the case before us, and I need not express a position on the matter. Even so, the author dealt with the subject of compensation and assessment of the appropriate amount of compensation in the case of a violation of a constitutional right. Her comments are applicable *mutatis mutandis* to the case before us, in which we are required to determine the sum of compensation for

negligence. Furthermore, they express the salient elements of my own views on the subject.

29. In the case before us no detailed evidence was submitted regarding the damage sustained by Appellant. The lack of evidence as such does not vitiate Appellant's right to compensation for general damage of the violation of her autonomy. When dealing with general damage as opposed to pecuniary damage, the court may, in appropriate circumstances, award monetary compensation even absent specific and detailed proof of concrete damage.

This was the spirit of the Supreme Court ruling in *Matzraba* [23], mentioned above. That case concerned a woman's action in tort against her ex-husband who had divorced her against her will, in contravention of section 181 of the Penal Law, 1977. Plaintiff adduced no evidence of the damage caused to her as a result of defendant's act. Justice Goldberg ruled that nonetheless, there can be no doubt that the plaintiff suffered by reason of the coerced divorce. Justice Goldberg wrote that, in these circumstances:

> Even absent proof of concrete damage sustained by plaintiff, the court should have ruled an estimated compensation for general damage that she no doubt suffered as a result of the respondent having severed the marital bond against her will. Para. 9 of the judgment.

Accordingly, Justice Goldberg accepted the plaintiff's appeal to the extent that it related to the tort grounds on which her claim was based, and he assessed the general damage sustained by her due to her divorce at NIS 30,000.

Justice Netanyahu made a similar ruling in *Carmeli* [22], which dealt with a plaintiff's forced hospitalization in an institution for the mentally disturbed. The plaintiff's action was based on violation of a statutory duty. The judges disputed whether an action on that basis could be

substantiated in circumstances in which there were specific defenses regarding the tort of unlawful confinement. The majority answered in the negative and did not even address the question of damage caused to the plaintiff. Justice Netanyahu, having answered in the affirmative, proceeded to address the question of damages. She ruled that even though pecuniary damage was not proven, "general damage was caused by the mere virtue of her [the plaintiff's – T.O.] forced confinement in a hospital for the mentally disturbed, and such damage does not require proof." *Id.* at 772. She therefore awarded an estimated sum of damages, fixing the amount at NIS 10,000 as of the judgment date (May 30, 1984).

The principle evidenced by these judgments is similarly applicable to our case. The judgments cited relate to the tort of breach of statutory duty. Like the tort of negligence that concerns us here, the element of damage is similarly a component of the tort of the breach of a statutory duty. Yet this did not preclude a compensatory award for the general damages caused by the tortuous act. This expresses the general principle whereby there is no need to prove general damage and its scope because the existence of damage and its scope derive from the very fact of the tortfeasor's breach of his duty. In a similar vein, we can refer to the language of the Second Restatement of the Law of Torts [114], which states the following:

> In many cases in which there can be recovery for general damages, there need be no proof of the extent of the harm, since the existence of the harm may be assumed and its extent is inferred as a matter of common knowledge from the existence of the injury as described.

Id. at note 'a' of sec. 912.

And in note (b) of section 912, similar comments are made regarding non-tangible damage, to the effect that:

> In these cases the trier of fact can properly award substantial damages as compensation for harms that normally flow from the tortious injury even without specific proof of their existence, such as pain from a blow or humiliation from a scar. Evidence to prove that the harm is greater or less than that which ordinarily follows is admissible. The most that can be done is to note such factors as the intensity of the pain or humiliation, its actual or probable duration and the expectable consequences.

Considering these principles, I would award the appellant a certain compensation for the violation of her right to autonomy. I dealt above with the circumstances surrounding the appellant's agreement, noting that they did not comply with the requirements of informed consent. Even if the appellant had general knowledge that they were going to perform a biopsy on her shoulder, the intention to perform the biopsy at the time and the place in which it was done was only made clear to the appellant immediately before the actual performance of the procedure, when she was in the operating room. This did not allow the appellant to exercise real discretion regarding the performance of that particular action on her body, and as such there was a violation of her basic right to control what would be done to her body. In view of the totality of circumstances in this matter and in the absence of any particular detailed evidence of the damage caused to the appellant as a result of that violation, I would award the compensation in the amount of NIS 15,000.

The Result

In view of all of the above, I would grant the appellant's appeal, and in consideration of all that has been explained, I would rule that she receive compensation in the sum of NIS 15,000. Under the circumstances, I would order the respondents to pay appellant's expenses in both courts in the sum of 10,000 NIS.

Justice T. Strasberg-Cohen

1. Should appellant be compensated for the respondents' negligence in the receipt of informed consent for performing the operation on her shoulder? And if so – for which kind of damage? These are the questions to be decided.

My colleagues are divided on the matter. Justice Beinisch maintains that the appellant would not have agreed to the operation had her informed consent been requested, and that she should therefore be compensated for all the damage caused to her by the operation. On the other hand, Justice Or believes that the appellant would have agreed to the operation and is therefore not entitled to compensation for the injury. At the same time, he recognizes a new head of tort - violation of autonomy - and suggests that she be compensated only for that.

Unfortunately, on some of these issues I cannot concur with my colleagues, although our approaches do occasionally converge. In my discussion of the issues at hand, I will rely on the set of facts and its attendant conclusions as determined by my colleague, Justice Beinisch, and to which my colleague, Justice Or, agreed. The first assumption is that no medical negligence was involved in the decision to perform the operation, in the operation itself, or in the subsequent treatment. The second assumption is that the failure to receive the appellant's informed consent provides grounds for a negligence-based action, and not an assault-based action. The third assumption is that the respondents were negligent by reason of their failure to receive appellant's informed consent to the operation. What are the implications of this negligence? For the purpose of discussing this question, I briefly present the facts.

2. About one and a half months prior to the operation, the appellant was examined in the Health Fund and told of a suspicious finding on her shoulder requiring a biopsy. No appointment was made for this operation, which was supposed to be elective; the doctor did not indicate any urgency for it, and during the period that elapsed after the examination, nothing was done in preparation for the operation on the shoulder, and no date was set for it. On January 7, 1988, the appellant was hospitalized for

an operation on her leg. During the two days following her arrival in hospital, all the arrangements required for her leg operation were made. Records show that no tests were conducted in relation to her shoulder, nor is there record of any consultation at the hospital regarding substituting the leg operation with an operation on the shoulder. While the appellant was in the operating room, prior to the operation on her leg, and after receiving tranquilizers and sedatives, she was asked to consent to an operation on her shoulder instead of on her leg, and such consent was forthcoming. Nothing in the evidence indicates that she received any explanation of why the operation on her leg was replaced by the operation on her shoulder; what was the urgency of the operation on the shoulder necessitating its performance then and there instead of the leg operation, and no less important - she was not informed of the risks involved in performing the shoulder operation. The shoulder was operated on, and the appellant was left with a "frozen" shoulder, suffering from disability.

The Case and its Problems

3. As my colleague, Justice Or, noted, the appellant was silent regarding whether or not she would have agreed to the operation had she been asked to give her informed consent since, according to her own testimony – which was rejected by the lower court – she had no idea that an operation was about to be performed on her shoulder. The lower court did not believe her, and there is no cause for intervention in that determination. Nonetheless, the question remains: what would she have done if her informed consent had been sought under the appropriate conditions, having received a full explanation of the risks and prospects of the medical action? Even had she testified on the matter, it is doubtful whether significant weight would have attached to her testimony, and even had she testified that she would not have consented, how much value could be ascribed to such testimony? (We will return to this below). At the same time, one can rely on the objective background facts connected to the case. It was recommended to the appellant that she undergo an operation on her shoulder about two months before it was

performed. During this period, she did nothing to promote the performance of the operation. She was not told that the operation was urgent; she did not express her wish to perform an operation on her shoulder when she was told that she needed one; and she did not make an appointment for an operation on her shoulder. On the contrary, she set an appointment for an operation on her leg and preferred to have that operation performed rather than the shoulder operation. From a subjective perspective therefore, there is nothing to indicate that the appellant had prepared herself for a shoulder operation after it was recommended to her to do so, despite the passage of time.

An assessment of her behavior from the point of view of a reasonable patient also presents difficulties. How can one know what a reasonable patient would have decided absent any indication in the evidence as to the risks of the operation? Such risks were neither explained nor presented to her, and no medical evidence was presented to the court stating that there were absolutely no risks. One cannot learn anything from the subsequent consequences – the frozen shoulder –about the risk involved in performing the operation. Neither did the respondents enlighten the court as to whether it is rare or common for that risk to materialize or whether or not the patient should have been informed of its existence. Absent the elementary information that would have guided a reasonable patient in such circumstances, how does one determine what that reasonable patient would have decided? What do we have, apart from a disagreement between my colleagues over whether or not the appellant would have given her consent? Their dispute is not a legitimate difference of opinion between judges, which frequently leads to different conclusions. Rather, it is a different assessment of a hypothetical factual possibility, regarding the type of decision that might have been made by a patient in circumstances that never took place. Each of my colleagues laid out a series of grounds for their assessment. Each of them provided respectable explanations, but these do not enable a conclusion one way or the other. All they do is to indicate the existence of two feasible options.

How should we decide the law under these circumstances, and what are the questions requiring a response? If the need for the operation at that time and the risks involved had been explained to the appellant, would she have consented to it? Who should bear the burden of proof – the patient, that she would not have consented, or the doctors, that she would have consented? What degree of proof is required? Should the probability be over 50%? Should it be less? Do doctors bear the burden of proof because of their failure to obtain informed consent, irrespective of what the appellant would have done had her consent been duly sought? Should we impose the burden of proof on them because of the evidentiary damage caused to her in that they did not obtain her informed consent, such that she cannot prove what would have happened if … ? These questions and others hover over our case and have no single agreed-upon response, save that informed consent for treatment should be obtained from a patient and that from the patient in this case, no such informed consent was obtained.

"Informed Consent"

4. Today, it appears to be undisputed that a doctor must obtain informed consent from a patient for medical treatment in general, and for performing an operation on his or her body in particular. This rule is expressed in the literature. *See e.g*. Shultz, *supra* [94] at 220-23. *See also* Giesen [86] at 254-56; M. Jones, *Medical Negligence* [90] at 283; Shapira in his article [77]. In the case-law, *see* CA 560/84 [2]; CA 3108/91 [1]. In legislation, *see e.g*. Patient's Rights Law, ch. Four, titled "Informed Consent to Medical Treatment", secs.13-16; Mental Patients Treatment Law, 1991, sec. 4(a); Use of Hypnosis Law, 1984, sec. 5; Anatomy and Pathology Law, 1943, sec. 6A(b), and the various Public Health Regulations. In medical ethics, this rule is anchored in society's basic concept of a person's right to autonomy and sovereignty over his or her own body. The concept is also accepted in other legal systems. *See* Canadian Supreme Court judgments *Hopp v. Lepp* (1980) [70] at 70-71; *Malette v. Shulman* (1990) [71] at 336; *Schloendorff v. Society of New York Hospital* (1914) [53] at 93 (Cardozo, J.); in England: *Chatterton v.*

Gerson (1981) [59]. I shall not expand on the issue, which my colleagues addressed at length in their opinions.

Causal Connection in a Hypothetical Occurrence

5. A distinction must be made between a causal connection in past factual-*actual* occurrences, on the one hand, and causal connections in past factual-*hypothetical* occurrences, on the other. In past hypothetical occurrences, we are not dealing with an actual occurrence but with something that never happened, the consequences of which – had the event occurred – would also be hypothetical. We encounter such an occurrence in the case of an omission, when the question is asked – what would have happened if the injuring party had not omitted performing his or her duty but rather fulfilled it. The law does not preclude dealing with questions involved in proving hypothetical facts. Proving a hypothetical fact is often required as one of the basics of liability, in order to determine the extent of the injury and to quantify compensation. Not all omissions are in the same class. *See e.g. Bolitho v. City and Hackney Health Authority* (1997) [60]. Sometimes there is no difficulty involved in determining what actually would have happened were it not for the negligent activity, and sometimes a negligent occurrence in the past teaches us nothing about another event that might have occurred or been prevented were it not for the omission. The possibility of drawing a conclusion regarding "what might have been," based on a retrospective hypothetical test, is limited to certain cases which do not concern us. We will restrict our discussion to the omission of failing to obtain the patient's informed consent.

6. Consider an action based on a breach of the duty of care intended to prevent injury of a particular kind: The injury actually occurs, and we do not know how the plaintiff would have behaved in a hypothetical eventuality in which the defendant actually discharged his or her duty. In certain cases, the courts would be ready to assume, in the plaintiff's favor, that had the duty been discharged, the injury would have been prevented. This assumption is often based on experience, which serves as

a yardstick for such assumptions. *See* R. Shapira, *Hamechdal Hahistabruti shel Dinei Haraayot – Chelek 1 – Bikorot Mesortiot* [81] at 234-37. On the other hand, when the action is based on negligence in obtaining informed consent, and proof is required of a causal connection between the doctor's negligence and the injury to the patient, it has been argued that assumptions should not be made in the plaintiff's favor, given our ignorance of what he or she would have decided; nor does experience teach us anything in this respect. *See* W.S. Malone, "Ruminations on Cause-in-Fact" [103] at 85-88.

7. Where there is negligence in obtaining informed consent, the doctor failed to act in conformity with his or her legal duty. The case therefore concerns a negligent omission, related to the hypothetical situation of having made a human decision which in fact was not made, due to the negligent omission that preceded it. We must therefore examine what would have happened were it not for that omission. For the purpose of this examination, we substitute actual negligent behavior with alternative hypothetical behavior, which is counterfactual. This question concerns the factual and legal causal connection between the negligent omission and the injury caused by performing the operation without obtaining informed consent. In other words, we assume a hypothetical situation in which it is assumed that the patient would have consented to treatment if his or her informed consent had been requested. If the assumption is that the patient would have given consent, then even if such consent were not sought, it may be stated that there is no causal connection between the doctor's omission and the performance of the operation and consequent injury. On the other hand, if the counterfactual assumption is that the patient would not have consented to the operation, then applying that counterfactual assumption would mean that when the operation was performed without his or her consent, there is a causal connection between the doctor's omission and the operation and consequent injury.

The question of what would have happened had the doctor fulfilled his or her duty has no clear answer, since the scenario is one in which the doctor did not provide the information, the patient did not receive it, and

the patient did not make a decision based on the information. Examining the causal connection in this kind of case requires an assessment of expected conduct when the offense was committed and hindsight during the legal inquiry. This state of affairs is described in the book by Powers & Harris:

> [The event – T.S.C.] was not a past fact – it lay in the future at the material time [i.e. when the tort was committed – T.S.C.].
>
> …
>
> [The event – T.S.C.] lay in the future at the date of commission of the tort, but cannot at the trial date be established as past or present facts because the circumstances make this impossible.

M.J. Powers, N.H. Harris, *Medical Negligence* [91] at 403-04.

8. The difficulties inherent in proving causal connection in cases involving vague, hypothetical and speculative aspects have been described by scholars and courts in Israel and other parts of the world. Hart & Honor wrote that:

> The main structure of ... causal connection is plain enough, and there are many situations constantly recurring in ordinary life to which they have a clear application; yet it is also true that ... these have aspects which are vague or indeterminate; they involve the weighing of matters of degree, or the plausibility of hypothetical speculations, for which no exact criteria can be laid down. Hence their application, outside the safe area of simple examples, calls for judgment and is something over which judgments often differ ... Very often, in particular where an omission to take common precautions is asserted to be the cause of some disaster, a speculation as to what *would have* happened had the precaution been taken is involved. Though arguments one way or another over such hypothetical issues

> may certainly be rational and have more or less "weight", there is a sense in which they cannot be conclusive.

H.L.A. Hart, T. Honor, *Causation in the Law* [92], at p. 62).

Reference to the difficulty raised by the proof of causal connection in a human hypothetical occurrence can be found, *inter alia*, in Englard's article [74], pp. 229-30:

> Significant difficulties are raised in replying to the hypothetical causal question: What would have happened had they acted in accordance with the law? The answer necessarily depends on estimates and guesses, especially when the question concerns hypothetical human responses.

The plaintiff generally bears the burden of proving his or her claim. As such, the plaintiff may find himself or herself in a problematic situation in which the evidentiary difficulties of presenting proof are liable to thwart the claim, even when it is substantial. Justice Mazza addressed this fundamental difficulty:

> And if, indeed, [the plaintiffs, the deceased's dependents – T.S.C.] are required to prove the existence of a causal connection … how can they do it? Who can testify, veritably from the mouth of the deceased, that had the doctors apprised her of the extent of the risk involved in continuing the pregnancy after her water had broken so early, she would have chosen to avoid taking the risk and demanded that the doctors immediately discontinue her pregnancy?

CA 4384/90 *Vaturi* [3] at 191.

Giesen also notes this:

> It would make little sense if the plaintiff could "in theory" bring an action in damages for breach of the duty of disclosure

> but would, as a general rule, find his claim shipwrecked because he cannot prove how he would have reacted in the hypothetical event of having been informed about the risks.

Giesen [86] at 35.

9. These difficulties stem not only from the fact that the plaintiff must prove how he or she would have hypothetically responded to the omission of another person (the doctor) [– trans], but also from the inadequacy of the tools at his or her disposal for proving the same. Some say that the evidentiary weight of the plaintiff's testimony in such cases is small, if not nil, since the plaintiff is on the witness stand testifying as to what he or she would have decided in a hypothetical situation that never took place. The plaintiff's reply does not establish a fact but itself consists of a hypothetical conjecture. The plaintiff testifies while suffering from an injury caused by the medical treatment. The plaintiff testifies in a proceeding in which he or she is claiming compensation for the injury suffered, knowing that success in the claim depends on his or her reply. Even if the plaintiff is naïve and believes retrospectively, while suffering from the consequences of the operation, that he or she would not have agreed to the operation, what weight should be attributed to this belief? The Canadian Supreme Court expressed this problem well:

> [There is an – T.S.C.] *inherent unreliability of the plaintiff's self-serving assertion.* It is not simply a question as to whether the plaintiff is believed. The plaintiff may be perfectly sincere in stating that in hindsight she believed that she would not have consented to the operation. *This is not a statement of fact that, if accepted, concludes the matter. It is an opinion about what the plaintiff would have done in respect of a situation that did not occur.* As such, the opinion may be honestly given without being accepted. In evaluating the opinion, the trier of fact must discount its probity not only by reason of its self-serving nature, but also by reason of the fact that it is likely to be colored by the trauma occasioned by the failed procedure.

Hollis v. Dow Corning Corp. (1995) [72] at 643 [emphasis added – T.S.C.].

Solutions Under the Rules of Evidence

10. In view of the above difficulties, the courts searched for various ways of coping with such situations. The solutions they adopted for the difficulties that arose – which were of various types – involved developing the rules of evidence. The laws of evidence in civil law are designed to serve the purpose of the substantive law, which is to find a just and fair solution – in the framework of the law – for providing relief to whomever is entitled thereto, and to withhold it from the non-entitled. The laws of evidence do not establish rigid, insurmountable rules; they establish flexible rules to serve the purpose they were designed to realize. These rules are established in legislation, and they are given effect in accordance with judicial interpretation, which is duty bound to find – within the framework of the law – an appropriate and just solution for every case.

The basic and widely used evidentiary rule in the civil law of our system, as in many others, is *that the plaintiff bears the burden of proof, and the degree of proof is determined by the balance of probability,* as in the ancient rule that "he who deigns to take must bring proof." Accordingly, a plaintiff wins the suit if he or she proves more than a 50% probability, in which case the defendant bears complete liability or responsibility. Failure to bring that degree of proof means that the plaintiff loses the suit. *Prima facie,* the rule is effective, fair, rational, uniform, and applicable in all of civil law. However, there are many and varied situations in which it is either inappropriate or impossible to implement this rule. One of them, perhaps the most typical, is the situation in which the plaintiff bears the burden of proving, based on the balance of probability, how he or she would have behaved and what he or she would have decided, had he or she been given the information relevant for making a decision. Negligence in obtaining the patient's informed consent illustrates this dilemma in full force.

What is the applicable evidentiary rule for proving the causal connection in a case like ours, and who bears the burden of proof? What degree of proof is required? To which legal test should we resort? The various possibilities include: requiring the plaintiff, who bears the burden of persuasion, to prove the causal connection by the balance of probability and subjecting the plaintiff to the full risk of failing to discharge the burden; transferring the burden of proof to the defendant, so that the defendant bears the burden according to the balance of probability rule and subjecting the defendant to the full risk of failing to discharge the burden; leaving the burden of proof on the plaintiff but reducing the degree of proof required; transferring the burden of proof to the defendant but reducing the degree of proof required; and assessing the chances that the hypothetical event would have occurred and awarding compensation proportionally, even if the degree of the proof provided by the plaintiff amounts to a probability of less than 50%.

The importance of adopting any particular test lies in the variant results obtained by each one. If a plaintiff is required to prove a causal connection, and the degree of proof is based on the balance of probability, if the plaintiff is unsuccessful, he or she loses the case. However, if the plaintiff discharges this burden by demonstrating a probability higher than 50%, the defendant bears full liability for the damage - a situation of "all or nothing." On the other hand, if the doctor bears the burden of proof, according to the balance of probability test, the doctor must prove facts related to the spirit, mind and personality of the specific patient, or of a reasonable patient (see further below). If unsuccessful, the doctor bears liability for the entire injury. Both these results are harsh and unsatisfactory.

11. As in all cases, the case before us too requires us to start with an examination of whether one can apply the basic rule, under which the plaintiff bears the burden of proving the causal connection as one of the foundations of his or her action, requiring the degree of proof to be the balance of probability. For the rule is that "a judge's primary function …. is to do his best to decide, based on the balance of probabilities (in civil

law), between the conflicting versions ...” CA 414/66 *Fishbein v. Douglas Victor Paul by Eastern Insurance Service* [32] at 466. Only if it transpires that this rule does not resolve the particular problems of the case do we attempt to find a solution in alternative rules which will lead to a more appropriate and just result.

12. The road to formulating an appropriate and satisfactory solution for difficulties arising in the present issue is a hard one, requiring us to pay attention to various competing values and interests. See Justice Shamgar's comments in CA 3108/91 [1] at 507-08:

> The laws governing this subject should be allowed to develop and to gradually crystallize within a normative, formulated system, by way of proceeding from case to case. To that end, we should take the following principal considerations into account: the changing nature of the science of medicine; the relevant competing values in the particular context, including the patient’s right to control over his or her own body, the shared desire of the doctor and the patient for the treatment to succeed (including the need to create an appropriate framework for the exercise of medical discretion) ...

The problems we mentioned and the evidentiary difficulties presented by this case are not unique. They occupied scholars and courts in other countries who also deliberated and searched for appropriate solutions. The various solutions they proposed included transferring the burden of proof, reducing the amount and degree of proof, dividing up the burden of proof, and using presumptions, the doctrine of evidentiary damage, and the test of evaluating chances.

13. The Federal Supreme Court in Germany considered the issue in a case in which full medical information was not provided to a patient. The court emphasized the evidentiary difficulties which thwart the claims of those who are unable to prove how they would have acted had they received the full relevant medical information. In searching for a solution

for this difficulty, the court chose to diverge from the ordinary burdens of proof and to impose the burden of proving the absence of any causal connection on the defendant, who had breached his duty of care, such that the defendant would be subject to the risk of failing to discharge the evidentiary burden. The scholar Giesen gives the following description of the solution, as formulated by the Federal Supreme Court in Germany:

> … in such cases the defendant in breach of his duty has to bear the risk that the causal link cannot be established with regard to the question of how the plaintiff would have reacted had the defendant properly discharged his legal duty of disclosure.

Cited in Giesen, *supra* [86] at 352.

The Swiss Federal court adopted a similar approach. Giesen [86] at 353.

The Canadian Supreme Court also adopted the solution of easing the plaintiff's burden of proof and transferring it to the defendant. *Hollis* [72]. A woman filed an action for the emotional and physical injury she sustained due to the leakage of silicon implants in her body that had ruptured. The defendants were the manufacturer of the silicon implants and the doctors who operated on her. The court ruled that the woman was not required to prove that had the manufacturer included a warning in the pamphlet that came with the product that the implants might rupture while inside her body, then the doctor would have informed her accordingly. It was sufficient for her to prove that had she been aware of this risk, she would have chosen not to undergo the operation. Once the plaintiff proved this, the burden of proof was transferred to the manufacturer, who failed to discharge it. In another case, the Australian Supreme Court ruled that the plaintiff must prove that the doctor had breached his duty to provide relevant information about the risk involved in administering the medical treatment and that this risk actually materialized. Having proved this, a presumption was established of a factual causal connection between the negligence and the injury, which in

turn transfers the burden of proof to the doctor who must prove that there was no causal connection. See the recent case of *Chappel v. Hart* (1998) [44].

Regarding relaxing the degree of proof needed to establish the factual causal connection that compels a response to a hypothetical question:

> There is no doubt that, in establishing the factual causal connection requiring a response to a hypothetical question ... the courts might actually reduce the amount of proof required, contenting themselves with doubtful conjecture. They do this for considerations of legal policy.

Englard [74] at 230.

It should be noted that the author draws attention to the fact that the courts did not adopt this rule but continued to adhere to the principle of guilt, recoiling from ruling against a defendant whose liability had not been proven at greater than 50% probability.

14. Another solution for problems of evidentiary difficulties lies in the doctrine of evidentiary damage. A doctor's negligence in receiving informed consent creates difficulties in proving the causal connection and denies the plaintiff the possibility of proving how and what he would have decided had he received the required information under the appropriate conditions. As such, his claim would *seem* to be doomed to failure. This negligence caused evidentiary damage to the plaintiff which, under the evidentiary damage doctrine, may lead to liability for the plaintiff's injuries being placed on the doctor's shoulders. In some cases, the defendant bears full liability for the plaintiff's injuries, whereas in others, only relative liability is imposed. *See* A. Porat, A. Stein, "Liability for Uncertainty: Making Evidential Damage Actionable" and A. Porat, *Doctrinat Hanezek Haraayati: Hahatzdakot LeImutza Veyisuma Bematzavim Tipussim shel Ivadaut Begrimat Nezakim* [82].

15. Another solution referred to in case law and the literature is the risk evaluation test. This test involves an evaluation of the odds of a particular event occurring. The rate of compensation is then determined as a function of those odds. This test was applied by the House of Lords in England when it addressed the subject of causal connection for cases involving speculation and hypotheses. The court considered an appeal of ruling by the Court of Appeals (*Davies v. Taylor* (1972) [61]) concerning a widow claiming compensation after her husband's death in an accident. The couple was separated, but she claimed that they had been planning to get back together and that his death prevented that.

The House of Lords applied the risk evaluation test, preferring it to the balance of probability test. I agree with the conceptual basis for this preference, and it seems applicable to a case such as ours. The House of Lords took the view that the requirement that facts be proven based on the balance of probability is intended to establish the truth of facts that occurred in the past, not hypothetical facts which never happened. It is not applicable with respect to a hypothetical fact that might have occurred at a future date after the tort was committed, but which did not actually occur. The balance of probability test is not suited for proof of this kind of fact, since there is no way of establishing any factual finding in that regard. We cannot decide the truth or falsity of hypothetical facts, because deciding whether there is truth in a factual claim means deciding whether or not the fact existed. That is not the case with respect to a hypothetical fact that did not occur, and that can never occur. When there is a reasonable expectation of an occurrence even though the chances of its occurrence are less than balanced [less likely than not – ed.], this chance must not be ignored – unless it is negligible; the chance must be evaluated, and compensation should be determined accordingly. In this context, Lord Reid (joined by Lord Simon, Viscount Dilhorne, Lord Morris, and Lord Cross) wrote the following:

> No one can know what might have happened had [the husband] not been killed.

> … But the value of the prospect, chance or probability of support can be estimated by taking all significant factors into account … The court … must do its best to evaluate all the chances, large or small, favorable or unfavorable.
>
> … [W]e are not and could not be seeking a decision either that the wife would or that she would not have returned to her husband. *You can prove that a past event happened, but you cannot prove that a future event will happen and I do not think that the law is so foolish as to suppose that you can. All that you can do is to evaluate the chance*...

Id. at 838 (emphasis added – T.S.C.).

And further on:

> [Thus], all that you can do is to evaluate the chance. Sometimes it is virtually 100 per cent, sometimes virtually nil. But often it is somewhere in between. *And if it is somewhere in between I do not see much difference between a probability of 51 per cent and a probability of 49 per cent*.

Id at 838 (per Lord Reid) (emphasis added – T.S.C.).

Referring to the *Davies* [61] judgment, scholars Powers & Harris wrote the following:

> The House of Lords held that this approach [i.e., the balance of probability] was erroneous. Where the issue is whether a certain thing is or is not true, or whether a certain event did or did not happen, then the court must decide that issue one way or the other. If there is a balance of probability in favor of it having happened, then for legal purposes it is proved that it did happen. In the instant case, however, whether the widow would or would not have returned to her husband was not a past fact
>
> it lay in the future at the material time (the time of the

> husband's death). Therefore, the chance of reconciliation had to be evaluated ... It is clear ... that the principle of the evaluation of a chance applies ... where events ... lay in the future at the date of commission of the tort, but cannot at the trial date be established as past or present facts because the circumstances make this impossible ... [T]he death of the husband which gave rise to the cause of action itself prevented a reconciliation from ever occurring ...

Powers & Harris, *supra* [91] at 403-04.

The final ruling was that the plaintiff did not even discharge the burden under the easier test of evaluating the chances, having failed to show that there was a real chance - as distinct from a negligible chance - that she would have returned to her husband had he remained alive.

16. This Court made similar comments in CA 591/80, *Chayu v. Ventura* (hereinafter - *Chayu* [33]). Referring, by way of affirmation, to the House of Lords judgment, it adopted its test of evaluation of chances in an action for damages. It must be stressed, however, that the evaluation of chances rule was established by the House of Lords for proof of the causal connection as a component of *liability* in torts cases, while in the *Chayu* case, Justice Bach adopted it in order to prove the causal connection required for *proof of damage* - loss of income:

> In this context a clear distinction must be made … In an ordinary civil case, when the court considers a factual claim regarding what happened in the *past*, the party bearing the onus of proof must prove his or her story to a degree of persuasion exceeding 50%. Otherwise the court will assume that the alleged fact never actually occurred, and will altogether ignore the argumentation relying on it….However, when the claim relates to the chances of a particular event occurring in the future, which in the nature of things cannot be proved with certainty, it is only reasonable that the court should evaluate

this chance and give it expression in its ruling, even if it estimates its persuasive value at less than 50%.

Id. at 398-99.

17. Readiness to adopt the method of proof by evaluation of chances was also expressed in the *Vaturi* [3] ruling at 191:

> Having proved damage, and assuming that they succeed in proving breach of duty, the court will be able to determine, by way of a judicial assessment, whether it was the breach of the duty which caused the damage, and to what extent; this means that it may also be possible to make a probability assessment which can serve as a basis for charging the defendants for only part of the liability…. (Mazza, J.) (my emphases – T.S.C.).

Justice Mazza explains his position as follows:

> Causal connection for our purposes does not require a finding according to the accepted tests of causality. These tests are required for (full) attribution or (absolute) negation of the defendant's liability for the plaintiff's injury. In other words: according to these tests, there is no partial causal connection, and the question to be decided is whether or not a causal connection existed, a situation of "all or nothing" … *These tests enable decisions based on the balance of probability test, but they are inappropriate for cases in which the court faces the need to make a hypothetical assessment about how a certain patient would have behaved if the doctors had advised him or her in advance of the risks and prospects inherent in a particular medical treatment.*

Id. at 19 (my emphases – T.S.C.).

A similar approach was expressed in CA 437/73 *Aik (minor) v. Dr. Rosmarine* [34].

Justice Barak (as his title was then) left for further examination the question of applying the ordinary probability test to prove a hypothetical occurrence

> I wish to leave the following question pending: whether the rule shouldn't be that where proof of probability is not related to proving a fact but rather to proving a hypothetical occurrence, the regular balance of probability is not required.

CA 145/80 *Vaknin v. Beit Shemesh Local Council* [35] at 144.

Balance of Probability, Transferring Burden of Proof, Assessing Chances and the Differences Between Them.

18. The various solutions regarding the fundamental problem of proving causal connection in cases involving hypothetical assumptions illustrate the difficulty inherent in leaving such cases to the authority of the ordinary rules of proof based on the balance of probability.

In the nature of things, a human decision about whether or not to consent to medical treatment is a direct consequence of numerous influences and varied considerations: the type of operation which the patient must undergo; the degree of necessity of the operation or medical treatment; the attitude of the patient to the risk – fear and revulsion, indifference or sympathy; the gravity of the patient's medical condition; the possibility of choosing another treatment, different in quality and in the risks involved; the degree of the patient's trust in the doctor and in the information given to the patient by the doctor; the patient's willingness to rely on the doctor, and other, similar considerations. It is impossible to determine which of the considerations is the principal focus in the decision-making process. The weight and importance of the considerations when making a decision are not constant; they may change according to the character and inclination of any person considering whether to consent to or to refuse the performance of an operation on his or her body. It is impossible to determine the weight and importance that

may attach to the numerous considerations that inform a person's decision to consent to or to refuse the operation (the question of whether the appropriate test for examining the considerations is objective, subjective or a combination thereof will be discussed later on).

19. When the plaintiff bears the burden of proof, the balance of probability test places the risk of failure of proof squarely on him or her. Failure to substantiate the plaintiff's claim by proving that the balance of probability indicates the existence of a causal connection means that the action will be rejected outright. Success in proving the plaintiff's claim based on the balance of probability means that the doctor will be fully liable for the injuries which are causally connected to the doctor's failure to obtain the patient's consent. "After all, there is no half-way causal connection." *Vaturi* [3] at 191 (Mazza, J.). The same applies when the burden of proof is transferred to the defendant, who must discharge it based on the balance of probability test. The same disadvantages occasioned by placing the burden of proof on the plaintiff based on the balance of probability test await the defendant, when the burden of proof is transferred to him or her, according to the same test. This solution transfers the plaintiff's difficulties to the doctor, who now confronts the same difficulties faced by the patient who attempted to prove his or her claim. Transferring the burden of proof to the defendant might therefore lead to accepting claims which would otherwise have been denied. In both cases, the situation is one of "all or nothing," and the test of transferring the burden of proof in either direction is not appropriate for proving a hypothetical human occurrence which never occurred in reality.

20. It would appear that in a situation which precludes proof of the causal connection between hypothetical occurrence and injury, other than on the basis of conjecture regarding assumed human behavior which never actually occurred, neither the test of balance of probability on the one hand, nor transferring the burden of proof on the other, is satisfactory. These tests do not provide the judge with the best tools for adequately protecting and balancing all the relevant interests.

This is particularly true of the doctor-patient relationship. This relationship consists of a delicate, fragile web of special trust, requiring an assessment of which is the most appropriate rule for imposing liability on the doctor. The doctor should be neither under-deterred nor over-deterred. Under-deterrence might be a by-product of a test of proof based on balance of probability, in view of the inherent difficulties confronting the patient, rendering it almost impossible for him or her to prove the claim. The plaintiff's failure to prove his or her claim due to evidentiary difficulties, even when the claim is justified and substantial, compromises appropriate protection of the patient's right and the inculcation of the duty of care owed by the doctor to the patient. On the other hand, the doctor's failure to prove his or her defense due to similar difficulties compromises the protection of the doctor's right not to be held liable for damage that he or she did not cause. Furthermore, transferring the burden of proof to the doctor who is sued might cause over-deterrence which could jeopardize the doctor's activities, leading the doctor to practice defensive medicine.

In my view, in cases where the determination concerning the causal connection is not a determination of facts but rather the choice between hypothetical possibilities of human behavior, the appropriate test is that of evaluating the chances, under which the chances of a hypothetical event occurring are evaluated; this is the appropriate test to be applied, as a matter of policy as well.

In view of its flexibility, the test of evaluating the chances enables the imposition of relative and partial liability, and it precludes a situation where the doctor either is released from all responsibility or bears full responsibility in a situation of uncertainty. It would appear, then, that the above complex of considerations leads to the conclusion that proving the causal connection according to the evaluation of chances is the most appropriate and balanced solution which can provide an appropriate response for special situations of uncertainty in cases of this sort.

The Evaluation of Chances Test in Various Fields of Law

21. The chances evaluation test and preferring it to the balance of probability test are not foreign to our legal system, having served us in a number of fields. Accordingly, where it is necessary to prove damage, proof according to the balance of probability is not required, and proof of a lesser degree is sufficient. *See e.g*. FH 24/81 *Honovitz v. Cohen* [36] at 420-21:

> It is necessary to examine … the chances for the existence of reliance in the future, were it not for the accident. These chances cannot be established based on the balance of probability but on the extent of reasonability. Therefore, even a chance of less than fifty percent will be taken into account, provided it is not zero or speculative (see *Davies v. Taylor* (1974)).

See also CA 20/80 Fleisher v. Laktush [37] at 628-29 and CA 410/83 Petrolgas Israeli Gas Company (1969) Ltd .v. Kassero [38], where the Court stated:

> The intention is not that the plaintiffs had to prove, at the level of persuasion required in a civil proceeding, that the deceased had already planned or prepared to return to his country of origin; it would have been sufficient for them to prove the existence of such a possibility, provided that there was a real chance and it was not just a hypothetical.

Id. at 514.

A similar approach was taken with respect to proving the loss of chances of a hypothetical [physical – ed.] recovery. Justice Levin (as his title was then) wrote:

> It could be said that determining a risk is like determining a fact that occurred in the past, and in that respect, a finding can only be established on the basis of the balance of probability

> …. In my opinion, the process involved is not one of determining facts in the regular sense, where the tendency is to determine what did or did not actually happen; rather it is a process of assessing "what would have happened if…."

CA 231/84 *Histadrut Health Fund v. Fatach* [39] at 319.

The same rule applies to proving a causal connection between hypothetical occurrences in claims based on breach of contract, where the alleged damage is loss of an anticipated transaction. In this context, Justice Barak (as his title was then) wrote that "in principle, chances can be evaluated, and even a chance of less than fifty percent warrants compensation…" CA 679/82*, Netanya Municipality v. Tzukim Hotel Ltd.* [40], par.8. *See also* CA 355/80 *Nathan Anisivmov Ltd v. Tirat Bat Sheva Hotel Ltd* [41].

Evaluating Chances as the Basis for Liability and the Principle of Blame

22. Although the chances evaluation test serves as proof of damage, it has not made its mark with respect to proving liability. The primary reason for this apparently lies in the perception that proving causal connection as one of the foundations of liability, according to the balance of probability, involves the concept of blame, and settling for the lesser proof than the balance of probability opens the door to imposing liability where no blame exists: The problem was addressed by Englard in his book:

> It appears that the local courts are not inclined to relax the demand for the regular degree of proof, even regarding hypothetical causality. This trend in the local rulings is commensurate with their general approach in the field of

> liability in torts, typified by full insistence on the concept of blame in torts.

[74] at 230.

It seems to me that an approach demanding that, in every case, the plaintiff must provide proof based on the balance of probability test is not sufficiently flexible, and it does not address the problematic aspects of these situations which justify such flexibility. The evidentiary difficulties of proof constitute obstacles for the plaintiff who created a situation in which we must deal with hypotheses concerning the patient's possible response. As such they justify the adoption of rules that prevent the dismissal of a substantial claim just because of the balance of probability test. Addressing the issue of placing the burden of proof on the plaintiff:, the Canadian Supreme Court stated that:

> To require [the plaintiff] to do so would be to ask her to prove a hypothetical situation relating to her doctor's conduct, one, moreover, brought about by [the defendant's] failure to perform its duty.

Hollis [72] at 638-39.

Even in our system, rules have been developed within the rules of evidence relaxing the causal principle of "all or nothing." One of them is the transfer of the burden of proof. In this context, Justice Levin (as his title was then) wrote:

> In a legal system that, for a case of partial injury, operates on the basis of the causal principle of "all or nothing," there is occasionally no option other than to develop evidentiary rules which soften that principle by transferring the burden of proof in certain cases to the defendant, in order to prevent unjust results.

CA 231/84 [39] at 320.

Evaluating the Chances - in Practice

23. One cannot ignore the fact that the balance of probability test creates uniformity and relative certainty, and that it is not easy to evaluate chances. However, when evaluation is possible, or when we find ourselves in a "tie" situation in which the scales are balanced, the plaintiff will receive a proportional part of the compensation for the damage incurred by means of imposing partial and proportional liability on the defendant.

It will be claimed that recognition of a burden of proof that is less than the balance of probability entails the risk of flooding the courts with baseless claims. Our response would be that arguments of the "flooding risk" have often been brought to the court's attention, meriting little, if any, weight, both because the reality was a far cry from the predictions and also because the courts have found ways of dealing with claims which should never have been submitted in the first place. Furthermore, in principle, the plaintiff should be required to prove that there is a real chance that if the doctor had not been negligent in obtaining informed consent, the plaintiff would not have consented to undergo the operation. An insubstantial and minimum chance is not sufficient (*de minimis non curat lex*) to entitle the plaintiff to proportional compensation. In adopting the evaluation of chances as a test for proof, we do not intend to abandon the principle of blame and to entitle the plaintiff to relief on the basis of any proven possibility, however remote. This extent of proof is intended to overcome the insurmountable difficulties in presenting proof but not to create a right to compensation out of thin air. The House of Lords said in this matter:

> [O]n an application of the *de minimis* principle, speculative possibilities would be ignored... To my mind the issue, and the sole issue, is whether that chance or probability was substantial. If it was it must be evaluated. If it was a mere possibility it must be ignored. Many different words could be and have been used to indicate the dividing line. I can think of

> none better than "substantial" on the one hand, or "speculative" on the other. It must be left to the good sense of the tribunal to decide on broad lines, without regard to legal niceties, but on a consideration of all the facts in proper perspective.

Davies [61] at 838 (Lord Reid).

> In such cases, so long as the chance... was substantial or fairly capable of valuation the court ought, I think, to set a value on it even though it was less and possibly much less than a 50 per cent chance.

Id. at 847 (Lord Cross of Chelsea).

See also Justice Bach's comments in the *Ventura* case [33] at 399:

> When the court is convinced that the injured party had a chance … and this chance had been withheld from him or her due to the defendants' actions, it would be only just for the court to give expression to the frustration of this chance in its judgment, provided that it has been convinced that the chance in question is not negligible, remote, or speculative.

Application of the Chances Evaluation Test: Subjective, Objective or Combined

24. In adopting the chances evaluation test in order to prove causal connection in our case, we must fill it with content. The problem is how to determine the degree of probability that the appellant would have made a particular decision, had her informed consent been obtained. Three possible tests present themselves: the subjective test, the objective test, or a combined test consisting of both. The subjective test is accepted on the European continent and in New Zealand and England. Giesen [86] at 347; *Bolam v. Frien Hospital Management Committee* (1957) [62]; D. Manderson, *Following Doctors' Orders: Informed Consent in Australia* [105]. This test examines how the specific patient would have responded

and what the patient's decision would have been, had he or she received complete information. The objective test, accepted in Canada and various part of the U.S. (*Riebl* [67]; *Canterbury*, [48]), examines how a reasonable patient would have responded and what his or her position would have been, had he or she received complete, full information. The combined test is also used in Canada, and it examines how a reasonable patient would have responded, in that specific patient's circumstances, and what the patient's position would have been in relation to the proposed treatment if he or she had been given full information. *See* Giesen [86] at 343; M.A. Somerville, *Structuring the Issues in Informed Consent* [106]. My colleagues, Justice Beinisch and Justice Or, described these tests, one emphasizing the subjective test and the other stressing the objective test. Personally, I think that the combined test is the most appropriate.

25. Each of the aforesaid tests employs a different method for protecting the relevant values and interests. The subjective test provides maximum protection of the patient's interest in ownership of his or her body and ensures broader protection of the autonomy of the patient's will. This test is lenient with the patient. The objective test provides less protection of these interests, since it is less concerned with the wishes of the specific patient, focusing rather on the wishes and considerations of a reasonable patient. This test is lenient with the doctor. The combined test strikes a balance between the other two. Choosing either of the first two tests affects the manner of enforcing the doctor's duty of care in receiving informed consent. Choosing the objective test may signal to doctors in general that failure to give information of importance to a specific patient does not impose any liability and that they therefore may refrain from giving it. Choosing the subjective test forces doctors into the difficult position of having to consider the patient's subjective characteristics, even where they are characteristics which would not reasonably have been considered and which are not typical of a reasonable patient. The objective test minimizes the need to cope with the problematic testimony of the plaintiff, even when it is not tendentious and is given in good faith. At the same time, it cannot be said that the possible response of the

reasonable patient accurately reflects the possible response of a specific patient who is not necessarily the reasonable patient. These difficulties, and considerations similar to those listed above, tip the scales in favor of adopting the combined test; its subjective aspect ensures that weight is attached to the special circumstances of the patient, the patient's character, concerns, ability to weigh the considerations specific to himself and herself, and the like, while its objective aspect ensures that liability is not imposed on doctors in situations in which refusal to accept treatment could be considered an unreasonable deviation.

Application of the Law in Our Case

26. It appears to me that in applying the combined test, it is difficult to reach a conclusion as to whether or not Appellant would have agreed to perform the operation on her shoulder. This is similarly true of any other test (objective or subjective), since we have no real information, and we have nothing to rely on apart from conjecture. To illustrate the dilemma, it is sufficient to review the arguments presented in the judgments of my colleagues, Justice Or and Justice Beinisch. Both of them examined the question of causal connection using the combined test and in practice applying the balance of probability rule, but they reached opposite conclusions. Personally, concerning our case, I think it neither possible nor appropriate to decide on the basis of the balance of probability, be it on the factual level, the legal level, or on the level of proper policy for the examination of such cases.

Regarding our case, I do not believe that the events of the past provide any indication as to what the appellant would have decided, if her informed consent had been sought, and if the relevant information had been given to her for the purpose of choosing whether to perform the operation, in circumstances appropriate for making a decision. The question of what the appellant's decision would have been if the doctor had fulfilled his duty is a hypothetical assumption about human behavior that never occurred, and it requires formulating a decision based on various and varied considerations. The most that can be said is that

appellant might have agreed to the operation, and by the same token that she might have refused. This being the case, it is appropriate to award the appellant compensation for half the damage caused to her as a result of the operation, in accordance with the chances evaluations test.

Compensation for Damage Due to Violation of the Right to Autonomy

27. Having concluded that appellant should be compensated for the bodily injury caused to her, a further question arises. Given that Appellant's informed consent to perform the biopsy was not received, is she entitled to compensation under the tort of violation of the right of autonomy? And, assuming she is, should such compensation supplement the compensation for her bodily injury, replace it, or be awarded independently, and what is the appropriate rate of compensation for such damage?

In his opinion, my colleague, Justice Or, conducted an extensive analysis of the general elements of a person's basic right to autonomy and specifically regarding a person's sovereignty over his or her body in the context of consent to medical treatment. He concluded that violation of autonomy should be viewed as a separate head of damage and awarded compensation to appellant under that head. My colleague, Justice Beinisch, also considered the importance of this basic right but stated that the appellant is entitled to compensation for the full damage caused to her, and that she should not be awarded additional compensation under the head of violation of autonomy. Both of them provided extensive reasoning for their positions, and indeed the issue and its adjudication are far from simple. Having given the matter extensive consideration in all its relevant aspects, I concur with the position of my colleague, Justice Or, and I shall add a few comments of my own.

The Right to Autonomy and Informed Consent to Medical Treatment

28. The value of a person's autonomy is among the primary and fundamental values in our legal system, as in other legal systems. The

right to autonomy means that one is free to shape one's will as one deems fit, to voluntarily and independently determine one's lifestyle, to make decisions regarding actions and to have a certain degree of control over one's fate. On the conceptual expressions of the term autonomy, see J. Raz, *Autonomy, Toleration and the Harm Principle* [107] at 314 and J. Katz, *Informed Consent - Must it Remain a Fairy Tale?* [108] at 83.

29. The right to autonomy is anchored in the recognition of a person's value and dignity – values that are entrenched in the Basic Law: Human Dignity and Liberty. This is a "framework right" – in the language of President Barak – constituting, as a matter of fact, a flowing spring for the complex of various rights. Barak [76] at 357-361. The right to autonomy is also based on the right to privacy. Basic Law: Human Dignity and Liberty; Protection of Privacy Law, 1981. A patient's right to freedom of decision with respect to his or her body, health, and receipt of medical treatment derives from the patient's right to autonomy. *See* the Patient's Rights Law, secs. 1 and 13. Some believe that by virtue of a person's sovereignty over his or her body, that person has the right to object to an operation designed to save his or her life and to refuse treatment, even if doing so endangers the patient's life. *Airedale NHS Trust v. Bland (1993)* [63] at 860, 889, in the judgment of the House of Lords.

This approach was recently affirmed in the Court of Appeals ruling in *St. George's Healthcare NHS Trust v. S (1998)* [64] at 685-86. The case concerned a pregnant woman who refused to undergo a Caesarean operation, deciding to give birth naturally, despite her medical condition which created a risk to her fetus, all of which she was aware. At the hospital's request, an order was given *ex parte* permitting the performance of the Caesarean operation without obtaining the woman's consent. The operation was performed, and the woman filed a complaint in court against the decision permitting the performance of the operation on her body. The court ruled that performing the operation without her consent constituted assault, and that the declarative order issued previously could not serve as protection against a claim for damages.

The Rise of Autonomy and the Gradual Decline of the Traditional Approach

30. Consent to perform medical treatment is one of the outstanding situations which test the degree of protection provided by law for a patient's autonomy. A person's right to autonomy in receiving medical treatment has not always been taken for granted. The centrality of a person's right to autonomy in making decisions concerning medical treatment, and the rejection of the traditional approach which gave preference to the doctor's control of the patient's body over the patient's control of his or her own body, are concepts that have been emphasized anew over the past few decades. Informed consent to medical treatment has been recognized as a tort doctrine in the judgments of the Appeals Court of the State of California since 1957. C.J. Jones, *Autonomy and Informed Consent in Medical Decisionmaking: Toward a New Self-Fulfilling Prophecy* [109] at 388-89 and citations therein.

The historical perception, still adhered to by some today, is based on the principle that a person in need of medical treatment waives his or her will and autonomous status from the moment of requesting assistance from the doctor, placing his or her body and health in the doctor's hands along with the authority to decide on the treatment to be given. According to this perception, the doctor has dominance over the patient's body, and the doctor makes all the decisions. This approach derived, *inter alia*, from the gap in knowledge that separated the doctor from the patient, given that the doctor possesses the professional and scientific tools and skills to make the appropriate decision about the medical treatment required by the patient. On this point, Shultz says:

> …the patient was seen as making only one key decision, to place herself in a given doctor's care, thereby delegating all subsequent authority to the doctor. Such a model assumed that the patient lacked the technical ability to make medical decisions, and that expertise justified the doctor's making decisions on the patient's behalf.

Shultz [94] at 221.

31. The perception giving primacy to the doctors' opinion received expression in the English judgment *Bolam* [62], which established that the criterion for violating the duty of care applicable to the doctor to give the patient information on his medical treatment was based on "medical judgment." This principle was applied by a majority opinion of the House of Lords in *Sidaway v. Governors of Bethlem Royal Hospital (1985)* [65], with Lord Scarman dissenting. The majority ruled that the question of whether failure to inform a patient of the risks entailed in performing a treatment may be considered negligence by the treating doctor is governed by the principle established in *Bolam* [62], under which giving a patient medical information and determining the extent thereof is a matter within the scope of the doctors' medical expertise. The principle established in the judgment and its progeny was the subject of extensive criticism. *See* J. Keown, *Burying* Bolam*: Informed Consent Down Under* [110] at 17. Lord Scarman's dissenting opinion was adopted as the binding rule in the ruling of the Australian Supreme Court in *Rogers* [43] which rejected the *Bolam* principle [62]. According to this opinion, the criterion for examining the duty of care and the extent of the duty to disclose information will be established by the court according to the law's perception of the doctor's duties in this matter, paying attention to the patient's right to sovereignty over his or her body, and not only according to a medical opinion concerning the custom and accepted practice in medicine at a given time. The Australian Supreme Court said:

> …it would be illogical to hold that the amount of information to be provided by the medical practitioner can be determined from the perspective of the practitioner alone or, for that matter, of the medical profession.

Rogers [43] at 52.

This principle was also adopted in the judgment of the Federal Appeals Court in the District of Columbia in the case of *Canterbury* [48], which stated:

> … we [cannot - T.S.C.] ignore the fact that to bind the disclosure obligation to medical usage is to arrogate the decision on revelation to the physician alone. Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves.

Id. at 784.

This statement shows that in recent decades there has been a decline in the popularity of the traditional approach - based on a paternalistic attitude - in favor of the trend that focuses less on the treating doctor and more on the patient, who has been recognized as the central actor in formulating the decision on performing medical treatment on his or her body. However, changing the center of gravity and placing the patient at the focus of the decision making process is a slow procedure, to be done step-by-step.

32. The trend toward regarding the patient as the focus of medical activity originated in growing awareness of basic human rights and the need to protect them in all areas of life. This trend also stems from the transition to modern and developing practices of medicine. Medical information is available to all, and therapeutic alternatives are at the disposal of all patients. These products of modern medicine have also contributed to displacing the treating doctor from the position of exclusive advisor in the choice of appropriate medical treatment. This perception is apparently the assumption underlying the provisions of Section 7 of the Patient's Rights Law, which establishes the patient's right to a second medical opinion before deciding to undergo any medical treatment.

Preferring one method of treatment over another may involve various complex considerations which the patient weighs in accordance with his or her desires, stances, concerns or hopes. *See* Shultz [94] at 221-22. The prevalent contemporary view is that giving a patient medical information prior to performing a medical procedure on his or her body is no longer considered an activity within the exclusive expertise of the doctor, like the determination of diagnoses and prognoses, and accordingly, there is no justification for preferring the professional-medical viewpoint rather than the patient's individual approach. The Australian Supreme expressed this view in *Rogers* [43]:

> [N]o special medical skill is involved in disclosing the information, including the risk attending the proposed treatment. Rather, the skill is in communicating the relevant information to the patient in terms which are reasonably adequate for the purpose, having regard to the patient's apprehended capacity to understand that information.

Id. at 52.

This was also Shultz's view:

> [T]he more intense and personal the consequences of a choice and the less direct or significant the impact of that choice upon others, the more compelling the claim to autonomy in the making of a given decision. Under this criterion, the case for respecting patient autonomy in decisions about health and bodily fate is very strong.

[94] at 220.

33. The duty of those treating to receive the informed consent of the patient for the medical treatment is primarily intended to protect the basic right of a person in need of medical treatment to autonomy over his or her body and will. *See* Justice Cardozo's opinion in *Schloendorff* [53]; CA

3108/91 [1] at 507; LCA 1412/94 [18] at 525. The decision whether to receive a particular medical treatment, if at all, should be a balanced, voluntary, and independent decision of the person receiving the medical treatment.

> [I]t is established that the principle of self-determination requires that respect must be given to the wishes of the patient ... the doctors responsible for his care must give effect to his wishes, even though they do not consider it to be in his best interests...

Airedale [63] at 866 (Lord Goff of Chieveley).

Information is Critical in Order to Reach an Autonomous Decision

34. The patient's wishes to perform or refuse the treatment cannot be informed and intelligent unless they are based on the information necessary for making the decision in question. *See* Powers and Harris [91] at 322. Where the patient is not aware of the risks, prospects and implications of the treatment about to be undergone, the existence of alternative treatments, and the implications thereof, the patient's wishes cannot be regarded as his or her own, nor can the choice to accept or refuse treatment be regarded as a real choice. *See Canterbury* [48] at 780. Accordingly, failure to give the patient information or giving the patient partial and incomplete information is tantamount to violating a person's right to autonomy over his or her body, since it detracts from the patient's ability to formulate an informed and intelligent decision about whether to accept the medical treatment.

The Doctor – Patient Relationship

35. The patient's dependence on the doctor and their respective interests creates a great deal of dualism in the relationship. On the one hand, the doctor, whose goal is the patient's health, frequently believes

that he or she best knows which treatment should be given to the patient and how the patient's illness can be cured. On the other hand, the patient might examine the same facts weighed by the doctor through a slightly different prism, in the framework of which he or she may consider a variety of subjective factors, including the quality of life he or she may expect following the success or failure of the treatment and similar considerations – which are not always taken into account by the doctor. In that situation, the patient's right to autonomy in making the decision concerning medical treatment, as an expression of a person's right to dignity, is a value worthy of protection. This means recognition of the patient's independence and status as a participant in the decision making process. The following comments of D. Feldman give expression to this view:

> The notion of autonomy is tied to that of dignity. In order to develop and exercise a capacity for self-determination, one needs to take oneself and others seriously as moral agents. One aspect of dignity is self-respect, which … includes respect for one's own and other people's moral rights…

D. Feldman, *Secrecy, Dignity or Autonomy? Views of Privacy as a Civil Liberty* [111] at 54.

The scholars Twerski & Cohen made similarly appropriate comments:

> The right to participate in, and indeed, make important decisions concerning one's health is a critical element of personal autonomy … The legal system should protect these rights and provide significant recompense for their invasion.

Twerski & Cohen, *supra* [96] at 609.

Recognition of the Right to Compensation Due to Violation of Autonomy: Framework of Doubts and Critical Arguments

36. The critical nature of the information and its centrality in the patient's autonomous decision-making process requires us to consider whether the law protects the patient's right to receive the information that is essential to his or her case, and to decide his or her fate with respect to the medical treatment, what that protection is, and whether the extent of the existing protection adequately satisfies the patient's right to autonomy, including the right to receive information.

A review of the judgments rendered in various countries worldwide indicates that there is a real gap between judicial rhetoric which speaks in favor of the right to autonomy and its operative expression, which lacks effect:

> …. judges have made impassioned pleas for patient self-determination, and then have undercut them by giving physicians considerable latitude to practice according to their own lights.

J. Katz, *The Silent World of Doctor and Patient* [93] at 49.

One of the obstacles to the recognition of the right to compensation due to violation of autonomy is that most courts in the various legal system consistently demand proof of a causal connection between breach of the duty to provide information regarding the risks of performing a medical procedure and the real damage caused by the medical treatment. The courts have consistently ruled that in order for the plaintiff-patient to succeed in a claim filed against a doctor for breach of the duty to give information and negligence in obtaining informed consent, the patient must prove that the risks involved in the treatment –about which the patient was not given information – actually materialized and caused him or her injury. *See Canterbury* [48] at 790.

U.S. courts have not recognized the duty to give medical information to the patient as independent grounds for compensation, based exclusively on the breach of the duty to give information, independent of

the existence of real damage caused by the breach of the duty. In fact, the courts did not even recognize the breach of the duty as constituting a separate head of damage within the framework of negligence. Jones [109] at 394-95, 426.

In Israel as well, the violation of autonomy has not been recognized as constituting grounds for an action or a separate head of tort for which compensation is due. Should it be recognized as such? My colleague, Justice Or, answered the question in the affirmative, and I concur with his opinion.

37. The requirement of the existence of a causal connection between the breach of the duty to give medical information and to obtain informed consent and the real damage caused by the medical treatment has restricted the award of compensation to real, physical or mental, injury caused to the patient due to the medical treatment. This demand has been the subject of scathing criticism, to the effect that the demand for causal connection undermines the theoretical and conceptual justification of the requirement of informed consent to performing a medical procedure. This position found expression, *inter alia*, in the following statement:

> … courts have tended to impose causation requirements that appear to conflict with the underlying theoretical justifications of the informed consent doctrine itself.

M.A. Bobinski, *Autonomy and Privacy: Protecting Patients from their Physicians* [112] at 343.

Violation of the right to obtain information occurs as soon as the doctor breaches his or her duty. It inheres in the tortious behavior as such. It therefore seems that the causal connection – constituting the basis for liability for negligence – is an integral element of the doctor's breach of duty. To that effect, it is immaterial whether the negligence relates to the breach of duty or the violation of the autonomy. Consequently, on a practical level there is no justification for making the protection of the

patient's right to autonomy contingent upon proof of the causal connection between the breach of the duty and the actual damage caused by the medical treatment.

38. As mentioned above, there is no unanimity concerning recognition of entitlement to compensation due to violation of the right to autonomy where there is no causal connection with the actual injury caused by the failed medical treatment. According to those who believe that the right to compensation due to violation of autonomy should not be recognized, the information given to the patient concerning the risks involved in performing medical treatment contains technical details that are within the doctor's field of expertise, and the patient does not have the appropriate tools, the required skills, or the knowledge to properly understand and appreciate such information. As proof, they point to many cases in which patients prefer that the doctor advising them on what medical treatment is best decide for them which procedure should be performed. Some even argue that a treating doctor convinced of the wisdom of the proposed method of treatment might present the information in a manner that leads the patient to adopt the proposed treatment which the doctor considers to be the most effective in the circumstances. This might make the consent superfluous since, in any case, it is not informed consent. *See* Jones [109] at 406.

These arguments represent a paternalistic approach, predicated on a perception of the patient's inability to process and weigh information with which the patient is not conversant, patients' fears about taking responsibility for their medical fate, and the doctor's ability to maneuver the patient into following the doctor's lead. These arguments contribute considerably to preserving the doctor's superior status vis-à-vis the patient in the decision-making process. Indeed, there are certainly cases in which patients may be about to make a decision regarding medical treatment, without having properly understood the medical information, or they prefer that the doctor decide for them, or they make ostensibly autonomous decision based on latent persuasion made in good faith by the doctor. Nonetheless, I do not think that negating the recognition of the

right to compensation due to violation of autonomy is the correct response to these arguments. The response should be to increase patients' awareness of their right to decide autonomously and to emphasize the doctors' ethical duties, such as their duty to explain the medical information in simple language that is clear to every particular patient in accordance with his or her circumstances. In this context, one may adopt a range of methods that will enable the patient to absorb and process the medical information given. *See Natanson v. Kline* (1960) [54] at 1106; *Cobbs v. Grant* (1972) [55] at 11; Jones [109] at 412-14.

39. Another difficulty, which should also be noted, is the one raised in her opinion by my colleague, Justice Beinisch. My colleague referred to the concern that the attempt to strengthen the right to autonomy will paradoxically lead to its weakening, since the courts might avoid confronting the need for the complex determination of the causal connection so essential for awarding compensation for bodily injury, instead remaining content with nominal compensation based on violation of autonomy. Personally, I do not think that this concern is sufficient to negate proper compensation under this head of damage, especially since compensation for violating autonomy – as explained below – should not replace compensation for bodily injury, but should be in addition thereto.

40. Summing up, recognition of the right to compensation due to violation of autonomy protects the interest of patient participation in the decision-making process in his or her case, as well as the patient's independence as an entity possessing a will and not just as an object for the performance of a medical procedure. Protecting a person's right to receive the relevant information about his or her case is vital to assuring the right to autonomy in making decisions about medical treatment. This is the basis for the doctor's duty to obtain the patient's informed consent concerning the patient's treatment, and when this duty is breached, the patient deserves compensation for the violation of his or her personal autonomy.

Despite the existence of various grounds and considerations indicating the difficulties inherent in recognizing the right to compensation due to violation of autonomy, it appears that they can be appropriately dealt with and adequately resolved as indicated above, so that these arguments do not inveigh against the conclusion that the right to compensation for violation of autonomy should be recognized.

Compensation for Violation of the Right to Autonomy: Independent Grounds or Head of Damage?

41. What is the appropriate legal domain for the protection of a patient's right to autonomy over his or her body?

A number of scholars have expressed the opinion that anchoring the protection of the right to autonomy under the damage head of violation of autonomy as part of the offense of negligence does injustice to the protection of the right to autonomy, maintaining that it is preferable to anchor the protection – if at all – as an independent cause for action which does not require the existence of a causal connection between the violation of autonomy and the actual injury as a condition for imposing liability. *See* N.P. Terry, *Apologetic Tort Think: Autonomy and Information Torts* [113] at 193-94; Bobinski [112]. These scholars maintain that with respect to negligence, the patient may succeed in his or her claim only if he or she proves that the doctor was negligent in obtaining the informed consent, according to tests prevailing in the context of the tort of negligence, which require the application of objective criteria that do not give a *full* answer to the patient's right to autonomy. Despite that argument, I think that protection of the right to autonomy as part of the offense of negligence could constitute appropriate protection, since it takes into account the heavy burden imposed on the doctors to ensure the patient's participation in all respects, on the one hand, and the patient's interest in receiving full information concerning his or her case, on the other. Accordingly, it would appear that the legal domain of negligence – as a means for

protecting the patient's right to autonomy – could constitute an appropriate balance between the conflicting interests.

42. Indeed, it is possible to protect a person's right to autonomy in general, and to receive medical information in particular, even within the framework of an action based on violation of a basic right of supreme importance, which is akin to a constitutional offense. The development of grounds for a claim based on violation and infringement of basic rights is a complex issue, just now emerging in the Israeli legal system. Recognition of the existence of constitutional grounds for a claim raises a spate of difficulties and questions which have not yet been clarified and discussed in court precedents and scholarly writings, such as which rights should be protected on constitutional grounds; what are the tests for protecting these rights; what are the appropriate remedies for violation of a constitutional right, and so on. At this stage, when these issues have yet to be discussed in depth, it seems appropriate to take another track suited to the solution of the problem confronting us. We can content ourselves with the determination that a person's right to autonomy should be afforded protection in the legal domain of an independent head of tort separate from those known to constitute negligence. The decision on the weighty question of whether the right of autonomy should even be protected as an independent cause of action ought to be left for an appropriate occasion. *See* Barak [76] at 681.

Compensation for Physical Injury and for Violation of Autonomy: the Appropriate Relationship Between Them

43. What is the appropriate relationship between compensation granted under the various heads of tort recognized as part of the offense of negligence and compensation under the damages head of violation of the right to autonomy, where the imposition of the liability and the compensation are based on the doctor's failure to obtain informed consent?

When the doctor's negligence, constituting the basis for compensating the patient, is expressed by failure to obtain informed consent to perform the treatment, the question arises whether the compensation award for bodily injury is also compensation for violation of autonomy, meaning that by paying separate and cumulative compensation for violation of autonomy, one is, in practice, paying double compensation.

The fact is that there is only instance of negligent behavior constituting the basis for imposing liability on the doctor, consisting primarily of the doctor's failure to receive informed consent prior to performing the medical procedure. This negligent behavior generates various types of damage, on different levels. The violation of the right to autonomy may find its expression on different levels, both in inherent and direct but intangible damage, which is a direct consequence of the actual violation of the right, and in indirect but tangible damage. Bodily injury may be caused because of the failure of the treatment, which would never have been performed on the patient if his or her consent had been sought and refused. Intangible damage may be the result of the failure to obtain informed consent, and denial of the patient's right and ability to decide autonomously about what should be done with his or her body.

44. In my opinion, the head of tort concerning violation of autonomy should be viewed as an independent head of damage in all respects, to be added to the compensation due for bodily injury or other damage, and should not be considered a substitute. These are separate heads of damage, providing protection for different interests. Recognition of the right to compensation due to violation of the right to autonomy provides protection for the patent's autonomous status in the decision-making process and his or her right to receive information for the purpose of formulating a position about the performance of a medical procedure. Twerski & Cohen [96] at 649. As a matter of principle, protecting these rights and interests should not be conditional upon providing compensation for the real harm caused by the medical treatment, which protects the interest of preservation of a person's bodily integrity. Compensation for the bodily harm caused by failure of the treatment does

not give expression to the intangible damage caused to the patient due to the violation of his or her right to autonomy. For that reason, the fact that two heads of tort are located under one roof does not mean that compensation therefore constitutes double compensation, since the interests protected by each head of tort are separate and different. The argument that bodily harm precludes compensation for damage caused by violation of autonomy does injustice to the appropriate protection for the specific interest inherent in each of the said heads of damage. Accordingly, from a principled-legal perspective, it appears to me that there is neither reason nor justification to cancel the one because of the other.

At the same time, there might certainly be reciprocity between the two heads of tort. In other words, the intensity of a person's feelings due to violation of his or her right to autonomy might change, *inter alia*, in accordance with the result of the treatment performed on the patient's body without obtaining informed consent, the extent of bodily harm caused, the importance of the information which was not given to the patient due to the doctor's negligence, etc. For example, where the failure of the treatment caused bodily harm to the patient, the intangible injuries due to the violation of the right of autonomy might be regarded as grave. And *vice versa*: the success of the medical treatment – despite the fact that it was performed without obtaining informed consent – might appease the patient and calm him or her to such an extent that the damage caused is minimal (*de minimis non curat lex*).

Evaluating the Damage Due to Violation of Autonomy

45. What, then, is the extent of the damage and how should it be evaluated? What test should we use to evaluate the damage to a person's autonomy? Should we adopt the perspective of the specific patient, and accordingly examine how he or she feels as a result of not having received the information (subjective test)? Or should we examine the damage caused by the violation of autonomy, as seen through the eyes of the reasonable patient (the objective test)? Or perhaps we should adopt

another point of view, incorporating the objective elements while placing emphasis on the special and unique circumstances of the patient before us (the combined test)?

I will preface my remarks by saying that the combined test is the one I proposed as the most suitable for assessing the chances that the patient would have made a particular choice, had his or her informed consent been sought (*supra* paras. 24-25). The reasons I presented there are also appropriate in the current context. An expression of the combined test can be found in the following:

> That [doctor-patient - T.S.C.] relationship also gives rise to a duty to provide information and advice. That duty takes its precise content, in terms of the nature and detail of information to be provided, from the needs, concerns and circumstances of the patient. A patient may have special needs or concerns which, if known to the doctor, will indicate that special or additional information is required…. In other cases, where, for example, no specific inquiry is made, the duty is to provide the information that would reasonably be required by a person in the position of the patient.

Rogers [43] at 54.

46. Evaluating an intangible injury raises numerous difficulties, and the effort to quantify it is particularly difficult. In applying the combined test in order to evaluate the harm caused by violation of autonomy, we must examine the injury caused while adopting the viewpoint of a reasonable patient, and we must also express the individual and autonomous aspects of the particular patient:

> The measure of the non-pecuniary harm to be compensated depends, from the strictly tortious point of view, upon the extent to which an individual values his or her autonomy,

taking into account his or her mental and emotional reaction to the violation.

Englard [83] at 164.

For the purpose of evaluating the injury, the court must assess the degree of the violation of the patient's autonomy caused by the failure to give the patient the information that he or she should have been given. And note: the information which the doctor is obligated to give the patient is not all the information which the patient would like to receive, but only such information which, if omitted, would constitute negligence in obtaining informed consent. Accordingly, when the court evaluates the harm caused to the patient due to the violation of autonomy, it must examine the damage caused due to failure to provide the specific information which the doctor was duty bound to give to the patient.

47. The doctors' duty to give the information is not uniform, and it does not cover all particulars of the information down to the remotest of risks. *Vaturi* [3] at 182. Failure to give information on particular and real risks which are not "far-fetched or fanciful" might also constitute negligence on the doctor's part. *Rogers* [43] at 54. Accordingly, both the doctors and the courts must consider the extent and nature of the information that must be provided by the doctor, and they should address the special value of the information not provided, compared with the information provided (see the Patient's Rights Law, sec. 13). The extent of the violation might be more severe if the patient believes that the information not provided could have altered his or her position regarding performance of the medical treatment. In this context, it is appropriate to take into account the patient's position and attitude to the provision of the medical information concerning himself or herself. In many cases, the patient freely forfeits his or her own free will, leaving the decision-making solely to the doctor, and even asking not to be apprised of his or her medical condition.

> … in the context of doctor-patient relationship, the latter's genuine desire for full autonomy in the decision-making process is rather rudimentary. It is a well-known and widespread phenomenon that people are reluctant to assume full responsibility for their personal fate, especially in cases of difficult medical decisions… At present, the wish for autonomy in medical decision-making is far from being fully developed in the patient.

Englard [83] at 164-65.

Under this state of affairs – so the argument goes – protecting autonomy under the head of tort awarding compensation, where no harm was caused to the patient, is not appropriate.

> If patients lack the consciousness of self-determination, why compensate them for its assumed loss? In the absence of harm, there is no place for compensatory rectification.

[83] at 165.

Indeed, there will be cases in which the patient will prefer not to receive the medical information and to leave the medical decision-making to the doctor, because of the patient's fear of receiving information about his or her real medical condition and of making his or her own weighty decisions. Ostensibly, this approach is not commensurate with the perception of a person as an autonomous entity, although a person's refusal to take responsibility for making an autonomous decision may also derive from the autonomy of his or her will. In any event, in order to evaluate the extent of the damage caused by violation of autonomy, it is necessary to take into account the position and wishes of the specific patient regarding receipt of the medical information, because if the patient is not interested in receiving the information and making an autonomous decision, there is no basis to the claim that this autonomy was violated.

48. Another consideration that might arise when evaluating the damage caused concerns the consequences of the treatment performed. I do not think it appropriate to make exhaustive observations on this issue, and each case should be considered on its merits, in accordance with its circumstances. Nonetheless, it would appear that the results of the treatment performed could be of significance when evaluating the damage caused by the violation of autonomy. For example, the fact that the medical treatment succeeded, despite the fact that it was provided without obtaining informed consent, might render the damage caused by the violation of autonomy theoretical or negligible (*de minimis*). On the other hand, where no informed consent was given, and the treatment failed and even caused bodily harm, the failure of the treatment may exacerbate the injury to the patient and to his sensibilities. In any event, the compensation is not intended exclusively as punitive or theoretical compensation.

The Burden on the Doctors – Is It Excessive?

49. Recognition of the right to compensation for damage caused due to violation of autonomy is not free of doubts and difficulties. It is clear that that recognizing the head of tort entitling a person to compensation due to violation of autonomy *per se* imposes a heavy burden on the treating doctors. Recognition of this head of damage might expose them to legal liability not only when they are negligent in obtaining informed consent and where there was bodily and other injury, but also in the case of successful medical treatment where they are nevertheless liable for intangible injury caused by the violation of the right. Indeed, the burden imposed on the doctors is a heavy one. At the same time, the power held in the doctors' hands may have a significant –if not irreversible – impact on the patient's life-style and health. Consequently, despite the doctors' well-intended desire to benefit the patient, they should always keep the patient's wishes in mind.

50. At the same time, it is appropriate to state that fear of "defensive medicine" is not unfounded (CA. 2989/95 [27] at 698), and it is occasionally raised when doctors are exposed to a broadening of their legal liability. Indeed, the burden borne by the doctors is a heavy one, but the courts will presumably be able to distinguish between information whose delivery is vital, the non-delivery of which would have violated the patient's autonomy, and information whose delivery is not vital, the non-delivery of which would not have violated the patient's ability to make an informed, considered, and autonomous decision. Similarly, courts will presumably be able to distinguish between cases in which informed consent was obtained and cases in which it was not. Adopting this path, while paying attention to the conflicting interests and making a considered and cautious evaluation of the compensation awarded for the violation of autonomy in accordance with the merits of each case, guarantees the patient's right to autonomy on the one hand, and provides protection for the doctors' important work, on the other.

51. Furthermore, it must be remembered that recognizing this head of damage is only one stone in the mosaic, by which I mean placing the patient's autonomy at the center of the medical treatment and anchoring the patient's status in the process of making medical decisions that concern him or her.

> *It is not enough for the law to say to doctors,* "*Disclose*"*, or ... to say to patients,* "*Decide*". Rather, physicians must relinquish some of their power and patents must relinquish some of their vulnerability…. Patients and physicians must develop different attitudes toward each other … Patients clearly need to trust more in themselves – to trust their abilities to understand information, to ask the appropriate questions, and to make the "right" decisions. Patient self-trust does not come from trusting doctors less, but instead from doctors' and others' (including the law's) trusting patients more.

Jones [109] at 425 (emphasis added – T.S.C.).

And Now to the Matter at Hand:

52. How does all of the aforesaid affect our case?

In the circumstances of this case, the doctor did not obtain the appellant's informed consent for the treatment, nor was it proven that he gave her the medical information that was essential in this particular case; the operation was an elective one and was not the operation for which she had come to the hospital. Failure to give her the information under these circumstances, as stated above, amounted to negligence in obtaining informed consent. This negligence prevented the appellant from deciding, on an informed and considered basis, whether she was willing or unwilling to perform the biopsy on her shoulder. The voluntary and informed decision concerning the performance of the biopsy is one that ought to have been made autonomously by appellant. Accordingly, we can rule that this negligence violated the appellant's right to autonomy over her own body. However it is insufficient to rule merely that there was a violation of the appellant's autonomy, since that ruling is on the level of liability only, and we must further examine its concrete expressions in the circumstances of this case. This requires us to determine, through evaluation, the extent of damage caused to appellant due to this violation of her autonomy.

It was after the performance of the biopsy on her shoulder that the appellant became aware that it had been performed without her having received the relevant information and that the doctor had been negligent in obtaining her consent to the operation. The evidence presented does not indicate how she responded upon becoming aware of these facts. We do not know how important it was from her perspective – if at all – to make an autonomous decision about the performance of the procedure and what she would have decided had her informed consent been requested. She did not testify on these matters and categorically denied having even been aware that she was about to undergo such an operation. The trial judge rejected her testimony as unreliable, and there was nothing to do apart from awarding her an estimated compensation under

this head of damage. In conclusion, I concur with the opinion of my colleague, Justice Or, concerning the right to compensation under the head of the tort of violation of autonomy and the amount stipulated by him as compensation. In my view, the compensation under this head of damage should be added to the compensation for half the sum of compensation for bodily injury to be awarded to the appellant due to performance of the operation without obtaining her informed consent, all as set forth in my opinion.

President A. Barak

I concur with the judgment of my colleague, Justice Or. As such, I am not required to decide the case before us on the basis of path proposed in the judgment of my colleague, Justice Strasberg-Cohen. Indeed, cases in which the casual connection cannot be resolved on the basis of the balance of probability present difficult problems in terms of deciding the applicable law. This was also the position of my colleague, Justice Beinisch, reflected in her comments on the subject. Personally, I do not need to decide the issue in the current case, and I leave it for further review when the time comes. The reason for this is that in view of the contents of the judgment of my colleague, Justice Or, it was proved in the present case that appellant would have agreed to the performance of the biopsy on her shoulder, if she had been duly advised and had given her "informed" consent.

Deputy President S. Levin

I concur with the ruling of my learned colleague, Justice Or.

Justice M. Cheshin

I concur with the ruling of my colleague, Justice Or. However, I must confess that in circumstances such as ours, I was attracted by the doctrine of evaluating the chances of the existence of a causal connection (as opposed to the doctrine of balance of probability), on which my colleague, Justice Strasberg-Cohen, based her opinion. "In circumstances such as ours" means in circumstances in which the injured person – the plaintiff – due (also) to the defendant's actions and omissions, finds it difficult to prove a causal connection between the defendant's actions and omissions and the injury incurred (by the plaintiff). Thus, for instance, one could argue that in circumstances such as ours – to which I confine my remarks – the justice of the principle of distributing and spreading the damage is preferable to the justice of the principle of "all or nothing." This was also the case in the past when, in cases of contributory negligence, the principle of division of liability between the tortfeasor and victim replaced the principle of full exemption or full liability. It could therefore be argued that the same rule should apply in our case. The same rule is also applied regarding the division of liability between joint tortfeasors. Concededly, with respect to a causal connection between action or omission and damage caused, these two [aforementioned – ed.] cases are not identical to the case before us. Even so, it would seem that the underlying principle of distributing and spreading the damage should also find expression in circumstances such as ours. Since I concur with the opinion of my colleague, Justice Or, I have the good fortune of not having to decide the question. Its time will come.

Justice I. Englard

I concur with the judgment of my honorable colleague, Justice Or.

It was therefore decided by majority opinion in accordance with the opinion of Justice Or.

August 29, 1999.