**CA 8710/17**

Appellants: 1. A.

2. B.

*v.*

Respondents: 1. Clalit Health Services

2. C.

Appeal of judgment by the Haifa District Court of October 6, 2017, in CC 54431-06-14 by Judge A. Toubi

*Supreme Court Cases Cited*:

[1] CA 3056/99 *Stern v. Haim Sheba Medical Center,* 56(2) IsrSC 936 (2002)

[2] CA 2781/93 *Daaka v. Carmel Hospital, Haifa*, 53(4) IsrSC 526, 549 (1999) [https://versa.cardozo.yu.edu/opinions/daaka-v-carmel-hospital]

[3] CA 4960/04 *Sidi v. Clalit Medical Fund*, 60(3) IsrSC 590 (2005)

[4] CA 1303/09 *Kadosh v. Bikur Holim Hospital* (unpublished) (March 5, 2012)

[5] CA 6153/97 *Stendhal v. Sadeh*, 56(4) IsrSC 746 (2002)

[6] CA 3108/91 *Ravi v. Veigal*, 47(2) IsrSC 497 (1993)

[7] CA 434/94 *Berman v. Mor Institute for Medical Information, Ltd*. 51(4) IsrSC 205 (1997)

[8] CA 8126/07 *Estate of Zvi v. Bikur Holim Hospital* (unpublished) (January 3, 2010)

[9] CA 1997/10 *Tsoref v. Rosenbaum* (unpublished) (February 13, 2012)

[10] CA 10306/08 *Shmueli v. Mor Institute for Medical Information, Ltd*. (unpublished) (March 16, 2011)

[11] CA 2600/09 *Maccabi Health Services v. N.S.* (unpublished) (November 10, 2013)

[12] CA 7416/12 *Meuhedet Health Fund v. A.* (unpublished) (November 4, 2014)

[13] CA 6936/09 *Yehuda v. Clalit Health Services* (unpublished) (March 5, 2012)

[14] CA 2342/09 *N.G. v. Clalit Health Services* (unpublished) (April 6, 2011)

[15] CA 1615/11 *Ein Tal Clinic – Ophthalmology Center v. Finkelstein (Albalah)* (unpublished) (August 6, 2013)

[16] CA 718/06 *Satkhi v. State of Israel* (unpublished) (October 30, 2007)

[17] CA 7756/07 *Gerstel v. Dan* (unpublished) (December 21, 2010)

[18] CA 8693/08 *Herman v. Sternberg* (unpublished) (March 24, 2011)

[19] CA 119/05 *Halifa v. State of Israel* (unpublished) (September 10, 2006)

[20] CA 355/11 *Hadassah Medical Organization v. Meuhedet Clinic* (unpublished) (February 9, 2015)

[21] CA 1326/07 *Hammer v. Amit* (May 28, 2012) [https://versa.cardozo.yu.edu/opinions/hammer-v-amit]

[22] CA 5604/94 *Hemed v. State of Israel*, 58(2) IsrSC 498 (2004)

[23] CA 9936/07 *Ben David v. Entebbi* (unpublished) (February 22, 2011)

*District Court Cases Cited*:

[24] CC (Jerusalem District Court) 19055-12-13 *Abu Dahesh v. Clalit Health Services* (unpublished) (February 10, 2016)

[25] CC (Haifa District Court) 195060-07-14 *R.A.B. v. Clalit Health Services* (unpublished) (December 18, 2016)

[26] CC (Tel Aviv District Court) 39999-05-13 *P.A. v. Rafaelov* (unpublished) (December 25, 2014)

[27] CC (Haifa District Court) 16010-02-16 *A.P. v. Odeh* (unpublished) (June 20, 2019)

[28] CC (Tel Aviv District Court) 5691-12-08 *M.N. v. State of Israel – Ministry of Health* (unpublished) (September 22, 2013)

*U.S. Cases Cited*:

[29] *Piper v. Cumberland Med. Ctr.*, 2017 Tenn. App. 33 (2017)

[30] *Canterbury v. Spence*, 409 U.S. 1064, 464 F.2d 772, 786 (D.C. Cir. 1972)

[31] *Fain v. Smith*, 479 So. 2d 1150, 1155 (1985)

**<u>The Supreme Court sitting as a Court of Civil Appeals</u>**

(August 6, 2019)

*Before: Justices N. Hendel, D. Mintz, and Y. Willner*

## Judgment

**Justice Y. Willner:**

Does a physician's duty of disclosure include the duty to disclose religious information or medical information adapted to a particular patient's religious beliefs? That is the central question presented by this appeal.

1. This is an appeal of the Haifa District Court's judgment (Judge A. Toubi) in CC 54431-06-14 of October 26, 2017, rejecting the Appellants' suit for wrongful birth in regard to the birth of their daughter, who has Down's Syndrome.

2. At the age of 41, Appellant 1 (hereinafter: the Appellant) was pregnant for the sixth time, and her prenatal care was mostly conducted through Clalit Health Services (hereinafter also: Clalit). The relevant medical records show that due to the Appellant's age, the medical staff began providing her with prenatal care in the first weeks of her pregnancy, and explained a number of times the importance of undergoing various tests, including chorionic villus sampling, amniocentesis, antenatal ultrasound scans and nuchal translucency screening. However, the medical records indicate that the Appellant decided not to undergo chorionic villus sampling and preferred to wait until it would be possible to undergo amniocentesis.

3. During week 12+6 of her pregnancy, the Appellant underwent a nuchal translucency screening. The results indicated a high risk that the fetus had Down's Syndrome. Accordingly, the Appellant was referred to genetic counseling, and again the possibility of undergoing an amniocentesis was explained to her. She was even referred to a genetic clinic so that, *inter alia*, she could undergo amniocentesis.

4. During week 14+2 of her pregnancy, the Appellant came to the Clalit Health Services clinic in Nazareth for genetic counseling by Prof. Joel Zlotogora (hereinafter: the genetic counselor), after which Prof. Zlotogora noted in the medical records that he recommended that the Appellant undergo amniocentesis.

5. An antenatal ultrasound scan and blood test that the Appellant underwent in the 16th and 17th week of her pregnancy indicated problematic results, and the medical records indicate that the importance of undergoing amniocentesis to diagnose the fetus's condition was repeatedly explained to her.

6. During week 18+5 of her pregnancy, Respondent 2, Dr. Yaakub Zakrian, an obstetrics and gynecology specialist at Clalit, referred the Appellant for amniocentesis, which she underwent during week 20+2 of her pregnancy. The results, which were received during week 23+1, indicated that the fetus had Down's Syndrome. The next day, the Appellant and her husband, Appellant 2 (hereinafter: the Appellant's husband), met with Dr. Hazanchuk, who performed the amniocentesis. During that meeting, Dr. Hazanchuk explained the results of the amniocentesis and their significance and referred them urgently to the Termination of Pregnancy Committee. Two weeks later, at an additional visit with Dr. Zakrian, he also explained to the Appellants the significance of the amniocentesis results and raised the possibility of terminating the pregnancy.

7. However, after receiving the results of the amniocentesis, the Appellant's husband went to a Muslim clergyman, who informed him that the Islamic religion prohibits terminating a pregnancy later than 120 days from conception (hereinafter: the 120-day limit). Given that the time period for terminating the pregnancy according to their religious faith had, as noted, passed, the Appellants decided to continue the pregnancy. On November 13, 2007, the Appellants' daughter was born, and she had Down's Syndrome.

8. The Appellants then filed a tort suit in the District Court against Clalit and against Dr. Zakrian on the grounds of medical malpractice. In their lawsuit, the Appellants primarily argued that throughout the pregnancy, they were not informed of the possibility of conducing a FISH test – a test that would have facilitated early discovery of the fetus's condition, as well as an informed decision regarding terminating the pregnancy before 120 days had passed from the date of conception. The Appellants added that the negligence in this case was particularly serious, given the fact that it was a clinic dedicated to treating Muslim women, such that the Respondents were

aware of the 120-day limit. It was further argued that, although the FISH test requires an additional payment, the Respondents should have disclosed to the Appellant that she had the option of undergoing it, as the Appellant had undergone an antenatal ultrasound scan and nuchal translucency screening privately, indicating that she does not take risks, and that had she known about the existence of the FISH test she definitely would have been willing to pay to have it performed. It was also argued that the amniocentesis that the Appellant underwent was done too late, and that the Respondents should have performed it earlier, so that its results would have been available before 120 days had elapsed from the date of conception.

Regarding the genetic counseling, it was argued that Prof. Zlotogora was negligent in not asking the Appellant about her religious beliefs, and that he also breached his duty of disclosure by refraining from informing the Appellant about the 120-day limit.

The Appellants also raised alternative arguments, in the event that the court ruled that the Respondents did not owe them a duty to disclose religious information or medical information adapted to their religious restrictions. In that context, the Appellants argued that Dr. Zakrian customarily informed patients about the possibility of performing a FISH test, and that Prof. Zlotogora customarily informed Muslim patients about the 120-day limit. It was thus argued that the Respondents' conduct regarding this issue should be evaluated according to the higher standard of disclosure with which they customarily conducted themselves. In that context, the Appellants relied on this Court's decision in CA 3056/99 *Stern v. Haim Sheba Medical Center* [1] (hereinafter also: the *Stern* rule), which held that the conduct of a medical institution that has adopted a more cautious practice than is customary for a reasonable medical institution will be evaluated according to the more stringent standard of conduct that it has adopted.

The Appellants also argued that Prof. Zlotogora's medical notes were inadequate, and that they did not include, *inter alia*, details of the information that was provided to the Appellant regarding the possibility of performing a FISH test, nor did they contain documentation about an inquiry into her religious faith. Thus, the Appellants argued that the District Court should have started from the assumption that Prof. Zlotogora indeed refrained from asking the Appellant about her religious beliefs and did not inform her of the possibility of performing a FISH test, as noted.

9. On the other hand, the Respondents argued that from the early stages of the pregnancy, the Appellant was informed of the relevant risks of her pregnancy, and she was given the required

explanations according to accepted medical practice. Despite that, it was argued, the Appellant preferred at first not to terminate the pregnancy until there was *definitive* confirmation of the fetus's status through an amniocentesis, and even afterward, the Appellants consciously decided to refrain from terminating the pregnancy. Thus, it was argued that the Respondents' aforementioned decision severed any chain of causation between the prenatal care and the birth of their daughter.

It was also argued that it is not the role of physicians to enquire into their patients religious beliefs or discuss the restrictions related to them, and that requiring physicians to do so would impose an unduly heavy burden on them. Furthermore, it was argued that asking patients about their religious beliefs could infringe their right to privacy. Thus, the Respondents argued that even if Prof. Zlotogora did customarily talk with patients about their religious faith, it would be inappropriate to make such conduct a mandatory standard.

Given the aforesaid, it was argued that once the Appellant refrained from informing the medical staff providing the prenatal care about the 120-day limit, there was no reason to deviate from the customary practice regarding the dates for performing the necessary tests and diagnosing the condition of the fetus.

*The District Court Judgment*

10. In its judgment, the District Court rejected the Appellants' lawsuit for a number of reasons.

*First*, it was held that the Respondents cannot be found to have acted negligently toward the Appellant, because the Appellants themselves consulted with a member of the clergy only after receiving the results of the amniocentesis, and in any event, the Appellants did not inform the medical staff about the 120-day limit during earlier phases of the prenatal care. Instead, it was held, the Appellant wanted to exhaust all stages of the medical examination, and decide whether to continue the pregnancy only after definitive confirmation of the fetus's condition through an amniocentesis – even though the results of the additional tests performed where explained to her, as were the risks arising from such results. It was also held that a FISH test is a test that provides only partial results, and it is not included in the basket of publicly funded health services. The District Court therefore held that in the absence of a medical reason for urgency, as noted, there

were no grounds for urging the Appellant to undergo an amniocentesis at an earlier stage, or for informing her of the possibility of performing a FISH test.

Given that conclusion, the District Court refrained from ruling on the factual dispute between the parties regarding the question whether the Appellant was informed of the possibility of performing a FISH test. Similarly, it was held in that context that Prof. Zlogotora's notes following the genetic consultation were indeed inadequate, but they did include a notation that he had recommended that the Appellant to undergo amniocentesis, and that is sufficient in our case.

*Second*, it was held that it was not the duty of the medical staff to ask the Appellant about her religious beliefs or to discuss her religion's obligations with her. In that context, it was held that asking patients about their religious affiliation, their level of observance and similar questions would likely infringe their right to privacy, and that requiring physicians to adapt the information they provide patients to particular religious obligations would impose an undue burden on them, and might even undermine the uniformity of the care provided to different patients.

*Third*, it was held that even if Prof. Zlotogora customarily discussed patients' religious beliefs and the restrictions related to them, the *Stern* rule should not be applied in our case, because it is the practice of a single physician, it concerns information that is not medical, and the practice is not in itself desirable – as noted above.

*The Current Appeal*

11. In their appeal, the Appellants focus their arguments on the breach of the duty of disclosure. In this context, they mostly repeat the arguments they made before the District Court. Thus, it was argued that Dr. Zakrian breached his duty of disclosure by not informing the Appellants of the possibility of performing a FISH test, and that Prof. Zlotogora breached his duty of disclosure by refraining from discussing the 120-day limit with the Appellants. It was also argued that the aforementioned negligence of Dr. Zakrian and Prof. Zlotogora constitutes a deviation from the standard of care that they themselves had adopted in their medical work up until that point, which is binding upon them pursuant to this Court's ruling in the *Stern* case, which, they argue, should be applied in our case, as well.

Additionally, it was argued that the District Court erred in holding that the question of the Respondents' negligence is affected by the fact that the Appellants consulted with a member of the clergy *only after* receiving the results of the amniocentesis. According to the Appellants, that fact could be relevant only after ruling on the liability of the Respondents, via the doctrine of contributory negligence. Similarly, the Appellants repeat their arguments regarding Prof. Zlotogora's inadequate medical notes and regarding the delay in performing the amniocentesis, as well as in transmitting its results to them after 120 days had elapsed from the date of conception.

12. The Respondents rely on the District Court's decision, and mostly repeat the arguments they made before that court. Similarly, the Respondents argue that Dr. Zakrian customarily informed his patients about the possibility of performing a FISH test only when patients complained about the prolonged wait for the results of the amniocentesis. Thus, it is argued that the Appellants did not prove the existence of a more stringent medical practice that could raise the standard of care required of Dr. Zakrian.

*Discussion and Ruling*

13. This appeal focuses upon two central questions: *first,* the issue of the scope of the duty of disclosure imposed on the attending physician – does it also include disclosing *religious* information regarding obligations and restrictions deriving from religious faith, as well as disclosure of *medical* information that is adapted to religious characteristics of this kind? Even if we answer that question in the negative, we need to rule on *an additional question*, which is: should we raise the standard of the duty of disclosure required of a physician who customarily expands his disclosure to his patients to include religious information or medical information adapted as noted, in light of the rule established by this Court in the *Stern* case.

Below, I will address these questions in order – first-first and last-last – but first, I will begin by setting out the normative framework for our discussion.

*Duty of Disclosure – the Normative Framework*

14. Our legal system ascribes great importance to a person's right to autonomy, in light of which it has been held, *inter alia*, that one cannot provide treatment or subject someone to a

medical procedure without consent (See: Amos Shapira, "*Haskama Midaat" Litipul Rifui – Hadin Hamatzui Viharatzui* ["*Informed Consent*" *for Medical Treatment – De Lege Lata and De Lege Ferenda*], 14 IYUNEI MISHPAT 225, 225-226 (5749); RUTH R. FADEN & TOM L. BEAUCHAMP, A HISTORY AND THEORY OF INFORMED CONSENT, 7-9 (Oxford University Press, 1986)). In order for a person to genuinely exercise the aforementioned right to autonomy, it is incumbent on that consent to be "informed consent", meaning consent that derives from orderly, intelligent consideration of the medical information and the entirety of relevant risks and prospects.

However, in general, the average patient does not possess medical information of this kind, and thus places his trust in his physicians – they are the experts in the medical field, and they possess extensive medical knowledge, as well as the ability to delve into the relevant information and process it as needed. The gaps in information and understanding between a patient and a physician therefore require the latter to present the patient with "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" (CA 2781/93 *Daaka v. Carmel Hospital, Haifa* [2]; see also: CA 4960/04 *Sidi v. Clalit Medical Fund* [3] 600; CA 1303/09 *Kadosh v. Bikur Holim Hospital* [4], para. 16 of Deputy President E. Rivlin's opinion; Assaf Yakov, *Gilui Naot V'haskama Mudaat* [ *Disclosure and Informed Consent*], 31(3) IYUNEI MISHPAT 609, 641 (2009); Adi Niv-Yaguda, *Ikaron Hahadadiut Bamifgash Harefui – Bein Hovat Hagilui (Mitapel) La'ahrayut Hamitupal V'Hovat Hayidua*" [*The Principle of Reciprocity in the Medical Meeting – Between the Duty of Disclosure (Provider) and the Patient's Responsibility and "the Duty to Inform*"], 13 ALEI MISHPAT 183, 191-193 (2016); On the duty of disclosure as a "an obligation of trust" that the physician owes his patients, see: Yossi Grin, *Hovat Emun Shel Rofeh – Bein Hama'arehet Ha'ezrahit Latzvait* [*A Physician's Duty of Trust – Between the Civilian and Military System*], in HOVOT IMUN BADIN HAYISRAELI [FIDUCIARY DUTIES IN ISRAELI LAW] 321, 331-333 (Ruth Plato-Shinar and Joshua Segev, (eds.) 2016)).

15. The duty to obtain informed consent prior to providing medical treatment, like the duty of disclosure that derives from it, were expressed in Chapter D of the Patient's Rights Law, 5756-1996, and in Chapter D1 of the Medical Ethics Rules (See: The Ethics Bureau of the Israeli Medical Association, ETIKA RIFUIT – KLALIM V'NIYAROT EMDA [MEDICAL ETHICS – RULES AND POSITION PAPERS], (Tami Karni (ed.), 2018)). Having said that, an appropriate venue for addressing the *breach* of the duty of disclosure has yet to codified in an orderly fashion. Therefore, the issue can

be examined in a number of ways. Thus, *inter alia*, one can argue that a breach of the duty of disclosure constitutes a breach of a statutory duty (See sec. 63 of the Civil Wrongs Ordinance [New Version]), and that it constitutes negligence pursuant to sec. 35 of the Civil Wrongs Ordinance (for an extensive discussion of the multiplicity of potential homes for the duty of disclosure – positive and normative – see the *Daaka* case, pp. 544-548; CA 6153/97 *Stendhal v. Sadeh* [5], 759-760; the *Kadosh* case, paras. 14-25 of Justice Y. Amit's opinion; Nili Karko-Eyal, *Doktrinat "Hahaskama Mida'at" – Ilat Hatvia Har'uya Makom Shebo Hufra Zchut Hamitapel L'autonomia* [*The Doctrine of "Informed Consent" – The Appropriate Cause of Action for Suit when the Patient's Right to Autonomy has been Violated*], 49 HAPARKLIT 181 (5767)). In our case, the Appellants chose the path of the tort of negligence, and they focused their arguments before the District Court on that tort. I will therefore devote the following discussion to it.

*The Nature and Scope of the Duty of Disclosure*

16. What is the scope of the information that a physician must disclose to a patient in the context of the duty of disclosure imposed on him as aforesaid, and what is the standard for delimiting the scope of this duty?

First and foremost, as noted above, we find an answer to this question in sec. 13(b) of the Patient's Rights Law, which states:

> (B) In order to obtain informed consent, the clinician shall provide the patient *medical information* to a reasonable extent, so as to enable the patient to decide whether to agree to the treatment proposed. For this purpose, "medical information" includes:
>
> > (1) The diagnosis of the patient's medical condition and its prognosis;
> > (2) A description of the essence, course, goal, anticipated benefit, and likelihood of success of the treatment proposed;
> > (3) The risks entailed in the proposed treatment, including side effects, pain, and discomfort;
> > (4) The likelihood of success and the risks of alternative forms of treatment, and of nontreatment;

> (5) Where the treatment is innovatory, the patient shall be so informed (emphasis added – Y.W.).

This provision is relevant to our case because it has been held on more than one occasion that "the standard of conduct established by the law constitutes an indication of the level of conduct in the tort of negligence … therefore, breach of the duty of disclosure under the Patient's Rights Law can constitute an indication of deviation from the level of disclosure required as part of the tort of negligence" (*Kadosh* case, para. 22 and references there; See also: Yaakov, pp. 626-627); And the reverse is true (see: YISRAEL GILADI, DINEI NIZIKIN – GVULOT HA'AHRAYUT [TORT LAW – THE LIMITS OF RESPONSIBILITY] 522-532 (2012)).

17. This Court's extensive case law shows that, in the past, the test for determining the scope of the duty of disclosure that a physician owes his patient was the "test of *the reasonable physician*", similar to the test that generally applies to evaluating conduct or omission by a physician toward his patient. In other words, the question of whether a physician was negligent in refraining from disclosing certain information to the patient is to be determined according to *customary medical practice* regarding disclosure of that same information. However, over the years, it was decided to reject "the reasonable physician" test, which ignores the patient's needs and desires and was therefore viewed as unnecessarily paternalistic. In its place, it was decided to emphasize the patient's *needs* in particular, and the right to autonomy, and it was thus held that the duty of disclosure includes all the information necessary for *the patient* to be reasonably able to make an informed decision about treatment or a particular medical procedure. Therefore, the test that currently defines the scope of the *duty of disclosure* is "*the reasonable patient* test" (see: CA 3108/91 *Ravi v. Veigal* [6], 511; CA 434/94 *Berman v. Mor Institute for Medical Information, Ltd*. [7], 212-214 (1997); the *Sidi* case, pp. 599-600); CA 8126/07 *Estate of Zvi v. Bikur Holim Hospital* [8], para. 7 of the opinion of Justice E. Rubinstein; AMNON KARMI, BRIUT UMISHPAT [HEALTH AND LAW] 1116 (2nd ed., 2013); Niv-Yaguda, p. 194).

18. In passing, I note that in the *Kadosh* case, Justice Y. Amit proposed to modify slightly the customary test regarding the duty of disclosure, and to evaluate it according to the reasonable patient test in the circumstances of the specific patient *as he is seen in the eyes of the reasonable physician*, as he noted: "According to the proposed test, the physician owes a duty to disclose to the patient information that the physician knows or should know will be grasped as important by

a reasonable person in the patient's position … in order to make an intelligent decision regarding the proposed treatment" (see: *ibid.*, paras. 50-51 of his opinion). I also think that there is a logical-conceptual challenge in imposing liability upon a physician on grounds of negligence – which in principle evaluates the conduct of the *physician* according to an objective test – without evaluating his own conduct at all (in addition to the standard that relates to the needs of the *patient*). In any event, the test proposed by Justice Y. Amit was not adopted by this Court, and the established test for evaluating the scope of the duty of disclosure remains "the reasonable patient".

19. Much ink has been spilled discussing the nature and scope of what *the reasonable patient* needs to know in order to give informed consent. In this context, we can find many, varied opinions in this Court's case law – some expanding the duty of disclosure and some limiting its scope.

Thus, it has been held that informed consent requires a verbal exchange between the physician and the patient (see: CA 1997/10 *Tsoref v. Rosenbaum* [9], para. 8); that a physician does not fulfill the duty of disclosure just by having the patient sign a standard form consenting to medical treatment that does not include a detailed explanation that fulfills the required duty of disclosure (see: the *Daaka* case, p. 549; and *cf*: CA 10306/08 *Shmueli v. Mor Institute for Medical Information, Ltd*. [10], para. 18; and that this duty exists even when the patient is generally aware of the possible risks of a particular kind of medical treatment (see: the *Estate of Zvi* case, para. 10; CA 2600/09 *Maccabi Health Services v. N.S.* [11], para. 8; CA 7416/12 *Meuhedet Health Fund v. A.* [12], para. 8 of the dissenting opinion of Deputy President M. Naor (hereinafter: the *Meuhedet* case)).

It has further been held that the duty of disclosure also includes informing someone of the risks associated with not consenting to the proposed medical procedure (See: the *Meuhedet* case, para. 25), as well as disclosing the diversity of medical schools of thought (see: CA 6936/09 *Yehuda v. Clalit Health Services* [13]), and various clinical alternatives (see: CA 2342/09 *N.G. v. Clalit Health Services* [14], para. 6); and also that the scope of the duty of disclosure expands in cases of innovative, non-urgent (elective) treatment performed in the private system (see: *Stendhal* case, pp. 15-16); CA 1615/11 *Ein Tal Clinic – Ophthalmology Center v. Finkelstein (Albalah)* [15], para. 8); and also where the patient in question had in the past used private health services, thus demonstrating having the means to undergo treatment that requires monetary payment (see: the *Sidi* case, p. 605). Furthermore, it has been held that the duty of disclosure includes providing

information about various screening and diagnostic tests – including their overall benefits and their limitations (this matter was left undecided in the *Berman* case – see *ibid.*, pp. 218-220; and was decided in the *Sidi* case – see *ibid.*, p. 603).

20. In addition, it has been held that the duty of disclosure does not mean "flooding" the patient with endless treatment alternatives and remote and minor risks that might result from the medical treatment he faces. Instead, it has been held that the scope of the duty of disclosure should be limited to *actual* risks that are substantial and relevant under the circumstances, and for which there is a *medical* indication for their disclosure to the individual patient – balancing the nature of the medical treatment, its necessity and its potential benefit with the probability of its expected risks (see: the *Stendhal* case, p. 758; CA 718/06 *Satkhi v. State of Israel* [16], para. 13; CA 7756/07 *Gerstel v. Dan* [17], para. 22; CA 8693/08 *Herman v. Sternberg* [18], para. 24; the *Meuhedet* case, paras. 21-22).

In that context, it was held, *inter alia*, that once a patient is informed of a necessary course of treatment or test, the physician is not required to repeat himself and try to persuade the patient to undergo it (See: CA 119/05 *Halifa v. State of Israel* [19], para. 36). Moreover, the scope of the duty of disclosure is more limited when we are concerned with a patient who has previously undergone the medical procedure in question, and is thus aware of its nature and implications (see: the *Herman* case), as well as when the information is a matter of public knowledge (see: the *Meuhedet* case, para. 35).

It has further been held that the duty of disclosure is more limited in regard to screening and diagnostic tests where there is no concrete medical indication of their necessity, when such tests are not precise or unequivocal (see: the *Gerstel* case, para. 25).

21. It is also important to note, as background to the discussion on the merits, that in general, we should take care not to expand the duty of disclosure excessively and risk leading to "defensive medicine" – a phenomenon in which "in the area of informed consent … is expressed in providing information to patients and making a comprehensive investment in a large-scale process of informed consent whose cost outweighs the benefits inherent in such a process. That cannot be justified by medical discretion or the good of the patient, but rather derives from physicians' fears of legal liability" (see: NILI KARKO-EYAL, DOCTRINAT HAHASKAMA MIDAAT B'HOK ZCHUYOT

HAḤOLE 5756-1996, IN ḤOK ZCHUYOT HAḤOLE [THE DOCTRINE OF INFORMED CONSENT IN THE PATIENT'S RIGHTS LAW 5756-1996] 151 (2008) (*hereinafter*: KARKO-EYAL, THE DOCTRINE OF INFORMED CONSENT)). Exposing patients to excessively extensive information can make it hard for them to make a balanced decision, based on meaningful, relevant considerations. Similarly, endless expansion of the scope of the duty of disclosure risks imposing too heavy a burden on physicians, and in any event can make it hard for them to provide efficient and sufficient treatment to all their patients (See: the *Satkhi* case; the *Gerstel* case; the *Meuhedet* case, para. 21; the *Sidi* case, p. 602; the *Kadosh* case, para. 27 of Justice Y. Amit's opinion; ADI AZAR AND ILANA NURENBURG, RASHLANUT REFUIT [MEDICAL MALPRACTICE] 251 (2nd ed., 2000); KARKO-EYAL, THE DOCTRINE OF INFORMED CONSENT, pp. 151-153; Yaakov, pp. 649-654; *cf*: GILAD, pp. 654-656).

*The Duty to Provide Religious Information or Medical Information Adapted to the Patient's Religious Characteristics*

22. In light of the above, I will now evaluate the first question at the focus of the current appeal, which is essentially divided into two sub-questions: *First*, within the framework of the duty of disclosure, is the physician required to disclose *religious information* to a patient regarding requirements and restrictions deriving from religious faith or law that are relevant to the medical treatment? *Second*, is a physician required to provide a patient with *medical information* adapted to such requirements and laws?

It should be noted that similar questions have arisen on more than one occasion in trial-court decisions, which have overwhelmingly found that medical advice and treatment should not be adapted to religious characteristics (see: CC (Jerusalem District Court) 19055-12-13 *Abu Dahesh v. Clalit Health Services* [24], para. 33); CC (Haifa District Court) 195060-07-14 *R.A.B. v. Clalit Health Services* [25]. para. 20); *cf*: CC (Tel Aviv District Court) 39999-05-13 *P.A. v. Rafaelov* [26], paras. 16-17; CC (Haifa District Court) 16010-02-16 *A.P. v. Odeh* [27], paras. 49-55).

I will already state that I also believe that a physician is not required to provide religious information to a patient, or adapt the medical information provided to a particular patient to that patient's religious restrictions. However, in cases in which the patient asks, at his own initiative and explicitly, to adapt the *medical information* to the religious limitations that he communicates to the physician, then and only then is the physician required to do so in accordance with the reasonableness tests that apply to the duty of disclosure.

## *A. The Obligation to Provide* ***Religious Information*** *Relevant to the Medical Treatment*

23. The starting point for the legal discussion of any issue, including the issue of the scope of the duty of disclosure, is the law. Indeed, as noted above, sec. 13(b) of the Patient's Rights Law establishes that the duty of disclosure for informed consent includes only the duty to provide *medical information* regarding the patient's condition, the characteristics of the proposed treatment, chances and risks deriving from such treatment, and only that (see: para. 16, above; also see: KARKO-EYAL, THE DOCTRINE OF INFORMED CONSENT, pp. 339-341; *cf*: Yaakov, p. 657).

Furthermore, a review of the case law regarding the scope of the duty of disclosure in the context of medical malpractice, as described above, indicates that even according to expansive views of the scope of the duty of disclosure, there is no doubt that the duty relates to *medical information*, and to information of this type alone, and does not include a duty to provide religious information.

24. The relevant statutory provisions and the case law thus show that the duty of disclosure imposed on physicians extends to *medical* information *alone*, and does not include religious information concerning restrictions or obligations of religious faith.

25. Furthermore, I believe that this conclusion is also consistent with the *purpose* of the duty of disclosure, given the *professional* advantage the physician has over the patient, and because of the confines of the physician's role. As noted above, the duty of disclosure imposed on physicians derives, *inter alia*, from the inherent gap in the physician-patient relationship concerning issues *of medicine* (see para. 14 above and the references there). However, for every other issue, including issues of religious faith, a physician, as a physician, has no advantage over the patient in terms of

information or expertise, and it is also not the physician's role to advise patients on issues that deviate from the area of medicine. In general, patients go to a physician to obtain medical information, to a member of the clergy to obtain religious information, to a psychologist to receive mental health treatment, and to an accountant for financial advice. Accordingly, the duty of disclosure imposed on each is limited to his or her areas of expertise and profession. Thus, the duty of disclosure imposed on a physician is also limited to *medical* information – the information that *the reasonable patient* expects to get from a physician.

26. Justice Y. Amit's comments in the *Meuhedet* case are interesting in this context. There he addressed the difficulty of relying on *medical* advice given by a *member of the clergy*:

> "Does one heed the words of the rabbi or the words of the physician?"[1] In dealing with issues that are unequivocally medical, the question would appear to be rhetorical … even the rabbi, as learned in the Bible and religious law as he may be, is not a physician … someone who goes to a rabbi to get advice-guidance-recommendation regarding issues unequivocally within a profession such as … medicine should know that the rabbi's words are not on the purely professional plane, and they are mixed with considerations of faith and religious law (see: *ibid.*, para. 58).

Justice N. Sohlberg added that "it is appropriate to remember and note the words of Abtalion in Ethics of the Fathers: 'Sages, be careful with your words …' (Mishna, Avot 1:11), and in any event, also – rabbis with your advice" (see: *ibid.*, para. 9 of his opinion).

These words, and their inversion, reinforce my above conclusion that physicians do not have a duty to advise their patients regarding religious obligations and restrictions, and that it is also not their role to do so, even when advice of this kind is relevant to the medical treatment. It would also seem preferable, in general, for medical issues to be the responsibility of physicians, and for religious issues to be left to those conversant in them.

### *B. The Duty to Provide **Medical Information** Adapted to the Patient's Religious Restrictions*

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[1] Ed: The quote is a paraphrase of a Talmudic question, "Does one heed the words of the rabbi or the words of the student?" (see, e.g., TB Bava Kama 56a).

27. We have therefore arrived at the conclusion that a physician is not obligated to provide a patient with *religious* information relevant to the medical treatment. The next question we should address is whether, in the framework of the duty of disclosure, the physician is required to disclose to a patient *medical* information about treatment options that are adapted to the patient's religious restrictions.

28. I will not conceal the fact that, at first glance, the case before us may give rise to a liberal-moral intuition in favor of ruling that the duty of disclosure imposed on physicians also includes a duty to disclose *medical information* adapted to each patient's religious restrictions. That is because, in the case before us, it is argued that the patient's "Muslim appearance" was apparent, and had the medical information been adapted to her obvious religious restrictions, she would have been able to make an intelligent decision regarding continuing or terminating the pregnancy before 120 days had elapsed from its inception. However, as I will clarify below, once we take into consideration the perspective of tort law, the overall ramifications of such a ruling, and the good of the patients, this initial moral intuition may quickly change.

29. Thus, in my opinion, even though we are dealing with *medical* information, it would be inappropriate to expand the scope of the duty of disclosure only in order to adapt the medical information to the patient's religious characteristics when there is no *medical* indication for such disclosure. I say this even though it is clear that the patient's informed decision naturally also comprises considerations deriving from his religion and beliefs (see: CA 355/11 *Hadassah Medical Organization v. Meuhedet Clinic* [20], para. 32; Niv-Yaguda, p. 194).

30. I would first note that adapting medical information to religious characteristics involves a certain subjectification of the *reasonable patient* test. However, this kind of subjectification appears to be inconsistent with the essence of the tort of negligence – which is generally evaluated using *objective* standards of reasonableness.

Similarly, I believe that there are policy considerations that make it problematic to expand the duty of disclosure to one adapted to religious characteristics as noted above, because adapting medical information to the individual patient's religious characteristics requires investing substantial effort, thought and time, and would therefore make the duty of disclosure significantly more expensive – expenses that would ultimately be passed on to those needing medical treatment.

Additionally, there is a real difficulty in evaluating the tort liability of a physician using a retrospective, subjective test, because such a test is based almost entirely on the testimony of the patient *in retrospect* regarding his preferences and personal needs *at the time of the alleged breach of the duty of disclosure*, even though he is unequivocally a party interested in the results of the proceeding. Imposing a burdensome duty of disclosure like this on physicians, while granting patients a structural advantage in the framework of determining liability, as noted, risks creating excessive deterrence which, at the end of the day, would have a boomerang effect on the entire community of patients (see: para. 21, *ibid.*, and also see: the *Sidi* case, p. 602; the *Kadosh* case, para. 48A; Azar & Nurenberg, pp. 237-238; KARKO-EYAL, THE DOCTRINE OF INFORMED CONSENT, 367-369; Yaakov, pp. 665-666; Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J.L. & MED. 429, 443–445 (2006).

31. Additionally, refraining from imposing such a duty also derives from the structural difficulty of assuming, as a point of departure, that a physician knows the religious characteristics relevant to the individual patient. As will be explained below, disclosing such information – not in response to a request by the patient – may lead to many mishaps, infringe the patient's privacy and autonomy, and even harm the medical treatment itself. In this context, we might think of two possibilities for the physician to initiate disclosing such information: the first, through *questioning* the patient about his religious beliefs; the second, through *an initial assumption* that the patient belongs to a particular religious group.

(1) *Questioning the Patient about Religious Beliefs*

32. In my opinion, questioning the patient about issues of faith and religion risks infringing the privacy of the patient and the patient's right to freedom of religion and freedom from religion. Thus, for example, asking a question about the religious characteristics of a patient who comes for prenatal care risks putting her in a problematic situation regarding the physician and perhaps even regarding herself. In that context, the question might expose the said patient to an ethical or religious conflict that may never have arisen had the physician not asked the patient about her beliefs or the extent of her devotion (see: the *Abu Dahesh* case, *ibid*; the *R.A.B.* case, *ibid*; the *P.A.* case, para. 17; and *cf*: Niv-Yaguda, p. 205).

(2) *Initial Assumption about the Patient's Religious Beliefs*

33. Indeed, just as it is inappropriate to *question* the patient about matters of faith and religion, it is certainly inappropriate to make an *assumption* about a particular patient's individual religious characteristics, and accordingly adapt the medical information provided in the framework of the duty of disclosure. The reason is not just that an assumption of this type is unequivocally paternalistic, but it also risks leading to medical treatment *that does not correspond* to the patient's true will and needs. Thus, for example, if a physician assumes that a patient who appears to be religious is not interested in undergoing tests that might justify terminating a pregnancy, he might refrain from providing that patient with medical information about tests of this kind, even though she might indeed be interested in undergoing them. Under these circumstances, it is clear that refraining from disclosing information about relevant medical tests would seriously infringe the patient's autonomy and her right to decide independently whether to continue the pregnancy.

34. An illustrative example is the case heard by the State of Tennessee's Court of Appeals in *Piper v. Cumberland Med. Ctr.*[29]. That decision addressed the case of a woman whose husband went to the hospital for medical treatment, and his medical file mistakenly listed him as a member of the Jehovah's Witnesses, who generally avoid blood transfusions. Because of that documentation, the medical staff refrained from performing critical treatments that would have required him to undergo blood transfusions and he died. While the lawsuit was denied for procedural reasons, and the appeal of the judgment was also denied, the case testifies to the serious ramifications that can result from a physician making an assumption about a patient's religious beliefs.

35. We may therefore further note that there are many religions and beliefs, and even within them there are various and diverse ideological movements, opinions and approaches as numerous as the sands of the seashore. Furthermore, not everyone who belongs to a particular religion or movement feels bound by all of its obligations and restrictions. Given what was written above, I think it would be inappropriate for a physician to assume that a woman who lives in a Muslim neighborhood would undoubtedly see herself bound by the entirety of Islam's commandments; would think that a Jewish patient wearing a yarmulke is necessarily religious, traditional, ultra-Orthodox or a member of a particular Hasidic sect, where sometimes each of the above may hold

a different position regarding the medical treatment at hand; or would conclude that a woman coming to him for medical treatment wearing a cross around her neck, necessarily adheres to a strict Christian approach prohibiting termination of a pregnancy (*see*: the *Abu Dahesh* case, *ibid.*; and *cf*: CA 1326/07 Hammer v. Amit, paras. 52-53).

36. In conclusion, a physician is not required to adapt the *medical information* provided in the context of the duty to disclose to his patients' religious beliefs and restrictions if those arise in the context of *an inquiry initiated* by the physician or flow from *an assumption* based on external characteristics that appear to indicate the patient's religion.

37. In this context, it is worth emphasizing that sometimes a patient's failure to inform the physician of his religious beliefs or to initiate a conversation on the subject does not necessarily indicate a lack of information, but rather a conscious choice *not* to discuss subjects of this kind with the physician. *This conscious decision should be respected*, and thus it is inappropriate for a physician to initiate a discussion of a patient's individual religious beliefs, undermining the patient's wish to avoid doing so (see and compare: CC (Tel Aviv District Court) 5691-12-08 *M.N. v. State of Israel – Ministry of Health* [28].

*The Patient's Request to Receive Adapted Medical Information*

38. Having said that, when a patient asks a physician, *at his own initiative*, to receive *medical* information adapted to his religious beliefs – *then and only then* would the physician be required to disclose information of this type to that patient (see: the *R.A.B*. case, *ibid.*). That is because when a patient makes a request of his physician, at his own initiative, the question changes the standard relationship between the physician and the patient and creates a different standard of disclosure, based on the patient's expectation of receiving medical information conforming to his request from the physician. In such a case, in response to the patient's questions, the physician has a duty to disclose all the individual information that is relevant, commensurate with that request, in accordance with the test of reasonableness and the rest of the tests of the tort of negligence.

39. Therefore, if the patient wishes to receive *medical* information *adapted* to his religious characteristics – that is, a right to a disclosure that *deviates* from the customary disclosure – then he is the one who bears the *burden* of asking the physician, at his initiative, for medical information

adapted as noted (See: Karmi, pp. 1179-1181; and *cf*: Niv-Yaguda, pp. 203-204; similarly, on the nature of the *burden* as a requirement of any conduct "for the purpose of obtaining or continuing to obtain a legal advantage", and on the distinction between burden and duty, see: Gad Tedeschi, *Hanetel Uba'ayat Ha'ones Vihasikul* [*The Burden and the Problem of Coercion and Frustration*], 16 MISHPATIM 335, 335-337 and 339-340 (5746)).

40. And note: Even when a patient asks his physician for information adapted to his individual religious characteristics, which are communicated directly by the patient, the physician is not obligated to disclose *religious* information to him, but rather *medical* information adapted as noted. That is because *religious* information is completely outside the area of the physician's expertise. Therefore, in his role as physician, it has no place in the framework of the duty of disclosure.

*On the Subjectification of the Duty of Disclosure in U.S. Law*

41. Before we apply the aforementioned to the case at hand, I will dedicate a few words to the position of American law on the issue before us.

In American law, each and every state has discretion to determine the standard for a physician's duty of disclosure, and in general one can divide the customary standards on the issue into three groups. In some of the states, the duty of disclosure is evaluated in light of customary medical practice and commensurate with the scope and nature of the information that *a reasonable physician* would disclose to his patients. In some states, the duty of disclosure is evaluated according to the standard of *the reasonable patient*, similar to the test used in Israel. A few states have established a truly subjective test that defines the scope of the duty of disclosure by reference to the wishes and needs of a particular, individual patient. It is indeed true, as noted, that the subjective test has been rejected in the law of most American states, but many states have internalized certain subjective characteristics even within the objective test, such that *the reasonable patient* is evaluated as if he is standing in *the shoes* of *the individual patient* (see: William J. McNichols, *Informed Consent Liability in a "Material Information" Jurisdiction: What Does the Future Portend?*, 48 OKLA. L. REV. 711, 716–717 (1995); Elysa Gordon,

*Multiculturalism in Medical Decisionmaking: The Notion of Informed Waiver*, 23 FORDHAM URB. L.J. 1321, 1335–1336 (1996); and see also: King & Moulton, p. 445).

42. One of the leading cases concerning the test of *the reasonable patient* is the D.C. Circuit's decision in *Canterbury v. Spence* [30], which held, *inter alia*, as follows:

> In our view, the patient's right of self-decision shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by *the patient's need*, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: *all risks potentially affecting the decision must be unmasked* (emphasis added—Y.W.).

It was further held that shaping the duty of disclosure to the individual needs of each and every patient risks imposing an unduly heavy burden on physicians and is inconsistent with the nature of the tort of negligence, which is generally evaluated through objective standards of reasonableness. Therefore, it was held that physicians are required to disclose to their patients the information that the reasonable person in the patient's position would need in order to make an informed, intelligent decision commensurate with the information that the physician knows or should know about the patient before him (see *ibid.*, p. 787; similar to the test proposed by Justice Y. Amit in the *Kadosh* case, as cited above in paragraph 18):

> From these considerations we derive the breadth of the disclosure of risks legally to be required. The scope of the standard is not subjective as to either the physician or the patient; it remains *objective* with due regard for the patient's informational needs and with suitable leeway for the physician's situation. In broad outline, we agree that "*[a] risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy*" (emphasis added – Y.W.).

43. In order for the physician to adapt the relevant information to the patient before him – whether according to the subjective test or according to the test of the reasonable person in the patient's position – he must, of course, know his patient. Thus, American law also recognizes the physician's duty to question his patients (Duty to Inquire) (see: Robert Gatter, *Informed Consent Law and the Forgotten Duty of Physician Inquiry*, 31 LOY. U. CHI. L.J. 557, 567 (2000)). However, this duty is limited to questions regarding *medical* information related to the patient, as Gatter explained in writing:

> The majority of courts require a physician to ascertain only a patient's medical condition, proposed treatment, or sometimes both, in order to adequately determine what must be disclosed to that patient. Accordingly, the law generally permits physicians to remain ignorant of a patient's non-medical characteristics despite the relevance of those characteristics in providing useful treatment information to each patient. So, for example, under the majority approach, a physician may disclose the same information to every patient with colon cancer even if one patient's primary goal is to participate in his daughter's wedding rather than to maximize his chances for a cure. The physician is permitted to assume that the patient's goal is to maximize his chances of cure, and, therefore, the physician satisfies the duty of disclosure without explaining the likelihood that any of the patient's treatment choices will achieve the patient's goal"(*ibid.*, p. 568; emphasis added—Y.W.).

44. The scope of the duty of *inquiry* described above inherently affects the duty of *disclosure* that follows such inquiry. Thus, American courts have held more than once that a physician is not required to adapt the medical information he discloses to a patient to individual *non-medical* characteristics. That is due to the fact that, from the outset, he is not required to ask about such information in the framework of the inquiry and questioning of the patient (see: *ibid.*, pp. 558-559 and 568-574; and compare with the Alabama Supreme Court decision in *Fain v. Smith* [31].

45. It is also interesting to note that one can indeed find a number of decisions in which U.S. courts also recognized the physician's duty to disclose to his patient information adapted to his non-medical characteristics or needs. However, these decisions – most or all of them – dealt with

situations in which the physician *in fact knew* about his patient's unique non-medical characteristics, and despite that knowledge, refrained from giving them expression in the context of disclosing the relevant information. As Professor Gatter wrote in the article cited above:

> These cases… hold that, in determining what treatment information to disclose to a patient, a physician must account for every patient characteristic about which *the physician has actual knowledge* regardless of whether the physician was required to have discovered those characteristics. Accordingly, these cases *do not redefine the scope of the physician's duty to discover, or even inquire about, non-medical characteristics of patients* (*ibid*., p. 577; emphasis added — Y.W.).

46. We thus learn that, according to U.S. law, the duty of disclosure does not generally imply a duty to question the patient about individual, non-medical characteristics and needs, inquire about them, or assume their existence based on various external factors. Accordingly, the dominant American approach is that the duty of disclosure does not include adapting the medical information provided to individual, non-medical characteristics, as noted, unless the physician *actually* knows about such characteristics, desires or preferences.

*From the General to the Specific*

47. We will now return to the case before us. Applying all of the above to the circumstances of the case at hand leads to the conclusion that all the Appellants' arguments regarding breach of the duty of disclosure should be rejected.

*First*, Professor Zlotogora did not breach the duty of disclosure by not informing the Appellants of the 120-day limit, because it is *religious information* that is not part of the duty of disclosure (see: paras. 23-26 *ibid.*).

*Second*, Dr. Zakrian, as well, did not breach his duty of disclosure by not providing the Appellants with medical information *adapted* to the 120-day limit, which is the information regarding the possibility of undergoing a FISH test. That is because the Appellants did not ask Dr. Zakrian to disclose information that would allow them to make a decision about continuing the

pregnancy before 120 days elapsed from conception, and thus we are dealing with a standard physician-patient relationship in which the physician is not required to disclose adapted information, as noted.

Furthermore, as extensively detailed above, since the Appellants did not raise the issue of the 120-day limit with Dr. Zakrian, he was not allowed to ask them, at his own initiative, if they would be interested in medical information that would facilitate a decision about continuing the pregnancy during the 120 days, and it would have been inappropriate for him to assume that the Appellants wanted adapted information, given their Muslim appearance or their place of residence.

48. In this context, I would emphasize that I am not addressing whether it was appropriate at that time (2007) to inform every pregnant woman about the FISH test as an inherent part of the duty to disclose medical information, unrelated to the above-mentioned religious affiliation, as that question did not arise in the opinion of the expert (Dr. Peter Yaakobi) presented by the Appellants, and in any event it was not proven by them. In essence, an examination of Dr. Yaakobi's opinion shows that he did not claim that there was a *medical* indication that required informing the Appellants about the possibility of performing a FISH test, but rather relied only on the existence of a religious indication which, as noted above, does not create a duty of disclosure.

*The Duty of Disclosure in light of the Stern Precedent*

49. What is left, therefore, is to address the last question that this appeal raises: Should this Court's judgment in the *Stern* case be applied to this case? As noted, the Appellants argue in this regard that even if it were to be held that the duty of disclosure, *per se*, does not include disclosing religious information or medical information adapted to religious restrictions or preferences, it should still be held that in this case, because Prof. Zlotogora customarily informed his Muslim patients about the 120-day limit, and Dr. Zakrian customarily informed all his patients about the possibility of undergoing a FISH test, their conduct should be evaluated according to a higher-than-usual standard, pursuant to the *Stern* rule.

50. The judgment in the *Stern* case held that once a medical institution adopts practices and procedures that are more meticulous than the customary, reasonable practice, then it has shown

that it has the information and data necessary to operate more strictly and cautiously. Thus, it was held that the standard of reasonable behavior that *this institution* is required to meet should be "elevated", essentially by *attributing* the *specific* medical institution's unique knowledge and expertise to the test of *the reasonable* medical institution, according to which the conduct of the said institution would be evaluated.

51. At the outset, I will note that despite the logic of the *Stern* rule, it is not immune to criticism. That is because, *inter alia*, the subjectification that it introduces to the standard of reasonable conduct does not, in general, appropriately comport with the objective standards of the tort of negligence, and even risks "punishing" physicians who operate with extra caution, thus creating a negative incentive to adopt innovative practices or skills (see and compare: GILAD, pp. 494-495; RESTATEMENT (THIRD) OF TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM, § 12, Comment a). I will add that, in my opinion, that precedent may actually be relevant for the rules of reliance, and not the tort of negligence.

In any event, I think that it would be inappropriate to apply the *Stern* rule to our case, as I will explain.

52. *First*, as noted above, the crux of the *Stern* rule is raising the standard of conduct required of the reasonable physician or medical institution because of the special knowledge or skill and greater caution of a specific physician or medical institution. However, as noted, the duty of disclosure is evaluated from the viewpoint of *the reasonable patient*, and not according to the test of *the reasonable physician*. In any event, it would appear to be inappropriate to evaluate the unique skill and conduct of a *specific physician* (including a specific medical institution) in the context of the discussion of the duty of disclosure.

*Second*, and this is the main point, I believe that the *Stern* rule does not lead to the conclusion that a physician who customarily provides his patients religious information or medical information adapted to their individual religious characteristics is negligent in refraining to do so in a given case, and that is for reasons of legal policy, which I addressed at length above (see: the *Stern* case, p. 955; see also the comment of Justice E. Rubinstein in CA 5604/94 *Hemed v. State of Israel* [22], 518-519) (dissenting, joined by Justice J. Turkel)). Thus, including religious information or medical information adapted to individual religious characteristics in the context of the duty of disclosure (not in response to the patient's request) is not only outside the physician's

expertise and professional area, but it also raises, as noted above, significant difficulties. Therefore, it is clear that it would be inappropriate to perpetuate such a practice through the *Stern* rule, and to make it a binding standard of conduct.

53. In light of the above, I believe that the District Court was correct in ruling that it would be inappropriate to raise the standard of conduct required of Prof. Zlotogora and Dr. Zakrian to the point of obligating them to disclose information to patients about restrictions based in religion, or medical information adapted to individual religious characteristics, just because of their alleged custom of doing so.

*Result*

54. Given the result I have reached, there is no need to rule on the Appellants' argument regarding Prof. Zlotogora's inadequate medical notes, because even if they were to prove that he refrained from informing them about the 120-day limit, there would be no flaw in doing so, and perhaps the opposite is true.

55. Finally, we should also reject the Appellants' claim that the amniocentesis was performed at too late a stage, and therefore its findings were received after 120 days had elapsed from conception. By that, the Appellants argue medical malpractice by omission, and therefore the relevant test for evaluating their arguments is the test of the reasonable physician in the circumstances of the case. In that context, the customary medical practice is of great significance (see: AZAR & NURENBERG, pp. 320-321; GILAD, pp. 503-504). However, the Appellants did not prove that it was customary practice at the relevant time to perform an amniocentesis at an earlier stage. I will also note that the expert opinion submitted on their behalf stated that amniocentesis results are generally received "within 2-3 weeks, *as in the case in question*" (see *ibid.*, p. 6; emphasis added — Y.W.). It is worth adding that the Appellant was informed of the importance of an amniocentesis as early as the first stages of the pregnancy, and despite that fact, she did not communicate to the medical staff any desire to hurry and undergo it as soon as possible. The District Court therefore correctly held that there is no basis for ruling that the Respondents should have "urged the plaintiff to undergo the necessary tests, primary among them the amniocentesis,

in order to remain within the religious restrictions, when she herself did not express any desire or request related to that issue" (see para. 46 of the judgment).

*Afterward*

56. After writing the above, I received the opinion of my colleague, Justice N. Hendel. In that opinion, he argues, *inter alia*, that there are situations in which a physician should provide his patients with *religious* information that he possesses (see para. 2 of his opinion; emphasis added – Y.W.). I cannot agree.

I cannot deny that my colleague's words are touching, and relate to that same moral-liberal intuition that I addressed in para. 28 above. However, despite this initial intuition, as I explained in detail above, I believe that not only is disclosing *religious* information not part of a physician's duty *in his role as physician*, but also that disclosing such information is completely outside the bounds of his role and expertise, and he should avoid doing so (see para. 25 above).

57. This also hold true, in my opinion, for the examples brought by my colleague in his opinion. Thus, I am of the opinion that it is inappropriate for a physician to inform a patient about the stage at which she is permitted to terminate a pregnancy according to the dictates of her religion, even if she informed him that she is a devout Muslim. That is both because, as noted, a physician's job does not include providing religious information, and also because the fact that a particular patient is Muslim does not in any way indicate the specific theological tradition to which she adheres, her level of devotion, or the views of the specific religious leader on whom she relies. As explained extensively above, assumptions of this kind – that "paint" all Muslim patients, or all Christian or Jewish patients with a uniform religious "color" – are inappropriate, and even risk creating substantial mishaps (see paras. 33-37 above).

58. I would also say in regard to my colleague's second examples that the determination that a physician would do well to inform a patient of the possibility of talking to rabbis or other religious officials whose opinions may differ from those of the patient's rabbi, or would do well to talk to the rabbi advising the patient, clearly deviates from the role of the physician, and might be interpreted as offending the patient's sensibilities.

*Conclusion*

59. In light of the all the above, I propose to my colleagues that we deny the appeal without issuing an order for costs.

**Justice D. Mintz:**

I concur with the detailed opinion of my colleague Justice Willner. I will only add a small contribution of my own regarding providing "religious information" to a patient.

1. In my view, the attending physician should completely avoid providing "religious information" or medical information adapted to the patient's religious characteristics, unless asked to do so. The reason, and perhaps the only reason, is the physician's lack of knowledge regarding those same religious characteristics, which unquestionably deviate from his professional, medical expertise. That is true even if the physician has acquired some degree of broad knowledge of religious law as a result of his clinical experience over time. In our case, the Appellants believe that the physician should know the Muslim law regarding the period in which a pregnancy may be terminated. It is possible that every gynecologist knows this kind of information, but it is also possible, and even probable, that it is not the case. However, even if the information is indeed common among gynecologists, the range of religious-law questions concerning medicine in the various religions is so broad that it would be inappropriate to expect physicians, whose area of expertise is medicine, to possess it.

2. If only as the briefest example of the range of questions that arise at the interface between Jewish religious law and the various fields of medicine, one can point to the numerous articles on halakha published in the journal TEHUMIN—an annual devoted to the areas of Torah, Society and State. This journal contains articles in the field of medical ethics; gynecology, obstetrics and fertility; paternity and maternity; illnesses, geriatrics and disabilities; transplants; medical devices and para-medical roles, and more (see, e.g., in the field of gynecology, on the narrow question before us regarding terminating a pregnancy: Rabbi Moshe Feinstein, *Hapala Malachutit Linachrit* [*Termination of Pregnancy for a Gentile*], 5 TEHUMIN 64; Rabbi Dr. Aharon Lichtenstein, *Hapalot Malachutiot – Hebetei Halacha* [*Termination of Pregnancy – The Halakhic View*], 21 TEHUMIN

93; Rabbi Abraham Stav, *Keitzad Livatzea Hapala Malachutit* [*How to Terminate a Pregnancy*], 29 TEHUMIN 352; Rabbi Abraham Stav, *Shlavim B'herayon L'inyan Isur Hapala* [*Stages of Pregnancy in regard to the Prohibition upon Termination*], 31 TEHUMIN 53; Rabbi Moshe Tsuriel, *Hapalat Ubar She'uvchena Etzlo Mahala Kasha* [*Aborting a Fetus Diagnosed with a Serious Illness*], 25 TEHUMIN 64; Rabbi Yoel and Dr. Hana Katan, *Ubar Pagum – Ivchun Mukdam Um'niyat Herayon* [*A Fetal Defect– Early Diagnosis and Contraception*], 21 TEHUMIN 107; Rabbi Nahum Elazar Rabinovitch, *Zihui Hitpatchut Shel Valad B'emtzaut Ultra-Sound* [*Identifying the Development of the Fetus by Ultrasound*], 30 TEHUMIN 120; also see articles published on the website of Herzog College – Daat Jewish Studies and Humanities – Asia – Jewish Law and Medicine: www.daat.ac.il/he-il/refua and the Halakhic Medical Encyclopedia – Schlesinger Institute: www.medethics.org.il/articles-main, and there are many more).

3. It is therefore impossible to require a physician to provide any "religious information" related to the patient's religious characteristics. To paraphrase the Court's words in CA 7416/12 *Meuhedet Health Clinic v. A.* [12], which my colleague cited, just as the patient should look to the physician for his answers on matters of medicine, if he so wishes, the patient should look to a religious-law expert of his religion for answers on matters of religious law, if he so wishes.

**Justice N. Hendel:**

I concur with the main elements of the comprehensive opinion of my colleague Justice Y. Willner. Precisely because of the matters of principle raised by the issue, I will briefly address four comments, regarding which this is not the appropriate occasion or framework to expand.

1. Religion and medicine. There are various aspects to the tension that has developed between the two. Here, we examine the scientific perspective, or to be more precise, the providing of religious information in the context of medical treatment. My colleague Justice Willner explained why a physician must provide medical information and not religious information, even if the latter may be relevant. As noted, I agree with her. To be sure, in order to understand the issue we must present the character and scope of the physician's duty to provide medical information to the patient.

The scope of the duty of disclosure that a physician owes his patient is evaluated by reference to the question of whether the patient received all the information that a person reasonably needs to decide intelligently whether to consent to the treatment offered (and see CA 1303/09 *Kadosh v. Bikur Holim Hospital* [4], paras. 2-3 of Deputy President E. Rivlin's opinion (hereinafter: the *Kadosh* case); CA 4960/04 *Sidi v. General Federation Medical Fund* [3], 599-600). This test is called "the reasonable patient" test. But the name of the test can be misleading. The welcome innovation in the name of the test is meant to clarify that the emphasis is on the patient rather than the physician. However, the test does not replace the physician with the patient, but rather the reasonable physician versus the reasonable patient. That is a different move.

The test of the reasonable physician appears to be appropriate for evaluating the conduct of the physician. The test places an emphasis on the physician and his duty to act according to the standard of reasonableness that is at the heart of the element of negligent conduct as found in the negligence provision – para. 35 of the Civil Wrongs Ordinance [New Version]. The patient is the one who benefits from setting standards that may be strict for the physician. The latter must exercise a duty of care toward the former. The problem with the test of the reasonable physician is that the patient may find himself outside of the equation, even if that is not the intention. Such an approach does not comport with modern conceptions in medicine, including medical ethics. According to these conceptions, the patient is not a passive victim of his condition. The case law correctly rejected the paternalistic approach to the patient (and see: the *Kadosh* case, paras. 10-11 of Deputy President E. Rivlin's opinion). As I will immediately explain, "the reasonable patient" does not provide a real response to these modern conceptions. Reasonableness is not required of the patient in the way it is required of the physician – we are not dealing with the patient's duty, but rather with the patient's rights.

It is in this context that the information gap between the physician and the patient arises. The former is the expert, and the latter is the layperson. But because the patient has a right to dignity and autonomy, he must be given the possibility to choose (on the interwoven relationship of human dignity, individual autonomy and freedom of choice from the point of view of Jewish law, as well, see CA 9936/07 *Ben David v. Entebbi* [23], para. 12 of my opinion). The Patient's Rights Law, 5756-1996 (hereinafter: the Law) was intended to recognize the status of the patient in the treatment he receives. The focus is on para. 13 of the Law, which establishes: "In order to obtain informed consent, the clinician shall supply the patient medical information *to a reasonable*

*extent*, such as to enable the patient to decide whether to agree to the treatment proposed […]" (emphasis added – N.H.). Note that the requirement is for informed consent. That is a very complex issue. The patient cannot become an expert during the course of his treatment, but his lack of knowledge does not nullify his right to choose, which includes certain kinds of information. In that sense, the physician is not just the expert in the treatment but also the patient's advisor. According to the text of the law, as well, the reasonableness must be found in the information provided the patient. In this sense, it would be more accurate to call the test, "the reasonable information test" and not "the reasonable patient test". Of course, the question of what constitutes the reasonable information that should be given to the patient is one that is also based on policy considerations. The boundaries in either direction are important. However, in my view, the test emphasizes the *information* that is provided to the patient, and not just the patient's expectations. The reason is that the patient's expectation, before he receives information from the physician, can be misleading, because he has no idea what to expect. The purpose of the aforementioned para. 13 is to create informed consent – meaning a voluntary, independent choice (and see: para. 13(c)). That is the goal, and that is the condition for providing medical treatment. Reasonableness is, therefore, expressed in the information provided to the patient – both the content of the information, as well as the way it is transmitted.

Emphasizing the rules for providing information would appear to help in deciding hard cases. Of course, the name is not what determines the substance. The physician must act reasonably. There is no such requirement of the patient in the context of medical malpractice cases. The patient's conduct may have ramifications for determining the scope of the physician's liability, but that is not the focus. In contrast, the duty to provide the patient with the necessary information, reasonably, is imposed on the physician, and it derives from the patient's right to know, to choose and to consent in an informed manner.

2. The distinction between providing *medical* as opposed to *religious* information is an appropriate distinction from the point of view of legal policy considerations, which my colleague Justice Willner addressed. The physician is not a religious official, and he is not expected to know the ins and outs of the various religious laws, and to inform his patients about them. I will not deny that in certain cases, the physician presenting religious positions is unwelcome and may even be harmful. Just as partial information in medicine may confuse, that is also true of religious information. However, in examining the issue, there may be situations in which, in my view, the

physician would do well to provide his patients with religious information that he possesses, even indirectly, and I say that without establishing an obligation to do so.

I will give two examples, but there are more. The goal is not to impose new obligations on the physician, but rather to create a dialogue. Just as legal realism made its home in the legal world, such is also the case for medical realism. Refraining from imposing a legal obligation on the physician to act in a certain way is not the same thing as prohibiting acting in that way. Take for example a situation in which a patient informs a physician that she is a devout Muslim. The physician is well aware that, in general, according to her religion, a pregnancy cannot be terminated after 120 days from conception have elapsed. At the beginning of the pregnancy, the physician recommends performing a certain test that can reveal various syndromes in the fetus, which may lead the patient to decide that she wants to terminate the pregnancy. The patient, in response to the physician's recommendation, says that she is interested in these tests, but she will do them at a later stage of the pregnancy, for example five months into it. Only then will she consider the options at her disposal, commensurate with her religion. In such a case, is the physician obligated to remain silent, without mentioning that he knows that according to the patient's religion, terminating the pregnancy would not be permissible at that stage? I think the answer is likely to be no. Note well: The intention is not for the physician to provide the patient with recommendations on issues of her faith. The only meaning of this comment is that when a physician is well aware of certain religious information that is relevant to a patient according to the patient's declaration, the physician can recommend that the patient talk to an appropriate religious figure, to the extent that the issue constitutes a consideration for the patient. That should be done while emphasizing that the physician is not an expert in the field. Doing so can allow the patient to make an intelligent decision and prevent irreparable future harm. I would emphasize that this is not professional advice, and the physician should offer the appropriate caveats. But in some situations, we should not rule out providing information as noted, even if there is no obligation to do so. Doing so may even have benefits.

I will present another example. Let us assume that a physician believes that there is an essential, even life-saving, operation for a particular patient, but the patient makes it clear that he does not want to undergo the treatment because he spoke with a religious official, a rabbi, for example, who told him that the treatment is not necessary for his health, and that he will recover without it. Notice that in this example, the religious official takes a medical position, and the

patient accords it weight because of the official's spiritual role. In order to illustrate the example, we will add a description. A thirty-year old man was bitten by a dog, and it becomes apparent that the dog was rabid. The physician expresses the vital need to receive a vaccination quickly. The patient informs the physician that he consulted with his rabbi, who told him that there is no need for it, he should not receive the vaccination, and no danger awaits him. Again, without creating obligations for the physician, he would seem to do well to explain to the patient again that the treatment is essential, and even tell him that there is a possibility of talking with additional rabbis. In the appropriate circumstances, he might even offer to talk to the rabbi himself, if necessary. It should be clear that I am not making a determination about the appropriate course of action in this example, which is not theoretical, but I think that having the physician remain detached from any statement related to the religious element is not necessarily the best approach. It also does not reflect the needs of medical realism, and it may be contrary to the D.N.A. of a devoted physician.

These examples were not presented in order to rule on them, but rather to present the reality with which physicians must grapple, multi-faceted as it is. These are ethical issues that should be recognized. The general rule is as my colleague Justice Willner presented. It is the job of the physician to provide *medical* information and not *religious* information. The duty of a physician is to provide the first kind of information. However, in my view, reality is not always binary – not everything is a question of obligation or nothing. The argument about the difficulty of setting boundaries for the religious information that the physician provides requires great thought and caution, but on the other hand, it need not completely negate the possibility of seeking the appropriate balance. We should not forget that the slippery-slope argument can itself be a kind of slippery slope. It is therefore important to enrich the discourse and allow the physician a margin of discretion in dealing with his complex role, both from a medical and a human perspective.

3. This comment concerns the precedent set in CA 3056/99 *Stern v. Haim Sheba Medical Center* [1] (hereinafter also: the *Stern* rule). That case held that when a medical institution adopts an advanced medical practice, the law may hold that institution to a higher standard of caution, even if it is not required of other medical institutions. Similar to the approach of my colleague Justice Willner, I believe that it would be inappropriate to apply that precedent to the case at hand. In my opinion, that is primarily because the rule addresses situations in which a hospital chose an advanced medical practice, whereas informing a patient about religious restrictions does not address an issue of medicine. In other words, we are not dealing with an "advanced" practice.

Having said that, I would make two comments on the issue. My colleague noted that the *Stern* rule treats of the test of the reasonable physician, while the duty of disclosure is evaluated from the point of view of the reasonable patient. As noted, I think that the emphasis should be on reasonable information. In any event, as far as I understand, the *Stern* rule relates to the standard of conduct expected of an institution that has adopted an advanced practice, whether the standard is evaluated according to the test of the reasonable physician or according to the test of the reasonable patient. That is to say that for purposes of applying the *Stern* rule, we should not distinguish between negligence in breaching the duty of disclosure and negligence in the actual medical treatment. An additional question is why should there be a distinction between a physician and an institution in applying the *Stern* rule when the advanced standard is adopted consistently and continuously. In other words, it is appropriate to ask whether it is proper to differentiate between the logic that applies to a medical institution and the logic that applies to a specific physician. However, given that this question would not change the final outcome, I will leave it undecided.

4. I read the opinion of Justice D. Mintz, and without disagreeing with him, I would clarify the following point. My colleague concluded by saying that in matters of medicine, one hears the physician, and in matters of religion, one hears the religious arbiter or rabbi. However, according to Jewish law, even this issue is not necessarily characterized by perfect order that divides the decisions neatly into different, hermetically separated drawers – a drawer for the rabbi and a drawer for the physician. Take, for example, the important religious commandment about saving a life. Maimonides, who was himself a physician, expressed it well in his religious ruling regarding the laws of the Sabbath:

> Like all the other commandments, the Sabbath is overridden by danger to life. Hence, we execute all of the needs of an ill person in mortal danger *according to the word of an expert physician in that place* on the Sabbath. When there is a doubt whether there is a need to desecrate the Sabbath for him or there is not a need, and likewise if [one] physician said to desecrate the Sabbath for him but another physician said he does not need [it], we desecrate the Sabbath. For [even] a doubt about [danger to] life overrides the Sabbath (Maimonides, Mishneh Torah, Sabbath 2:1; emphasis added).

And later:

> When these things are done […] scholars and sages of Israel are to perform them […] One must not put off the desecration of the Sabbath in treating a seriously ill patient, as it is written: "If a man obeys them he shall live by them" (Leviticus 18:5) (*ibid.*, 2:3).

Therefore, according to Maimonides, the physician is the one who decides whether or not the issue is life-threatening, which allows overriding the Sabbath, and the religious actor must follow his instructions. Thus, Maimonides does not place the physician completely outside the sphere of Jewish law. This rule expresses a holistic view of the role of the physician, who is first and foremost committed to determine the patient's medical condition in order to preserve the sanctity of his life.

This and more will await at the appropriate opportunity.

Decided in accordance with the opinion of Justice Y. Willner.

Given this day, 5 Av 5789 (August 6, 2019)