The Ethics Board
Rules and Position Papers

Prepared by:
Dr. Tami Karni, 2018
Prof Avinoam Reches 2009, 2014
The Ethics Board

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Editing and proof reading:
Sefi Shefer

Design and production:
Studio log®

First edition 2009
Second edition (revised) 2014
Third edition (revised) 2018
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For the convenience of the reader the Code is written in the masculine gender but applies equally to women and men.
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Forward

Dr. Yoram Blachar
The ethical code of physicians and our profession, medicine, has from ancient times been anchored in the Hippocratic and other oaths sworn by young medical practitioners before commencing the unique practice of medicine. Maimonides' oath, and the oath of the Israeli physician, composed by Prof Halperin, are additional examples.

The ethical code constitutes a social covenant, one of the important foundations of society. On the one hand, society places its trust in its physicians that they will devote their capabilities, knowledge, and information to the benefit of individuals, while on the other hand the physician undertakes to observe the ethical code formulated by his professional colleagues. In accordance with this code, he devotes his professionalism and know-how for the benefit of his patient, whose good prevails over any other consideration.

This patient-physician relationship lies at the foundation of the health system and is based mainly on the ethical code. One of the most important products of the World Medical Association (WMA) in this area is the Geneva Declaration, on the subject of medical ethics. This Declaration, listing the fundamentals of medical ethical conduct, was formulated and adopted by the WMA in 1947, immediately after World War II, and concurrent to the shocking revelation of the events that occurred during that war. Incidentally, one of the founders of the WMA was the Israeli Medical Association.

Another example is the Helsinki Declaration, which was adopted in 1962 at the general assembly of the WMA in Helsinki, after a number of years of debate and formulation. This Declaration, constituting one of the mainstays of the medical code of ethics, addresses the ethical fundamentals of experimentation on humans, yet another reaction to the horrifying activities of the Nazi doctors who conducted such experiments.

The Helsinki Declaration constitutes an excellent example of the dynamic nature that must characterize the formulation of rules of ethics in a changing and developing world. Since its creation, the Helsinki Declaration has undergone five long and complex stages of amendment, in order to match its practical features to the development of medical research, including sociological changes and understanding of the consequences of experiments on humans on the good and future of the subjects of the research.

In recent years we are witness to far reaching changes in the relationship between the patient and the physician. The growing emphasis on the patient is characteristic of and parallels the development of society. The availability of medical information by means of the electronic and mass media, including television, has become a significant factor in the creation of patients' expectations of optimal treatment results. Claims for compensation are submitted with insufferable ease against a background of alleged medical negligence, where any unsatisfactory result of treatment is identified with neglect and negligence. There are economic pressures on the system and, by extension, on the individual physician. These and others have become significant factors in the changing physician-patient relationship.

It is a fact that no country is capable of supplying from its public budgets all that developing and advanced medicine can offer the patient. A health system that operates under economic constraints tests the implementation of the ethical code. At the same time, laws and rules enter the equation, such as the right to health, which enjoys a legal defense and is regarded as
a fundamental social right.

This right frequently finds itself between opposing forces when faced with society’s limited capacity to finance it. In addition, there are social consequences related to the individual's right to receive medical services at the expense of numerous other individuals who have the same fundamental right. This principle lies at the heart of the most difficult dilemma relating to the update of the basket of drugs and technologies, namely the recognition of the right of a small group to receive treatment over the right of a much greater public to preventative medicine designated to prevent illnesses and ailments.

Another major subject of increasing importance is the extended lifetime of patients suffering from chronic illnesses, and that of very old patients, resulting from the improvement and development of medicine.

Consequently, medical ethics is subject to constant debate with the progress of technology and in light of precedents and exceptional cases that arise as a result of the improvement of methods and means of treatment. Discussion of the principles and rules of medical ethics is therefore most fruitful in those countries with developed, advanced medicine, such as the State of Israel.

The Israeli Medical Association acts through its Ethics Board to assimilate the ethical code within the medical profession by all possible means, including promoting education and awareness of proper ethical conduct amongst physicians in Israel. This is achieved both by means of discussion and approval of decisions, rules and position papers on ethical subjects, and by means of public activities intended to influence the views of the public and legislation in subjects related to the status of physicians and medicine in Israel within the ethical context.

In addition, the Ethics Board regularly examines ethical complaints against physicians or against associations and societies, and it does not hesitate to bring to ethical trial physicians who have contravened the ethical code.

In light of the considerable importance that the Israeli Medical Association attaches to observance of the ethical code, and in the light of the extensive work conducted by the Ethics Board, led by Prof. Avinoam Reches, in recent years, it was decided to update the ethical code by means of a special committee set up for this purpose. The impressive, comprehensive, and important document formulated by the committee includes the numerous changes and developments that have taken place in recent years in the field of medical ethics, the fruit of the devoted work of the Ethics Board of the Israeli Medical Association.

I should like first and foremost to thank Prof Avinoam Reches, the chairman of the Ethics Board, who headed the committee for updating the medical ethical code, for his devoted and professional work, his considerable efforts, and his leading this very complex and sensitive process, resulting in a real masterpiece.

I should also like to thank the members of the committee for their considerable contribution to the formulation of this document, during long, spirited and deep debates, and for devoting many hours of their time, energy, and thoughts, and to all those who aided the work of the committee.

The media has an important and significant part to play in our ethical code and its development.
The medical ethical debate crosses boundaries and is encouraged by the media, which regards the public nature of the debate as a social-political agenda. The media discussions addressing various ethical issues are not the private concern of those engaging in the medical profession, but rather issues of common interest to the general public.

The Israeli Medical Association believes that only by means of encouraging the ethical debate and placing medical issues on the public agenda, can the public bring itself to understand the general and broader ethical issues reflecting the strength and openness of the modern technological society. By thrashing out these issues, the physician can harness technology to the needs of his patients and use it sensibly, while the patient enjoys more advanced and empathetic medical services.

We expect that every physician in the State of Israel will assimilate the ethical criteria presented in the updated ethical code, that this code will aid the physician in his current work and that its contents will form an integral part of the study program of medical students.

In addition we hope that other practitioners and medical functions apart from physicians, as well as the broader public, including patients, will become aware of the contents of the updated ethical code. We hope that this code, through a dynamic and constant process of updating and matching it to legal reality, will improve the relations of trust between the medical teams and the patients and will lead to continual improvement of the quality of medical service.

Dr. Yoram Blachar  
outgoing IMA president  
(1995-2009)

Dr. Leonid Eidelman  
incoming IMA president  
(2009)
Since the publication of an updated IMA Code of Ethics in 2009, a great deal has changed, both societally and professionally. Looking ahead to the 43rd national conference, we thought it proper to update the Code once again to include new and revised rules that the Board of Ethics has recently been working to formulate. The Code of Ethics comprises the basis for medical activity at all levels and in all medical fields, from the exciting moment when new medical students first enter the clinical departments, through retirement and beyond, so long as those bound by their medical oath are engaged in the practice of medicine. During those 40 or 50 years, day after day, the ethical challenges confronting the physician are many, and the Code of Ethics is meant to serve as their Guide for the Perplexed.

At the last IMA national convention we decided to include on the Board of Ethics all physicians who expressed a desire to serve as members and contribute their time, experience and worldview to furthering the ethical rules and adapting them to our ever more rapidly changing reality. The collective mosaic of physicians in Israel is large and diverse. Specialization is on the rise, with an increasing distance between one physician and another in terms of their areas of interest and daily practice, but the common denominator remains broad and steadfast, with the Code of Ethics as the shared foundation.

Generally speaking, deliberations about ethics typically proceed in the absence of one absolute truth, and precisely for that reason, there is no substitute for a set of rules determined by practitioners of the profession. Undoubtedly in the future the need will again arise to deliberate about the ethical rules and update them to accord with new developments and new challenges.

In the international arena, the World Medical Association also deemed it proper to update the physician’s oath, known today as the Declaration of Geneva. The current version, intended to address the demands of today, was approved at the organization’s General Assembly in 2017, around the 70th anniversary of the original Declaration of Geneva. Israeli physicians comprise an inseparable part of the international medical community and must continue to maintain an ethical position to be proud of.

Issues concerning relations between the doctor and the patient, between one physician and another, and between the doctor and society will arise and demand the attention of the Board of Ethics in the future, as they have done very acutely in the past, provoking lively public discussion. Israeli physicians have proven time and again the level of their ethical concern, which surpasses mere adherence to the law.

I would like to thank the members of the Board of Ethics for their contribution to advancing the Code of Ethics, and most notably to Dr. Tami Karni, Chair of the Board, for her commitment and dedication in leading the Board and in everything involved with a subject of such importance.

Prof. Leonid Eidelman, IMA President 2009–2018
Part A
Introduction
Why do we need medical ethics?

For centuries, physicians have enjoyed a considerable degree of professional autonomy and clinical freedom, through recognition of the fact that only in this way, when they are free from outside pressure, can they make the correct and proper medical decisions for the benefit of their patients.

This is the source of the obligation on the medical community to impose strict self-supervision of its members’ professional and ethical conduct. This conduct is expected to comply with the highest possible standards.

The medical ethical code allows for such supervision. The ethical code was formulated by physicians for physicians, in order to ensure that all members of the medical community will act, first and foremost, for the good of the patient and will, in this way, retain the public’s trust in its physicians.

The medical ethical code, based on the fundamental values of the organization, is intended to supplement the legal code, the regulations, and the instructions specified by the State and its regulatory functions. This legal framework provides the standard of proper conduct demanded from every physician, while the ethical code specifies a still higher standard. The ethical code derives its strength from the entire medical community, that sets its stamp on the rulings of the ethical code and takes upon itself to observe them, and thus permits the condemnation of specific conduct of a physician, even if the law does not prohibit his or her actions.

The ethical code formulates the physicians’ obligations vis-a-vis their patients, society, their professional colleagues and those entities with whom the Israeli Medical Association maintains reciprocal professional relations.

The ethical rules of the Israeli Medical Association are contained in a declaratory document known as the ethical code. The ethical code expresses the fundamental values, norms, and professional standards that form the agreement of physicians who are members of the organization, and their social and professional vision. The ethical code defines and styles the professional culture and identity of the physicians vis-a-vis society and other professionals. The ethical code guides physicians regarding proper conduct that maintains the fundamental values of the profession, its honor, and its status in society.

An organization with an actively implemented ethical code is regarded by the public as a respectable one, awarded a great deal of trust. Consequently, members of the organization, the physicians, are given social permission to continue to conduct their affairs independently, while government intervention in the organization’s affairs is reduced accordingly. Without doubt a respectable organization receives broad support from the public even when it demands professional rights for its members.

Medical ethics are dynamic and thus the ethical code is a dynamic document that must constantly address the changing reality in which physicians work. The dramatic changes that have taken place in medicine in recent decades, both in Israel and abroad, obligate the redefinition of the physician’s status and function in modern society.

Economic market conditions, the unbounded supply of medical information, and the
unprecedented involvement of the media and the courts have redefined the traditional link between the physician and the patient. The ethical code of the physicians must also change and reflect the positions of the physicians and their status in this new reality. The ethical code specifies and demarcates “the new professionalism” of the physicians while constantly seeking the required balance between conflicting values.

The new medical culture has turned the patient into a partner in determination of his or her medical treatment. This status also implies obligations, but the Patient’s Rights Law has defined the patient’s rights without defining corresponding restrictions on his behavior. Although it is not proper that we set ethical rules for patients, we wish to express to them our opinion and our expectations.

First and foremost, we believe that it is proper that the patient should cooperate with the physician with mutual integrity, transparency, respect and trust, and that he should be fair and honest in his relations with the physician and not conceal any medical information. It is proper that the patient should actively participate with the physician in responsibility and commitment for his medical condition, while observing the treatment program as agreed with his physician.

If the patient deviates from the treatment program, he should bring this to the physician’s notice. In a reality of advanced technology, it is important that the patient should be aware of the existence of limited resources, the limitations of the professional capability of medicine and of the physician, and of the fact that the physician cannot be expected to provide treatment that conflicts with his professional position, his conscience, or his personal belief.

A proper relationship between the physician and the patient obligates the patient not to act with verbal or physical violence towards the physician and the medical staff, and that to take steps to prevent such violence on the part of members of his family or of any other person. In addition, it is vital that the patient not be involved, in any way whatsoever, in acts of fraud or offences related to his relationship with the physician, or infringement of the medical ethical code, and shall not attempt to entice the physician to perpetrate such offences. In addition, it is obvious that the patient must avoid putting the health of others at risk.

If patients are wise enough to act in accordance with these rules, we believe that better cooperation will be achieved between the physician and the patient, which is also likely to improve the quality of the medical treatment.

The ethical code of the Israeli Medical Association was last written at the beginning of the 1990s by Dr. Ram Yishai, and has not been revised since the 38th conference of the Israeli Medical Association, held in 1995. Therefore, an urgent need has arisen to update the ethical code and match it to current needs.

The writing of the ethical code for the physicians is a complex and tense process. The writing reflects the natural and proper internal tension existing between the various poles of a large and variegated organization such as the Israeli Medical Association. The wording obligates reaching, with mutual agreement, the points of fine balance and equilibrium of the ethical code, behind which all members of the organization can stand.

I had the rare distinction to lead this sensitive process and to bring it to a successful ending. Thanks are due to Dr. Yoram Blachar, President of the Israeli Medical Association, and to
Advocate Leah Wapner, Secretary-General of the Israeli Medical Association, and to Advocate Malke Borow, the head of the legal department, for the unreserved backing and support in the work of the committee for updating the ethical code.

Thanks are due to members of the committee for the many hours of in-depth discussion, for their sense and advice, which brought this document to its current form, and especially to Advocates Adva Perry-Avishai and Gili Shilat, the committee's legal advisors, whose professional help was invaluable.

Special thanks are due to the members of the Ethics Board who helped to thrash out the ethical issues facing the physicians, and who at the end of sharp debate, with great patience and mutual agreement, formulated the position papers that constitute the framework on which this ethical code is constructed.

In the name of members of the Ethics Board and the committee for updating the ethical code, and in my own name, I wish to express the hope and wish that this ethical code will in fact serve as a guide for our colleagues, the physicians. Only if we are all wise enough to observe these rules will we be able to continue to preserve our independent status in society and our continued capability to grant uncompromising medical treatment to those who need our professional help.

**Prof Avinoam Reches**  
Chairman of the Ethics Board  
2009–2014
Why update the Code of Medical Ethics?

Medical ethics, like medicine itself, develops intermittently. Sometimes it occurs because we acquire new knowledge, and sometimes because we encounter new dilemmas that are not resolved by existing guidelines.

During the last four years, the Board of Ethics has deliberated on dozens of subjects; for some, a resolution was found in the Code, while for others the Board of Ethics deemed it proper to formulate new position papers.

In 2014, around the time that the previous version of the Ethical Code was published, Israeli physicians encountered a dilemma involving force feeding of prisoners and detainees engaged in a hunger strike. We are bound by the code of ethics of the WMA and hence our position was clear. I am proud of the impressive achievements of the physicians who treated the hunger strikers cared for in hospitals all over Israel. No hunger striker was force fed, and they all survived the strike. The doctors were subjected to social and political pressures, as the IMA appealed legislation on the matter to the High Court of Justice, and they did not give in. The doctors preserved the social order and maintained their traditional role to stand by every human being in need of their care. The doctors left the work of policing, incarcerating and adjudicating to those who perform those functions in our society. The Chair of the IMA and I watched closely as these events unfolded, stood by the physicians in the field, and were available to address any question at any time, which enabled us to resolve many problems as they were occurring.

New dilemmas came before the Board of Ethics: Remote medical treatment, which changes from day to day with technical advances in digital media; advances in genetics and their application to the needs of treatment and prognosis; the question of medical confidentiality and the boundaries of responsibility for its preservation in the context of cyber threats.

Medical research with mega data gathered from medical records ushers in a host of dilemmas about obtaining patients’ agreement to the use of their personal information for research versus the social need to find a cure.

Many of the dilemmas that arose remained without resolution, but the process of thinking about them, understanding them and defining the problems was in itself important.

The Declaration of Geneva, which has functioned as a kind of “Constitution,” was revised in October 2017 by the World Medical Association (the Chair of the IMA sits on its executive committee, and the IMA participated in the WMA working group that formulated the revised version). The Board members ratified the revised Declaration, and translated it into Hebrew. Our updated Code includes Prof. Halpern’s Oath for the Physician, written for the first cohort of physicians in Jerusalem, along with the WMA Declaration in English and in Hebrew.

The key change in the Declaration of Geneva addresses the physician’s duty to preserve his or her health and welfare, enabling him or her to provide care for more patients. The new code also contains a revised version of the physician’s obligation of mutual respect for colleagues, including students.

Ethical rules were added in accordance with the new position papers, and prior position papers were reviewed and re-evaluated for suitable adaptation.
I hope that more physicians will take an interest in the discourse of medical ethics, and that this volume will continue to serve as a guide for doctors in diagnosis and treatment as well as in their many administrative roles in medicine.

Dr. Tami Karni
Chair, IMA Board of Ethics
2014-2018
Part B
The Declaration of Geneva and the Physician’s Oath
WMA Declaration of Geneva
Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948
and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968
and the 35th World Medical Assembly, Venice, Italy, October 1983
and the 46th WMA General Assembly, Stockholm, Sweden, September 1994
and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005
and the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006
and amended by the 68th WMA General Assembly, Chicago, United States, October 2017
14th October 2017

The Physician’s Pledge
AS A MEMBER OF THE MEDICAL PROFESSION:
I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;
THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;
I WILL RESPECT the autonomy and dignity of my patient;
I WILL MAINTAIN the utmost respect for human life;
I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;
I WILL RESPECT the secrets that are confided in me, even after the patient has died;
I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;
I WILL FOSTER the honour and noble traditions of the medical profession;
I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;
I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;
I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard;
I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;
I MAKE THESE PROMISES solemnly, freely and upon my honour.
The Oath of the Hebrew Physician
18.04.2018

Medical cadets
You stand today before your teachers in the ways of medicine and its principles to take the medical oath and to fulfill the covenant to the best of your ability and judgement for the purpose of establishing a generation of physicians instilled with the desire to act and the belief in its mission to provide relief to those in pain.
And this is the covenant which I contract with you today:

- You will fulfill your duty day and night to stand by the sick in their distress at any time and at any hour.
- And fully serve human life from its emergence from the mother’s womb and the welfare of humans will unceasingly be your ultimate consideration.
- And you will aid the sick irrespective of whether they are converts or gentiles or citizens, whether they are ignominious or respected.
- And you will have the wisdom to understand the soul of the sick, to lift their spirits with perspicacity and love of man.
- Do not hasten to pass judgement and weigh your decisions on the scales of unqualified wisdom and experience.
- Be loyal to those who put their trust in you, do not disclose their secrets and do not spread what you know to others.
- Act to serve the health and welfare of the public and to alleviate the distress of the people.
- Honor and respect your teachers who guided you in the knowledge of medicine
- Seek wisdom and do not desist for it is your life and from it shall flow the outcomes of life.
- Heed the dignity of your friends for in honoring them you will be honored.

You will cherish the words of this covenant in your mind and in your heart and follow them and all answer Amen.

Amen thus we shall do.
We hope your endeavors will glorify the heritage of medicine.
Prof. L. Halpern, 1912, Jerusalem
The fundamental values of medical ethics

Patient autonomy
Autonomy means that the patient is fully entitled to make decisions, freely and independently, regarding the medical treatment given to him, and the granting of permission and informed consent prior to the commencement of his medical treatment. Such consent must be based on full medical information given to the patient by the physician with honesty, transparency, and in a reasonable and balanced manner. Autonomy also includes the patient’s right to reject or refuse the proposals of his physicians without their enforcing their opinion on him. Respect for the patient’s independence means preserving his dignity as a person, and strict observance of his privacy and medical confidentiality. The physician shall honor these rights and shall act together with the patient in accordance with them.

Non-maleficence
Non-maleficence means that the patient’s safety and health are a supreme value in medicine, and physicians shall act in order to avoid causing harm to the patient, neither deliberately nor by means of acts or omissions. The obligation to avoid maleficence to the patient also means that the physician has the know-how and qualifications required for execution of the medical treatment. From this we also derive the duty imposed on the physician for constant learning and training, in order to maintain the proper degree of professionalism.

Beneficence
Beneficence means that the physician will act for the good of the patient and will make every effort to prevent, reduce, or remove any existing harm to the patient’s health. The physician shall in all cases consider the balance of benefit and harm expected in the proposed medical treatment and its suitability for the patient, and shall choose the way offering the greatest possible benefit for that patient.

Distributive justice
Distributive justice in medicine means social justice, through granting equal access to all to the means of medical diagnosis and treatment, including fair distribution of limited medical resources and prevention of discrimination for any reason whatsoever. Social justice means that the physician must consider the needs of the entire society for limited medical resources, when coming to choose medical treatment for an individual patient.
Part C

General obligations of the physician
1. The physician shall place the patient's good above all other considerations.

2. The physician shall act to the best of his or her ability in order to preserve and improve the physical and mental health of the patient in particular and of society in general.

3. The physician shall act in order to heal the patient, to alleviate his suffering, to prevent him contracting illnesses and to minimize their harm, all while employing professional and updated medical treatment and with an attitude of compassion and preservation of the dignity of the patient and his rights.

4. The physician shall act at all times justly, fairly, and equally towards his or her patients and shall avoid discrimination for any reason whatsoever.

5. The physician shall observe the privacy and medical confidentiality of the patient.

6. The physician shall act while observing the human rights of the patient and shall not participate in any activity that violates these rights whatsoever, except in cases in which the good of the patient obligates this.

7. The physician shall not participate in any activity that harms the physical or mental entirety or dignity of any person, including a person kept in an enforced framework, and shall not aid in any way whatsoever torture or degradation.

8. The physician shall preserve the dignity of his or her medical colleagues, the dignity of other medical workers, and shall avoid any acts or omissions, either during or outside his work, that are liable to harm the dignity of the profession.

9. The physician shall strictly observe a proper standard of professional integrity, and shall be fair and honest in all his or her activities and shall also act in order to maintain these values between his professional colleagues.

10. The physician shall act with transparency and shall employ professional and independent judgment, free of alien considerations, and shall avoid personal, economic, or other conflict of interests that s/he may be liable to encounter in the practice of medicine.

11. The physician shall keep up-to-date professionally in both information and skill, from an obligation to medical self-education, and shall act to advance the medical and scientific knowledge of his or her professional colleagues, medical students, and of society in general.

12. The physician shall furnish any medical information with honesty and transparency, based on accepted medical knowledge.

13. The physician shall treat any person needing his or her help, but in certain circumstances, the physician shall be entitled not to treat a specific person, except in emergencies.

14. The physician shall recognize the importance of his or her participation in any activity intended to improve public health and shall act to the best of his or her ability to advance equality in access to medical treatment and fair distribution of medical resources for all of society.
15. The physician shall observe the law and shall act to update it, out of a sense of public responsibility, whenever the good of the patient community obligates this.

16. The physician shall not engage in any occupation unsuitable for the medical profession.

17. The physician shall not engage simultaneously in his or her profession and in some other activity that does not lie in the field of medicine, if this causes a conflict of interest of any kind whatsoever.

18. The physician is personally responsible for his professional practice and for the medical treatment given by him.

19. The physician shall be entitled to act in all fields of diagnosis and treatment, depending on his or her medical experience and capability. The physician shall recognize his or her professional limitations and shall avoid – except in exceptional circumstances – taking medical action that does not lie within the field of his or her medical capability or training.

20. The physician shall be responsible for maintaining his or her personal health. A physician who becomes ill shall request suitable medical aid from another physician.
Part D

The code of medical ethics
List of ethical rules

1. **Physician-patient relations**
   a) Cooperation between the physician and the patient
   b) The right to medical treatment
   c) Prohibition of discrimination
   d) Information regarding the identity of the patient
   e) Privacy of the patient and medical confidentiality
   f) Furnishing medical information to the patient
   g) Informed consent
   h) Administering medical treatment without the patient’s consent
   i) Furnishing information regarding innovative medical technology
   j) Furnishing information to the patient regarding the medical condition of the physician
   k) The right to continue proper medical treatment
   l) Appointment of a representative for the patient
   m) An additional medical opinion for the patient
   n) Medicine and faith in medical treatment
   o) Cognitive enhancement at the patient’s request
   p) Refusal of the physician to provide medical treatment
   q) Commencement and termination of the physician-patient relationship on physician’s initiative
   r) Notice to patients regarding a change of workplace
   s) Mistakes in medical treatment
   t) Prohibition of exploitation
   u) Receipt of gifts and contributions from patients
   v) Issuance of illness certificates
   w) Certificates of fitness issued by a physician
   x) Prohibition of lying for the benefit of the patient
   y) Use of generic drugs
   z) Receipt of payments in private treatment

2. **Physician-society relations**
   a) Inequality in medicine
   b) Prohibition of physician participation in interrogations and torture
   c) Prohibition of physician participation in solitary confinement in prisons
   d) Shackling prisoners and detainees in hospitals
   e) Prohibition of feeding a prisoner conducting a hunger strike
   f) The health of migrant workers
   g) The guarantee of medical and health services during the Israeli-Palestinian armed conflict
   h) Chemical sterilization of pedophiles
   i) Cooperation between the physician and law authorities
j) Treatment of minors  
k) Treatment of vulnerable populations  
l) Addressing a passerby whom the physician perceives to be ill  
m) Exclusion of women  
n) Artificial feeding of a patient in a permanent vegetative condition  
o) Trading in tissues and organs and the donation of organs  
p) Transplanting organs from persons sentenced to death  
q) The physician in the medical committee  
r) A physician acting on behalf of his employer  
s) Medical confidentiality and the physicians’ tax obligations  
t) Participation by medical students in the examination of patients  

u) Transparency regarding the health of national leaders  
v) Medical supervision of drivers  
w) The obligation to treat in a pandemic situation  
x) The obligation to treat in a multi-casualty event  
y) Medical tourism  
z) Imaging tests  
   aa) "Medicine" that is not evidence-based  
   bb) Shutting down medical institutions in response to violence against physicians  
   cc) Use of the title “Professor”  
   dd) Physician classifications

3. **Physician-physician relations**  
   a) Respect for a professional colleague  
   b) Giving medical treatment to a professional colleague  
   c) Teamwork  
   d) Sharing information between practitioners  
   e) Transfer of patients between physicians  
   f) Prohibition of fee splitting  
   g) Transfer of information to a medical team regarding an infectious disease  
   h) A physician who is incompetent from a health standpoint  
   i) Improper conduct  
   j) The prohibition of workplace harassment  
   k) The obligation to report a criminal or disciplinary charge  
   l) The physician’s conduct when changing workplaces  
   m) The obligation to publish the name of a person found guilty in a clarification committee of the Ethics Board
4. **The physician, science, and research**
   a) Medical research on humans – general obligations
   b) The good of the participant in medical research on humans
   c) Conducting medical research on humans
   d) Consent to medical research on humans
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   f) Due diligence – holders of an economic interest in medical research on humans
   g) Use of a placebo in medical research on humans
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   j) Genetic research in large populations
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   l) Ethical rules in a scientific article
   m) Sex selection
   n) Intellectual property

5. **The physician and commercial companies**
   a) Mining of medical data
   b) The connection with commercial companies
   c) Participation in research financed by commercial companies
   d) Participation in a lecture financed by a commercial company
   e) Participation in a consultative committee for a commercial company
   f) Receipt of medical samples
   g) The prohibition to receive gifts from a commercial company
   h) Prohibition of sales and publicity of commercial products

6. **The physician and the legal system**
   a) The physician as an expert witness
   b) A physician shall not act against his patient
   c) Forensic medicine
   d) Recording the examination of a medical expert

7. **The physician and the media**
   a) Furnishing medical information to the general public
   b) Privacy in the media
   c) Telemedicine
   d) Physician publicity and advertising
   e) Prohibition of misleading the patient by means of publicity and advertising
   f) Prohibition of the misleading use of a title in publicity and advertising
   g) Prohibition of harming the public through publicity and advertising
   h) Prohibition of harming the honor of the profession
   i) The physician and social media
   j) Physicians in the media—freedom of speech vs. the dignity of the profession
8. The physician and the medical institution
   a) The salaried physician
   b) Quality measurements for physicians
   c) Responsibility of managers
   d) Whistle blowers
1. Physician-patient relations

a) Cooperation between the physician and the patient
   1. The physician and the patient shall act jointly to create a relationship of mutual trust, and for the success of the medical treatment.

b) The right to receive medical treatment
   1. The physician shall assist any person to exercise his right to receive proper medical treatment in accordance with the arrangements existing in the medical system in Israel.

c) Prohibition of discrimination
   1. The physician shall not discriminate in the provision of medical treatment among patients on the basis of age, sex, origin, nationality, religion, social, personal, or economic status, physical or mental limitations, the viewpoints, belief, or opinions of the patient, or for any other reason.

d) Information regarding the identity of the patient
   1. The physician shall introduce himself clearly to the patient, including his full name, professional title, and medical experience, and shall describe his role during the treatment.

e) Privacy of the patient and medical confidentiality
   1. The physician shall observe the patient’s right to privacy and the confidentiality of his medical details at all stages of the treatment.
   2. The physician shall not furnish the patient’s medical details to any other person, except at the request of or with the express consent of the patient.
   3. The physician shall verify that the patient’s consent to exposure of the information is given after he has understood the meaning of the waiver of medical confidentiality.
   4. The physician shall furnish the patient’s medical details as required by law.
   5. The physician shall furnish the patient’s medical details as required for continuation of the medical treatment by another practitioner. The patient shall be appropriately notified.
   6. The physician shall be entitled to furnish medical information to another person with the approval of the ethics committee of the institution in which he is working, without the knowledge of the patient, if this information is liable to harm the patient.
   7. The physician shall furnish medical information, with the patient’s knowledge, even without his consent, if the information is required for protection of the health of others or of the public. This shall be done with the approval of the ethics committee of the medical institution.
   8. The physician shall be entitled to furnish medical information to the institution giving treatment or to a worker of the institution for the purpose of processing of the information, filing it, or for reporting it by law.
9. The physician shall be entitled to transfer medical information for the purpose of scientific publication, research, or teaching, provided that identifying details of the patient are not revealed.

10. The physician shall only furnish the relevant information required, in a reasonable way and in accordance with the circumstances, and shall avoid a sweeping supply of medical information.

11. The physician shall observe the privacy of the patient and the confidentiality of his medical information even before his professional colleagues, if they are not involved in his treatment.

12. The physician shall avoid looking at a medical record, whether computerized or not, without justification.

13. The physician is not released from the obligation of confidentiality even after the patient’s death.

14. The physician shall avoid discussing, in a public place, a person being treated by him.

15. The physician shall verify the safety of storage of the medical information controlled by him while observing the rules of medical confidentiality.

f) **Furnishing medical information to the patient**

1. The physician shall listen to the patient, and shall respect his autonomy and his right to choose the medical treatment and the method of its execution.

2. The physician shall explain clearly to the patient, in accordance with his ability to understand, his medical condition and the possible means for treatment of his condition. The physician shall verify that his explanations were properly understood by the patient.

3. The physician shall describe to the patient also the means of treatment he needs that are not included in the health basket, even if the physician is barred, for administrative reasons, from offering them to the patient.

4. The physician shall assist the patient in choosing the medical process suitable for him, using his professional knowledge.

5. The physician shall respect the patient’s right to examine and receive, if necessary, a copy of his medical records.

6. The physician shall be entitled not to furnish medical information to the patient, if in his opinion this information is liable to harm the patient. A decision regarding non furnishing of medical information to the patient obligates approval by the ethics committee of the medical institution giving the treatment.

7. The referring physician shall stress the importance of professional assistance and interpretation of all results of the test. It is recommended that the referring physician confirm in advance with the patient whether he wishes to get the results of the specific test directly, and if so this should be noted in the referral.

g) **Informed consent**

1. The physician shall give the patient clear and understandable details regarding
his medical diagnosis and the prognosis of his illness, including the nature of the proposed treatment, the risks, the chances, and the possible side effects. The physician shall present the patient with possible alternative treatments, in order to permit him to take a reasoned decision regarding continuation of the treatment.

2. The physician shall furnish the patient with the medical information at as early a stage as possible so as to permit him the maximum degree of understanding of the information, in order to make a decision that is based on free and independent choice.

3. The physician shall give medical treatment to the patient only after the patient’s informed consent has been received. The informed consent may be given, depending on the circumstances of the medical treatment, by behavior, orally, or in writing.

4. The physician shall receive specific and informed consent in writing, in the event of an operation, treatment, or invasive act, and in any other case obligated by law.

5. The physician shall respect the refusal of the patient to receive medical treatment, provided that the patient is aware of the risks he is assuming.

h) Administering medical treatment without the patient’s consent

1. The physician shall be entitled to administer urgent medical treatment in a medical emergency even without the patient’s consent, if, because of the circumstances, including the patient’s physical or mental condition, it is impossible to obtain his consent for the treatment. In specific cases, the treatment will be given with the approval of three physicians, unless the emergency circumstances do not permit this.

2. The physician shall be entitled to administer specific medical treatments to the patient if the patient’s physical or mental condition prevent him from giving his informed consent for this treatment, if the physician is unaware that the patient or his representative or guardian is opposed to giving this treatment, and if it is impossible to obtain the guardian’s consent to the required treatment.

3. The physician shall be entitled to administer to the patient medical treatment that must be given as soon as possible, contrary to the patient’s wishes, in circumstances of grave danger to his life and with the approval of the ethics committee of the medical institution.
i) **Furnishing information regarding innovative medical technology**

1. The physician shall exercise full transparency in giving patient details of the existing medical technologies relevant to his condition, even if they are not included in the health services basket. The physician shall furnish this information to the patient as soon as possible, in order to permit him to make a reasoned decision regarding his medical treatment.

2. The physician shall exercise full transparency in revealing to the patient his economic interests, or those of the institution providing the treatment, related to a specific innovative medical technology, if any.

3. The physician shall not act as an agent or mediator of a commercial company in the marketing of a new medical technology and shall not receive any consideration from the commercial company because of the very use of a specific medical technology recommended by him, unless he participated in the development of said technology.

j) **Furnishing information to the patient regarding the medical condition of the physician**

1. A physician who is ill is not required to inform the patient of his state of health.

2. A physician who is suffering from an illness liable to endanger the patient shall present himself for examination by a medical committee of physicians specializing in the field of his illness. This committee shall determine, in accordance with professional criteria, whether the physician is capable of continuing to work.

k) **The right to continue proper medical treatment**

1. The physician shall respect the patient’s right to continue medical treatment with another physician or as part of some other medical arrangement.

2. The physician shall respect the patient’s right to receive continuous treatment, with full cooperation from the physicians treating him.

3. The physician shall transfer to the other practitioner, with the patient’s knowledge, all the medical information held by him that is required for continuity of the treatment.

4. A physician replacing a colleague shall take care to transfer to the colleague the required information that he supplied to the patient in his absence, unless the patient objects.

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1. On this matter, see the position paper entitled “New technologies – the Cypher stent as an example”.

2. On this matter, see the position paper entitled “Must a physician inform his patients of his state of health?”
l) **Appointment of a representative for the patient**

The physician shall respect the power of attorney given by the patient to his representative so that the latter will be authorized to make medical decisions regarding the patient’s medical treatment. The power of attorney shall include the circumstances and conditions in which the holder of the power of attorney shall be authorized to decide regarding the medical treatment, instead of the patient.

m) **An additional medical opinion for the patient**

1. The physician shall respect the right of every patient, including a hospitalized patient, to an additional medical opinion.
2. The physician shall direct the patient to another professional, if asked to do so, based on trust in the capability and professional judgment of the other physician.
3. The physician treating the patient shall cooperate with the consultant physician and present him with all the medical information relevant to the patient.
4. The consultant shall properly introduce himself in the hospital to the physician treating the patient, the medical staff, and the patient.
5. The consultant in the hospital shall permit a representative of the staff giving the treatment to be present during examination of the patient.
6. The consultant in the hospital shall present his conclusions in writing to the patient and to the physician treating the patient, for the purpose of continuation of the medical treatment.
7. The physician treating the patient shall be entitled not to accept the conclusions of the consultant. If so, he must explain his reasons to the patient.
8. The consultant may become the physician treating the patient at the request of the patient and with the knowledge of the first physician.

n) **Medicine and faith in medical treatment**

1. The physician shall respect the wishes of the patient to act in accordance with his beliefs in connection with the receipt or non receipt of medical treatment.
2. The physician is not obligated to give medical treatment at the patient’s request, if the treatment conflicts with the physician’s conscience or his professional opinion or with general medical knowledge, even if the request results from the patient’s faith.
3. The physician shall take steps to prevent treatment that is not accepted medical treatment, and that originates in faith, if the said treatment may harm the patient, the other patients, or the medical staff, or if it comes at the expense of resources required for other patients.

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3 On this matter, see the position paper entitled “Rules for determining legal capacity.”
4 On this matter, see the position paper entitled “An additional opinion for a hospitalized patient”.
5 On this matter, see the position paper entitled “Medicine and faith in medical treatment”.

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o) **Cognitive enhancement at the patient’s request**

1. The physician may provide cognitive enhancement to a healthy, competent patient, if there is a benefit and the risk involved is only marginal.

2. The physician shall professionally consider every request for enhancement by a patient with extra caution and only following explicit informed consent.

p) **Refusal of the physician to provide medical treatment**

1. The physician shall be entitled not to give medical treatment at the request of the patient, if the request is contrary to his professional position, his conscience, or his beliefs. In these circumstances the physician shall, as far as possible, direct the patient to another suitable physician.

2. The physician shall object to giving medical treatment enforced on him for administrative or economic reasons, if this treatment is contrary to his professional position or his conscience.

q) **Commencement and termination of the physician-patient relationship on the physician’s initiative**

1. The physician is obligated to give medical treatment to everyone, in any urgent case and in every case of saving life.

2. The physician shall be entitled not to accept a person for treatment, or to terminate the professional connection with a patient, if a crisis of confidence exists that prevents the creation or the continuation of this connection, except in medical emergencies.

3. The physician shall be entitled to terminate the professional connection with the patient if he is exposed to verbal or physical violence on the part of the patient, his family, or anyone acting on his behalf.

4. The physician shall be entitled to terminate the professional connection with the patient, with the knowledge of the medical institution, if the patient does not cooperate with the physician regularly and in a manner endangering his health, or if he presents improper demands to the physician.

5. The physician shall not terminate the professional connection with the patient for any reason constituting discrimination.

6. The physician shall not terminate the medical connection with the patient solely because of the fact that the latter has requested to receive an additional opinion and/or treatment from another physician.

7. The physician shall notify the patient in advance of termination of the professional connection with him, and shall supply an explanation. The physician shall give the
patient a summary of the medical data held by him regarding the patient and shall
direct him, as far as possible, to the treatment of another physician.

8. The physician is obligated to the continuity of the patient’s medical treatment,
even if the professional connection with him has been terminated, and shall
cooperate with any other physician who also participates in the medical treatment
of the patient.

r) **Notice to patients regarding a change of workplace**

1. The physician shall respect the patient’s right to continuity of the medical
treatment and shall consequently inform him in advance of the expected change
to his place of work.

2. A physician employed in a medical institution or organization shall give notice
of the change to his place of work by means of the employer. In the absence of
cooperation on the part of the employer, the physician shall be entitled to give
notice of the change, without persuading the patient to transfer the treatment to
the new workplace.

s) **Mistakes in medical treatment**

1. The physician shall act, to the best of his ability, to preserve the safety of the
patient and to avoid mistakes in his medical treatment.

2. The physician shall take steps to educate his professional environment with the
aim of improving the safety of treatment by means of identification, reduction, and
prevention of mistakes in the provision of medical treatment.

3. The physician shall report to the appropriate professional function any mistakes
that occurred during the medical treatment. The report shall be confidential and
the information shall not be misused against the physician reporting or against
the members of the medical staff who erred.

4. The physician shall respect the right of the patient to receive reliable and full
information regarding the circumstances of the treatment that he received,
including a mistake that occurred during this treatment, if it has an important
influence on the state of the patient’s health or on continuation of his medical
treatment.

5. The physician shall explain to the patient the nature of the mistake made in his
treatment, the steps taken to correct it, and the action taken to prevent recurrence
of a similar mistake in the future.

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9 On this matter, see the position paper entitled “The physician shall be entitled to notify his patients regarding his new place of work”.

10 On this matter, see the position paper entitled “The ethical obligation of the physician to disclose to the patient that a mishap has
occurred in his treatment”.
t) **Prohibition of exploitation**

1. The physician shall not breach the patient’s trust and shall not physically, mentally, or economically exploit him. The patient’s consent shall not limit the physician’s responsibility.

2. The physician shall not, even with consent, conduct sexual relations with any of his patients during the period of the treatment and for at least one year from the end of the treatment. When dealing with a psychiatric patient, the period of the prohibition shall extend for at least three years.

3. The physician shall not receive, directly or indirectly, except if he is a lawful inheritor, an inheritance left to him by a patient who was in a therapeutic relationship with him, unless at least three years have elapsed from the end of the treatment until the date on which the patient left property to the physician. If the aforesaid times have not elapsed and the patient assigned his inheritance, in whole or in part, to the physician, the physician shall renounce the inheritance.

u) **Receipt of gifts and contributions from patients**

1. The physician shall not exploit his status in any way whatsoever in order to influence the patient to give him a gift or donation.

2. The physician shall not make the granting of medical treatment, its results, or its execution by a specific physician, conditional on the receipt of a gift or donation.

3. The physician shall be entitled to receive a gift not in cash from a patient, if this was given with the free will of the patient, if it is symbolic and modest in value and does not put the physician in a conflict of interests of any kind.

4. The physician shall be entitled to receive a donation from a patient, if it was given at the end of the medical treatment, with the free will of the patient, and by means of the medical institution in which the physician is employed, and only if the donation is intended for the advancement of the professional standards of the physician, for improvement of the level of the medical treatment given to patients or for improvement of the working conditions in the clinic or the department.

5. The physician shall not receive a gift in cash or a donation for his personal needs.

v) **Issuance of illness certificates**

1. A physician issuing an illness certificate intended for a non-medical entity shall maintain the confidentiality of the medical information and shall write in it only that “details of the illness are documented in the medical records held by him.”

2. A physician issuing an illness certificate shall observe his professional independence even in the presence of possible pressure on the part of the patient or his family.

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11 On this matter, see the position paper entitled “Sexual relations between the physician and the patient”.
12 On this matter, see the position paper entitled “The acceptance of donations from patients”.
13 On this matter, see the position paper entitled: “Issuance of illness certificates”.
3. A physician issuing an illness certificate shall avoid giving such a certificate retroactively, except in special and justified circumstances.
4. A physician issuing an illness certificate shall avoid giving such a certificate for non-medical reasons.
5. A physician issuing an illness certificate shall not give a certificate to a person for the illness of another person who is not the subject of the certificate.

w) Certificates of fitness issued by a physician

1. In signing a certificate of fitness, the physician is bound by exactly the same responsibility as in treatment of any medical problem brought before him.
2. The physician’s role is solely to grant certificates dealing with medical issues and which require a medical examination and/or a description of the patient’s health. It is not the physician’s role to reinforce declarations by the patient on matters beyond the scope of his or her medical condition.
3. In certifying fitness, the physician must professionally understand what is demanded physically or emotionally of the patient when performing the activity to which the certificate pertains, in order for the patient to take part in that activity.
4. The physician must recognize the limits of his professional knowledge, and refer to a specialist in the field whenever he is not adequately informed about what is required from a medical standpoint to perform the task.
5. The physician may refuse to grant a certificate of fitness for activity not consonant with his or her professional position, conscience or faith.

x) Prohibition of lying for the benefit of the patient

1. The physician shall not deliberately give erroneous or misleading information to any person or entity regarding the medical condition of the patient, or regarding examinations or treatments that he requires, even if this is allegedly done “for the benefit of the patient”.

y) Use of generic drugs

1. The physician shall be entitled to commence treatment with a generic drug as long as it is found to be equal in effectiveness and safety to the corresponding original drug.
2. The physician shall not replace an original drug with a generic drug only for economic considerations of a third party, especially in cases in which the patient is stable with treatment of a drug having a narrow treatment range.
3. The physician shall be entitled to offer a patient, who is stable in treatment with an original drug, use of a generic drug, if he is convinced that this will not harm the patient’s health, and after he has received the patient’s consent.

On this matter, see the position paper entitled “Certificates of fitness issued by a physician”
On this matter, see the position paper entitled “Is it ethical to lie for the benefit of the patient?”
On this matter, see the position paper entitled “Educated use of generic drugs”.
2. Physician-society relations

a) Inequality in medicine  
1. The physician shall act, to the best of his ability, in order to increase the awareness of the decision makers and members of the health professions, regarding the grave consequences – health, economic, and social – of the inequality existing in Israel regarding access to means of diagnosis and medical treatment.
2. The physician shall act, to the best of his ability, to identify and minimize situations of inequality in medicine, especially in regions of the geographic periphery.
3. A physician who fears that the patient’s safety or health are in danger because of the absence of access to medical treatment, equipment, or resources, shall warn decision makers of this situation and shall help, as far as possible, to correct the situation.
4. A physician who fears a conflict of interests between the benefit of the patient and budgetary considerations, shall remember that his first obligation is to supply the patient with the best treatment available.

b) Prohibition of physician participation in interrogations and torture
1. The physician shall not participate in any activity involving torture, cruelty, or humiliation of another person, regardless of the accusations against the said person or his acts.
2. The physician shall not give medical permission for the execution of torture and shall not supply medical information, instrumentation, or drugs for this purpose.
3. The physician shall preserve the confidentiality of the medical information held by him and shall not make use of it for torture or interrogations.
4. A physician who was a witness to interrogations or torture carried out contrary to international conventions shall report this to the appropriate authority.

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17 On this matter, see the position paper entitled “Health inequality in Israel”.
18 On this matter, see the position paper entitled “The treatment of individuals not covered by medical insurance”.
19 On this matter, see the position paper entitled “The prohibition of physician participation in interrogations and torture”.
5. The physician shall strictly observe his professional independence when selecting the proper medical treatment for a detainee or prisoner under his responsibility, while preserving the physical and mental health of said person.

c) **Prohibition of physician participation in solitary confinement in prisons**

1. The physician shall not give any medical permission for the solitary confinement of a prisoner for the purpose of punishment.
2. The physician shall strictly observe the confidentiality of the medical information held by him and shall make no use of it for the purpose of approval of solitary confinement, except for protection of the health of the prisoner or of other prisoners.
3. The physician shall strictly observe his professional independence when selecting the proper medical treatment for a prisoner who is in solitary confinement, while preserving the physical and mental health of said person.
4. A physician who identifies a real danger to the health of a prisoner, because he is held in solitary confinement, shall exercise his professional authority and give warning to the competent authorities, in order to terminate these restrictions immediately.

d) **Shackling prisoners and detainees in hospitals**

1. The physician shall preserve the dignity, privacy, and health of any person held in conditions of detention or imprisonment.
2. The physician shall respect the right of every detainee or prisoner to receive medical treatment like any other person, without being restrained by handcuffs.
3. The physician shall exercise his professional authority to remove the restraints of a detainee or prisoner being treated by him, except in cases in which there is a real and immediate danger to the patient himself or to the medical staff treating him.

e) **Prohibition of feeding a prisoner conducting a hunger strike**

1. The physician shall explain to a prisoner conducting a hunger strike the real risk to his life if he continues this strike.
2. The physician shall not apply improper pressure to a prisoner conducting a hunger strike to change his mind.
3. The physician shall verify, every day, the wishes of a prisoner conducting a hunger strike regarding the treatment to be given to him in the event of his losing consciousness. This shall be documented in a confidential medical record.
4. The physician shall decide, to the best of his medical awareness and conscience, how to continue to treat a prisoner conducting a hunger strike after the prisoner

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20 On this matter, see the position paper entitled “Solitary confinement of prisoners - without the participation of physicians”.

21 On this matter, see the position paper entitled “Shackling prisoners and detainees in hospitals”.

22 On this matter, see the position paper entitled “Feeding hunger strikers”.

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has lost consciousness, while conforming to the wishes of the prisoner, as these were expressed to him earlier in the hunger strike.

5. The physician shall not participate in the forced feeding of a prisoner conducting a hunger strike.

f) The health of migrant workers 23
   1. The physician shall act, to the best of his ability, in order to permit work immigrants in Israel access to proper medical treatment, and in order to prevent their exploitation.
   2. The physician shall, in an emergency, treat any work immigrant, even if he lacks means of payment.
   3. The physician shall preserve the medical confidentiality of the work immigrant like every other patient, and where required, also the very identity of the immigrant.

g) The guarantee of medical and health services during the Israeli–Palestinian armed conflict 24
   1. The physician shall regard the supply of medical and health services to the civilian population, both Israeli and Palestinian, and the treatment of persons injured, as an integral part of his professional commitment to preserve the value of life.
   2. The physician shall give medical and health services to every person, even during an armed conflict, when he is required to do so ex officio.
   3. The physician shall preserve his professional autonomy even under combat conditions and shall be entitled to absolute immunity as long as he engages in his professional work only.

h) Chemical sterilization of pedophiles 25
   1. The physician shall assess the medical condition of a sexual offender and his suitability for medicinal treatment for inhibition of his sexual urge, independently and untainted by conflicts of interest of any kind whatsoever.
   2. The physician shall not give medicinal treatment for inhibition of the sexual urge contrary to his conscience, if in his opinion this treatment is unsuitable for the said sexual offender.
   3. The physician shall give medicinal treatment for inhibition of the sexual urge only after the patient’s consent has been received of his own free will.

i) Cooperation between the physician and law authorities 26
   1. The physician shall respect the special status of medical institutions as places in which the patient is protected by the rules of medical ethics.

23 On this matter, see the position paper entitled “The health of migrant workers”.
24 On this matter, see the position paper entitled “Assuring medical and health services during the Israeli–Palestinian armed conflict”.
25 On this matter, see the position paper entitled “Chemical sterilization of pedophiles”.
26 On this matter, see the position paper entitled “Cooperation between medical institutions and law authorities”.
2. The physician shall respect the medical confidentiality and privacy of illegal residents and offenders since they are also patients.

3. The physician shall, at the same time, respect the good of society in general and its right to protect itself.

4. The physician shall be entitled to aid security authorities, at their request, even if this may harm the rights of the patient, only in cases in which there is a high probability that if he does not do so harm will be caused to society by the said patient.

5. In the event of doubt, the physician shall apply to the Court so that it shall give a ruling between the freedom of the individual and his rights and the good of the public in general.

6. The physician may consider, based on his conscience, whether to cooperate with the interpretation of bone age testing of illegal residents for non-medical reasons, at the request of the State, taking into account the questionable reliability of the test and the exposure to radiation.

j) Treatment of minors

1. The physician shall protect the health, welfare, and rights of minors, taking into account their medical and mental needs and those of their families.

2. The physician shall involve the minor in decisions related to his medical condition in accordance with his level of maturity and cognitive and mental capability. For this purpose, the physician shall give the minor information in a way that he can understand, shall be receptive to his views and shall answer his questions to the best of his ability.

3. The physician shall take steps to obtain the informed consent of the parents or guardian of the minor, except in case excluded by law, or when contacting them is contrary to the minor’s interest or places the minor in danger. In the last case the physician shall involve the authorized professional entities.

4. The physician shall attempt to encourage a minor, who opposes the participation of his parents or his guardian in his medical condition, to involve them in the treatment, if he is convinced that this is for the good of the minor.

5. The physician shall contact the competent authorities in order to permit medical treatment that in his best professional judgment is essential, even contrary to the opinion of the minor’s parents or guardian.

k) Treatment of vulnerable populations

1. The physician shall, to the best of his ability, protect the health, welfare, and rights of vulnerable or special populations: minors, old people, sheltered persons,
helpless people, or any person subject to authority.

2. The physician shall as far as possible involve a patient, who is included in the said population, in the determination of his medical treatment. In the event of the patient’s incompetence, the physician shall take steps to obtain the consent of the patient’s legal representative for the purpose of giving the medical treatment.

3. A physician who fears that a patient who came for treatment was or is subject to abuse shall take all the steps available to him to protect said patient, and shall report this to the competent authorities, depending on the circumstances.

l) Addressing a passerby whom the physician perceives to be ill

1. The physician may, but is not obligated to, draw the attention of a passerby to a medical problem.

2. The physician shall carefully consider the prospects for improving the person’s quality of life and health, in deciding whether to speak to someone who has not consulted him first.

3. The physician should behave with great sensitivity and approach the stranger privately so that no one else hears or observes the encounter.

m) Exclusion of women

1. The physician shall not enable the exclusion of women in the public health system, including any act that causes discrimination, degradation or humiliation of a woman.

2. The physician shall do his utmost to lead social processes that contribute to equality between the sexes and shall refrain from giving consent or recognition to acts that oppose this.

n) Artificial feeding of a patient in a permanent vegetative condition

1. At the request of the patient’s family, the physician shall explain the benefit of artificial feeding of a patient in a permanent vegetative condition and the risks and benefits involved as they relate to the patient’s continued existence.

o) Trading in tissues and organs and the donation of organs

1. The physician shall take steps, to the best of his ability, to promote education and information amongst the public in order to encourage the donation of organs after death for transplanting.

2. The physician shall avoid applying pressure of any kind in order to obtain consent for the donation of tissues or organs.

3. The physician shall not be involved, directly or indirectly, in any way, in the trading of tissues or organs for transplanting.

29 On this matter, see the position paper entitled “Should physicians inform a passerby if they detect an illness?”

30 On this matter, see the position paper entitled “The exclusion of women in the healthcare system and medical services”.

31 On this matter, see the position paper entitled “Artificial feeding of a patient in a permanent vegetative state”.

32 On this matter, see the position paper entitled “Trading in organs and organ donation”.

4. The physician shall not be involved in the transplanting of tissues or organs obtained by means of trading in organs.

p) **Transplanting organs from persons sentenced to death**  
1. The physician shall not cooperate, in any way whatsoever, in transplanting an organ if the tissue or organ transplanted originated in a person sentenced to death.

q) **The physician in the medical committee**  
1. A physician who is a member of a medical committee shall introduce himself to the examinee and explain his status and function in the committee.  
2. The physician shall not act simultaneously as the physician treating the patient and as a physician who is a member of a medical committee and shall avoid any conflict of interests.  
3. A physician who is a member of a medical committee shall act with respect and shall preserve the privacy of the examinee, taking into account his physical and mental disabilities.  
4. A physician who is a member of a medical committee shall formulate his opinion after examining all the relevant documentation of the examinee.  
5. A physician who is a member of a medical committee shall make an objective, independent professional decision that is not subject to the authority or needs of the institution in which he works.  
6. The physician treating the patient shall not instruct him to change the medical treatment that he receives in order to "worsen" his condition prior to examination by the medical committee.  
7. A physician who is a member of a medical committee who feels the presence of an attorney for the patient during the medical examination is liable to disrupt the proceedings or their results shall inform the patient and his attorney of this and note his reasoning in the committee report, in order to allow for the continuation of the examination.

r) **A physician acting on behalf of his employer**  
1. A physician acting on behalf of his employer shall make clear to the examinee his connection with his employer and shall not simultaneously act as the physician treating the said examinee.  
2. A physician acting on behalf of his employer shall not furnish the employer with details regarding the examinee’s medical condition, unless the examinee agreed to disclose them or if the physician is legally required to do so.

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33 On this matter, see the position paper entitled “Transplanting organs from persons sentenced to death”.  
34 On this matter, see the position paper entitled "Physicians on medical committees".  
35 On this matter, see the position paper entitled “The presence of lawyers during examinations in a medical committee.”
3. A physician acting on behalf of his employer shall not intervene in the treatment given to the examinee by the physician treating him, and shall contact the treating physician when the need arises.

s) Medical confidentiality and the physician’s tax obligations

1. A physician is obligated, like every citizen, to report to the tax authorities and pay taxes on the fee he receives from his patients.
2. A physician is obligated to protect a patient’s medical confidentiality and his dignity and privacy. Medical confidentiality is the right of the patient, and only he can waive it.
3. A physician shall not ask a patient to waive confidentiality for the purpose of his accounts, as doing so would put the patient in an uncomfortable position and potentially harm the trust he puts in the doctor. It is not proper for a patient to waive a basic right in order to uphold an interest that does not concern him.
4. The physician, in reporting to the tax authority, should cite the name of the patient and the amount paid, but should not specify in the receipt the illnesses from which he suffers or the treatment he received.

t) Participation by medical students in the examination of patients

1. The physician, as a teacher and educator, shall encourage the participation of students in the examination and the medical treatment of patients.
2. The physician shall receive advance consent from the patient or his legal representative for the presence of students during the examination or treatment.
3. The physician shall teach the students to respect the patient’s privacy and dignity, especially if the patient is disabled, legally incompetent, anaesthetized or unable to express his opinion.
4. The physician shall respect the patient’s refusal to consent to the presence of students during examination or treatment, and the refusal shall not influence the quality of the treatment given to the patient.

u) Transparency regarding the health of national leaders

1. A physician treating a national leader is obligated to maintain medical confidentiality vis-a-vis the leader, and shall not act with a conflict of interests regarding the public’s right to know about the leader’s medical condition.
2. The physician treating a national leader is permitted, with the leader’s consent, to give the public medical information regarding the leader’s condition.
3. The treating physician shall not determine the medical capability of the leader to continue in his position.

36 On this matter, see the position paper entitled “Medical confidentiality and the tax assessor.”
37 On this matter, see the position paper entitled “The examination of patients by medical students.”
38 On this matter, see the position paper entitled “Transparency regarding the health of national leaders.”
4. The treating physician shall, in suitable circumstances and to the best of his ability, take steps to persuade the leader of his obligation to submit to examination by the designated competent authority, so that the latter may assess his ability to continue in his position.

5. The treating physician shall, in suitable circumstances and to the best of his ability, take steps to persuade the leader of his obligation to disclose medical information to the general public, and in the absence of such consent – the physician shall give warning of the leader’s condition to the designated competent authority.

v) Medical supervision of drivers
1. Pursuant to the law and in accordance with his professional judgment, the physician is obligated to notify the competent authorities of the patient’s incapacity for driving. This obligation conflicts with the basic obligation of medical confidentiality and infringes upon it.

2. The physician shall inform the patient in advance of his intention to notify the competent authorities of the patient’s incapacity to continue driving.

3. The physician shall act through appropriate channels, including by means of his representatives, to change the law so that the legal obligation to disclose incapacity for driving shall be imposed on the patient and not on the physician. Such a change will strengthen the trust between the patient and the physician and will lead to improvement of medical treatment for the patient.

w) The obligation to treat a pandemic situation
1. The physician shall treat everyone, including a patient suffering from an infectious disease, even in the presence of a reasonable increased risk to the physician’s safety, and after he has taken suitable measures to protect himself.

2. The physician is obligated to give medical treatment to everyone in the event of a pandemic situation, when there is a danger to the public.

3. The physician shall continue to provide medical treatment as long as his professional services are required.

4. The physician is not obligated to take an unreasonable risk in order to give medical treatment to someone else.

5. In conditions in which he faces a real and increased risk, the physician shall balance the immediate benefit expected for the individual patient endangering the physician, and his ability to provide medical treatment in the future to other patients, as well as the value of saving his own life and that of his family.

39 On this matter, see the position paper entitled “Medical supervision of the competence of drivers”.
40 On this matter, see the position paper entitled “Is there a limit to the medical obligation in pandemic situations?”.
x) The obligation to treat in a multi-casualty event

1. A physician who is called on to treat in an event in which there are numerous casualties shall give the best possible medical treatment to the maximum possible number of victims, based on the triage system and on the circumstances.
2. The physician shall fulfill his professional obligation, as far as required, but in the event of personal risk, he shall assess, in cooperation with the appropriate entities, the risk involved in entry to the site of the event, against the obligation to save lives, and shall act accordingly.

y) Medical tourism

1. Physicians should strive to find the appropriate balance between improving the quality of public medicine through financial resources provided by medical tourism, and preserving the right to health and accessibility to services of the country’s residents in an environment of limited resources.
2. Physicians shall not prioritize treatment of medical tourists over that of residents of the country.
3. Physicians shall ensure that the provision of medical services in the framework of medical tourism shall not harm the health of residents of the country.
4. Physicians shall preserve the rights of the medical tourist and shall not terminate life-saving treatment of the tourist.

z) Imaging tests

1. The physician shall refer the patient for imaging tests when they are justified in terms of risk vs benefit and with consideration of the effects of accumulated radiation from numerous tests, both for the individual patient and for society in general.
2. The physician shall refer the patient for imaging tests with a detailed, reasoned instruction for their execution.
3. The physician shall notify the patient of the inherent risk in imaging tests, as part of the process of obtaining informed consent.
4. The referring physician shall emphasize the importance of professional assistance and interpretation of all results of the imaging test. It is recommended that the referring physician confirm in advance with the patient whether he wishes to get the results of the specific imaging test directly, and if so this should be noted in the referral.
5. The physician performing the imaging test should send his answer directly to the treating physician.

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41 On this matter, see the position paper entitled “Ethical aspects of a multi-casualty event”.
42 On this matter, see the position paper entitled “Medical tourism”
43 On this matter, see the booklet “The joint ethical forum of the IMA and medical tourism companies.”
44 On this matter, see the position paper entitled “Judicious use of medical imaging.”
6. A physician who identifies an emergency situation shall turn directly to the patient, in order to prevent any delay.

7. A radiologist shall take immediate action when there is no treating physician and when there is a need for follow-up tests, such as screening tests.\(^45\)

**aa) “Medicine” that is not evidence-based\(^46\)**

1. The physician shall take steps, to the best of his ability, to prevent false hopes among the public regarding “medicine” that is not evidence-based and that may sometimes involve fraud and theft.

2. The physician shall take steps, to the best of his ability, to warn the public against treatments given in “medicine” that are not evidence-based and that are liable to harm the health of the patient.

**bb) Shutting down medical institutions in response to violence against physicians\(^47,48\)**

1. Physicians are entitled to expect that society and the medical institution in which they are working will protect them properly against physical and verbal violence during their work.

2. In the absence of such proper protection, physicians shall be entitled to shut down the medical services in order to arouse public opinion, and cause the employers and the government to act against violence towards the physicians and other health workers.

3. The physicians shall be entitled to shut down the medical services in response to violence, in a reasonable and considered manner, in order to minimize the harm and suffering of all patients.

4. Physicians shall strike as a means of professional struggle only as a last measure and after taking into consideration the expected damage that will be caused to third parties versus the benefit to the strikers and to society.

5. Physicians shall ensure a cautious and measured strike action that allows for emergency and other vital services, a control mechanism, and an opportunity to examine exceptional cases as well as media opportunities to relay up to date information to the public regarding the strike.

**cc) Use of the title “Professor”\(^49\)**

1. The physician shall use the title “Professor” in his medical work if he has been appointed to this position in one of the medical faculties in Israel, including the

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\(^45\) On this matter, see the position paper entitled “Imaging results-do they go to the physician, the patient or both.”

\(^46\) On this matter, see the position paper entitled “Anti-aging medicine”.

\(^47\) On this matter, see the position paper entitled “Cease-fire”.

\(^48\) On this matter, see the position paper entitled “The ethics of a physicians’ strike in a labor dispute.”

\(^49\) On this matter, see the position paper entitled “Who may be called professor?”
status of full professor or associate professor, in the academic or clinical track.
2. The physician shall use the title “Professor Emeritus” in his medical work if he had been appointed as a professor, as set forth above, and has retired.
3. The physician shall use the title “Professor” in his medical work for three years at most, if he had been appointed as a professor, as set forth above, and is in transition between two universities in Israel.

**dd) Physician classifications**

1. Ranking or classifications of physicians appearing in the media have no scientific basis and are liable to mislead the public and discriminate against many other good physicians.
2. The physician shall explain to those contacting him the limitations of these classifications.

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50 On this matter, see the position paper entitled “The best physicians”. 
3. Physician-physician relations

a) Respect for a professional colleague
   1. In all professional matters, the physician shall maintain relations of respect and friendship towards professional colleagues.
   2. The physician shall not permit his personal opinions to influence his professional relations with his professional colleagues.
   3. The physician shall avoid criticizing his professional colleague in a crude or insulting manner.
   4. The physician shall express his opinion regarding medical treatment given by his professional colleague in an objective, modest, and restrained manner, based on accepted medical information at the time treatment was given.
   5. The physician shall not express himself in the media in a manner that insults or disparages another physician.

b) Giving medical treatment to a professional colleague
   1. The physician shall act in accordance with medical tradition and shall treat his professional colleagues without charge. The physician shall be entitled to levy a charge if a third party pays the cost.

c) Teamwork
   1. A physician working in a medical team shall be responsible for his professional conduct and for his personal part in the treatment that he gives to the patient as part of said team.
   2. The physician shall respect the qualifications and experience of his colleagues in the medical team and shall be ready to accept advice, criticism, or objective complaints from them.
   3. The physician shall verify that the division of responsibility for the medical treatment among members of the team is understood by all the members.

d) Sharing information between practitioners
   1. The physician shall enable open and reliable communications with colleagues in the medical team and with other physicians treating the same patient in the most effective way, in order to advance the treatment of the patient.
   2. The physician shall share with his colleagues knowledge, new treatment skills and the results of research.

e) Transfer of patients between physicians
   1. A physician shall avoid any action intended to transfer to himself patients of
another physician. If the patient left the first physician of his own free will, the second physician shall be entitled to treat him.

2. A physician replacing another physician in his absence shall redirect the patient to the first physician on his return, and shall transfer to him all the medical information added in his absence, unless the patient objects.

f) **Prohibition of fee splitting**

1. The physician shall not demand, receive, or give any brokerage fees for directing a patient for examination, diagnosis, treatment, receipt of medical instrumentation or referral to health resorts or institutions.

2. The physician shall be entitled to allocate from his salary payment to another physician, if the latter actually helped him and made a significant contribution to the diagnosis or the medical treatment of a specific patient.

h) **A physician who is incompetent from a health standpoint**

1. A physician who is professionally incompetent, health-wise, shall avoid giving medical treatment or taking medical responsibility for the health of the patient, and shall report this to the competent authorities.

2. An incompetent physician, including a physician who is suffering from an infectious disease, shall apply if necessary to the entity authorized to determine the limitations of his functioning and the way in which he may continue his work.

3. A physician shall notify an incompetent physician regarding the doubt that has arisen concerning his capability and shall make every effort to help him, including in the receipt of medical treatment.

4. The physician shall act to the best of his ability in order to protect the general public from an incompetent physician.

5. The physician shall report an incompetent physician to the appropriate authority, if the continuation of his work constitutes a danger to public health, after he has notified the incompetent physician in advance.

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52 On this matter, see the position paper entitled “The transfer of information to a medical team regarding an infectious disease”.

53 On this matter, see the position paper entitled “The incompetent physician”.
Part D

i) **Improper conduct**
   1. A physician who identifies improper ethical or professional conduct by his professional colleague shall warn the colleague of this.
   2. A physician who identifies improper ethical or professional conduct by his professional colleague that continues despite the warning he has given him, shall report this to the competent authorities.

j) **The prohibition of workplace harassment**
   1. Abusive behavior in the workplace is prohibited, as it is damaging to the dignity and functioning of the physician.
   2. The physician in a management role, like all his or her medical colleagues, shall refrain from demeaning or humiliating any other physician in any way whatsoever, including verbal abuse toward or about another physician.
   3. The physician in a management role is responsible for seeing that his or her subordinates can perform their work, that no untoward behavior is permitted that could damage their medical training, medical skills and level of professionalism, and that the workplace environment is not a hostile one; the physician in management must lead by personal example, morally and professionally.
   4. A physician shall refrain from joining in any abusive behavior toward another physician and shall do everything in his or her power to support a physician who is abused.

A physician perceiving behavior that is liable to be interpreted as abusive, shall do everything in his or her power to inform the abuser that his or her behavior is unacceptable.

k) **The obligation to report a criminal or disciplinary charge**
   1. A physician shall notify the professional association to which he belongs if he was found guilty of a criminal or disciplinary offence related to his medical occupation, whether it was perpetrated in Israel or abroad.
   2. A physician who was suspended by a medical organization or institution, or whose medical practice was limited, shall give notice of this to the organization or other institution in which he is a member or is employed in medical work.

l) **The physician’s conduct when changing workplaces**
   1. A physician is entitled to change workplaces.
   2. The physician manager shall respect the doctor who changes his place of employment and respect his desire to do so.
   3. The physician changing his place of employment shall give notice of his intention to change workplaces.

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54 On this matter, see the position paper entitled “Prohibition of workplace harassment”
55 On this matter, see the position paper entitled “The physician’s conduct when changing workplaces”
4. The physician changing workplaces shall assist, insofar as possible, in the transfer of information and shall provide professional support to colleagues remaining in the medical institution he or she is leaving or to new replacements, to assure continued quality care for patients.

5. A physician who is exposed to an attempt to prevent the employment of physicians in public institutions shall protest and act to prevent it, insofar as he is able, to enable maximum actualization of the medical knowledge and experience of the physicians for the benefit of the patients.

k) The obligation to publish the name of a person found guilty in a clarification committee of the Ethics Board

1. If a physician was found guilty by the Ethics Board and was sentenced to punishment of suspension or expulsion from the Israeli Medical Association, his full name shall be published, as seen fit by the committee that judged his case.

4. The physician, science, and research

a) Medical research on humans – general obligations

1. The physician shall act to advance medicine by means of medical research on humans and shall conduct the research in accordance with the rules applying to him as a physician.

2. The physician shall conduct medical research on humans only if qualified to do so and after he has learned the ethical rules and the methodology of the medical research that he is conducting.

3. The physician shall conduct medical research in accordance with accepted scientific principles and in light of previous substantiated medical and scientific knowledge.

4. The research physician shall notify the physician treating the patient participating in the research of such patient’s participation, and shall give him information regarding the nature and aims of the trial.

5. The research physician shall verify that the medical trial that he is conducting has been recorded in advance in a digital website, accessible to the public, and that this record contains all the relevant information on which the research is based.

b) The good of the participant in medical research on humans

1. The research physician is first and foremost obligated to ensure the good of the participant in the research. The good of the patient precedes any other motive,
including the good of society in general or of science.
2. The research physician is responsible for protecting the health and safety of the participant in the research. This obligation is not imposed on the participant himself, even if he gave his consent.
3. The research physician shall verify that the benefit latent in the research exceeds the estimated risk for the participant, and shall do everything he can to minimize the risk or harm liable to be caused to the participant during or as a result of the research.
4. The research physician shall halt the research if it transpires that its continuation is liable to harm the participant.
5. The research physician shall not conduct research on a vulnerable or special population or on one subject to authority, unless the research contributes to the health of said population itself, and if it is impossible to achieve the aim of the research without the participation of said population.

**c) Conducting medical research on humans**

1. The physician serving as the head researcher in medical research shall verify that the stages of the research are formulated clearly in the research protocol.
2. The head research physician shall furnish the research protocol to an independent ethical trials committee (the Helsinki committee) for its perusal, comments and guidance.
3. The research physician shall act in accordance with the approved protocol, and in the event of doubt he shall contact the ethical trials committee to receive the appropriate clarification.
4. The research physician shall verify that the medical research is planned and executed in accordance with all the requirements, laws, and ethical rules, both local and international, including the Helsinki Declaration, as updated from time to time, and that the research is subject to monitoring and inspection as required.

**d) Consent to medical research on humans**

1. The physician shall explain, in a clear and understandable manner, to the patient or to the healthy volunteer, that he is participating in research, and shall verify that the participant understands the nature of the research in which he is taking part. The research physician shall give the participant in the research all the information regarding the aim and methods of the research, as well as the benefit and the risks expected during or following it.
2. The research physician shall explain to the participant about alternative treatments and their advantages and disadvantages, if any.
3. The research physician shall inform the participant that he is entitled not to participate in the research, as well as to withdraw from it at any time, without this influencing in any way whatsoever the continuation of his treatment.
4. The research physician shall explain to the participant which medical treatment he
will receive in the event of harm to his health following the trial, and who shall be responsible for this treatment.

5. The research physician shall avoid applying pressure or persuasion of any kind whatsoever, directly or indirectly, including exploitation of relations of dependency or authority, in order to obtain the consent of a person for participation in the research.

6. The research physician shall verify, before commencement of the trial, that the participant has given his consent in writing, of his own free will, expressly and with awareness, for participation in the research, after he has understood all the explanations given to him and has received a reply to all his questions.

7. The research physician shall update the participant regarding any new information relevant to the research in which he is participating, including new side effects discovered during the research.

8. The research physician shall verify that in the event of legal incompetence of the participant in the research, or when physical or mental incompetence do not permit the receipt of consent, the informed consent shall be received from the participant’s legal representative.

9. When dealing with a patient whose capability to provide informed consent is in doubt, and in the absence of his legal representative, the research physician shall take steps to obtain the necessary informed consent by means of another, independent, physician who is familiar with the research protocol and who is the appropriate professional function.

e) Confidentiality in medical research on humans

1. The research physician shall verify that all information regarding the medical research, which may lead to exposure of the participant’s identity or his medical or genetic condition, shall be kept secret, like any other medical information.

f) Due diligence – holders of an economic interest in medical research on humans

1. The research physician shall give the participant in the research information regarding the entity financing the research, as well as whether the physician himself receives financial remuneration for execution of the research.

2. A research physician, who holds an economic interest in the medical research, shall be fully transparent in giving the participant all the details related to his personal involvement or the involvement of the medical institution in the economic interests of the research, including the receipt of consideration from any entity whatsoever and the reason for this.

59 On this matter, see the position paper entitled “Clinical trials on humans – ‘stakeholders’ in clinical trials”.
g) **Use of a placebo in medical research on humans**
1. The research physician shall permit use of a placebo in research only if no other known and scientifically proven method of treatment exists.
2. The research physician shall permit use of a placebo only if special methodological circumstances obligate this from the scientific aspect, in order to determine the effectiveness or safety of an innovative medical method, provided that the participant will not be exposed to any significant risk or irreversible harm following use of the placebo.
3. The research physician shall ensure that no adverse use shall be made of the placebo method.

h) **Reporting medical research on humans**
1. The research physician shall report to the participant in medical research any unusual event occurring during the medical trial that may affect the participant’s health, and shall notify the appropriate entities, in accordance with all existing rules.

i) **Academic freedom in medical research**
1. The physician shall participate in medical research only if he retains academic freedom. This means the freedom to plan the research, free access to all the medical information acquired and its processing, and the freedom to publish the results of the research, including any negative results.

j) **Genetic research in large populations**
1. The research physician shall inform the public regarding the existence of genetic research conducted on large populations, for reasons of transparency, supervision and public debate, except in cases in which the very act of publication may possibly harm the participants in the research or the population being researched.
2. The research physician shall ensure that all publication of the results of genetic research conducted on large populations shall be done with maximum sensitivity, in order to prevent negative characterization or stigmatization of the population being researched.
3. The research physician shall inform the participant of the precise aims of the research and its consequences, if any, for the research subject, his family and offspring, and for the population to which he belongs.
4. The research physician shall inform the participant of the personal benefit likely to arise for him and his family, if any, as a result of his participation in the research.
5. The research physician shall respect the right of the participant in the research not to know the results of the research and its consequences for him and for his family.

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60 On this matter, see the position paper entitled “Clinical trials on humans – the use of a placebo”.
61 On this matter, see the position paper entitled “Genetic research in large populations”.
k) Trials on animals

1. The physician shall be entitled to conduct trials on animals in order to advance science and medicine.
2. The physician shall conduct trials on animals in the absence of another alternative and in a lawful manner.
3. The physician shall use the minimum number of animals required for execution of the research, while preventing suffering to the animals during and after the trials.
4. The physician shall act, to the best of his ability, in order to advance the know-how and cooperation of the general public and the legislator regarding trials on animals.

l) Ethical rules in a scientific article

1. The physician shall treat a scientific article as the basis for the future treatment of patients, and shall consequently act with great caution and shall ensure the accuracy and completeness of the article by means of professional and personal integrity.
2. The physician listed as the author of a scientific article is the one who made a real contribution to the basic idea behind the research or its planning, to the analysis of the results or their interpretation, the one who wrote the article or significantly changed it while giving it new substantive intellectual content, and the one who finally authorized publication of the article.
3. The physician author must be a real participant in a large part of the research, so that he can answer criticism by his professional colleagues and by the general public regarding material parts of the scientific article.
4. The physician shall not receive the status of author solely because he made an economic contribution, collected general information or samples, or gave general supervision.
5. The physician author shall verify that the order of listing the authors of a scientific article shall be determined in advance with the agreement of all the researchers. It is customary that the list is headed by the name of the author whose contribution to the research was the greatest and most decisive, and that the last author will be the senior researcher in whose laboratory or under whose supervision the research work was conducted.
6. The physician author must carefully read the entire article before its publication and agree to its format and contents.
7. The physician author shall not send an article for publication without criticism and agreement of all the other authors of the said article.

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62 On this matter, see the position paper entitled “Trials on animals”.
63 On this matter, see the position paper entitled “Ethical rules in scientific publications”.
8. The physician author shall be personally responsible for the contents of the entire article and for its conclusions.

9. The physician author shall not participate in the duplicate or partial publication of a scientific article which harms and distorts the scientific truth.

10. The physician author shall affirm that the article sent for publication is original and that it was not sent simultaneously to another journal, and that the relevant information has not already been published somewhere else.

11. A physician authoring a scientific article or editorial, or who acts as a reviewer, shall, upon publication, expose any possible conflict of interests liable to influence his judgment.

m) Sex selection

1. The physician shall aid in choosing the sex of the newborn, when this is done in order to prevent serious genetic illnesses or for some other suitable purpose.

n) Intellectual property

1. The physician shall encourage the advancement of medical research, and shall regard it as part of his professional commitments towards society in general.

2. The physician shall be entitled to remuneration from his employers in a reasonable, proper, and non-discriminatory manner relative to his colleagues and relative to the standard arrangements in Israel and abroad, in respect of a product or service invented during and in connection with his work.

3. The physician shall be entitled to include his research activity in his clinical work without this affecting his working conditions.

5. The physician and commercial companies

a) Mining of medical data

1. The physician shall cooperate in the acquisition of information regarding the use of various drugs, in order to aid in the planning and operation of the national medical economy.

2. The physician shall cooperate in the acquisition of information regarding the use of drugs only if done in a compiled, non-identifying manner that preserves the privacy and anonymity of both the individual patient and physician.

3. The physician shall cooperate in the acquisition of information regarding the use of drugs only after he has given advance consent in writing that includes details of the information collected, the purpose of the collection, and the identity of the

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64 On this matter, see the position paper entitled "Sex selection using in vitro fertilization".

65 On this matter, see: "Executive summary - the position paper of the Israeli Medical Association referring to the report of the inter-ministerial steering committee for regulation of intellectual property in the health system".

66 On this matter, see the position paper entitled "Medical data mining - risks and precautions".
entity using this information. Such consent shall be granted for a limited time only.

4. The physician shall not cooperate in the acquisition of information regarding the use of drugs, if the information collected is intended to be used in order to apply any pressure whatsoever, overt or covert, on the physician or his colleagues, with the intention of changing their prescription behavior.

b) The connection with commercial companies

1. The physician shall be entitled to maintain suitable professional contact with a commercial company for the purpose of advancement of medicine and science.

2. A physician who is in contact with a commercial company shall strictly observe his primary obligation to act for the good of the patient and shall avoid any situation that involves a conflict of interests that impairs this obligation.

3. A physician who is in contact with a commercial company and who identifies a conflict of interests between the commercial company and the patient, shall act for the good of the patient.

4. The physician shall preserve his professional independence and intellectual integrity in all contacts with a commercial company.

5. The physician shall disclose a connection with a commercial company, if any, in any situation which may leave an impression that this connection is liable to influence his views or his professional opinions.

c) Participation in research financed by commercial companies

1. The physician shall participate in the conduct of research financed by a commercial company only if a reasonable scientific basis exists for the research, and provided that it was approved by the ethical authority authorized to do so.

2. The physician shall place the good of the patient above any other interest existing in the research.

3. The physician shall participate in the conduct of research only if informed consent has been received in advance from the patient or from his authorized representative.

4. The physician shall participate in the conduct of research financed by a commercial company only if the research is recorded as required, in advance, in a public website accessible to the public.

5. The physician who participates in the conduct of research financed by a commercial company shall not receive payment conditional on the results of the research, unless he participates in the research as the inventor or developer of the drug or accessory that constitutes the subject of the research.

6. The physician shall not receive payment for referring patients to the research.

67 On this matter, see the Joint ethical convention of the Israeli Medical Association and the pharmaceutical companies operating in Israel.
7. The physician shall not participate in the conduct of research financed by a commercial company if he does not retain full academic freedom, including free access to all the information acquired and the freedom to publish it in any suitable manner, except for reasonable limitations that do not affect the safety of the patients.

8. The physician shall disclose any possible conflict of interests and any economic connection existing between him and the commercial company whose product is the subject of the research.

d) Participation in a lecture financed by a commercial company
1. The physician shall be entitled to participate in a lecture financed by a commercial company if its main aim is the advancement of the professional knowledge of the physician.

2. A lecturing physician financed by a commercial company shall, at the beginning of his lecture, disclose the nature of the existing economic connections, if any, between him and the financing company or between him and any other company relevant to the subject of the lecture.

3. A lecturing physician financed by a commercial company shall take care to observe the professional truth and shall speak in an objective, balanced, fair, honest and complete manner.

4. A lecturing physician financed by a commercial company shall, in his lecture, use the generic name of the drug and not its commercial name, and shall also present in an objective, direct, and balanced manner all the other treatment options existing in the context of the subject of the lecture.

5. The physician shall be entitled to receive reasonable remuneration for his participation as a lecturer in a lecture financed by a pharmaceutical company, if he prepared and delivered a lecture having educational significance in a field in which he is already an authority. This does not include the delivery of a lecture prepared by a commercial company. Participation as a listener in a lecture cannot entitle the physician to any remuneration whatsoever.

6. The physician shall take care to observe these instructions with regard to a lecture recorded by him and sent by any digital means to viewers anywhere.

e) Participation in a consultative committee for a commercial company
1. The physician shall be entitled to serve as a paid consultant for a commercial company if his aim is to advance medical knowledge and the level of medicine.

2. The physician shall be entitled to receive proper financial remuneration for consulting, in accordance with his professional status and the scope of the work done by him.

3. The physician shall consider whether his paid work for a commercial company is liable to influence the quality and independence of his medical decisions. In the event of a conflict of interests, the physician shall decide in favor of his professional independence.
f) **Receipt of medical samples**
   1. The physician shall not receive any consideration for the receipt of drug samples from a commercial company.
   2. The physician shall not charge a patient for a sample of a drug given to him.

g) **The prohibition to receive gifts from a commercial company**
   1. The physician shall not receive any gift or personal benefit from a commercial company, except gifts of marginal value only.
   2. The physician shall be entitled to make use of a gift if it is not personal and is intended to improve the standard of the physicians and medicine in a department or clinic, or to improve the standard of the treatment and the service given to the patients, as long as receipt of the gift does not affect the professional independence of the physician and his colleagues in the department or clinic.

h) **Prohibition of sales and publicity of commercial products**
   1. The physician shall not engage in any way in the sales or advertising of medical products in his clinic, if these are liable to create undue pressure on the patient to use a specific medical product.
   2. The physician shall not engage in any way in the sales or advertising of commercial products and shall not provide his name, academic degree and professional status for the benefit of economic interests of any commercial entity whatsoever.

6. **The physician and the legal system**
   a) **The physician as an expert witness**
      1. The physician shall aid the Court and the competent authorities to reach a just decision, in the event his opinion is required.
      2. The physician shall serve as an expert witness only in a subject within his field of medical expertise, and only if he is well versed in the knowledge and relevant procedures customary in this field, including in the period relevant to the case in question.
      3. The physician shall present himself, his professional qualifications and his academic status, with transparency and integrity, and shall indicate whether he has a conflict of interests with any of the litigants.
      4. The physician shall present with objectivity, fairness and full truth, all the medical and scientific information related to the case in question.
      5. The physician shall write his opinion and deliver his testimony in relevant, unpretentious, and restrained language, based only on the facts and on the medical and scientific knowledge.

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68 On this matter, see the position paper entitled “The physician as an expert witness”. 
6. The physician shall be entitled in his opinion to dispute another medical opinion. This shall be done in a proper and restrained manner, without personal criticism of other medical experts.

7. The physician shall be entitled to demand a proper fee for his work, in accordance with his professional status, and the time and effort invested in this work. The fee shall not be conditional on the results of the legal proceedings.

b) A physician shall not act against his patient\(^{69,70}\)

1. The physician shall not act against anyone who is or was his patient, and shall not make use of the medical information held by him to the detriment of the patient.

2. The physician shall avoid giving a medical opinion against a person who was a patient of his, unless this was done in accordance with a court order.

3. A physician who stands in opposition to his patient, as a result of legal or other proceedings, shall transfer the treatment of the patient to another physician.

4. The physician shall request the involvement of the court in appropriate cases, when a demand arises to revoke medical confidentiality for his or her patient, and will strive to conduct the discussion in camera so as to better explain to the judge the risk to the patient.

c) Forensic medicine\(^71\)

1. The forensic physician shall be strictly objective, make impartial judgments, and preserve his independence. The physician is permitted not to perform a medical procedure requested of him, if the request violates his professionalism, conscience, or faith.

d) Recording the examination of a medical expert\(^72\)

1. The physician is not obligated to allow the medical examination to be recorded or filmed against his will, or if this would, in his opinion, prevent proper execution of the examination.

7. The physician and the media

a) Furnishing medical information to the general public

1. In a medical article intended for the general public, the physician shall take care to furnish reliable medical and scientific information existing on the date of the publication.

2. In a medical article intended for the general public, the physician shall take care

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\(^{69}\) On this matter, see the position paper entitled "A physician shall not act against anyone in his care".

\(^{70}\) On this matter, see the position paper entitled "Medical confidentiality and medical record privilege regarding psychiatric treatment for survivors of violence and sexual assault."

\(^{71}\) On this matter, see the position paper entitled "Forensic medicine."

\(^{72}\) On this matter, see the position paper entitled "The recording of medical expert examinations by the opposing side is forbidden"
to provide a balanced and considered picture regarding other possibilities of
diagnosis or treatment existing for the illness in question.
3. In a medical article intended for the general public, the physician shall take care to
use the generic name and not the commercial names of the drug.
4. In a medical article intended for the general public, the physician shall take care
to avoid giving a sweeping recommendation for a specific drug or method of
diagnosis that serves the economic interests of a commercial entity.
5. In a medical publication intended for the general public, the physician shall take
care to properly disclose any possible conflict of interest he has, including any
association or economic connection existing between him and the commercial
company related to the publication.
6. The physician bears responsibility for words appearing in his name in a medical
publication intended for the general public. Consequently, the physician shall
check, as much as possible, the words attributed to him before their publication.
7. The physician shall make careful use of methods to expose discoveries and new
techniques to the public via non-medical channels.

b) Privacy in the media

1. The physician shall preserve the privacy of the patient, including during terrorist
attacks or mass disasters that are of interest to the media or the public.
2. The physician shall not cooperate with the media if this infringes upon the patient’s
privacy, unless the patient’s consent has been received in advance. If the patient
is incapable of giving such consent, his privacy shall not be infringed in any way
whatsoever.
3. A physician treating a minor shall not permit his exposure to the media, unless
both parents have consented to this.
4. The physician shall permit the exposure of a patient to the media with the consent
of the patient, provided that his medical treatment and that of others is not harmed
and that the privacy of other patients is not harmed.
5. The physician shall not demand, receive, or give incentives of any kind whatsoever
in order to permit exposure of the patient to the media.
6. The physician shall ensure that medical education and/or medical publicity for the
public by filming or recording patients shall be done while preserving the privacy
of the patient and with his consent only.

c) Telemedicine

1. The physician shall be entitled to maintain remote contact with a patient, by means

73 On this matter, see the position paper entitled “Privacy in the media”.
74 On this matter, see the position paper entitled “Digital communication and social media”
75 On this matter, see the position paper entitled “Telemedicine”.
of the internet or some other suitable means of telecommunications.

2. The physician shall be professionally responsible for treatment given remotely.

3. The physician shall maintain remote professional contact with the patient while ensuring the privacy of the patient and the confidentiality of the medical information.

4. The physician shall avoid giving remote treatment to a patient he does not know, and shall, in these circumstances, limit the treatment to giving general advice only.

5. The physician shall avoid giving remote treatment in all cases in which a physical examination of the patient or a direct impression of his mental condition is required.

6. The physician shall be entitled to give remote medical treatment to a patient he knows, provided that the giving of the remote treatment is reasonable under the circumstances.

d) Physician publicity and advertising\(^{76,77}\)

1. The physician shall be entitled to publicize his name and degree, his medical qualifications (including recognized specialties), his fields of occupation, his positions, place of employment, reception times, and the means of contacting him.

2. The physician bears responsibility for all publicity issued by him or that was done in his name or for him, even if done by someone else, and shall make every effort to avoid improper publicity.

e) Prohibition of misleading the patient by means of publicity and advertising

1. The physician shall verify that the information published by him is correct and verifiable, and shall avoid publication of erroneous or partial information that misleads the public, or furnishing advertising information that purports to be objective.\(^{78}\)

2. The physician shall avoid indicating rates of success of the treatment given by him and shall not publicize a commitment to expected results or cures.

3. The physician shall avoid publicity that praises his skills, knowledge, or qualifications.

4. The physician shall not publicize the advantages of a specific medical treatment without listing its corresponding risks and disadvantages.

5. The physician shall not make use of images of famous and well known persons or of persons regarded as being famous, whether patients or physicians.

f) Prohibition of using a misleading title in publicity and advertising

1. The physician shall avoid using the term “specialist” or “specialization” regarding

\(^{76}\) On this matter, see the position paper entitled “Advertising and publicity”.

\(^{77}\) On this matter, see the position paper entitled “The prohibition of advertising on the radio or television”.

\(^{78}\) On this matter, see the position paper entitled “Marketing disguised as academia”.
fields that are not recognized in Israel by the Scientific Council as fields of specialization.

2. A physician who makes use of a non-medical degree shall expressly indicate the other field after his degree in medicine, in such a way that would not lead a reasonable person to assume that this is a medical degree.

3. A physician who makes use of a medical degree granted abroad, that is not recognized in Israel, shall state expressly the place and time when the degree was given, so as not to lead a reasonable person to assume that the degree was given or is recognized in Israel.

g) **Prohibition of harming the public through publicity and advertising**

1. The physician shall avoid any publicity liable to harm patients.

2. The physician shall not encourage the use of medical treatment not in accordance with medical indication.

3. The physician shall not persuade a patient to receive medical treatment by means of scare tactics or intimidation.

4. The physician shall not make use of private parts of the body for the purpose of self advertising.

5. The physician shall not make the giving of medical treatment dependent on the purchase or receipt of some other medical treatment.

6. The physician shall not make any use of patients, including publicity, even with their consent, including their names, appearances, voices, recommendations, or parts of their bodies.

h) **Prohibition of harming the honor of the profession**

1. The physician shall avoid any publicity liable to harm the honor of the profession.

2. The physician shall avoid the publication of tariffs for medical treatments and shall avoid publication of discounts, special offers, or any other benefit in consideration for receiving the medical treatment.

3. The physician shall avoid publicity or participation in advertising for commercial products, whether medical or non-medical.

4. The physician shall be entitled to participate in publicity for the advancement of public health, provided that the information has a scientific basis, and that no use was made of the commercial name of a product or technology of a specific company.

5. The physician shall avoid publicity that praises or encourages the receipt of private medical treatment over public medical treatment.

6. The physician shall avoid publicity that expresses contempt, slander, or denial of the capability of another physician.

7. The physician shall avoid publicity that emphasizes exclusivity or uniqueness of a skill or method of treatment.

8. The physician shall not advertise himself or permit others to advertise him by
means of the distribution of leaflets, telemarketing, billboards, agents, or PR persons. 
9. The physician shall avoid self-advertising on radio or television. 

i) The physician and social media

1. The physician shall carefully consider whether he wishes to include in his social network people under his medical care.
2. The physician shall take care to distinguish on social media between his personal and professional identity.
3. The physician shall be stringent about the textual and visual content that appears on his social network and shall work to maintain both his own professional status and the status of medicine in general.

j) Physicians in the media – freedom of speech vs. the dignity of the profession

1. The physician has the same right to freedom of expression as do all citizens of the country.
2. The physician shall weigh his words when speaking to the media, and when speaking in general, in the spirit of Avtalion’s injunction, Sages, be careful with yours words... (Mishnah, Tractate Avot).
3. The physician shall behave responsibly, with consideration, respect and tolerance when speaking generally, and to the media in particular.
4. The physician shall speak with restraint in any circumstances involving his profession or place of employment.
5. The physician shall not take improper advantage of his status when presenting an opinion in reliance on his or her knowledge of medicine.

8. The physician and the medical institution 

a) The salaried physician

1. A salaried physician employed by a medical institution or organization is not released from his medical obligations to the patient because of limitations imposed on him by the employer.
2. A salaried physician shall act for the good of the patient and shall give warning, to the best of his ability, if in his opinion, limitations imposed upon by him by the employer are liable to harm the patient’s health.

b) Quality measurements for physicians

1. The physician shall observe clinical guidelines and quality criteria based on scientific evidence as accepted means for improvement of the level of medicine,

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79 On this matter, see the position paper entitled “The physician and social media.” 
80 On this matter, see the position paper entitled “Physicians in the media—freedom of speech vs. professional dignity.” 
81 On this matter, see the position paper entitled “Quality criteria for physicians.”
provided that they are not used for purposes of enforcement or punishment against physicians.

2. The physician shall act through the relevant scientific associations and in cooperation with the employers, for the development of these means.

3. The physician shall be entitled to receive incentives, including financial remuneration, for clinical performance that complies with these quality criteria, provided that the criteria are implemented with prior agreement between the physician and the employer.

4. The physician shall not act contrary to clinical instructions or proper medical practice in order to receive any incentive whatsoever, including financial remuneration.

c) Responsibility of managers

1. The managing physician has an obligation to act for the good of the patients in the institution that he manages.

2. The managing physician shall take steps to ensure the assimilation of the ethical code amongst the workers subordinate to him.

3. The managing physician shall be responsible for the ethical and professional conduct of those subordinate to him, even if he is not directly involved in the medical treatment they provide.

4. The managing physician shall respect the ethical and professional autonomy of all the physicians acting under his authority.

5. The managing physician shall advance information and monitoring infrastructures, so as to permit him to be aware of and assume responsibility for what is done in the institution that he manages.

6. The managing physician shall strive to raise the professional standard of those subordinate to him and shall facilitate this in every possible way.

d) Whistleblowers

1. The physician shall act to expose corruption in the medical system brought to his knowledge.

2. The physician shall inform the direct manager heading the administration where the corruption occurred, and the Israeli Medical Association shall act to protect the whistleblower, if needed.

3. The physician shall consider whether to share with the patient the corruption he exposed, according to the circumstances.

82 On this matter, see the position paper entitled “Whistleblowing-exposing corruption in the healthcare system”
Part E

Position papers of the Ethics Board
1. New technologies – the Cypher stent as an example

Published in December 2004

Background

Our colleagues the cardiologists have recently found themselves, against their will, in the center of a public storm in which they are accused of a lack of sensitivity and indifference to the distress of patients treated by them. Most of the criticism has been directed at the physicians in the context of the new Cypher Stent, which is not included in the health basket. (See “The Dilemma of the Cardiologists”, Ha’aretz, 24.8.04, by Prof Michael Glickson and Prof Zvi Vered). But the Cypher is only one example of all the new technologies hammering on the doors of the health basket that have not been granted entry.

The physician giving treatment finds himself trapped in a constant dilemma that he cannot solve to the satisfaction of all those concerned. On the one hand, he has the ethical and legal obligation to explain to the patient that there exists a medical treatment, drug, or advanced technology of some kind, which in his professional opinion is the best for the patient at a given time.

On the other hand, the proposed treatment is frequently not included in the health basket and its use involves a significant financial expense. The distress and anger of the patient is sometimes absorbed by the physician, who although innocent, represents for the patient the injustice of the entire medical system.

The situation gets even more complicated since in various hospitals there exist different instructions and conflicting rules regarding to whom, for example, it is permitted and desirable to offer this or that innovative treatment. The solution lies in the Ministry of Finance and the Ministry of Health. The waiting time must be reduced as far as possible and innovative technologies of proven effectiveness that can clearly improve patients’ health must be added to the basket. Until then, the members of the Ethics Board have formulated rules for proper conduct for physicians facing a dilemma of this kind.

Position paper

- Medical research constantly yields new means of diagnosis and treatment.
- Sometimes a protracted period elapses between the appearance of a new medical technology that has been proven to be effective and its inclusion in the national health basket.
- During this period the health care organizations are not budgeted for the new technology and they do not reimburse the patients for use of this technology.
- Due diligence obligates the physician to inform the patient of the existence of the new technology, even if it is not included in the health basket.
- This obligation stems from the patient’s right to participate in the choice of treatment given to him.
- The relevant medical information shall be given to the patient as soon as possible in order to allow him time to think and consult, as needed, and to give his informed consent.
The information shall include details of the effectiveness, safety, and cost of the proposed treatment, as well as similar details regarding alternative treatments.

The information shall include details regarding economic interests, if any, of the treating physician and of the medical institution in which the proposed treatment will be given.

The physician giving the treatment shall not act as an agent or intermediary of a commercial company.

2. Must a physician inform his patients of his state of health?

Background
The affair of Dr Sergei Pontos is still fresh in the public memory. Dr Pontos, an anesthesiology resident, was infected with the Hepatitis C virus during the period of his employment in the hospital, and, according to the Statement of Claim filed against him, was addicted to narcotic drugs. He used to inject himself with these drugs during his work, while making use of the same syringe for himself and his patients, and thus infected about 30 patients with his illness.

Although this case is extremely unusual and does not reflect the reality customary in medicine in Israel, the affair, like that of the heart surgeon suffering from AIDS, aroused intense public debate. The questions that arose are whether a hospital is entitled to employ a physician, especially in operating theaters, when it is known that he is suffering from an infectious disease, and whether patients should be informed of the physician’s illness.

The Patient’s Rights Law states that medical treatment shall not be given to a patient unless he has provided his informed consent, after being informed of the risks and benefits in the proposed treatment. Some people hold that the state of health of the surgeon must be included in this information, in order to permit the patient to decide whether to agree that a specific physician, and only that physician, shall treat him.

Others who support this approach feel that even if a sick physician did not infect the patient, the later discovery that the physician suffered from an infectious disease, and the patient’s subsequent need to undergo periodical medical tests to check his state of health, are liable to cause emotional stress and physical harm. These can and should be avoided in advance by full disclosure. The proponents of transparency think that only this approach will maintain relations of trust between the physicians and his or her patients.

At the other end lies the sick physician’s right to privacy, self-respect and freedom of occupation, just like every other patient.

The Physicians Ordinance [new version] 5736-1976 states that "If the manager (the Director-General of the Ministry of Health – A.R.) saw that a certified physician is suffering from a dangerous disease (that endangers the public – A.R.) he shall be entitled to demand that he appear before a medical board for examination”. If the specialists in the said board were convinced that the medical condition of the physician does not constitute a risk to his patients, that physician is entitled to medical confidentiality like every other person, and he should not be obligated to
disclose the state of his health to his patients. The imposition of such a sweeping obligation would constitute disproportional damage to the sick physician. If the competent authorities ruled that a physician is entitled to practice medicine without restriction, then details of the medical condition of the physician are not presumed to be "medical information" required for the patient by virtue of the Patient’s Rights Law in order to make a decision. The knowledge that the state of health of the sick physician will be kept as confidential information will encourage sick physicians to report the state of their health on their own initiative and of their own free will. It will also permit them to receive early and effective medical treatment for their illness. Only in this way, will the broad interest of public health be best served.

**Position paper**

- A physician suffering from an infectious disease endangering his patients must avoid giving medical treatment or taking medical responsibility for their health.
- A physician suffering from an infectious disease that does not endanger his patients is not obligated to notify them of the state of his health.
- The decision regarding the likelihood that the infectious disease of a specific physician will harm his patients shall be made in accordance with the professional criteria customary in Israel and abroad.
- In this position, a balance is maintained between the public interest to receive safe medical treatment and the right of the physician to privacy, self-respect, and freedom of occupation.

**3. Rules for determining legal capacity - IMA steering committee recommendations**

*Published in February 2017*

**Background**

On June 2, 2015, the IMA Ethics Board conducted a discussion on the provision of expert opinions for guardianship in the State of Israel. According to the data presented to the Ethics Board, tens of thousands of people in Israel have been deemed incompetent and deprived of the autonomy to make decisions concerning their body or possessions. This compares to a relatively small percentage of patients considered incompetent in European countries.

In the wake of the discussion, the members of the Ethics Board surmised that there might be excessive use of the power to determine that a person lacks competence to make decisions concerning his body. Therefore, the Ethics Board decided to form a professional committee that would issue precise recommendations on medical decisions indicating that a person is incompetent. The Ethics Board also decided to establish a training course to define appropriate criteria for rescinding a person's right to decide about his body and possessions, while respecting and appreciating the importance of this right to autonomy.

The committee deliberated from January through May of 2016 and agreed on the following:
Part E

The basis for any medical treatment is the patient’s informed consent. This is based on the rules of ethics and the Patients’ Rights Law. Consequently, a physician is required to confirm that the patient is competent to give informed consent, and in the absence of competence to make decisions, an alternative agent must be found to act in the patient’s place.

The lack of competence to make decisions is a legal term, but in practice, the determination is performed by physicians who refer cases for further discussion in court.

With the rapid aging of the population, the challenges related to legal capacity and guardianship are growing. These challenges include: an increasing percentage of people with dementia and emotional disorders (depression, anxiety), a decline in function and increase in the percentage of incapacitated people who depend on others, the exclusion of the elderly in society and a condescending attitude toward them, and a lack of sufficient mechanisms for protecting the incapacitated and safeguarding basic rights.

The basic principles guiding the physician include safeguarding the patient’s autonomy and right to determine his preferences, and the obligation to care for the patient’s health and wellbeing. These principles often clash and create an ethical dilemma.

Society reserves a place of respect for an individual’s autonomy, as anchored in the Basic Law: Human Dignity and Liberty.

The Legal Capacity and Guardianship Law states:

"Every person is eligible for rights and obligations from birth to death;
"Every person is competent for legal activity unless this competence has been removed or restricted by law or by a court ruling;
“A person who is unable to tend to his affairs due to mental illness or impairment may be declared by the court as incompetent."

There are specific tools for assessing decision-making competence, and these are different from the tools used to diagnose dementia, intellectual disability or mental illness. For example, the Aid To Capacity Evaluation (ACE) tool83 is widely accepted in the world, but there are many other tools. Diagnostic tools suitable for assessing cognitive function are not necessarily suitable for assessing the capacity to make decisions.

Upon the appointment of a guardian for an adult, he ceases to be independent from a legal perspective and his affairs are managed by someone else. This entails a severe blow to his freedom and privacy.

Alternatives for safeguarding a person’s autonomy, without the need for a hurtful process of guardianship, include various powers of attorney for medical treatment (for example, under the Patients’ Rights Law and the Terminally Ill Patient Law).

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83 http://www.jcb.utoronto.ca/tools/documents/ace.pdf
Part E

Studies have shown that determinations made by a proxy under power of attorney are truer to a person’s wishes than decisions made by his relatives. It seems that the people closest to us understand our wishes on medical issues in only 30% of the cases. Therefore, the committee encourages the public to appoint a proxy while the person is still competent.

Assessing competence

Assessing competence to make decisions includes:

**Essential components:**
1. **Understanding** – the ability to understand the information communicated (treatment, surgery, research, etc.), complications/risks and opportunities.
2. **Evaluation** – the ability to evaluate the relevance of the information communicated about the health of the patient himself.
3. **Logic** – the ability to use information to conduct a logical process of decision-making.
4. **Expression** – the ability to express a decision.

**In addition:**
1. A diagnosis of intellectual disability, cognitive decline, dementia or mental illness does not in itself determine a person's incompetence to make decisions.
2. Competence to make decisions depends on the decision itself. Incompetence to make one particular decision does not imply incompetence for making other decisions. Therefore, competence must be examined for each decision separately.
3. Competence for decision-making is likely to change over time.

**Physicians who assess competence**
1. When suspicion arises that a patient is incompetent to make decisions, an expert’s assessment is required – under the directives of the Ministry of Health and in accordance with the area of expertise and training. A mentally ill patient must be assessed by a psychiatrist.
2. When an expert determines that a patient is incompetent, a signed expert’s certificate is required for submission to Family Court in order to issue a guardianship order.
3. The expert’s certificate should include the components of assessing decision-making competence and an explanation of how the expert concluded that it is necessary to appoint a guardian.
4. During a period of hospitalization, the certificate should be limited to the period of hospitalization and absolutely no assessment should be made regarding possessions. This is because the situations relevant to the determination are likely to be limited to this period only.

**Need for training**
The Israeli Medical Association, led by the steering committee on incompetence, will establish a training course recommended for all medical personnel whose work relates to this subject. The course will train physicians from fields of expertise who are able and interested in serving in this role. In addition to reviewing the illnesses and professional directives for diagnosis and examination, the course will include content related to the patient’s welfare and fidelity to the
patient, with an emphasis on the relevant rules of medical ethics.

**Professionals**
The committee believes that only a medical expert should be authorized to **declare a person incompetent**.

Professionals who are not physicians can be involved in determining that a person is competent (a positive decision), as long as there is no other valid determination by a medical expert, and provided that the professionals have passed the training course. It should be emphasized that professionals who are not physicians **will be required** to pass the training course.

It should also be noted that social workers are involved in the legal proceedings, and thus the committee believes that the determination of competence should be left in the hands of psychologists (experts in the clinical or rehabilitation field) or registered nurses.

**List of experts**
The committee believes that the IMA should compile a list of experts who passed the training course.

Members of the committee: Dr. Tami Karni, Prof. Rael Strous, Dr. Simona Naor, Dr. Igor Barash, Prof. Tzvi Dwolatzky, Dr. Yoram Maaravi, Dr. Irena Sibin, Dr. Leah Aharoni, Dr. Vera Rosenfeld, Prof. Yehudit Aharon-Peretz.

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4. **An additional opinion for a hospitalized patient**

*Published in February 2004*

**Background**
The Ethics Board has received complaints regarding the professional conduct of physicians who came as external consultants for patients hospitalized in a hospital or in departments that are not the regular place of work of said consultants.

We must clarify at the outset that every hospitalized patient or his representative is entitled, pursuant to the Patient’s Rights Law and in accordance with accepted contemporary medical culture, to call for medical consultation of their choice.

The medical staff is obligated to cooperate with the consultant. However, it is proper to set limitations and instructions for his work and cooperation with the medical staff treating the patient, in order to preserve the health of the patient on the one hand, and the position and respect of the medical staff on the other hand.

One of the complaints involved a question of whether it is proper to coordinate the visit in the ward where the patient is hospitalized. That case dealt with a family’s lawyer, who allegedly notified the staff in the ward of the arrival of the physician. In fact, as it subsequently transpired, he gave notice of the visit only to the nurse in charge that day, while the head of the department, his deputy, and the director of the hospital, were unaware of the intended consultation.

The consultant physician, meanwhile, assumed notice was given by the lawyer and did not himself bother to check whether notice of the visit had been given, as required, and that the staff in the department had in fact consented to his arrival.
Since the consultation centered on the hospitalization of a patient who at that time was at the center of a public storm and an intensive dispute regarding the ethical ramifications of his treatment, the management of the hospital viewed with great seriousness the consultation held without its knowledge, and submitted a complaint to the Ethics Board.

The members of the clarification committee of the Ethics Board invited the physician for clarification and received the impression that he had acted in good faith and that he had received misleading information from the lawyer. However, the members of the committee felt that the consultant should have coordinated the visit by himself, and consequently they decided to record a warning for the physician regarding his actions.

In another complaint, a sharp dispute arose around the issue of whether a consultant who arrived to examine a patient at the family’s request was entitled to write his opinion on the patient’s chart. The dispute in this specific case became even more acute since the consultant criticized the quality of the treatment received by the patient and even suggested that he give a different treatment.

The medical staff in the department felt that “the medical file of the patient belongs to the department” and that the department physicians “are not clerks who have to carry out the instructions of the consultant”. These physicians felt that the entire incident led to “a rift in physician-patient relations” and they demanded an apology from the consultant for his entry to the department during the evening, without their knowledge, and for the fact that he had not bothered to inform any of them directly of the findings and conclusions that emerged from his visit.

Following these complaints, the members of the Ethics Board felt that binding rules should be written for the proper conduct of a consultant of a hospitalized patient. We hope that their publication and implementation will prevent similar complaints in the future.

**Position paper**

- A hospitalized patient or his representatives are entitled to request an additional medical opinion.
- The medical staff shall permit this consultation in accordance with the choice of the patient or his representative.
- The consultant shall himself coordinate in advance with the department head or his deputy the date of the consultation.
- On arrival in the ward, the consultant shall introduce himself to the medical and nursing staff.
- The medical record shall be put at the disposal of the consultant, and if necessary, he shall receive additional details from the medical staff.
- During examination of the patient, the consultant shall permit the presence of a member of the medical or nursing staff of the department.
- At the end of the visit, the consultant shall summarize his findings, conclusions, and recommendations for the patient or his representative.
- The patient or his representative shall be entitled to decide whether a representative of the staff of the department treating the patient shall be present at the summary
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The consultant shall summarize in writing his findings, conclusions, and recommendations. The summary shall be given to the patient or his representative and, with their consent, to the department treating him. The consultant shall, at the end of the visit, inform the medical staff of his findings, conclusions, and recommendations. The medical staff shall consider the opinion of the consultant and shall act in its best judgment for the good of the patient.

5. Medicine and faith in medical treatment

Published in June 2006

Background
The capability of medicine to help and heal is not guaranteed in every case. Physicians are well aware of this limitation, but most of the public is not prepared to accept this reality. Consequently, it is common to find, especially in life endangering situations, that some patients, and their relatives, search in their distress outside the medical system in order to receive aid. In this way, the physician is liable to find himself facing advice and instructions of a religious person, or popular beliefs, which conflict with his professional knowledge or viewpoint. How should the director of an intensive care unit act when he is required to permit in his unit a ceremony involving the beheading of seven doves in order to save a mortally sick patient he is treating? More than one of us has been witness to such a demand. (According to popular belief, this is a proven remedy for grave jaundice.)
The medical literature addresses this dilemma very seriously, and in recent years, many articles have been published in the most distinguished journals on this subject. We have also been informed recently that a large hospital has begun to provide “spiritual support” inside its walls, while promoting an initiative to turn “spiritual supporter” into a recognized paramedical profession. Although there is no scientific proof that belief or prayer provide a better chance for recovery than for a patient who does not believe, this belief has considerable subjective value in the eyes of the believing patient that must be respected, even if not absolutely.
The Patient’s Rights Law and the principle of the patient’s autonomy over his body award him the freedom to choose treatment out of the possibilities available to him - both inside and outside the bounds of traditional medicine. As we have said, this choice is sometimes liable to conflict with the principle of the autonomy of the physician, although this has never been specified by law. The autonomy of the physician, in the opinion of members of the Ethics Board, includes, inter alia, his viewpoint, personal belief, and professional positions. In a debate held within the Ethics Board, its members attempted to formulate rules for proper medical conduct in situations in which the patient’s autonomy conflicts with the physician's autonomy, on the boundary of clarification between scientific-traditional medicine and belief.
The following are these rules:

**Position paper**

- The principle of the patient’s autonomy over his body permits the patient to determine the nature of the treatment given to him.
- Some patients within in the medical system prefer treatments in which an element of belief or religion is dominant.
- Belief and religion serve as a source of strength and hope for the believing patient, and this is the source of their subjective importance for the recovery of the patient.
- The physician shall permit the patient to receive services of belief or religion, but he is not required to supply them himself.
- Situations may occur in which treatments that originate in belief or religion conflict with the professional position of the physician treating the patient in particular and with medical knowledge in general.
- The physician must not be forced to give any treatment whatsoever that is contrary to his professional judgment or to his conscience.
- However, the physician shall respect the wishes of the patient for any such treatment, as long as acceptance of the patient’s request does not cause immediate harm to his health, danger to the health of the other patients or to the medical staff, and as long as the treatment does not come at the expense of the medical resources required for other patients.
- As far as possible, it is preferable to combine spiritual and belief aid simultaneously and in addition to routine medical treatment, without causing conflict between the two.

### 6. Medical treatment for cognitive enhancement

**Published in February 2011**

**Background**

Human beings have always adored human beauty. Beauty accords a Darwinist advantage in human society. It symbolizes youth, vitality and power, and portends a greater chance of success in life.

Aesthetic surgery aimed at preserving beauty, and in accordance with the public’s demands, entails “non-therapeutic” medical procedures. The attending physician does not determine the need for treatment, as in all other branches of medicine, but rather, the patients themselves. The patient does this because of a subjective need that springs from his self-image, even if in the eyes of an objective observer there is no need for any change in his body. The patient is also the one who determines the “success” of the treatment in accordance with his satisfaction with the result. The treatment is, by definition, designed to make the patient happier. Happiness becomes a consumer product and, like other consumer goods, moves from the supplier to the consumer.
However, medical capabilities today are not limited to the beauty industry. Today it is possible to utilize medical techniques to improve the motor skills, cognitive ability, mood and behavior not only of those who are sick or impaired, but also of healthy people. The pressure on the medical profession and physicians from healthy people seeking to acquire a social advantage in these areas is growing.

This requires physicians to define for themselves their role in the society. Is the role of medicine to heal sick people or to transform healthy people into gods? Are physicians permitted to improve and boost the cognitive ability of a healthy person upon his request?

This raises questions in the social discourse: Should we prescribe a medication used to treat patients suffering from attention deficit disorder (ADD) to a healthy student in order to increase his capacity to study and thus give him an advantage over his fellow students? Should we give an elderly person who is experiencing a decline a memory, which is natural and widespread at his age, a medication used to treat Alzheimer patients, even if he does not suffer from this disease? Should we give a medical intern a drug to boost his alertness during his night shift in order to lower the chance of him making an error during the long and demanding shift?

Advocates of “empowering medicine” believe that every person has the right to fulfill himself in every way, as long as this does not harm others. The improvement in quality of life, they argue, is not only measured according to indexes of illness, and the boundary between illness and health is not crystal clear. In responding to the patient’s request for empowering medicine, the physician is acting to help the patient and is not upsetting the social balance – after all, human society is not egalitarian to begin with.

Opponents of “empowering medicine” argue that if physicians broadly adopt this approach, the nature of society would change for the worse: The wealthy would be able to take advantage of this medical treatment and become, along with their descendants, smarter and richer still. These opponents believe this would create widespread social pressure for these medications. In fact, we already see the harbingers of this today in the prevalent use of Ritalin among healthy students. Moreover, employers could require the use of stimulants and drugs that sharpen thinking abilities, and the same might apply to government authorities including security forces, the army and the police. There is also concern that once this window is opened, even a crack, the pharmaceutical companies would leverage “market forces” and encourage the use of these medications at the expense of limited economic resources.

In an attempt to balance these extremes, the members of the Ethics Board formulated the following position paper.

**Position paper:**
1. The traditional role of the physician and the medical profession is to maintain the patient’s health and quality of life. The goal of modern medicine is to enhance the patient’s quality of life, even when not suffering from illness.
2. In defining the concept of health and quality of life, we take into consideration the patient’s subjective feelings about his condition. Consequently, the society accepts, for example, cosmetic medical treatments that sometimes change a person’s appearance, upon his request and in accordance with his desires.
3. Today, medicine is also capable of boosting the cognitive abilities of healthy people, but requires “societal authorization” to do so.
4. "Empowering medicine" is thus ethical if it benefits a healthy patient and entails only a marginal risk.
5. Physician-patient relations also exist in conditions of “empowering medicine” and are subject to all of the rules of the profession.
6. The physician will professionally consider any patient request for empowerment, but is not obligated to fulfill the request.
7. The physician will consider the request in light of the fact that it would be an off-label prescription.
8. The physician will ask the patient to sign his informed consent for any empowerment treatment and will conduct periodic assessment of the treatment’s effectiveness and necessity during its use, as is customary.
9. Prescribing medication in conditions of “empowering medicine” is prohibited in the context of patients who lack legal capacity.

"Empowering medicine” will be administered at the patient’s expense and its economic cost will not be imposed on the society at large.

7. Limitations on the obligation to provide medical treatment

Published in May 2007

Background
A few years ago, the medical committee in Britain was in uproar following the amputation of a healthy leg by an orthopedic physician at the request of the patient, who demanded the operation since he regarded his healthy leg as a foreign body that did not belong to him and even affected the quality of his life. The case caused a stormy argument that addressed various aspects, beginning with the neurological diagnosis of the foreign organ syndrome and ending in clear-cut psychiatric diagnosis of Munchausen Syndrome (Apotemnophilia).
One side of the argument focused on the role of the surgeon in this strange amputation and the ethical aspect of his actions. It was only a short step from here to the obvious question – is a physician obligated to accede to the request of a patient for any medical treatment whatsoever or should he limit his agreement, and if so what is the limitation that he must set.
This issue was raised in Israel after the death of a woman who gave birth by caesarian section, without medical justification. Although the woman expressly demanded the operation and gave proper advance approval for its execution, a rare but known complication of the operation caused her death. As in Britain, here, too, the case aroused questions regarding the balance required between the wishes of the woman giving birth and the prima facie obligation of the physician to meet them, or his right to refuse to do so.
Israeli law has codified basic human rights and a person’s full autonomy over his body. A patient has the right of absolute refusal to receive medical treatment, but the right to receive medical treatment is limited by other interests, including laws enacted by the State, as well as the
autonomy of the physician and his right not to give medical treatment that is contrary to his professional conscience or position, except in life threatening emergencies.

In a caesarian section performed without medical reason at the request of the woman, opposing interests come into conflict. On one hand, lie the principles of freedom, dignity, and autonomy of the woman, that express her right to decide what is done to her body and how to bring her children into the world. On the other hand, no ethical or legal obligation is imposed on the physician to carry out every demand of the woman giving birth. The physician is entitled to retain his freedom of choice and decide whether to accede to the woman’s demand to receive medical treatment that in his opinion is unsuitable from professional or ethical standpoints.

In the attached position paper, the members of the Ethics Board have specified the circumstances in which the physician is entitled to refuse to give medical treatment at the request of the patient.

**Position paper**

- Optimal medical treatment is based on full cooperation between the patient and the physician.
- Basic Law: The Dignity and Freedom of a Person and the Patient’s Rights Law grant the patient the freedom to choose alternative forms of the medical treatment that he will receive. This right is not absolute and is limited.
- The physician has no ethical or legal obligation to carry out every demand of the patient, except in the case of urgent lifesaving treatments.
- The physician must refuse the request of the patient to receive medical treatment that is contrary to the laws of the State.
- The physician is entitled to refuse the request of the patient to receive medical treatment if this treatment is contrary to his professional position or his conscience.
- The physician must attempt to persuade the patient not to receive treatment that in the physician’s opinion has no medical justification.
- The physician shall examine the patient’s request in a professional manner, without foreign considerations.
- The physician’s freedom of choice not to give treatment without medical justification preserves his autonomy and professional integrity.

**8. Termination of the physician-patient relationship on the physician’s initiative**

*Published in September 2009*

**Background**

The professional connection between the physician and the patient obligates cooperation based on full mutual trust. Unfortunately, this connection does not always match reality. In most cases, the patient is the one who expresses dissatisfaction with the physician – regarding his character, professional conduct or personal behavior or even regarding the very medical
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Position paper

- The physician is obligated to give medical aid to the patient as long as the patient needs this aid.
- In emergencies, this obligation is absolute.
- Circumstances exist in which the physician is entitled to terminate an existing medical connection with a patient.
- Such circumstances include, for example, a violent patient, a patient who does not obey medical orders, or a patient who makes excessive demands on the physician.
- Termination of the connection is also possible when the physician retires, when the physician moves to a different geographic region, or when the physician changes his field of occupation in medicine.
- The patient's health must not be affected during termination of the medical connection.
- The patient must be notified in advance of termination of the relationship and be permitted to make alternative arrangements.
- As far as possible, the patient must be helped to find an alternative physician.
- The medical record must be transferred, with the patient's consent, to the alternative physician.

9. The physician shall be entitled to notify his patients regarding his new place of work

Published in June 2006

Background

Dr B. stopped working in a certain hospital after 24 years and after being unsuccessful in a tender for management of the institute in which he worked. The termination of his work was accompanied by much discord, and required the intervention of the chairman of the physicians' committee and the chairman of the Israeli Medical Association in order to settle the terms of his retirement. A few months later, Dr B. began working in another hospital, from which he sent a letter to all his patients in the former hospital, informing them of his new place of work, and even offering a free first visit in his new place of work.

The management of the first hospital complained to the management of the second hospital about this letter. In response, the management of the second hospital sent a letter of apology, which was also sent to Dr B.'s previous patients. In addition, Dr M., who had been appointed as the director of the institute in which Dr B. worked in the first hospital, sent his own letter...
to all the said patients. In this letter, he alleged that Dr B.’s conduct was not compatible with the accepted ethical code. Dr B. then sent a complaint to the Ethics Board of the Israeli Medical Association, claiming that the letter harmed his good name.

The clarification committee of the Ethics Board found the complaint to be justified, but also that the complainer himself had committed an ethical offence. The committee rejected a counter complaint of “stealing patients” or unauthorized use of a list of patients, but found a defect in the letter of Dr B., who offered a free first visit.

The clarification committee decided, inter alia, that Dr B. would apologize in writing to Dr M. and the management of the first hospital for the wording of the letter, which prima facie implied enticing patients to transfer to the new hospital. The management of the first hospital and Dr M. would themselves publish an apology for the letter in which it was written that Dr B. had not acted in accordance with the ethical code.

Dr B. did in fact apologize as required, but Dr I., the director of the first hospital, appealed against the decision of the clarification committee. The appeals committee of the Ethics Board ratified the decision of the clarification committee that Dr B.’s letter from his new place of work constituted an attempt to entice patients to transfer to the new clinic, thus constituting an ethical offence. The committee also ratified the previous decision, that Dr M.’s direct approach to Dr B.’s patients – in the wording used – constitutes libel against a professional colleague and should also be condemned.

It was also clarified that in addition to his actions as set forth above, Dr. M. sent “inaccurate” details to the second hospital regarding the termination of Dr. B’s employment at the first hospital. Regarding Dr I., the director of the first hospital, the appeals committee ruled that he had committed no ethical offence, and that it was not authorized to decide whether the hospital as an institution had committed such an offence.

Both Dr B. and Dr M. were given a warning by the appeals committee of the Ethics Board. The committee decided that the details of the affairs would be published without stating the names of those involved. The committee also decided that the subject would be brought for discussion in a plenary session of the Ethics Board.

Following the discussion held in the Ethics Board, it was decided to publish the position paper as set forth below.

**Position paper**

- The patient has the right to receive continuous and orderly medical treatment.
- This right also implies the right to receive medical treatment from a permanent personal physician.
- From this is derived the patient’s right to know where the physician who had treated him until now has gone to work.
- This information would permit the patient to take “a considered decision” where, how, and by whom he will continue to receive the medical treatment he requires.
- The employer must notify the patients of the physician changing his place of work of this change, within a brief and reasonable time.
- If the employer does not fulfill this obligation, the physician shall be entitled to contact
his patients and notify them of the change to his place of work.

10. The ethical obligation on the physician to disclose to the patient that a mishap has occurred in his treatment

Published in May 2004

Background
The report of the Institute of Medicine, published in the US in 1999, created waves throughout the world. It transpired from the report that more persons die in hospitals in the US from mistakes during their medical treatment than from road accidents, cancer, or AIDS. The public interest aroused in the subject was tremendous and medical mistakes became a “hot” subject from the social, legal, administrative, and ethical points of view. It is not surprising that the involvement of the regulatory authorities was sweeping and rapid and led to the commencement of a deep and fundamental, if slow, change to the way in which medicine is conducted in the US. In the wake of American medicine, medicine throughout the western world has also changed.

Medicine is not a precise science, and it cannot guarantee the absolute success of every treatment. Mishaps in medical treatment are sometimes unavoidable, and not every error or malfunction in the medical treatment necessarily constitutes medical negligence. Extensive research indicates that the great majority of the patients wish to know about every error and malfunction, even those of a minor nature, which occurred during medical treatment. However, other research, no fewer in number, indicates that we, the physicians, tend to conceal information from our patients, and do not tend to disclose the mistakes we have made. This gap between the patient’s desire and the reality on the ground becomes rapidly apparent to the patient and seriously harms the trust between him and the physician, and forms the basis for most medical negligence actions filed against physicians. Most patients who sue express feelings of anger, bitterness, betrayal, and humiliation, when they feel that vital information has been concealed from them. Most are even ready to admit that they would not have sued the physician if he had treated them in real time with fairness and integrity, while giving a full and reliable explanation and an honest apology for what had occurred.

Every person has the right “to know what treatment he is about to receive and what treatment he has already received – events, acts or omissions, and instructions that led to the situation in which he finds himself after the treatment” (Judge Aharon Barak, in the “Hadassah v. Gilad” court ruling).

At the same time, an ethical obligation exists to notify the patient of any error that occurred during treatment, which influences his health or the continuation of his treatment. Such disclosure is fully consistent with the most fundamental ethical principles – it is done for the benefit of the patient, prevents additional harm to him, preserves his autonomy in choosing the continuation of the medical treatment, and is an expression of the transparency and integrity required in the professional and human connection with him.

The pragmatic viewpoint also holds that a pro-active approach of initiated disclosure reduces the hostility towards the physician, reduces the desire to sue him in case of negligence, and
prevents sensational public exposure, which always causes damage to the physician. Many barriers exist in the path towards a culture of full exposure of errors in medicine. The public atmosphere is one of “accuse, disgrace, and punish” the physician who erred. Physicians justifiably fear that any such disclosure will lead to negative publicity, loss of reputation, loss of professional status, loss of patients, as well as disciplinary and legal proceedings, whose price is liable to be unbearable.

We are obligated to create a new social approach, in which the physician can freely report any error that he made, without necessarily being brought to trial. Only in this way can we, in the final analysis, improve the level of medicine in Israel and better preserve the health of the patient consigned to our care.

Position paper

- Medicine is not a precise science and it cannot guarantee positive results for every treatment.
- Consequently, a mishap in medical treatment is sometimes unavoidable. A mishap means a negative, unintended, and unexpected result during medical treatment.
- Not every error or mishap in medical treatment necessarily constitutes medical negligence.
- Consequently, admission of a mishap in the treatment does not mean admission of medical negligence.
- The patient has the right to know what medical treatment he has received. This right is derived from his right to know about himself, as an expression of the autonomy of the private wishes of the person and his dignity.
- Due diligence regarding a mishap in the treatment will preserve the essential trust in the physician-patient relationship.
- The patient should be informed of a mishap in treatment that has an influence on his health or on continuation of his treatment.
- The mishap should be disclosed to the patient as soon as possible, while expressing empathy and regret for the mishap that occurred.
- Disclosure shall be made by the physician in charge, and shall include information that answers the questions: what happened, when it occurred, how it happened, and what steps have been taken so that such a mishap will not recur in the future.
- The disclosure shall include information regarding the possible influence of the mishap on the patient’s health, and the steps taken to correct it.
- Assumption of responsibility is not an admission of guilt. Consequently, the physician reporting shall avoid a declaration or agreement that he, or another physician in the medical institute, are guilty of the mishap that occurred.
- Suitable rules shall be formulated, and a social and organizational culture should be created, of transparency and full reporting to the patient in the event of a mishap during the medical treatment.
11. Sexual relations between the physician and the patient

Published in August 2002

Background
The Ethics Board recently discussed the case of a physician accused in the Magistrates Court of sexual harassment of a woman he was treating.

The Court protocol indicated that “when the complainant was leaving the clinic, after she began opening the door with one hand while blowing him a kiss in the air, the accused kissed the complainant on the mouth and with one of his hands grasped her breast without her consent”. The Court sentenced the physician to six months suspended imprisonment for three years, a fine of NIS 1500 or 20 days imprisonment in its place, financial compensation in the sum of NIS 2000 to the Fund for Victims of Sexual Assault, and 100 hours community work.

The members of the Ethics Board felt that disciplinary steps from the ethical aspect should also be taken against a physician found guilty by the Court of sexual harassment of a patient. A committee of three was chosen, and met with the physician and heard his version of the incident. At the end of the meeting and after a discussion the committee decided by majority vote to punish the physician. The plenary session of the Ethics Board accepted the recommendations of the committee, as follows:

a) The accused physician shall be expelled from the Israeli Medical Association for three months.

b) The court ruling and the disciplinary proceedings in the Ethics Board will be publicized.

c) The name of the accused physician shall not be publicized.

In its decision the Ethics Board set an important precedent, despite the fact that the punishment imposed by the Ethics Board was apparently relatively light. The Ethics Board ruled that the community of physicians regards such conduct with gravity and will not hesitate to expel physicians accused of sexual offences in their relations with their patients. The plenary session of the Ethics Board held, concurrent with and following this case, a fundamental debate regarding sexual relations between a physician and a patient, even when there is no element of “attack” but rather prima facie “consent” on the part of the patient.

The basic assumption is that in the physician-patient relationship there is not, in fact, full and real agreement on the part of the patient for sexual relations with the physician, since the balance of power between them is unequal. There is a unilateral dependency by the patient on the physician. This is particularly striking in psychiatry and gynecology, where mental or physical intimacy is created between the physician and the patient. Research indicates that ten percent of physicians report having sexual relations with their patients. Other studies clearly indicate the mental harm caused to these patients as a result of such a relationship.

In a well known study, psychiatrists were asked about patients being treated by them, who were exposed to sexual relations with a previous physician; the vast majority of the physicians questioned thought that these previous relations had harmed the patient, but only a small majority of them reported this to the competent authorities. Physicians routinely defend their professional colleagues.
As members of the medical profession in Israel, we must set appropriate standards with respect to the intimate zone between the physician and the patient. We must give these ethical rules maximum publicity and, if necessary, enforce them. The rules of the Ethics Board regarding sexual relations with a patient are intended to meet this need.

**Position paper**

- Sexual relations between a physician and a patient in his care are unethical and liable to cause harm to the patient, and are consequently forbidden.
- Sexual relations between a physician and a patient who was previously treated by him are also liable to be unethical and to cause harm to the patient. Consequently a cooling-off period of at least one year is required for conducting sexual relations between a physician and a patient who was treated by him.
- Sexual relations between a physician and a patient who was previously treated by him are unethical at all times, if during them the physician exploits the trust, information, feelings, or influence acquired during the professional relationship he had with the said patient.
- Before conducting romantic or sexual relations between a physician and a patient who was previously treated by him, the physician must consider the possible negative influence of such relations on the patient’s mental condition. In the case of doubt, it is recommended that the physician consult with one of his colleagues.
- If a physician becomes aware of sexual relations, as set forth above, between a patient now being treated by him and another physician, he must report this to the competent authorities, subject to receiving the consent of the patient for this disclosure. The physician should encourage the patient to herself report the sexual relations conducted with the other physician.

**12. The acceptance of donations from patients**

Published in September 2005

**Background**

An unusual legal action has recently been filed against a surgeon by the Society of Friends of the hospital and by the management of the hospital in which the physician worked. According to the petition, the defendant is required to return to the family of a patient, who died about three months after an operation, the sum of the donation, that the deceased allegedly gave the physician in order to ensure that only he would operate on him.

The petition also states that shortly before the date of the donation, the patient and his family “were in a state of tension and anxiety and feared for the deceased’s life if the operation were to be unsuccessful, and were in such a mental state that they were prepared to pay a lot of money to ensure that the specific physician would operate on the deceased and that if complications arose during the operation, the defendant’s considerable experience and skill would help to save the deceased’s life”.

Published	in	September	2005
It was also stated that the deceased and his family “were unaware of the fact that monetary consideration provided in exchange for the surgery, whether paid directly to the surgeon or given as a donation to the Society of Friends of the hospital, was an act forbidden by law and falls within the category of bribery”.

The entire affair received considerable coverage in the press, and caused the director of the hospital to return the donation to the deceased’s family. In his statement the director emphasized that it was impossible to maintain a medical center in Israel without donations from patients. These donations are used to improve the conditions of hospitalized patients, fund additional staff members, and purchase advanced medical equipment—purposes for which the specified donation was, in fact, utilized. On the other hand, the director clarified that he did not wish to receive a donation that was not given wholeheartedly and voluntarily. This marked the end of the affair.

**Position paper**

- Medical institutions have traditionally been supported by donations. This philanthropic culture is still in effect.
- Donations shall be given voluntarily by the donor and on his initiative.
- In the event of a hospitalized patient, the donation shall be given at the end of the hospitalization and the completion of the medical treatment received.
- No pressure should be exerted on a patient in order to receive a donation.
- Neither the receipt of medical treatment, its results, or the identity of the physician giving the treatment, shall be contingent on the receipt of a donation.
- The donation shall be made through the management of the medical institution, with orderly recording and the due furnishing of a receipt to the donor.
- The donation shall be used for advancement of the professional standards of the physicians, for improvement of the service given to the patients, or for improvement of the working conditions in the department or the clinic.
- The donation shall not be used for the personal needs of its recipient.

**13. Issuance of illness certificates**

*Published in October 2006*

**Background**

The issue of illness certificates is a burdensome task imposed mainly on family physicians. Writing these certificates consumes a considerable part of their valuable time and sometimes generates friction between the physician and his patients. In an application directed to the Ethics Board a family physician asked how she should act when she is requested, for example, to approve “retroactive sick leave”. On the other hand, it is clear that it is impossible to invite every patient suffering from flu to visit the clinic in order to document his illness in real time. Representatives of the Association of Family Physicians who were invited to participate in a debate in the Ethics Board presented an additional set of ethical dilemmas related to the giving of illness certificates: Should the medical diagnosis be revealed in every certificate given to the employer? Should a certificate be given for sick leave even when not in the presence of
the patient? Is it proper to give an illness certificate to a specific person for an actual illness of another member of the family? Should the physician engage in the identification of imposters or should he believe every patient in all cases? Is the physician obligated to give warning in every case of suspicion of exploitation of the system by the patient?

A tangible economic significance exists for these ethical issues, since the certificates have a clear financial value that often constitutes a source of conflict between the vehement demand of the patient to be given the desired certificate and the professional conscience of the physician. Family physicians who work in specific communities are always subject to a real threat “of losing patients” that may harm their livelihood, if they persistently refuse to grant the desired certificate. The increasing demand on the part of employers to supply a medical certificate in respect of the employee’s absence from work contributes to a negative process, in which the physician becomes, against his will, the moral judge of his patients.

Many family physicians would consequently prefer not to be involved in issuing illness certificates. This problem may be solved by a material change to the relationship between employers and employees by means of definition or extension of "declaration days", in which the worker reports his illness without needing a medical certificate. At the same time, the granting of real financial remuneration should be encouraged for those who do not exploit these days.

Such an approach, which obligates new and revolutionary thinking, will lead to improvement of the connection and the mutual trust between the physician and his patients.

Position paper

- The illness certificate is a document that reflects situations of illness in the judgment of the physician.
- Illness certificates furnished to many entities at the same time sometimes have a considerable economic and legal significance.
- The issuance of illness certificates is part of the physician’s job, which creates considerable pressure on his professional time.
- The issuance of illness certificates sometimes creates considerable tension in the physician-patient relationship, since it is liable to produce a conflict of interests between the demand of the patient and the judgment of the physician.
- The issuance of an illness certificate to a non medical entity is liable to compromise the patient’s privacy.
- Consequently, in an illness certificate given to a non medical entity, one may write in the diagnosis section, at the patient’s request, as follows: "Because of an illness documented in the medical file".
- The granting of retroactive certificates should be avoided except in special circumstances, and if the physician is convinced that such a certificate is appropriate.
- An illness certificate should not be given for non medical reasons.
- An illness certificate should not be given to one member of a family in respect of the illness of another member of the family.
- It is proposed to extend the use of "declaration days" while granting incentives to those who do not exploit these days.
14. Certificates of fitness issued by a physician

Published in February 2015

Background

Physicians, through their practice and training, understand the human body and its proper function, as well as sickness and its effects on patients and their physical and mental capabilities. Therefore, it seems natural that the physician should be assigned the duty of “certifying” the competence of an individual to perform various tasks.

The Ethics Board was presented with requirements for competence certificates in various fields, some anchored in legislation. For example, the Fitness Club Law stipulates in section 4.a.1: "A fitness club will accept permanent members only after they submit a medical document certifying their medical competence to work out in a fitness club and which was issued within 90 days prior to the application to join the fitness club as a regular member.” Another example is the Youth Work Law, which states in section 11.a: “A youth will not be employed unless he is medically examined, and the family physician who performed the examination gives medical authorization for his employment.”

Other examples include various physical, and occasionally mental, competence forms required of slaughterhouse workers, adoptive parents, educators, medical school applicants, participants in sporting events, divers and more. Another category of competence certificates entails authorizing arrest or detention, which are inherently problematic.

During the Ethics Board’s discussion, we distinguished between the professionalism of the physician in determining a patient’s health condition, and the physician’s ability to predict the outcome of performing various tasks or participating in certain events.

In order to issue a competence certificate, a physician is required not only to evaluate the patient’s health condition at the time of the examination and any medical-related limitations that could exacerbate his or her condition; the physician must also be familiar with the physical and mental demands entailed in performing the particular activity relevant to the request. These things are not simple and require an appropriate level of professionalism.

For example: a competence certificate for a fitness club requires the physician to examine the patient’s current medical condition, but also requires knowing what the patient will do in the fitness club. There is quite a difference between walking two kilometers at a steady pace and running ten kilometers on an incline. Does the family physician really know the differences between the various activities available at the fitness club, or might this require a physician with specific training in sports medicine?

Many experts in the field claim that medical risks related to exercising should be divided into life-threatening risks – mainly acute cardiac events such as myocardial infraction or cardiac arrest (during stress or following it), and non-life-threatening risks – mainly orthopedic issues in the muscle system and skeleton. Various organizations around the world have different opinions on pre-exercise screening examinations required for fitness club memberships. The American Heart Association recommends a stress test before issuing a competence certificate for men over 45, women over 55 and people with diabetes, while the American College of Sports
Medicine recommends a stress test for anyone planning to engage in mid- or high-intensity physical activity, regardless of age or medical condition. This is only one of many examples of the different kinds of certificates needed and the problems that may arise.

Regarding the broad subject of “competence certificates” for arrest or detention, there are further limitations stemming from the commitment of physicians to their patients and the basic rule stating that a physician will do no harm to a patient. In a position paper published in the past, the Ethics Board stated that a physician should not provide any medical authorization for the seclusion or isolation of a prisoner intended for punitive purposes. The physician's role is to examine the prisoners and determine their health condition, while maintaining professional independence and responsibility for the patient's well-being.

The position paper:
1. Competence certificates issued by physicians should be based on medical discretion and a professional analysis of the medical requirements, if any, pertaining to the particular certification the patient requires.
2. When signing a competence certificate, the physician has the same responsibility as in treatment of any other medical issue.
3. A distinction should be made between a health certificate, which describes the health condition of the patient at the time of the examination, and certification of the patient's competence to perform/participate in particular tasks.
4. The physician will only be involved in certificates concerning medical issues and which require a medical examination and/or a description of the patient's health condition. It is not the role of the physician to confirm the patient's statements in issues beyond his medical condition.
5. As a rule, the wording of certificates should be as uniform as possible and focus on certifying and describing the current health condition. Certificates should not focus on the future condition or on approving a specific activity of various characteristics.
6. When certifying competence, the physician should have professional knowledge of the physical and mental requirements for participating in the activity addressed in the certificate.
7. The physician should acknowledge the limits of his professional knowledge and refer the patient to an expert in the field whenever he is unfamiliar with the medical requirements for performing the task.
8. Physicians will not automatically certify competence when they lack the required professional knowledge on the issue.
9. Physicians may refuse to issue a competence certificate for an activity that is contrary to their professional position, conscience or beliefs.
10. A physician's examination to determine competence will be conducted according to the rules of ethics and under appropriate conditions, including protection of privacy and patient consent.
11. Physicians will treat or refer a patient for suitable medical treatment if they discover a medical issue during the examination for a competence certificate.
15. Is it ethical to lie for the benefit of the patient?

Published in February 2005

Background
At first glance, the debate of this question in the Ethics Board seems to be untenable. After all, on the one hand the very question raises the possibility that physicians lie, which isn’t good. On the other hand it is clear that members of the Ethics Board can never agree to a lie for any reason whatsoever. A lie is always a lie, and cannot be accepted. Nevertheless, the changing reality imposed upon us a debate around this sensitive issue. A short search in the databases immediately produces a long list of articles in the most respectable medical journals, which provide a platform for this issue and for a variety of opinions that, surprisingly, do not always reject such a lie.

The reasons given by the proponents of such a lie are clear-cut: The physician is obligated, first and foremost, to the good of the patient for whose health he is responsible. The health system is neither egalitarian nor just, and it constantly discriminates against poor people and old persons. Consequently, it is permissible to lie to “the system” for the benefit of those patients and thus correct the wrongs of “the system”. This causes a more just distribution of the wealth between the rich and the poor.

It is permissible to lie, according to this view, if the patient cannot pay for the required treatment, which has no other effective substitute, and if in the absence of this treatment the health of the said patient will be harmed. The proponents of the lie regard the medical insurance companies as an “enemy” who conceals from the patients the small details in the insurance policies sold to the public, and feel that it is consequently justified and correct to lie to them. The fact that the patient is a real entity situated in the physician’s room, while the insurance company is an intangible abstract entity, also helps in coming to terms with the lie.

The extent of the problem in Israel is not known. Estimates in the professional literature regarding the US indicate that the damage from “small white lies” totals about 80 billion dollars a year. The results of the surveys conducted there raise difficult ethical questions. 30%-50% of the physicians admitted, according to these surveys, that they had deceived “the system” at least once for the benefit of their patients. Some of them had exaggerated the seriousness of the illness in order to prevent early release from the hospital. Some had changed a diagnosis or invented symptoms that did not actually exist in order to guarantee for the patient financial remuneration from his insurance company.

But even this lie has its own ethics. The physicians in the survey admitted that they would be prepared to lie for the benefit of the patient when speaking of life saving essential treatments. Some of them expressed readiness to lie even when speaking of cosmetic operations such as straightening the nose.

Beside the above, there are medical approvals and letters perfunctorily written by the physician, in which he rounds corners in order to give the patient a few more days of unjustified sick leave, simulated disability before a medical board and even deferment of a flight date, for prima facie medical reasons.
Opponents of the lie argue on the other hand that a lie is totally unacceptable in all circumstances. The main argument voiced by the opponents is that the connection between the physician and the patient is based on fairness and truth between the two, and that a lie that yields the patient a benefit to which he was not fairly entitled turns the physician into a criminal and a participant in a fraud. A physician who lies is regarded by the patient as an unreliable person. Consequently, a lie for the patient can rapidly turn into a lie against him. In the long term, this will cause unavoidable destruction of the reliability of the physician and the trust placed in him by the patient.

A lie in a medical report is liable to deceive other physicians who are treating the patient and will also destroy the mutual trust amongst the physicians themselves. Furthermore, if it becomes widely known in society that physicians lie, this will mortally harm the trust of the general public in medical community.

The insurance companies will not remain indifferent to these lies and will increase their means of supervision and control of the work of the physicians. The physicians will, in the end, lose part of their clinical independence, their professional pride and their social status. Such a move will inevitably lead to the diversion of resources from drugs and treatments to means of monitoring and enforcement, and we shall become the losers. The financial resources available to patients will be reduced, and the spiral will continue. The lie will always sweep the real problems under the carpet, and will delay and prevent public debate of the painful problems of management of the national medical economy.

It is not surprising that at the end of the fascinating debate held in the Ethics Board on this subject, all the participants reached the conclusion that there is no basis for lies, and that it is desirable to prevent them from entering our ranks.

16. Educated use of generic drugs

Published in November 2007

**Background**

The traditional Hippocratic medical culture, on which generations of physicians have been educated, was one of absolute commitment to the individual patient. This culture was free from considerations of "allocation of resources" or of "just distribution". These currently form the foundation stone for the post-Hippocratic economic and ethical reality of modern medicine. We no longer possess absolute economic freedom in the wasteful management of treatment of an individual patient, since by doing so we harm a broader interest of preservation of the health of the entire public.

To his detriment, the physician in the present age encounters a dual identity, one that is liable to harm his social status. On the one hand, he is the clear agent of the patient, and is supposed to act for his good in every possible way. On the other hand, the physician must also act as the agent of society as a whole, which restricts the freedom of the individual to receive every treatment and at any price.

The moment when a physician prescribes a drug for a patient clearly emphasizes this conflict.
The pharmaceutical companies are constantly developing new drugs, “ethical drugs” as they call them, whose protracted development demands tremendous investments, and the period of the patent protecting them is limited to a few years. For this reason, it is not surprising that the prices of these drugs are astronomical.

Other pharmaceutical companies specialize in the preparation of copies of the original drugs, which they rapidly introduce into the market on the date of expiry of the protection for the original drugs. Since these companies are exempt from the development of these drugs from the beginning, they can position in the market “generic drugs” that are far cheaper than the “ethical” ones. Consequently, the use of generic drugs is a broad social interest that serves the public good in that it reduces the cost of management of the national medical economy.

Health care organizations have a built-in interest to use drugs that are as cheap as possible. We must respect this economic interest as long as the substitute drug is identical in its action to the original drug, and as long as this policy is conducted properly.

The State Health Insurance Law, 5754-1994, states that “the health services included in the basket... shall be given in Israel in accordance with medical discretion, of reasonable quality... and all as part of the sources of financing available to the health care organizations”. “Reasonable quality”, in the opinion of the health care organizations, means that they can replace one drug by another as long as the substitute does not cause harm to the patient, and the continuity of the treatment is preserved. If it is proved that a specific drug is preferable for the patient, the health care organization is obligated to give the patient the drug that suits him best.

The health care organizations have not always been wise enough to observe this commitment. We all recall some foolish attempts by the health care organizations to make a sweeping, ill-considered change to the original drugs, for whole populations of patients whose medical condition was stable. The patients were required to start using the “target drugs” of the health care organization, which were always cheaper than the current drugs, whether the current drug is ethical or another, more expensive, generic drug.

There is no medical, moral, or ethical problem in starting to give generic drugs to a new patient, knowing that the substitute drug is identical in its action to the original drug, but it is not correct for the health care organization to force a physician to alter the existing treatment of a stable patient for economic considerations.

Special care is required in cases in which the patient receives a drug having a “narrow treatment range”, in which the minimum toxic level is a multiple of the minimum treatment level, and any deviation from this narrow range is liable to cause harm. Examples of this are drugs that counter epilepsy or anti-arrhythmic drugs.

The members of the Ethics Board call on the Ministry of Health to prepare, in cooperation with the scientific associations of the Israeli Medical Association, a list of drugs in this group, any change to the use of which may be done only with the express approval of the physician.

Finally, it should be recalled that pursuant to the Pharmacists Order [new version], 5741-1981, the pharmacist is entitled to sell to the consumer a commercial form of a generic drug that differs from that indicated by the physician in the prescription, unless the physician expressly specified in the prescription that the drug must be issued in the commercial name only.
The health care organizations do not always strictly observe this procedure, and no mechanism exists to notify the physician that his patient has received a drug different from that which he chose for the treatment.

Warnings should be re-issued of these systemic defects and action taken to correct them, while understanding that the physician cannot bear responsibility for the results of use of a drug not chosen by him.

Position paper
- The physician is obligated to give every one of his patients the best possible medical treatment.
- There is a concurrent on the physician to preserve the good of the general public.
- The use of generic drugs reduces costs for the medical economy in Israel, and is therefore ethically proper.
- Generic drugs shall be used provided that the health of the patient is not harmed.
- There is no impediment to commencing treatment with a generic drug, provided that it has been tested and found to be identical in its action to the original drug.
- In general, an existing drug, either ethical or generic, which has achieved treatment stability, should not be replaced for economic reasons of a third party.
- Notwithstanding the above, the physician is entitled to suggest to a stable patient that he replace an original drug with a generic drug, if he is convinced that it will not harm the patient, and provided that the patient consents, without pressure.
- An original drug that has a "narrow treatment range" should not be replaced for economic reasons of a third party, for a patient for whom treatment stability has been achieved. The State health authorities should prepare a list of drugs belonging to this group.
- Whenever the instructions of the health care organization for selection of drugs conflict with the physician’s professional judgment regarding a specific patient, an appeal mechanism, in which the physician's opinion will be heard and respected, should be employed.
- If a patient is given a drug different from that prescribed by the physician, and the replacement was made without his knowledge, it is not proper that the physician should bear medical responsibility for this.

17. Health inequality in Israel

Taken from the position paper of the Israeli Medical Association, published in February 2008

Inequality in health exists between different groups of the population in Israel and has expanded in recent years. The Israeli Medical Association recognizes the serious personal and socio-economic significance of inequality in health and in the health services, and sees as its obligation to warn against the grave consequences of the letting the existing situation continue without immediate intervention.
The inequality is reflected, inter alia, by the following criteria:

- Life expectancy (3-4 years less in the peripheral areas in the south and north as compared to the center of the country; 4-5 years more in Jews than in non Jews).
- General mortality rates related to the level of education (significantly higher in persons having 0-8 or more years of education than those having 13 or more years of education).
- Mortality rate in babies (in addition to the fact that the mortality rate in the non Jewish population remains twice that for the Jewish population). The mortality rate in babies born to women with very low education is 4.6 times higher than that amongst those whose mothers have academic education. A few years ago the ratio was 3.5:1.

The situation is similar regarding morbidity. For example, the incidence of diabetes is significantly greater amongst those having low socio-economic status. In these patients the level of stability of the disease is far lower than those belonging to the upper class. Health practices, such as rates of smoking, are higher amongst blue color workers than amongst educated people. We are also witness to a lower rate of response to early diagnostic tests that can save lives (breast cancer and colonic cancer), which are performed at a lower rate in lower socio-economic populations and amongst those with a strong religious orientation.

In addition to the increasing differences in the state of health, significant differences also exist in the availability of and access to quality health services. For example, in peripheral regions in the north and the south there are fewer general beds per 1000 people and fewer beds and services for special situations (such as pediatric intensive care, urgent medicine stations, dialysis stations, etc.).

These constitute only a small part of the data that indicate inequality in health in Israel. These differences not only exist but are expanding despite the principles of "justice, equality, and mutual aid" expressed in the State Health Insurance Law. Inequality in health has social significance (harm to the social unity of population groups), moral significance (damage to the principle of equality and social justice) and economic significance (for the individual, the family, the health system, and Israeli society in general).

Without doubt the increasing socio-economic gap in the country, which is especially reflected in differences between the periphery and the center, is the major cause of the development and expansion of health disparities. Consequently, changes to the existing socio-economic policy, together with a large investment in education, will lead to reduction of inequality in the health criteria. This material change lies outside the fields of responsibility of the health system. However, the health system, including all its elements, in close cooperation with other systems, and after receiving the required resources, has the readiness, capability, and responsibility to act and to bring about a reduction in health disparities.

In the light of the fact that the greatest significance of socio-economic inequality for citizens of the State is the differences in their state of health (including excessive mortality and morbidity), the Israeli Medical Association recognizes the urgent need to act in order to reduce the clinical differences, and takes upon itself to take an active part, together with other entities in leading a process of change that will benefit all populations in the State.

Recommendations of the committee for courses of action to reduce health disparities
The State, including its institutions, and especially the Ministry of Health and the Ministry of Finance, must recognize the need to change priorities in order to reduce the socio-economic inequality in general and inequality in health in particular. The decision makers must understand the grave (health, moral, economic, and social) significance for the individual and for the general public, of the existing situation. The State must recognize the vital need to invest efforts and means for reduction of the social, economic, and regional differences and thus reduce the inequality in health.

The health system, led by the Ministry of Health, has responsibility for confronting the health ramifications of socio-economic inequality and assuming a central role in initiating activities aimed at reducing the existing differences. This will be done by:

a) Setting up a permanent organization (division) in the Ministry of Health, or alternatively, a separate national council (authority) for reduction of the inequality and injustice in health.

The first task of this organization will be to prepare a comprehensive multi-year program, with the formulation of specified milestones, defined in content and time, as well as the determination of the resources required to achieve these aims. The new organization shall be allocated resources required for ongoing survey of the existence of differences, formulation of priorities for their reduction, and supervision of execution of the tasks. An annual summary shall be published of "inequality in health in Israel" that will review and estimate the changes in the extent of disparities and that will reflect the results of the interventions.

b) Reduction of the differences in the physical infrastructures and in the availability, accessibility and quality of the health services between geographic regions (north, south and center) and also within large populations (the periphery of large cities) that constitute a significant barrier to the provision of quality egalitarian health services for various populations. For this purpose, positive discrimination is required in peripheral regions, with the aim of reducing the differences in infrastructures and services between the regions in the country as well as the differences in quantity and quality of the professional manpower.

c) To achieve this aim, the new organization (section (a) above) must, together with the service providers, map the availability and accessibility of different population group, of all ages, to primary and secondary health services, general hospitalization, geriatric, mental, and rehabilitation services throughout the country. Priority in this process shall be given to inequality between settlements in the periphery and the center and to neighborhoods having a low socio-economic status within the large cities.

d) Keys must be determined for the minimum services required for the size of the population, as well as differential keys for population groups with special health needs.

e) Increasing the awareness of personnel in the health professions to the significance of inequality in health. These personnel bear responsibility for acting on two levels, in order to:

- Recognize and locate the health risk of cultural-economic-social inequality, in
order to prevent the resulting effects on health.

- Allocate greater resources for the diagnosis and treatment of vulnerable groups in the population (such as stabilization of chronic illnesses) in order to reduce the health damage.

f) Minimizing the economic barriers facing the population in order to receive health services:

- Cancellation of copayments for preventative services (such as tipot halav fees, early diagnosis tests in the basket of services, immunization, dietary advice for chronic patients and overweight patients).
- Cancellation or significant reduction of copayments for drugs, tests for chronic patients in illnesses such as diabetes, high blood pressure, chronic heart failure, malignant diseases.
- Cancellation or significant reduction of copayments for persons with special needs, such as disabled persons or holocaust survivors.
- Cancellation of copayments for drugs for children under 6 years of age.
- Alternatively, in the three previous sections the copayments shall be income dependent.
- Inclusion of dental treatment (to be decided upon by specialists) for children aged up to six years and for adults above 70 in the basket without copayments (or income dependent).
- Reduction of the cultural barrier, by matching the supply of the services to the cultural background of the various population groups.

Information

- In all the health services, the signs shall be in Hebrew, Arabic and English and in additional languages (for example Russian, Amharic) depending on the composition of the target population.
- All the explanatory material shall be supplied in Hebrew and Arabic and in additional languages (for example Russian, Amharic, English) depending on the target population.
- During preparation of the explanatory material (technical and health), the contents and means of distribution shall be adapted to the cultural background of the target population in coordination with persons from the said population group.
- Every health service shall provide a translation service in Hebrew, Arabic, Russian, and English by a person from the service staff who has received training in the subject of professional medical translation. If the target population is very small, action should be taken in accordance with the next section.
- Regarding other languages, phone translation, with a recognized service, shall be available. (If the need for another language is significant, the institution shall consider the possibility of training a worker within the institution.)
- In every service, data shall be collected regarding the language spoken and the education level of the population served, with the aim of locating persons/groups
having special needs.
- The explanations for various population groups (especially weaker ones) shall match their cultural background, with the aim of supplying knowledge and skills, promoting life styles that are good for health such as avoiding/giving up smoking, avoiding obesity, correct diet, physical activity, prevention of childhood accidents, minimizing marriage to close relatives, and immunization.

**Training of professionals**

a) Study of the subject of inequality in health (extent, gravity, the health and economic significance for the individual/ family/ health system/ society in Israel, reasons, the need for reduction and the means of doing so), and the furnishing of tools for cultural qualification in all the academic frameworks in the field of health (medicine, nursing, social work, administration, diet, physiotherapy, occupational therapy, etc.).

b) Teaching the subject of inequality in health (extent, gravity, the health and economic significance for the individual/ family/ health system/ society in Israel, reasons, the need for reduction and the means of doing so), and the furnishing of tools for cultural qualification in all the medical specialties by planned participation during specialization. The subject shall be included in the stage A and B examinations in all the medical professions.

c) Development and training during service for all members of the health professions working in the system on the subject of inequality in health (extent, gravity, the health and economic significance for the individual/ family/ health system/ society in Israel, reasons, the need for reduction and the means of doing so), and the furnishing of tools for cultural qualification.

d) Appointment of a suitable professional who shall be responsible for the training programs during service and shall constitute an address and support for the professionals in every framework.

**The periphery**

It is clear from the data included in this document that inequality in health and in the accessibility and quality of the health services is significantly greater in the geographic periphery of the State of Israel. In addition, the starting point, from the socio economic aspect, is worse in regions remote from the center.

More precisely, the combination of a poorer state of health, inferior health services, and a lower socio economic status than in the center of the country, clearly leads to the conclusion that these areas are a priority and special and urgent attention must be paid to them.

The positive discrimination required must be reflected in:

- Reinforcement of service infrastructures (general beds, specialized units in hospitals).
- Release of slots for the development of essential services (such as pediatric intensive care) that are lacking in the periphery, as well as training of professional manpower to fill them. In addition to the infrastructures, quality professionals should be encouraged to move to the periphery and stay there.
The method of execution is both by means of a different distribution of the budgetary resources currently available to the health system and by preferential allocation to health services in the periphery.

**General**

- Reduction of disparities in health requires multi system attention, and especially cooperation in the field of health/welfare/ the Ministry of Finance/ the Ministry of the Environment/ local government.
- The need to provide knowledge and skills to the entire population on the subject of health and illness from an early age in order to develop person's responsibility for his health.
- Reduction of the inequality in health will be achieved by integrated planning of advancement, prevention, treatment, and rehabilitation activities.
- A policy of inequality reduction will guide the working of all health systems, health care organizations, and the hospitals.

As physicians in Israel, we constitute only one element of the entire system. The initiative of the Israeli Medical Association is likely to lead to the change required in other systems and thus lead to significant reduction of the inequality in health. The need therefore exists for formulation of an overall policy on the subject that will lead to coordinated activities between the health system and other systems. The Israeli Medical Association will support and cooperate with the relevant functions in order to achieve an improvement to the health of the entire population and reduction of the inequality in health in Israel.

### 18. The treatment of individuals not covered by medical insurance

**Background**

Physicians from public hospitals in northern Israel presented the Ethics Board with ethical questions and dilemmas that arose while treating injured Syrians who reached Israel. The Board’s discussion was broadened to address the treatment of all uninsured patients, including illegal residents, infiltrators and refugees.

There are international conventions addressing the obligation to provide healthcare. The obligation varies from country to country, based on the healthcare provided to citizens of that country.

In countries with national health legislation, like Israel, the uninsured become eligible for various levels of medical treatment after a period of time. For example, in the U.S. this population is included in "Obamacare."

Theoretically, these residents could purchase private health insurance, however their economic situation is usually poor and doesn't allow it. This, along with the language barrier and unfamiliarity with the local healthcare system, lowers the quality of care these people receive in different countries.
From the lectures presented to the Ethics Board and the ensuing discussion, it appears that physicians in the Israeli public health system treat every patient equally and in accordance with his or her medical issues.

The questions that arose in the discussion included:

- **Level of treatment** – is there a need for humanitarian aid or further rehabilitative treatment?
- **Should the provided treatments include only emergency life-saving treatment or a comprehensive treatment program?** In what way can treatment continue when the patients return to their country, or do not come for follow-up treatment in Israel due to legal issues?
- **Another difficult question addressed the hospital bed shortage: how to maintain high-quality easily accessible health care for the local populace?** Is it right to treat “foreigners” at the expense of medical care provided to citizens, and to deprive citizens of the treatment stipulated in the National Health Law?

**The position paper:**

1. A physician must provide life-saving medical treatment in emergency situations to anyone in need.
2. An Israeli physician should provide treatment to any patient who approaches him without discrimination.
3. A physician should provide a proper treatment plan for all patients in accordance with their circumstances and their ability to return for treatment.
4. An Israeli physician should provide patients living outside of Israel with a release letter in English (possibly without source identification) that details their medical issues, the treatment they received and recommendations for continued treatment, just as he would with any other patient. This allows the patients to receive continued treatment in other countries.
5. The Ethics Board calls on the State of Israel to facilitate the treatment of the uninsured without impairing the economic and medical ability of public hospitals to treat Israeli citizens.

**19. The prohibition of physician participation in interrogations and torture**

Published in December 2007

**Background**

The 1975 Tokyo Declaration of the World Medical Association (WMA), which was revised twice in the period 2005-2006, prohibits participation by physicians in interrogations and torture of any kind whatsoever.

This declaration is based on the knowledge that the medical profession serves humanity by means of a humane approach, that it is intended to preserve and restore the physical and
mental health of every person whoever he is, and to alleviate any suffering and discomfort to which he is subject, regardless of any other factors. The supreme commitment of the physician to the life, dignity, and welfare of a person is even more important when a threat to these values exists.

Several international conventions and ethical declarations of large international bodies also refer to this prohibition.

The Israeli Medical Association, as a member of the WMA, accepts the contents of the Tokyo declaration, and ratifies the latest version dated May 2006, as set forth below.

Position paper

- A physician is obligated, as a person and as a physician, to respect the personal dignity of every other human being.
- A physician shall not participate in any activity that includes torture, cruelty, or humiliation of another person, regardless of the acts of the said person, the accusations against him, or his beliefs.
- A physician shall not give medical permission to inflict torture nor shall he supply medical information, instrumentation, or drugs for this purpose.
- A physician examining a detainee or prisoner, who is liable to be subject to interrogation or torture, shall be especially careful to observe the confidentiality of the medical information at his disposal, and shall make no use of it for the purpose of the interrogation or the torture.
- A physician who is witness to an interrogation or torture that are carried out contrary to the international conventions, shall report this to the appropriate authority.
- A physician shall not be present in a place where interrogation or torture is being carried out.
- The physician shall ensure his professional independence in choosing the proper medical treatment for a detainee or prisoner for whom he is responsible, as part of his responsibility for the physical and mental welfare of the said person.
- If a prisoner chooses to go on hunger strike, and the physician becomes convinced, after he has explained to the prisoner the possible consequences of the decision, that the decision was taken after consideration and with rational judgment, he shall not be forcibly fed. An additional independent physician shall confirm the capability of the prisoner to make such a decision.
- The Israeli Medical Association undertakes to support every physician who observes these rules.
20. Solitary confinement of prisoners - without the participation of physicians

Background
The solitary confinement or separation of a prisoner from other prisoners is practiced in Israeli prisons. The isolation is done for the purpose of punishment, for the prisoner's protection from other prisoners, or for the protection of the State. Isolation means the prevention of human contact with other prisoners, and sometimes even with the staff of the prison. Data supplied to members of the Ethics Board indicate that out of about 20,000 prisoners in the State of Israel, about 150 are held in solitary confinement.

Solitary confinement for 48 hours may be imposed by authority of the prison commander. A longer period of time requires a disciplinary court ruling, with the approval of an officer of a rank equivalent to colonel. Solitary confinement for more than six months obligates approval by the Court. Solitary confinement of a prisoner brings with it the loss of additional rights, such as use of television or phone, smoking, or receiving visitors.

Solitary confinement for a protracted period of time is liable to cause serious mental harm to a prisoner, whether or not he suffered from a previous mental illness. It is generally agreed that solitary confinement in excess of a specific period of time is liable to cause irreversible mental harm.

The decision to place a prisoner in solitary confinement is not medical in nature, but the Israeli Prison Service (IPS) Commission regulations state that "the holding of a prisoner in a solitary confinement cell obligates examination by a physician, or in his absence, by a paramedic". The regulations also state that a prisoner held in solitary confinement shall be entitled to "a visit by a paramedic every day and to a visit by a physician at least once a week". The date of the visit shall be recorded in the solitary confinement log, giving the name of the medical professional and his findings.

The regulations also state that it is possible to stop the solitary confinement in accordance with "the medical ruling of a physician, and in his absence, of a paramedic, that holding the prisoner under the current conditions is not appropriate in light of his medical limitations." Sometimes a specific prisoner requires, in addition to the routine medical examination, an examination by a psychiatrist. Such an examination is not regularly carried out prior to solitary confinement, so as not to be regarded as "approval" for the isolation.

Several psychiatrists, members of the organization "Physicians for Human Rights" contacted the Israeli Psychiatric Association a number of months ago with a request that it publicly "formulate its position in the matter, in order to preserve the rights of prisoners held in solitary confinement, their health, and the ethical rules". Members of the Psychiatric Association, for their part, felt that the issue was fundamental and warranted the issuance of a statement by the Israeli Medical Association".

Consequently, the Ethics Board held a discussion on this subject with the participation of Dr Alex Adler, chief medical officer of the IPS, Dr Moshe Berger, head of the Psychiatric Service in the
IPS, advocate Dina Lehman, the legal advisor of the IPS Mental Health Service, and Dr Adi Doron, representative of the Israeli Psychiatric Association.
Following the discussion, the Ethics Board formulated the following position paper that is intended to strike a balance between the needs of the State to protect its security and that of its prisoners, and the obligation to preserve the health and dignity of the prisoners.

**Position paper**

- Solitary confinement is practiced in prisons in Israel as a means of punishment or a means of protection of the prisoner or the State.
- Protracted solitary confinement has a negative influence on the physical and mental health of the prisoner.
- A physician shall not take an active or passive part in punitive measures against a prisoner.
- A physician shall not give medical approval for the execution of solitary confinement.
- A physician examining a prisoner who is liable to be subject to solitary confinement shall take special care to maintain medical confidentiality, and shall make no use of information held by him, for a non medical purpose.
- A physician examining a prisoner who is held in solitary confinement shall maintain his professional autonomy when choosing the proper treatment, out of responsibility for the mental and physical welfare of the prisoner.
- A physician who identifies a real risk to the health of a prisoner as a result of his being held in solitary confinement shall exercise his professional authority in order to halt these restrictions immediately.
- The Israeli Medical Association calls upon the Director-General of the Ministry of Health and the government authorities to transfer the IPS physicians to the Ministry of Health, in order to prevent the inherent conflict of interest to which they are subject.

**21. Shackling prisoners and detainees in hospitals**

*Published in December 2008*

**Background**
The medical profession contains a unique commitment to ensure the physical and mental welfare of every person, as a person, regardless of his actions or status in society, while respecting his dignity and privacy. This commitment is even more prominent in conditions of detention or imprisonment, where there is a tangible threat to these values because of society’s need to protect itself against law breakers.

How therefore should a physician behave when he is required to treat a prisoner or detainee brought to him in the hospital, handcuffed? Law authorities have already found that they meet the conditions obligating that they be kept under lock and key. These conditions are met even when the prisoner or detainee enters the hospital, and consequently, chaining in the hospital is the proper substitute for imprisonment. However, we should remember that although the
prisoner has been denied freedom, he should not also be denied his dignity. Giving medical treatment to a handcuffed person without a doubt harms his dignity and privacy. The chaining causes suffering and sometimes even injury, and is also liable to harm the quality of the medical treatment. The very act of consent to treat a handcuffed person is liable to be interpreted as if the physician has become part of the enforcement system and has abandoned the ethical code of medicine for the benefit of the regime. The ethical code presented here bridges, in the opinion of members of the Ethics Board, between the conflicting obligations of the physician – the obligation to treat an individual prisoner or detainee on one hand, and the broad commitment to the security and welfare of society in general on the other. The members of the Ethics Board had before them a previous position paper on the subject, by the Ethics Board in its previous composition, dated August 6, 1997, the report of the committee for evaluation of the procedures for handcuffing prisoners and detainees in hospitals, headed by the then deputy Attorney-General, Meni Mazuz, published in December 1998, and the guidelines of the Medical Administration at the Ministry of Health (44/2005) dated November 30, 2005.

Position paper
- A physician has the ethical obligation to respect the dignity, privacy, and health of every person and to prevent him from experiencing suffering and pain. This obligation is even more important under conditions of imprisonment or detention.
- On the other hand, this ethical obligation sometimes conflicts with the need of society in general to limit the freedom of the individual in order to protect itself.
- The rule is that every prisoner or detainee is entitled to be examined and to receive treatment like any other person, without being handcuffed.
- The authority to determine the need for handcuffing is held by the law enforcement authority holding the patient.
- Handcuffing is not a routine operation, and is done only in the absence of some other, less serious, means.
- Handcuffing is not a substitute for a shortage of manpower required to guard the patient.
- If the handcuffing prevents medical treatment, endangers the life of the person handcuffed or is liable to cause him real and irreversible injury, the patient shall be released from his handcuffs even at the price of the risk involved.

22. Feeding hunger strikers
Published in February 2005

Background
The brief hunger strike of security prisoners in Israel several months ago prompted the Ethics Board to address the status and function of doctors charged with professional responsibility for the health of hunger strikers.
Part E

Naturally, this is an extremely sensitive social issue in which lofty values of a person's right over his body sometimes conflict with political, national or religious positions and the desire to prevail over the hunger strikes at any cost.

Since we are speaking in most cases of prisoners whose liberty has been denied, the medical ethics issue is even more acute. In Israel the dilemma is even greater, since the principle of the sanctity of life is perceived by some parts of Israeli society to prevail over any other value, including that of individual freedom.

In response to the application of the State, Judge Sarah Sirota permitted in 1996 the forced feeding of a group of hunger strikers who were disciples of Uzi Meshulam. In this case, the Court deviated from the accepted Western bio-ethical approach. In the inevitable conflict between violating the prisoners' dignity and preserving of their lives by force, the Court ruled in favor of the right to life (OM 96/829-A dated 9.5.1996).

Forced feeding of hunger strikers is regarded as a form of torture. The World Medical Association's 1975 Tokyo Declaration, which prohibits the participation by physicians in torture, also prohibits their involvement in forced feeding.

Dramatic events in several countries throughout the world – in Ireland, Turkey, and S. Africa – where hunger strikers who maintained their strike died, led the WMA in 1992 to compose the Madrid Declaration, which is wholly devoted to the role and responsibility of the physician treating a hunger striker.

At the end of their discussion on this issue, the members of the Ethics Board adopted the main features of the Madrid Declaration, with minor changes.

Position paper

- A hunger striker is a competent person who has expressed his wish not to receive food and/or liquids for an unlimited period, while knowing that this is liable to cause his death.
- A physician must obtain full medical information regarding the hunger striker and give him a full medical examination at the onset of the hunger strike.
- A physician must explain to the hunger striker the risks involved in such a hunger strike, including the risk that the strike may cost him his life.
- A physician must inform the hunger striker whether he will be willing to accept the latter's request to refuse any food and/or liquids, including artificial feeding, if he should lose consciousness.
- A physician is forbidden to apply any pressure whatsoever with the aim of dissuading the hunger striker from continuing his hunger strike.
- A physician shall not participate in forced feeding of a hunger striker.
- A hunger striker shall be entitled to receive a second medical opinion and to request that the second physician be the one to treat him. If the hunger striker is a prisoner, this matter shall be coordinated with the prison physician.
- A physician shall be entitled to suggest to the hunger striker that he continue to receive treatment with drugs, if the hunger striker took such drugs before beginning his strike, and that he agree to accept liquids during the hunger strike.
In cases of environmental pressure, the physician shall be entitled to demand the isolation of the hunger striker from his comrades – the other hunger strikers. The physician must verify every day that the hunger striker is ready and wishes to continue his hunger strike and that this decision was taken voluntarily and without any external pressure whatsoever being applied. The physician must verify every day how the hunger striker wishes to be treated if he loses consciousness. The physician shall record this information in his records and these shall be kept confidential. If the hunger striker loses consciousness and is no longer able to express his wishes, the physician shall be free to decide to the best of his awareness and conscience how to continue to treat the hunger striker, while respecting to the utmost the views and wishes of the hunger striker as expressed to him during the hunger strike. The physician shall notify the hunger striker’s family of the hunger strike, unless this is expressly forbidden by the hunger striker himself.

23. The health of migrant workers

Published in March 2003

Background
The double suicide bombing in the Neveh Sha’ananim pedestrian mall in South Tel Aviv in January 2003 forced us, the physicians, to observe a new reality in all its ugliness. In this horrific terrorist attack, 23 people were killed and more than a hundred others were injured. The dead and wounded included both Israelis and foreign workers who lived and worked in the neighborhood. While the rescue services rushed to take the Israelis to hospitals, the foreign workers, although wounded and bleeding, preferred to hide in a safe corner out of fear of the police. The fear of being arrested and deported from the country as part of the mass deportation policy decided against them overcame even the need for urgent medical treatment. Even the generous declaration of the then Minister of the Interior, Eli Yishai, that persons injured in the terrorist attack and their families would be granted temporary residence permits, did not ease the fears of this community. Many of the foreign workers even avoided coming to hospitals to visit their hospitalized friends because of the fear of deportation. This was a new and ugly peak in the inequality of accessibility to and exploitation of means of health and medicine in Israeli society.

About a month after this event the Ethics Board held a debate regarding the status of work immigrants in Israel. The members of the Ethics Board felt that they should voice a decisive opinion on the subject of the basic human rights of those lying at the bottom of the social ladder in Israel. Also participating in the debate were representatives of organizations that aid foreign workers – “Worker’s hotline” and “Physicians for Human Rights”. At the end of the discussion the members of the Ethics Board adopted the following position paper.
Position paper

- Emigration for the purpose of work is a universal phenomenon that cannot be solved by administrative means only.
- The presence in Israel of hundreds of thousands of work immigrants obligates the institutions of the State to address the basic human rights of these workers, including their welfare, health, and medical condition.
- The state of health of the work immigrants has a direct influence on the health of the entire population. Consequently, a dual obligation is imposed on the authorities to ensure the health of these immigrants.
- Proper living and working conditions must be set and enforced in order to prevent exploitation and illness of the work immigrants.
- A proper legal framework must be created to the immigrants free access to health services, while collecting from them health tax.
- Every physician has the ethical obligation to give urgent medical treatment even to work immigrants who have no health insurance.
- Medical treatment for work immigrants that is not regarded as urgent shall be given at the physician’s discretion, even if they are not covered by the State Health Insurance Law.
- As part of the maintenance of medical confidentiality, the identity of work immigrants requesting medical treatment shall be concealed.
- The Ethics Board calls on physicians who are members of the Israeli Medical Association to volunteer and contribute from their professional experience for the good of work immigrants in Israel.

24. Assuring medical and health services during the Israeli-Palestinian armed conflict

Published in June 2002

Background

The developing political reality forces us to address extremely difficult moral and ethical issues regarding the provision of medical and health services to the Arab population in the West Bank and in the Gaza Strip. The defense and security needs of the State of Israel clash with the free granting of these services, amidst conditions of the violent dispute existing between us and the Palestinians.

Exactly now, when we are burying our dead every day, innocent victims of unrestricted terror, it is very difficult to talk about the human rights of the Palestinians. However, the Israeli Medical Association, as a non political, professional organization, must formulate its position on this sensitive subject. It must publicize this position and act to advance it, while striking the required balance between the opposing needs of the two populations. This urgent need is even more highlighted following numerous applications to the management of the Israeli Medical Association, from ordinary physicians and human rights organizations in Israel and medical
associations abroad, including an application by the World Medical Association.
The management of the Israeli Medical Association set up a special committee for this purpose.
The mandate awarded the committee was to meet with the relevant entities and formulate a
document that, after its approval by the appropriate institutions in the IMA, would constitute
the official position paper of the IMA on this matter.
Members of the committee met with representatives of the International Red Cross, with
representatives of the "Physicians for Human Rights" organization, and with Maj. Gen. Amos
Gilad, the Coordinator for Activities in the Territories. Present at the meeting with Maj. Gen.
Gilad, apart from members of his staff, were the Chief Medical Officer and a representative of
the Chief Military Prosecutor.
The position paper appearing below reflects the position of members of the committee as
formulated at the end of these meetings and after an exhaustive debate among its members.

Position paper

- The Israeli Medical Association (IMA) is an independent, non-political organization
  representing all Israeli physicians, Jews and Arabs alike.
- The IMA reasserts its conviction that life is a supreme value, together with its
  commitment to this value with respect to each and every individual, regardless of
  differences in race, religion or nationality.
- The IMA remains firmly committed to declarations of the World Medical Association
  and international agreements of which it is a signatory, including those related to the
  protection of human life.
- The IMA views the provision of medical and health care services to the civilian population
  and treatment of the wounded and injured as an integral part of its commitment to the
  preservation of human life.
- The IMA expresses its satisfaction with the Israeli Defense Forces’ acknowledgement,
  as expressed to us by its official representatives, of its commitment to the continued
  assurance of these medical and health services, even in a period of armed conflict.
- The IMA calls upon the Israeli Defense Forces, in the context of this commitment and the
  recent Supreme Court decision, to take all possible action to ensure the continuation
  of essential medical services in general, and hospital services in particular, including
  those in areas of fighting. Directives of this nature should be conveyed and implemented
down to the individual soldier in the field.
- The IMA unequivocally denounces the employment of terrorism in general, and the
  use of human bombs, whose sole objective is the indiscriminate killing of innocent
  civilians and the spread of fear among the general public, in particular.
- The IMA condemns the amoral use of ambulances for purposes of terrorism and
  sabotage and calls upon all medical entities not to support such use.
- The IMA denounces any unnecessary restriction, obstruction or attempt to interfere
  with the activities of medical personnel in the course of their professional duties.
- The IMA expresses deep sorrow at the loss of life and suffering caused to both peoples
  in the course of the present conflict, and is concerned over the spread of the conflict to
innocent civilians in large population centers.

- The IMA supports all medical teams engaged in the saving of human life and treating the victims of this conflict, often at risk to their own safety.
- The IMA stresses once again that medical teams are entitled to absolute immunity from harm and the assurance of unrestricted freedom of movement, while they are strictly engaged in the fulfillment of their professional duties.
- The IMA is aware of the need to strike a balance between the assurance of medical and health services and the need for security, and calls upon the military establishment to preserve this balance with the greatest of care.
- The IMA calls upon both sides to halt immediately the armed conflict that results in the spilling of human blood, loss of life and great suffering to all inhabitants of the region, and to bring an end to the conflict in a peaceful manner.

25. Chemical sterilization of pedophiles

Published in May 2009

Background
Sexual offences are among the gravest ones with which every society must cope. Especially grave are sexual offences directed at minors and children. Despite the fact that pedophilia has apparently a biological basis, and is expressed by interference with control of the sexual urge, from a legal aspect it has been ruled that this does not exempt the pedophile from legal responsibility for his acts.

Various societies throughout the world have dealt with pedophilia in various ways over the years. Apart from the punishment of imprisonment, both physical and medicinal measures have been taken to reduce the sexual urge of the offenders, starting from physical castration by removal of the testicles and ending in protracted medication treatment, intended to reduce the level of testosterone in the pedophile's blood.

Exposure of the large pedophile network that operated until recently in Israel has further intensified the public debate regarding this serious offence. Bills have recently been submitted to the Knesset that award the Court the right “to order the giving of medication treatment to a sexual offender in addition to any punishment” (the bill of M.K. Eli Aflalo), or “to leave in jail for a period of up to 20 years or until he agrees to undergo treatment to reduce the sexual urge and reduction of the risk involved in his release” (the bill of M.K. Yuval Steinitz).

Since this medication treatment is controversial and also involves latent health risks to the patient, a clear need arises to strike a balance between the obligation to protect the public and the obligation to protect the health of the offender. Even if we accept the argument that in a conflict of interests the interest of the victims precedes that of the offender, we still have to set limits to the medication treatment for reduction of the sexual urge, currently proposed as enforced treatment for these offenders.

The attached position paper expresses the opinion of members of the Ethics Board, after a protracted debate held in the presence of endocrinology specialists who engage in this field.
and with the participation of physicians and psychiatrists who work in the Prisons Service in Israel.

**Position paper**

- Sexual offenders, especially those diagnosed as pedophiles or possessing other sexual perversions, are liable to cause grave and protracted physical and mental harm to victims of the attack.
- In order to protect the public against sexual offenders, these offenders are tried in accordance with the criminal law of the State.
- The bills recently submitted to the Israeli Knesset recommend awarding the Courts the right, in addition to punishment in accordance with the criminal law, to order medication treatment to be forcibly given for inhibition of the sexual urge of the offender.
- Medication treatment for inhibition of the sexual urge is a controversial medical act both from the aspect of using the drugs for such a purpose and since it has latent risks to the health of the patient.
- Estimation of the sexual offender’s medical condition and his suitability for medication for inhibition of the sexual urge shall be done independently by a physician who has no conflict of interest of any kind whatsoever.
- The physician shall not give medication treatment for inhibition of the sexual urge if in his opinion this treatment is not suitable for the offender.
- Medication for inhibition of the sexual urge shall be given only after the patient has given consent of his own free will.
- The aim of medication treatment for inhibition of the sexual urge is to prevent additional sexual offences in the future, and this treatment should not be used for reduction of the period of imprisonment or for the receipt of vacations.
- A sexual offender suffering from pedophilia shall be entitled to apply to the Court, of his own initiative and free will, to exchange part of the term of imprisonment imposed on him for the receipt of medication treatment for inhibition of the sexual urge.

**26. Cooperation between medical institutions and law authorities**

Published in October 2006

**Background**

An application was made to the Ethics Board that addressed the question of the proper balance between the rights of a hospitalized patient and the rights of society to protect itself. The application referred to an event that occurred in a specific hospital, which received for treatment an injured prisoner who was arrested on suspicion of setting fire to a government office.

The detainee received full medical treatment, under guard, but prior to his release the police contacted the hospital with a request not to release the detainee, but rather to hold him with artificially determined additional hospitalization. The intention of the police was to enable use...
of covert methods of interrogation, while he was still in the hospital, in order to extract from him information related to the criminal act attributed to him.

The director of the hospital who contacted the Ethics Board wrote that the hospital has a clear and natural interest to cooperate with the police and aid it in the investigation of crimes against society, but on the other hand there is the question of infringement of the ethical rules that protect the rights and privacy of the patient.

Another aspect of the same issue arose in a complaint sent to the Ethics Board by a public entity that engages in the rights of foreign residents in Israel. According to this complaint, the director of another hospital, on his own initiative, contacted the immigration authorities and invited them to interrogate a resident of a foreign country who had come to the hospital to receive urgent medical treatment. The activities of this director, in the opinion of the complainers, compromised the ability of the hospital to protect the rights of its patients and their ability to seek treatment when a medical problem arises.

This complaint recalls the unfortunate incident in January 2003, when many foreign workers, some of whom are here without a visa, were injured in a terrorist attack in south Tel Aviv, and avoided seeking medical treatment in the hospitals because of their fear of being handed over to the immigration authorities. In this way, they tangibly endangered their lives and their health.

In the ethical rules appearing here, members of the Ethics Board have attempted to strike a delicate balance between the obligation to preserve the rights of the patient on the one hand and the obligation to preserve the right of society, on the other hand, to protect itself.

**Position paper**

- Medical institutions should be regarded as places in which patients are protected in accordance with the medical ethical code.
- Consequently, even illegal residents and criminals are entitled to protection of their rights and privacy, as patients in a medical institution.
- This protection is not absolute, and is sometimes overridden by the good of society and its right to protect itself.
- Therefore a medical institution shall cooperate with the security authorities in compromising the rights of the patient only where there is reasonable certainty that if they do not do so, harm will be caused to society by the said patient.
- The determination of the balance between the freedom and rights of the individual, and the public interest, lies with the Court and not the physicians.
- Consequently, in any case of doubt, in which physicians are asked to harm the individual rights of the patients for the public good, application should be made to the Court to give a ruling on this issue.
27. Evaluation of bone age at the request of the State

Published in November 2012

Background
The Ethics Board was presented with the question of what physicians should do when required by the state to evaluate the bone age of an underage illegal resident, in order to determine his chronological age and thus decide how the state will deal with him.

In recent years, the number of illegal residents in Israel has rapidly increased, some of whom are held in custody pending the conclusion of legal proceedings initiated against them for illegal residence. Many of them carry no documents that could attest to their chronological age – a crucial legal factor.

On June 10, 2007, the Ministry of Justice issued the “Procedure for Evaluating the Biological Age of Teenagers and Young Adults in Legal Proceedings Regarding Illegal Residence in Israel.” According to this procedure, biological age can be determined in three ways: a physical examination of the patient by a physician specializing in pediatric endocrinology, evaluation of a hand X-ray or assessment of dental maturity in an orthopantomogram (panoramic teeth X-ray).

The procedure further stipulates that these examinations should only be carried out after receiving a court order or a decree from the “Immigration Detention Review Tribunal,” and that X-rays of the hand or teeth should be taken only if the age cannot be evaluated “with high probability” without them. Prior to performing the examinations, the procedure also requires providing the patient with information about the examinations and their purpose, and receiving his consent, in accordance with the Patient’s Rights Law, 1996.

The Ethics Board was presented with a case where the police transferred an illegal resident from a detention facility to a nearby hospital and requested to perform an X-ray of his hand in order to determine his age. This request was not accompanied by a warrant from a court or tribunal, by “informed consent” or by a report stating that a physical examination had previously been performed by a pediatric endocrinologist and was inconclusive.

During the discussion by the Ethics Board, Dr. Gideon Flusser, an expert in diagnostic radiology and the director of the Skeletal Imaging Unit at Sourasky Medical Center, presented the main points of the medical opinion he gave to the Hotline for Aid to Foreign Workers in a lawsuit against the state regarding a minor who was sent for a hand X-ray to determine his age.

The examination used in order to evaluate bone age relies on Greulich’s bone age atlas, which was published in 1959 and relies on images taken during the 1930s from hundreds of white children in the area of Cleveland, Ohio. The images in the atlas are supposed to represent the average development of bones at different ages.

The first edition of the atlas already contained a warning that the X-ray standard should not be expected to apply to other populations. According to the editors, there is significant variance in findings among different ethnic groups. Considering the 80-year gap and the immense changes in diet and health in various populations, there is no doubt that the atlas is far from capable of providing a credible scientific assessment of a patient’s age.
This warning is doubly relevant to underage illegal residents, who come to Israel from countries stricken by hunger and sickness, which clearly alter the biological maturation of those minors. According to data presented in the atlas itself, even within the specific population referred to in the book, there is a high standard deviation. For example, at age 17 the standard deviation is 16 months. This means that even within the population in this study, a minor who is supposed to be 17 according to the atlas could actually be as young as 15 years, 8 months or as old as 18 years, 4 months. This data was confirmed in a study that only found a match between chronological age and bone age in 20-30% of patients.

There is no doubt that this is an obsolete diagnostic tool with very questionable scientific credibility. The only reason it exists is that nowadays, knowing the risks of ionizing radiation, it’s impossible to X-ray thousands of healthy children in order to create a new standard. Despite all this, the Ministry of the Interior and the Population and Immigration Authority rely exclusively on evaluations of bone age in order to determine the age of illegal residents. As a result, minors who were ostensibly shown to be adults have been transferred to jails and incarcerated in harsh conditions alongside adults.

Many Western countries that face problems of illegal immigration have completely stopped using a hand X-ray to determine the age of immigrants, or alternatively determine the age using additional measures such as dental examinations and interviews with a psychologist.

The national policy on determining the chronological age of illegal residents should be reconsidered. Until this policy is altered, each physician should decide for himself how to act professionally in such cases.

**The position paper:**

1. The assessment of bone age in minors for determining their chronological age relies on an atlas of X-rays performed 80 years ago in a homogenous population of white children in the U.S. Midwest.
2. The scientific validity of the atlas is nowadays very doubtful vis-à-vis populations that vary in any way from the sample group.
3. Evaluating bone age is not a precise way of determining biological age, the correlation to chronological age is very low, and there is a high standard deviation.
4. The use of ionizing radiation for X-ray imaging is forbidden when there is no benefit to the patient. This is especially problematic when regarding minors.
5. The use of ionizing radiation for imaging that is not for medical purposes is forbidden without freely given informed consent.
6. Requests for a bone age evaluation should state why such an examination is necessary.
7. Bone age evaluations intended to determine a person’s age should be performed only in accordance with a court warrant, and with informed consent signed by the examined person.
8. Evaluating bone age for non-medical reasons is subject to the discretion and conscience of every physician.
28. The rights of the minor in medical treatment

Published in December 1997

The Patient’s Rights Law, 5756-1996, is a pioneering law that established a legal basis for various rights of the patient in Israel, including the right to receive medical treatment, the right to refuse medical treatment, and the right to medical confidentiality. However, although it addresses many different subjects, the Law does not refer to the rights of a minor in medical matters. As a result, the legal status of minor patients is unclear, and many physicians are unclear as to how to conduct themselves.

The legal status of minors in the State of Israel is addressed in the Legal Competence and Guardianship Law, which states that “a person who has not reached the age of 18 years is a minor”. Consequently, a child up to the age of 18 is not regarded as an adult by law. However, there is no significant difference between a youth aged 17 and one aged 18. Although it is necessary to define the age of a minor and of an adult, when speaking of medical matters and sometimes even of life and death matters, in our opinion it is incorrect to specify an arbitrary age at which the patient may receive medical treatment or refuse it.

It should be noted that in the State of Israel this problem is even more serious. There is no logic to a situation in which youths aged 17 or 18 are inducted into the army, but cannot receive, for example, contraceptives.

The problem regarding reference to minors from the medical aspect is expressed in different ways and includes a broad range of medical circumstances. In each of these areas there are different considerations, but the common factor in all of them is a certain degree of consideration for the wishes of the minor, especially youths.

In case of routine examinations and treatment (for example, a sore throat) in which it is likely that the child will come for an examination unaccompanied by his parents, it may be presumed that the parents agree to the treatment. In contrast, if the treatment is complicated or the physician fears that the child is insufficiently mature to guarantee continuation of his treatment, the parents should be involved. We are not speaking here of a specific age – it all depends on the maturity and understanding of the youth.

In the US there is a concept in most states of “the mature minor” that awards minors above a certain age (generally 14 or 15) rights to receive medical treatment with their consent only, if the physician treating such a minor is convinced that the minor understands the risks and advantages involved in the treatment, and the treatment is of benefit to the minor and to no one else. In some states, such as California, the law does not refer to age but to the type of treatment (such as reproductive treatment, use of drugs) and the details of the child (marital status, economic independence, etc.).

The prescription of contraceptives is a special point within the broader topic. In April 1997, a private bill was submitted to the Knesset to amend the Legal Competence Law. Pursuant to this amendment, a physician would be entitled to give contraception to a minor above the age of 15 even without the consent of her parents or representatives. (Of course, the physician is not obligated to do so, if in his opinion the young girl is not sufficiently mature to manage the treatment.)
It should be noted that at the beginning of 1998 the Attorney-General recommended not to change the existing situation, in which physicians give minors contraceptives without receiving the consent of the parent or the guardian, and the State does not intervene. This is in accordance with other countries, which permit girls above a certain age to receive contraceptive pills without the need for their parents’ consent. However, as we have said, the determination of an arbitrary age simply skirts the issue. Maturity is a process, not a one-time event. The maturity of a minor cannot be predicted on age alone. Ethical rules must evaluate each case separately and only use the arbitrary age as a guideline.

Interestingly, in accordance with Israeli law a minor does not need the consent of her representatives in order to terminate her pregnancy, if the other conditions required by law are met. It is thus unreasonable to permit a minor to terminate her pregnancy without the consent of her representatives but not to allow her to prevent the pregnancy without involving a parent.

**The right of a minor to refuse medical treatment**

The Supreme Court has ruled that “every person in Israel, including minors, has the right to refuse medical treatment”.

In order to refuse medical treatment, the patient must understand the nature of the treatment, its benefits and risks. A minor may be involved in his treatment to a degree appropriate to his age and maturity. In other words, medical information should not be given to an 8 year old child to the same extent as to a 16 year old. However, the right to refuse medical treatment is complicated and depends on the circumstances, such as the type of illness, the risks involved in the treatment, the chances of full recovery, and, of course, the maturity of the minor. It should be noted that the maturity of a youth is influenced by the circumstances in which he lives. A child suffering from a chronic illness, or a grave and terminal illness, generally matures earlier, and his decisions are more similar to those of an adult.

**The right of parents to refuse medical treatment for a minor**

Pursuant to the Legal Competence Law, parents must “act for the good of the minor in the way devoted parents would act in the circumstances”.

In most cases it is reasonable to assume that parents will act for the good of their children, but this is not always the case. When a parent or guardian refuses to agree to treatment of the minor, and the physician is convinced that prevention of the treatment is liable to endanger the minor’s life, or to cause his health to seriously and irreversibly deteriorate, and there is no accepted substitute in the spectrum of medical treatment, the physician may request approval from the Court to carry out the required treatment.

**Confidentiality**

Pursuant to section 19 of the Patient’s Rights Law, and pursuant to the Physicians Order, section 36, a physician is obligated to uphold confidentiality for all his patients. However, the law does not specifically address a minor. If a minor requests confidentiality, it is preferable that the physician attempt to convince him to involve a parent, and try and clarify why the child does not want to involve a parent, and correct erroneous ideas that may cause his objection. However, the physician must be aware of the fact that there are cases, such as addiction to...
drugs or matters of sex and violence, in which the intervention of a parent may not help and may even cause harm.

If the physician attempts to persuade the minor to involve a parent, and the minor nevertheless refuses, there are cases in which it is ethically desirable that the physician treats the child and maintains confidentiality, all in accordance with the circumstances and at the physician’s discretion, after he has considered the damage to be caused by his not maintaining confidentiality.

In cases in which it is permitted to infringe confidentiality even with an adult, or in cases in which the physician strongly fears that the child is insufficiently mature to give his consent to the treatment, or that without the parents’ guidance the child’s health might be seriously affected, the physician may disclose information acquired during treatment or medical consulting, but he must first explain to the child his reasons for infringing the confidentiality.

**The position of the WMA**

At its 50th conference, held in Ottawa, Canada, in October 1998, the WMA adopted a declaration regarding the right of the minor to medical treatment.

The Israeli Medical Association was an active participant in composing the wording of the Declaration, which refers to both general and specific principles, such as the quality of treatment, consent, access to information, confidentiality, and hospitalization. Some of the principles are identical for adults and minors, such as the right to receive high quality treatment without discrimination. However, there are special principles for minors, which take into account the fact that treatment of minors is not simply treatment of “short adults”, but requires a different clinical and personal approach. Consequently, the Declaration calls for pediatricians to receive suitable training to handle the medical, mental, and development needs of children and their families.

It is impossible to treat every minor the same, and a distinction must be made between minors based on their age and maturity. Physicians must work by the principle that minors should be involved in their treatment, including giving them information and receiving their consent. However, this principle depends on the child’s ability to understand, decide, and cope.

It is also desirable to involve the parents, but in cases in which the child is sufficiently mature, and the type of treatment is not complex and dangerous, the minor’s right to confidentiality should be respected and the parents not involved. In cases in which the parent objects to the treatment, which has no accepted alternative, and without which the child will be endangered, legal approval should be obtained to carry out the treatment.

**Conclusions**

In the opinion of the Israeli Medical Association, specific reference to the rights of minors for medical treatment is lacking. The law, in its current form, does not award any rights to minors. This omission is to our disadvantage, since it leads to disputes inside the family and between the family and the staff giving the treatment.

In the current technological era, in which teenagers surf the Internet, understand their situation far more than we realize, and cooperate during their treatment, it seems strange to prevent
them from expressing their position regarding their medical treatment, and not take their wishes into account.
Arbitrary determination of an age for medical treatment is unsuitable, among other reasons, because every child must be judged in accordance with his maturity and capability of understanding his situation and the alternative treatments available to him. The physician treating him can assess this, and the physician should be given the option to decide whether or not to give the child what he requests.
Naturally, one should always strive to obtain the consent of the parents of the minor, but sometimes for everyone’s benefit it is preferable to dispense with this consent.
In light of all these considerations, we suggest conducting an in-depth evaluation of the possibility of permitting minors to receive or refuse medical treatment, even without the consent of their parents, without this being regarded as an offence against the law for the physician giving the treatment.

29. Should physicians inform a passerby if they detect an illness?

Published in December 2017

The Ethics Boards was presented with the question: Should a physician who spots an indication of a medical issue in a random person actively approach that individual, mention the indication and warn him?

Such situations could occur, for example, when a physician sees a person on the street with a suspicious mole that could be a melanoma. Should he stop that person and mention it? Does an enlarged thyroid require that a physician approach someone on the street and bring the matter to his attention? Where do we draw the line? Should a physician warn a teenager that inappropriate treatment of acne on his face could leave scars? Is there room to address cases such as smoking and obesity?

This involves weighing a person’s health, well-being and even life against the person’s right to privacy, confidentiality and autonomy.

The Ethics Board discussed the required balance between these conflicting values, all of which are important.
The discussants noted that physicians should exercise sensitivity and deliberation when deciding whether to approach an individual, depending on the severity of the issue and the circumstances. Life-threatening issues, such as a skin lesion that raises suspicions of cancer, are of course much more severe than the example of teenagers’ acne that may cause scars. In the latter case, even raising the issue may appear invasive and embarrassing.

Clearly, the decision how to act needs to consider the severity and circumstances of each case. The higher the severity and risk, the more likely the physician will tend towards initiating a conversation. At the far end of this scale, there are immediate emergencies, where physicians must offer help.

If a physician decides to approach a person on his own initiative, he should approach him gently, out of respect for his right to autonomy, in a way that allows the person to turn down medical
advice or treatment he does not desire. Furthermore, physicians should remember that patients have the freedom to choose the medical treatment they receive. Therefore, the conversation should entail a suggestion to be examined by any physician, not necessarily the physician who approached them, and should not be an attempt to convince patients to receive medical treatment. The rules that protect the privacy of patients should apply to such conversations. Therefore, the physician should approach the specific individual and not his or her relatives or other people (unless that individual is incapacitated or a minor). The Ethics Board's discussion concluded that:

- Generally, a physician may bring a medical issue to the attention of a passerby, but is under no obligation to do so.
- Physicians should carefully consider whether there is a chance to improve an individual's health and quality of life before deciding whether to approach him.
- Physicians should act with extreme sensitivity.
- Physicians should approach the stranger privately, where no one else can observe or hear the conversation.

30. The exclusion of women in the healthcare system and medical services

Published in January 2012

Background

Two women, a physician and a nurse, were recently excluded, in a humiliating fashion, from participating in an awards ceremony sponsored by the Ministry of Health and attended by the deputy minister of health, in which awards were given for scientific papers in the field of medicine and Jewish law (halachah). At the ceremony, held at the Shaare Zedek Medical Center, the two women, who were among the award recipients, were asked to sit in the gallery – not among the award-winning men – and not to go on stage to receive the award due to the attendance of rabbis at the event. The demand was presented to the physician and nurse at the site of the ceremony, several minutes before it began, and although they both felt uncomfortable with it, they acceded to the request. Women’s organizations, the Ethics Bureau of the Nurses’ Union of Israel, and the president of Ben-Gurion University expressed their dismay over this incident to the Ethics Board of the Israeli Medical Association.

The Ethics Board also learned of a fertility and women’s health convention, where female speakers, medical experts in their field, were asked to find male speakers to replace them. The members of the Ethics Board heard the award-winning physician who was not allowed to go on stage at the state ceremony, and discussed the spreading phenomena of the exclusion of women in the context of various incidents covered recently in the media. The members of the Ethics Board are aware that we are dealing with a form of religious extremism that reflects a widespread and deep social process extending beyond the medical
world. However, the members of the Board feel obligated to express a strong opinion against the exclusion of women in general, and particularly in the healthcare system, as presented in the following position paper.

The position paper:

- The exclusion of women is an unacceptable phenomenon that violates the value of equality and the values of democracy and therefore infringes on human dignity.
- The exclusion of women in the healthcare system can be expressed when receiving or providing medical services, in medical publications, at conferences, in the receipt of awards for professional achievements, or in the selection of positions in the healthcare system and more.
- Physicians should not condone any exclusion of women in the healthcare system, including any act that creates discrimination, humiliation or disrespect towards a woman, whether she is a patient or a physician.
- Physicians, including medical directors, should strive to set an example and to lead social action that contributes to equality between the sexes and should abstain from recognizing or accepting, through action or inaction, measures that contradict that principle.
- Physicians should not attend any medical or scientific event where there is exclusion of women, whether patients or physicians.

31. Artificial feeding of a patient in a permanent vegetative state

Published in August 2005

Note: The 41st General Assembly of the Israeli Medical Association, held in September 2009, did not approve this position paper.

Background
The extensively media covered death of Terri Schiavo in the US a few week ago brought to an end a complicated and protracted human affair. Terri suffered from cardiac arrest and serious brain damage, following which she remained in a vegetative condition for about 15 years. Her life depended on a feeding tube, around which an acute legal battle was waged between her husband, who wished to disconnect it, and her parents, who opposed this. The struggle divided the citizens of the US into two camps, each fanatical in its position: On the one hand, conservative and religious Republicans who were opposed to the disconnection and on the other hand, secular, liberal democrats who called to accede to the husband’s request. The dispute reached the Congress and the White House, but attempts at their intervention were unsuccessful and even received harsh public criticism. The Court finally permitted Terri to be disconnected from the feeding tube, and she died about a fortnight later without recovering consciousness. There had never been such a strong conflict in the US between politics, religion, and medicine, that was given such broad media coverage. The echoes of the dispute will continue to resound for a long time, and will almost certainly
change existing legislation there regarding “the sanctity of life”. The bill regarding “the dying patient”, which is currently tabled in the Knesset, greatly advances the rights of a person to jurisdiction over his body and grants binding legal status to a “living will” that expresses the wishes of a person regarding how he should be treated near the time of his death. The bill even permits not forcibly feeding a “competent” patient who has expressed his opposition, provided that he is “about to die” and his days are numbered. The bill does not address a patient who is not close to death, and consequently it was impossible, for example, to use it to settle the Schiavo affair.

Forced feeding of a patient lying in a persistent vegetative state (PVS) does not improve his prognosis, and extends his life beyond the natural limit of his illness, sometimes expressly contrary to his wishes or those of his family.

Members of the Ethics Board who devoted a number of meetings to this issue, permitted halting the feeding of a patient in a persistent vegetative state with the worldview that regards this as passive euthanasia that does not intervene in the regular course of the illness and addresses the wishes of the patient and his family.

It is important to clarify that this position paper is intended to influence the social process and the position of the legislators in this sensitive issue. In a court ruling in the case of Mrs Gamliel Lovitzky who was in a vegetative state, the late Judge Moshe Telgam, in his capacity as deputy president of the District Court (OM 10403/99 dated 15.4.1999), permitted not to extend her life artificially and to cease the artificial feeding that he regarded as “futile treatment”. His opinion at that time was that it was “not the halting of the treatment that would cause the patient’s death, but rather her terminal illness”.

The State appealed against this ruling and the Supreme Court in its ruling (CA 3031/1999 dated 30.5.1999) overturned the ruling of the District Court. The Supreme Court judges felt that it had not been adequately proven that the patient had agreed in advance that they should cease feeding her if she should encounter the circumstances she was presently in. Furthermore, the judges thought that it had not been medically proven that the patient’s condition was “irreversible” and that she could not feel pain and suffering because of starvation. For these reasons the judges saw fit to reject the application of Mrs Lovitzky’s son to order the physicians treating his mother to cease the artificial feeding given to her.

In the years that have elapsed since this court ruling a slow but clear change has occurred in the position of the public, the legislator, and the Court regarding complex issues of medical decisions on the “end of life”. The opinion of the patient and his family is currently heard more than in the past, and there is greater readiness than in the past to meet them halfway at such difficult moments.

The position paper will strengthen this trend even more and will permit us, the physicians, to make the difficult decision of ceasing artificial feeding, with the backing of the law.

**Position paper**

- A persistent vegetative state (PVS) is characterized by maintenance of the activity of the brain stem, while the cerebral cortex is no longer active.
- In the absence of activity of the cerebral cortex, to the best of medical knowledge,
there is no consciousness and consequently no ability to sense pain or suffering.

- A patient in a vegetative state can continue to live for long periods, as long as he receives artificial feeding, including liquids and food.
- There is emotional, symbolic, and religious value to the giving of food and water, which distinguishes it from other forms of medical treatment. However, this is a medical treatment that has to meet the test of cost effectiveness like every other medical treatment.
- Medical treatment that brings no benefit to a PVS patient may be halted if this is the wish of the patient, as expressed earlier, or at the request of his authorized representative in accordance with the law.
- The cessation of feeding to a patient diagnosed as PVS is permitted provided that a neurological specialist, in addition to the physician treating the patient, has approved the medical diagnosis and also after receipt of the agreement of the ethics committee of the institution.
- Steps should be taken at the national level to set up ethics committees in the community, in order to meet the needs of those patients treated at home.
- These rules permit a physician to accede to the request of the patient or his authorized representative, but do not obligate him to act contrary to his conscience.
- If the physician treating the patient cannot accede to the request of the patient, or his authorized representative, to cease feeding, he should refer the patient for treatment by another physician.

32. Trading in organs and organ donation (*)

Published in August 2003

**Background**

The sensitive issue of organ trade continues to appear in the public discourse, and is from time to time pushed to center stage. This subject naturally arouses strong feelings and penetrating arguments, and creates an urgent need to bridge conflicting and uncompromising positions. On the one hand, we must solve the problem of patients waiting for transplants, while on the other hand it is difficult, and perhaps impossible, to accept the idea that it is permissible to trade in human organs and tissues.

The need for organs for transplantation considerably exceeds the existing supply from donations from deceased persons. For example, in Israel about 600 persons are waiting for kidney transplants, while the number of transplants actually performed does not exceed about 150 operations per year. The list of people waiting increases by between 10-20% per year. It is not surprising that some of the patients waiting die before the awaited transplant.

Until now, organs have come from a deceased donor or from a living relative, for purely altruistic motives, without any direct or indirect financial remuneration. Since the demand exceeds the supply, those needing a transplant approach in despair other, generally anonymous, donors. When the buyer meets the seller, a worldwide black market is created, which crosses borders
and countries and to which all the rules of supply and demand apply. A patient in one country may contact an intermediary in another country. The latter locates a donor in a third country, while the operation itself is performed in a fourth country. Everything is done covertly or at least with the authorities turning a blind eye, and always against the laws of the countries involved. In this complex process a great deal of money changes hands, going to the intermediary, the surgeon, the hospital, and the organ donor. In most cases, the latter receives a marginal sum from the money involved in the transaction.

The directives of the Head of Medical Administration at the Ministry of Health (68/97) prohibit all trading in organs as well as the transplantation of organs received in consideration for payment. A physician who infringes these rules risks disciplinary and criminal proceedings against him and the loss of his license to practice medicine. The position paper of the Ethics Board of the Israeli Medical Association (December 1997) also prohibits trading in and using such organs, in the spirit of the stance of the Ministry of Health. This is also the position adopted in all countries in the western world, including all international medical organizations.

In this vein, the government submitted to the Knesset a bill for amendment of the Public Health Order (No. 13), 5751-1991. Pursuant to this bill, it is prohibited to sell or purchase organs. The transaction itself is null and void, and the parties to it are subject to criminal proceedings.

However, reality forces us to re-consider the issue. It is necessary to find an urgent solution to the distress of patients and their desperate need for organs available for transplant, which is not met by the current situation. Many voices advocate allowing trading in organs, from a living donor, within a national framework in which all trade will be conducted through a central organization rather than directly between parties. This organization will be responsible for compensating the donor and will transfer the donated organs to those for whom the organ is most suitable.

The Supreme Court addressed this issue in a single hearing (SC Atri, M.I. 161/94) in which it rejected the petitioner’s application that the Court order the Minister of Health to enact regulations that would permit the plaintiff to sell a kidney and thus solve his financial problems. The Court agreed with the position of the Minister of Health that a solution for this complex and sensitive subject should be decided in primary legislation that addresses the legal, moral, and ethical aspects.

Against this background, the Ministry of Health recently completed a “Bill for Organ Transplants, 5762-2002”, which permits, in specific circumstances, compensation to a living organ donor for the costs involved in execution of the medical activities, including loss of time, loss of income, and temporary loss of earning ability. The compensation shall be paid to the donor by the national transplanting center. In addition, any form of brokerage between the donor and the recipient is absolutely prohibited. The social debate on this proposal has only begun.

The Ethics Board held a protracted debate on the subject of organ trade, in order to find the correct moral and ethical balance between the needs of patients requiring transplanting and the possible harm to the sellers of the organs, and the broader social significance of such trade. The position of most members of the Ethics Board, as emerged during this debate, appears here. The members of the Ethics Board are aware of the fact that this position expresses a
sensitive balance between conflicting approaches- a compromise between profit and loss, some tangible and immediate, some intangible, relating to abstract values of social morality that determine the nature of our existence as a human society. Since these values are not absolute, but are liable to change in the future, this position of the Ethics Board should be raised for renewed debate in the future.

**Position paper**
- The donation of organs is a moral obligation imposed on society in general.
- State authorities should take steps to educate and explain this matter to physicians and to the public.
- It is preferable that individuals donate organs for altruistic motives only.
- In the event of a donation from a deceased person, the State shall be entitled to compensate the family of the donor.
- The donation and the compensation shall be done by means of a central national organization.
- No direct link shall exist between the family of the donor and the recipient.
- Compensation shall be made in the form of medical-economic benefits and not direct financial payment.
- Trading in organs from a living donor creates class discrimination, is unethical, and ab initio improper.
- Consequently, organs may not be sold or bought from a living person.
- A physician may not be directly or indirectly involved in the purchase or sale of organs.
- A physician may not transplant an organ purchased from a living person.
- This position shall be re-examined if the legislation or the positions of the public change.

(*) This position paper should be read subject to the Transplantation Law, 5768-2008.

### 33. Transplanting organs from persons sentenced to death

**Published in January 2007**

**Background**
The ongoing public debate regarding trading in organs continues unabated, with seemingly unbridgeable internal tension. On the one hand, there is a clear-cut social obligation to solve the distress of patients waiting for organs vital for their health and lives. On the other hand, it is impossible to solve this distress by trading in body parts of someone else and physically impairing him.

The hardship of the patients is real, and no one doubts this, but social awareness in Israel for the donation of organs after death is painfully low. It is not surprising that in this bitter reality, in which the number of cadaver donations does not approach the urgent needs of patients, that the latter search for donations from living persons, mainly in countries outside Israel, and engender a vibrant ethical debate regarding organ trade. Trading in organs from living persons is contrary to the ethical and legal norms in all countries in...
the western world, which prohibit trading by means of legislation or by binding medical norms and guidelines. Even international medical entities, including the WMA, the WHO, and the EUC, have taken clear decisions that unequivocally reject trading in organs. The position paper of the Ethics Board, published some time ago, states that trading in organs from living persons is unethical and improper. This position paper even forbids physicians from participating in any way whatsoever in the purchase, sale, or transplanting of organs originating in such trading. The Bill for Prohibition of Human Trade (legislative amendments), 5766-2006, which passed second and third readings in the Knesset in October 2006, also prohibits, in section 12 of the law, “human trade” for the purpose of “removing an organ from the body”. The law specifies punishment of 16 years imprisonment for this offence.

Recently, the issue of transplanting organs from China, was raised for discussion. According to evidence from international human rights organizations, China conducts trading in organs originating in executed prisoners who prima facie donated their bodies for transplantation prior to their execution.

China is the only country in the world that permits trading in organs taken from prisoners who were executed. The number of persons executed there is increasing, and according to the evidence, opponents of the regime constitute a significant percentage of those executed. The descriptions given in the US Congress by refugees from China indicate a developed method by the regime. The courts, prisons, and hospitals all cooperate to transfer the organs of the person sentenced to death to the recipient, who is primed to receive these organs on the operating table of a hospital near the prison.

A lot of money changes hands around the prisoner who “donated” his organs. Everyone who was near the prisoner and controlled his fate benefits from the dubious spoils. Does anyone believe that a person sentenced to death, imprisoned in a cramped cell and subject to the mercy of the jailers, gave his consent of his own free will?

As long as this heavy shadow lies on the practices in China, it is best that we take no part in the trading of organs originating there.

Position paper

- The ongoing problem of a shortage of organs for transplant is a bitter reality that shortens the life expectancy of patients waiting for organs.
- This distress drives patients to travel to various countries throughout the world, in an attempt to obtain the required organs.
- Trading in organs for transplantation is contrary to the accepted rules of ethics, morality and law throughout the enlightened world.
- There is evidence of places in which trading has developed in organs originating from prisoners sentenced to death.
- Where there is concern that the execution was done in order to obtain organs for transplanting, the consent of the person sentenced to death to the donation of his organs after death cannot be regarded as having been given of his own free will.
- Consequently, it is forbidden to cooperate in the transplantation of organs in cases in which it is feared that the execution was done in order to obtain the said organs.
34. Physicians on medical committees

Published in September 2008

Background
The Ethics Board, as well as the press, has received complaints from the general public regarding alleged faulty management of the medical boards in the National Insurance Institute and in the Ministry of Defense. The complaints mainly raise accusations of a short, contemptuous, and humiliating examination, conducted without giving the examinee the possibility of properly presenting his viewpoint, in an atmosphere of suspicion directed against the examinee. Another constant argument is that since the physicians receive their salaries from the institution for which they are working, they are faced with a conflict of interest, forfeit their professional independence and submit to the dictates of the secretaries of the boards, employees of the institution, and allegedly act contrary to objective professional criteria.

On the other hand, the physicians of the boards claim that there are many cases in which the examinees exaggerate their complaints, and sometimes actually pretend, in order to receive financial compensation for a non-existent disability. They also claim that there were cases in which physicians treating the examinees instructed them, prior to the medical board, to cease or change the medical treatment they were receiving in order to worsen their medical condition in preparation for the examination by the medical board, with the intention of receiving maximum disability.

We must emphasize that the medical boards are a kind of judicial entity, bound by a decision making process whose rules are specified in court rulings. These boards should be regarded as independent entities whose function is to give a ruling regarding the medical rights of the examinees, without the physicians on the boards being subject to the authority of the institution for which they are working, or owing them any fiduciary duty. The physicians on these boards must act in accordance with independent professional criteria.

The Ethics Board held a debate on the subject, with the participation of Dr Mario Skolsky, the head physician of the National Insurance Institute, and advocate Leah Dekel-Greenblat, who represents claimants on medical boards.

Position paper
- Medical boards are quasi-statutory entities, whose function is to rule in medical disputes between the insured and the institution on behalf of which they act.
- Physicians of the medical board shall regard the examinee as a person with disabilities even before these have been determined.
- The medical examination shall be conducted while respecting the privacy and dignity of the examinee, and while paying maximum consideration to the normal running of his life.
- The examinee shall be given a suitable opportunity to present his point of view.
- The medical decision shall be given after collection, evaluation, and summarizing of the medical data.
- The major points of the discussion held by the board shall be recorded in a protocol, with clear and understandable reasons given for the decision taken.
The physicians of the board shall make an objective, independent, professional decision that is not subject to the authority of the institution in which they work.

Independence of the medical boards is an essential condition for their functioning and purpose.

It is improper for a physician treating a patient to instruct him to cease or change the medical treatment that he is receiving in order to “worsen” his condition prior to examination by the medical board.

35. The presence of lawyers during examinations in a medical committee

Published in January 2013

Background:
Recently, the Ethics Board discussed the question of a lawyer’s presence during an examination at a medical committee. The topic was raised after an incident where a bitter argument developed between committee physicians and a lawyer who appeared before them alongside his client – the patient. The argument centered on the appropriate extent to which the lawyer could intervene in the proceeding and his very presence there.

The medical committee acts as a quasi-judicial body, so every person is entitled to be represented there by a lawyer under the rules of natural justice and the law. The directives in circular 40/2001 of the Ministry of Health’s Medical Directorate also stipulate: “Every person is entitled to the presence of another person, medical staff or otherwise, of their choice, during a physical examination.” The above was written in regard to the issue of “physical examinations in the realm of personal privacy,” but the directive applies to every medical examination, according to current medical norms. This is particularly true when the examination involves handicapped or legally incompetent patients who cannot duly stand up for their rights in a medical committee.

These rules are meant to help protect the rights of the represented person, to ensure the fairness of the proceedings and to prevent the abuse of the power disparity between the patient and the physicians.

It is widely agreed that a lawyer can participate in a medical committee and even present his client’s position and claims during the first stage of the committee’s work. However, the lawyer’s intervention in the medical examination, whether physical or psychiatric, is liable in certain circumstances to disrupt the very performance of the examination.

In recent years, the district courts in Jerusalem and Tel Aviv have discussed the demand to record the physical examinations conducted by medical experts hired by defendants in personal injury cases. No uniform position has emerged on this matter, and the court recently ruled against such a recording.

Since the physical presence of a lawyer while conducting a medical examination could also disrupt the physician’s work in some circumstances, it is appropriate to quote some of the judges’ statements:
“It should not be permitted to record the medical expert since it expresses doubt regarding the integrity of the expert and his professionalism ... The credibility, reliability and professional quality of the examination requires a comfortable working environment for both the expert and the patient.”
(The honorable Judge Ganot, Tel Aviv District Court 1919/06)

“It is a physician’s right to design his work environment according to his best judgment and understanding.”
(The honorable Judge Inbar, Jerusalem District Court 2196/08)

“It is hard to assume that the patient’s readiness to disclose intimate details regarding his physical or mental condition to the medical expert will not be affected by the presence of the recording device. Thus, recording the medical examination may impede the cooperation and honesty sometimes required to reach the medical findings.”
(The honorable judges Rivlin, Denziger, Hendel, Civil Appeals Authority 2948/10)

Therefore, in an attempt to balance the occasionally clashing principles of patient autonomy and physician autonomy, the members of the Ethics Board have taken the following stance:

**Position paper**

1. Patients should be allowed, at their request, to be accompanied by another person in a medical committee as stipulated in the law, including a lawyer and including during the actual medical examination.
2. This right is especially important in medical committees that discuss the medical condition of people with disabilities.
3. Under exceptional circumstances, the presence of a lawyer at a medical examination may influence the procedure and its results. This occurs when the behavior of the lawyer interferes with the performance of the medical examination, and is especially true during a psychiatric examination, where the presence of another person is likely to have a greater effect.
4. If the physicians on the medical committee deem the lawyer’s presence at a medical examination to be potentially disruptive to the procedure or its result, they will notify the patient and lawyer and record the special justifications for this decision in the committee’s report.
5. Under these exceptional circumstances, the medical examination will continue without the presence of the lawyer.
36. Medical confidentiality and the tax assessor

Published in July 2014

A decision made by the Income Tax Appeals Committee on February 4, 2014 was brought before the Ethics Board. The committee’s decision, involving a physician who has a private practice, states that in order to facilitate an audit of the physician’s tax statements, he must specify the nature of the medical care in the invoice he gives to the patient, and not just the type of service – “consultation” or “operation,” etc. The committee determined there was no reason the physician should not specify details such as “nose surgery” or “treatment of stomach ache.”

The members of the Ethics Board discussed the extent of the obligation to give a detailed report to the Income Tax Authority, considering the physician’s obligation to maintain medical confidentiality. They discussed a fundamental question that pertains to medical confidentiality: Does the medical confidentiality belong to the physician or the patient? Why have physicians been obligated to it and sworn to uphold confidentiality since the dawn of medicine?

The commitment of a physician to maintaining medical confidentiality took root as a basic ethical rule in ancient times. The Hippocratic Oath states: “Whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets.”

The Oath of the Hebrew Physician was written by Professor L. Halperin in Jerusalem, 1952. Since then, all aspiring physicians in Israel swear by it, from the first class of medical school graduates in Jerusalem to this day. This oath emphasizes the obligation to confidentiality: “Be loyal to those who put their trust in you, do not disclose their secrets and do not spread what you know to others.”

The obligation of physicians to uphold medical confidentiality is based first and foremost on the need to hear the complete and honest medical history and symptoms from the patient. The medical history leads us, as physicians, to the correct diagnosis in over 90% of cases. The other tests we perform – blood tests, X-rays, MRI, etc. – are meant to confirm the medical diagnosis. Therefore, it is immensely important to receive the full story from the patient, without him or her withholding information out of fear of exposure.

Medical confidentiality is also a central component in developing trust between physician and patient. This trust is an important factor in recovery, and should be seen as one of a physician’s basic professional tools.

The obligation to maintain medical confidentiality stems directly from our obligation to respect the autonomy of the patient. The medical secret and the medical record, in our ethical worldview, and in our legal framework (the Patient’s Rights Law), belong to the patient, and not to the physician.

84 https://en.wikipedia.org/wiki/Hippocratic_Oath
85 https://www.ima.org.il/eng/ViewContent.aspx?CategoryId=4139
Part E

The autonomy of the patient is one of the core values of medical ethics: “Respecting the autonomy of the patient means protecting his human dignity, and maintaining his privacy and medical confidentiality. The physician should respect these rights and should act with the patient in accordance with them.”

The Ethics Board has often discussed maintaining the privacy and medical confidentiality of the patient. It has defined this obligation as one of the main duties of a physician: “The physician should maintain the privacy of the patient and his medical confidentiality”; “the physician should honor the human rights of the patient and not participate in any action that violates any of those rights, except in extraordinary cases where the patient’s best interests require it.”

Even though, in general, the medical secret belongs to the patient, there are extraordinary cases where the physician is obligated to violate medical confidentiality. These cases occur when failure to expose the medical secret would pose a threat to the patient or the public – for example, when a physician diagnoses a contagious illness that could harm other patients or medical staff, or when the danger posed to the general public outweighs the value of keeping the individual’s medical secret. Even in these cases, the information should be disclosed in a measured fashion and include only the relevant details.

On these grounds, the Ethics Board believes that facilitating the work of tax auditors does not justify setting aside the right of many thousands of patients to medical confidentiality. Ever since we have been taking the physician’s oath, there has been no change in the social norms and expectations from physicians that justify or explain why we should violate the autonomy of our patients and expose their condition or treatment.

In a meeting held on July 1, 2014 the Ethics Board decided:

1. The Ethics Board recognizes the importance of the sound operation of the tax authorities, and emphasizes the obligation of physicians to file reports and pay taxes to the authorities for the payments they receive from their patients, as required by law. However, physicians in Israel are obligated to maintain the medical confidentiality, dignity and privacy of their patients.

2. Medical confidentiality is a right vested in the patient, and he alone can decide to relinquish it.

3. It is inappropriate for a physician to ask a patient to waive medical confidentiality in order to include details in a receipt, because this puts the patient in an uncomfortable situation and could harm the trust between the patient and his physician. It is wrong for a patient to relinquish a fundamental right in order to further an interest that does not involve him.

4. When filing a report to the income tax authorities, the name that appear on the receipts and the sum paid should be enough. There is no need to specify the illness or the nature of treatment given in the receipts in order to validate the sum paid to the physician.
5. The potential benefit to the audit process from the blanket waiver of medical confidentiality is unclear, and is probably very small. In extraordinary cases where the tax authorities suspect an offense has been committed, there are well-defined ways to further investigate the data.

6. Furthermore, violating medical confidentiality by specifying the treatment given to the patient will, for the most part, not help the auditor determine whether there is a reasonable correlation between the nature of the treatment and the sum paid.

7. The wholesale and disproportionate waiver of medical confidentiality will greatly damage public health and doctor-patient relationships, and even pose a danger. Therefore, it should not be allowed.

37. The examination of patients by medical students

Published in January 2008

Background
A journalistic investigation was recently published in the media, according to which medical students were required to conduct gynecological examinations of anaesthetized women without their knowledge or consent. The students, whose identities remain unknown, issued a complaint to the press, and from there the affair went public.

It is difficult to conduct a balanced discussion in a heated emotional atmosphere. Although the issue of examination by medical students of private body parts crosses the boundaries of gender, and is identical for men and women, 19 feminist organizations demanded that the Minister of Health immediately set up a commission of inquiry. The language in which the public debate was conducted was strewn with harsh expressions, ranging from "scandal, appalling incident, outrageous conduct, degradation and humiliation" to "rape of women" and "gang rape". The entire "medical establishment" was accused of "a humiliating, contemptuous, blind attitude to women".

The meeting between the patient and the medical student is defined in advance for both parties: A patient who wishes to be admitted to a hospital for treatment signs an application, in which the following paragraph appears: "I am aware that the ... hospital is a university hospital and students participate in the evaluation and treatment under full supervision". (Similar wording appears in the admission forms of the various hospitals in Israel.)

The activity of medical students is defined in a Directive of the Medical Administration of the Ministry of Health, dated July 2005, which specifies the conditions regarding "the participation of students in clinical activities" and obligates, inter alia, the express advance consent of the patient for the presence of or examination by students.

It seems that these instructions were not adhered to. The investigation exposed, unfortunately, an intolerable gap between what patients were supposed to know and consent about the medical staff treating them, and what actually took place in the operating theater.

In order to close this gap, and in order to stress the ethical code regarding "examination of patients by medical students", the Ethics Board conducted a debate in which Dr. Nili Karako
Eyal from the Law School of the College of Management and Mrs. Hedva Eyal, coordinator of the Woman to Woman Organization, who represented the feminist organizations, also participated. Following the debate, the members of the Ethics Board formulated the following rules, with the intention of striking a balance between apparently opposing interests: the obligation to respect the privacy, dignity, and modesty of the patient, and the social necessity to train the next generation of physicians in the State of Israel. We hope and believe that these rules, binding on all physicians, will enable them to preserve the trust and transparency required in their relations with their patients. At the same time, the general public must be made aware of the need for those who will soon become physicians to acquire the necessary medical skills.

**Position paper**

- The physician-patient relationship is based, first and foremost, on trust, honesty, and mutual transparency.
- Consent for medical treatment is given, inter alia, based on the patient’s knowledge of who will be involved in his evaluation and treatment.
- Consequently, the examination or treatment of a patient shall not be conducted by a person who is not part of the medical staff approved by the patient.
- It is doubly obligatory to respect the dignity and privacy of the patient when he is anaesthetized and cannot express his opinion.
- Physicians bear the social responsibility and obligation to educate the future generation of physicians in the country, while observing the highest professional and ethical standards.
- The hospitals and clinics in the community serve to advance the knowledge and clinical skills required in the training of medical students. The students take an active part in evaluating the state of the patients and their treatment, under the full supervision of the medical staff.
- It should be clarified to the patient that medical students will participate in all stages of his medical treatment, and that this plays an important part in their professional training. The patient’s informed consent for this must be obtained in advance.
- It should be clarified to the patient that the students’ evaluation and treatment will be done in the presence of the physician treating him, while respecting his dignity, privacy, and modesty.
- At the request of the patient, his examination or treatment shall be done in the presence of a medical staff person of the same sex as the patient.
- It should be clarified to the patient that he reserves the right to object to the presence of students or to examination by them, and that this will not affect the continuation of his treatment.
38. Transparency regarding the health of national leaders

Published in January 2007

Background
The dramatic events surrounding the illness of Prime Minister Ariel Sharon, the unprecedented involvement of the media in the physicians’ decisions, and the amount of information furnished or not furnished by them to the public in real time, restarted the public debate about the transparency required regarding the health of national leaders.

Modern history abounds with cases of heads of countries who concealed from their people, for many years, the fate of their illness. Without doubt, in some of those cases the quality of the decisions they took was influenced by their state of health. The outstanding example is that of US President Franklin Roosevelt, who participated in the Yalta Conference opposite Stalin while suffering from malignant high blood pressure, which caused his death from a cerebral hemorrhage a short time later. The sick Roosevelt lost Eastern Europe to Stalin, and thus the "iron curtain" descended on Europe for more than a generation.

In our short national history, there were two prime ministers whose illness was an open secret – the details of the illnesses of Golda Meir and Menachem Begin are only now starting to become clear. History will judge how the stroke experienced by Begin when he was prime minister, the treatment with steroids that he received, and the deep depression into which he sank, influenced his functioning as a Prime Minister and the way in which he conducted, for example, the first Lebanon War.

In a democratic and open society each of us is entitled to know that the person standing at the top of the pyramid is medically, physically, and mentally competent to bear the heavy burden. The obligation for this disclosure should not be imposed on the personal physician of the leader, placing him in a conflict of interests between his obligation to the patient on one hand, and his public responsibility on the other. This physician must preserve the trust between him and the leader, based on the obligation of medical confidentiality towards the patient, even if he is a national leader.

Voluntary disclosure of his entire medical file will preserve and strengthen the public's trust in the leader, but there is no certainty that all leaders will act in this way. Consequently, governmental tools should be created to evaluate the leader’s medical capability. These tools must include internal checks and balances in order to prevent their misuse and harm to the democratic process.

Position paper

- Those bearing responsibility for national leadership are naturally subject to constant physical and mental pressure.
- The decisions of national leaders are liable to decide the fate of many people, and sometimes of the entire nation.
- Consequently, these leaders must be in good health in order to fill their roles.
- A national leader waives in advance some of his privacy, including that related to his state of health.
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- A national leader’s personal physician is obligated, first and foremost, to the patient, and he must not be placed in a conflict of interest with the obligation for disclosure to the general public.
- Similarly, the personal physician should not be obligated to decide regarding the ability of the leader to continue to fulfill his position.
- Suitable state tools should be created to examine the medical condition of the national leader and transfer the relevant medical information to the public’s knowledge.

39. Medical supervision of the competence of drivers

Published in December 2008

Background
Every year about 450 persons are killed in Israel in road accidents, and tens of thousands are injured. Medical treatment and rehabilitation of the injured demand considerable medical and economic resources. Driving, although it has become a routine activity for all of us, obligates physical, cognitive, and emotional capability, as well as constant attention and concentration. The human factor in accidents is significant. Medical competence for driving is a personal matter, since numerous factors are liable to affect the ability to drive: specific medications, lack of sleep, consumption of drugs and alcohol, etc.

The Traffic Ordinance obligates every driver to notify the Licensing Authority by registered mail of any illness limiting his capability to drive. The law imposes an identical obligation on "the physician treating the driver" who "has diagnosed an illness (in the driver) and is convinced that the said person is liable to endanger himself or others because of this when driving".

The instructions of the Medical Administration from 1998 clarify that the obligation applies to "any physician treating a person, including one-time treatment or diagnosis only". The instructions impose the obligation for reporting a long list of illnesses and situations that have no connection with driving, including, for example, kleptomania, pyromania, and pathological gambling. On the other hand, in clear-cut cases of illnesses liable to affect driving, no threshold for reporting has been specified, and the question remains open of when to report to the Authority in cases such as Alzheimer, Parkinson, or epilepsy controlled by medication.

In the absence of data regarding the number of accidents caused by the medical incapability of the drivers, it is not at all clear if public benefit will be derived from the cancellation of these drivers’ licenses. In contrast, the damage expected to the physician-patient relationship because of the breach of the patient’s privacy and the effect on his ability to function in society – such damage is very certain and tangible. It is not surprising that only one percent of the physicians in Israel report to the medical institute for road safety patients who seemingly constitute a risk on the road.

The law has failed in an attempt to turn physicians into watchdogs of the medical capability of drivers in Israel. This is a decree that the physicians cannot comply with, as long as they are not convinced that it sacrifices the traditional connection with the patient for a worthy cause. Furthermore, since the identity of the physician making the report is known to the patient, there
is a real fear on the part of the physicians of violence against them in respect of such a report. It appears that the State cannot impose the responsibility for road safety on the shoulders of the physicians, some of whom are not even aware of this legal obligation. The law should be stayed and the entire approach re-evaluated. It would be better for the responsibility for reporting to be imposed on the driver only, with the physician retaining the right to report if it becomes clear to him that the patient himself does not intend to report his illness. Even then, the list of illnesses that obligate reporting should be drastically reduced, and the physician reporting should be given proper legal defense.

Position paper

- The human factor in road accidents constitutes a major reason for mortalities in Israel.
- The good of the public obligates monitoring of the medical capability of the country's drivers.
- The Traffic Ordinance imposes on the physician the obligation to report to the Licensing Authority every driver who, in the physician's opinion, endangers through his driving both himself and others, as a result of his illness.
- The instructions of the Medical Administration in the Ministry of Health on this matter include a long list of illnesses that obligate reporting, some of which are totally irrelevant to driving.
- The obligation to report, which infringes the patient's right to privacy, harms the patient's trust in the physician and the professional connection between them.
- The physician is obligated to notify the patient in advance of his obligation and intention to report to the State authorities regarding his capability to drive.
- The obligation to report causes the patient to conceal the medical truth from the physician, and is thus liable to cause deterioration to his state of health and increase the risk in his driving.
- Against their will, physicians have encountered a conflict between their ethical obligation to the individual patient and their legal and ethical obligation to the general public.
- Because of this conflict, the majority of physicians do not report the state of medical competence of patients for driving.
- The State should re-evaluate the effectiveness of the existing law and its replacement by another, acceptable, law that will exempt physicians from the ethical conflict they have encountered.

40. Is there a limit to the medical obligation in pandemic situations?

Published in December 2008

Background

The SARS epidemic that broke out in 2002 raised incisive questions regarding the limits of medical responsibility in pandemic situations. The epidemic, caused by the Corona virus,
within a few days from China to five additional countries by means of persons who contracted the illness and flew to other destinations. Within about five months, more than 8,000 people contracted the illness.

The mortality rate from the illness is about 10% on average, but the percentage of medical workers amongst the dead in Singapore and Canada was 45%. Dr Carlo Urbani, a specialist in infectious diseases who first identified the virus in Hanoi, Vietnam in March 2003, was himself one of the victims of the disease and died from it a month later.

Avian influenza, which was diagnosed in 2006, attacked “only” a few hundred persons, but the mortality rate among those affected reached 70%. If this virus should change its structure and become more contagious to humans, society will have to contend with a catastrophe whose dimensions are very difficult to estimate.

Spanish influenza, which raged in Europe at the beginning of the last century, caused the death of about 50 million persons. Today, when nearly a billion people fly every year all over the world, a violent virus like Spanish influenza is liable to spread globally within a few months. Based on accepted estimates, this is liable to cause the deaths of about 100 million persons, and to harm tens of millions more, who will require hospitalization in critical respiratory condition. No country in the world is prepared for such a catastrophe.

How should a physician act when required to treat patients suffering from an infectious disease under conditions in which the chances of contracting the disease are so real and threatening? How should we act towards a physician who, in order to save his and his family’s lives, deserts his post in the hospital? Should he be brought to trial?

Despite the urgent need to do so, no country in the world has solved this conflict of interests. It is clear to everyone that it is impossible to force a physician by legal or disciplinary means to return to work against his will. As has already happened, physicians will prefer to leave their profession rather than being forced to pay with their lives and those of their families for their unbounded devotion and altruism.

A partial solution to this problem lies in renewal of the physicians’ social contract. Alongside ratification of the special commitment of the physicians to the general public during a crisis, the public should recognize the additional, unique risk that physicians voluntarily assume, beyond the normal risk inherent in the profession, and compensate them accordingly. Compensation means the acceptance of special responsibility for medical workers who become ill, and for their families.

Society must nurture physicians and medical workers in general, and encourage in them feelings of responsibility, leadership, and personal example. The free will of every physician in the moment of truth will only come from these values.

**Position paper**

- In states of emergency of widespread epidemics and mass disaster, the involvement of all physicians in the country is required.
- Medical knowledge and professional skills reduce the risk of the physician contracting the disease, and therefore he is permitted to give aid to persons suffering from an infectious disease more than anyone else.
Therefore, the rule is that the physician has an ethical obligation to treat any patient suffering from an infectious disease.

The obligation to give treatment also applies in the presence of a reasonable increased risk to the safety, health, or life of the physician.

Situations may occur in which the plausible risk to a physician from a patient suffering from an infectious disease is more tangible, and exceeds the usual risk of the profession.

A physician also bears ethical obligation to preserve the health of his family and all the patients he is treating.

Consequently, when treating a patient suffering from an infectious disease, the physician should strike a balance between the immediate benefit expected for the individual patient and his ability to provide medical treatment in the future to other patients, as well as the value of preserving the health of the physician himself and that of his family.

### 41. Ethical aspects of a multi-casualty event

**Published in May 2008**

**Background**

A multi-casualty event is characterized by the inability or lack of means of the physician involved to do the maximum in order to save life or limb of all the casualties. The guiding professional principle is to do the most possible for the maximum number of casualties, and not the best for all of them.

In such a situation, the physician is required to employ the triage method, which implies a potential of less than optimal treatment for some of the casualties and is even liable to cause their death or disability.

In such an event, non-medical entities such as relatives, curious bystanders, police personnel and media people, are also involved and their contribution to the task is minimal and sometimes even negative or an encumbrance.

The aim of this position paper is to formulate the position of the Ethics Board of the Israeli Medical Association on various aspects related to a multi-casualty event.

**Definition of a multi-casualty event**

A multi-casualty event is the result of a catastrophic incident that affects a large number of persons. An event of this kind may occur during wartime, armed conflict, a terrorist attack or a civilian disaster. In an event of this kind, there is generally an imbalance, if only fleeting, between the needs of those requiring treatment and the capability of those giving the treatment to meet this need within a given period of time. Medical service in such situations requires organizational and technical aspects in addition to the ethical aspects. This position paper will, however, be limited to addressing the ethical aspects.

**The ethical code for medical treatment during a multi-casualty event or disaster**

a) The ethical principles of medical screening during a multi-casualty event or disaster:
medical screening (triage) is intended to solve a momentary or permanent situation of a relative lack of means and/or manpower, as opposed to the needs of the patients. In triage, the physician is required to decide the order of priorities and the allocation of resources for treatment of the patients and the casualties. By its very definition, it is possible that giving priority to some of the casualties may deny, or at least delay, the best treatment for another casualty.

b) The guiding ethical principles in triage, which aim to make it fair and professionally optimal, include the basic ethical principles familiar to us from the accepted literature:

1. The principle of beneficence
2. The principle of autonomy
3. The principle of non-maleficence
4. The principle of distributive justice
5. In addition, the principles include the rights of those giving the treatment, such as the right to personal security of the treating personnel, the rights of society and of the State.

1. The principle of beneficence
   The physician has an obligation to do his best and attempt to ensure that the system in which he works will do its best to give the patient the best treatment, to prolong his life, and prevent disability and suffering.
   In a multi-casualty event or a disaster, the incompatibility between the needs of numerous casualties and the limited existing capabilities, if only in the first stage, obligate maximum caution in the formulation of priorities for treatment, but also maximum speed. Triage is sometimes performed under difficult physical conditions and with limited data. The physician doing the triage will formulate a triage policy based on the concrete conditions existing at the time of the event.
   - First priority – The physician will treat casualties and patients with an immediate risk to their lives, whom he thinks can be saved.
   - Second priority – The physician will treat patients and casualties who need immediate treatment, even if the treatment is not lifesaving.
   - Third priority – The physician will treat patients and casualties whose treatment may be delayed for a reasonable time without causing harm.
   - Fourth priority – The physician will treat patients and casualties whom it seems to the physician performing triage that the chances of saving their lives are non-existent in the relevant conditions of time and place.

In cases of human violence that also cause casualties to those responsible for this violence (the enemy), the obligations vis-a-vis these entities must be fixed expressly. Here, the principle of “charity begins at home” must apply.

2. The principle of autonomy
   Even someone being treated in a multi-casualty event has the right to decide about his fate, such as where he wishes to be taken and who will treat him. Furthermore, the patient is entitled to refuse to receive medical treatment in general or a specific treatment in particular. The
physician treating him shall, as far as possible, respect the wishes of the patient. The physician shall primarily be subject to the need for proper distribution of resources and of prevention of preference for one patient over another. For example, it is possible that the team moving the casualties from the area to a hospital will not take into account the wishes of the casualty to be taken to a specific hospital. Furthermore, the physician may fix a treatment priority different from that desired by the patient.

3. The principle of non-maleficence
The physician treating the casualty shall use accepted medical methods in accordance with the standards customary at that time.

4. The principle of distributive justice
The physician shall give medical treatment in accordance with the priorities determined by him or by someone authorized to do so, in accordance with medical criteria, with no other considerations, such as the age, sex, religion, nationality, social or economic status of the casualty. In general, the physician giving the treatment shall attempt to save the maximum number of casualties possible, even at the possible price of reducing the chances of saving an individual.

5. The safety and security of the medical team—rights and obligations of the medical team when faced with a potential threat
The teams treating casualties during a state of emergency experience various levels of personal risk as part of their jobs (police, soldiers, MDA personnel, physicians and nurses). During the event, the physician is obligated to assume a relevant and immediate risk, if this will lead to the fulfillment of his professional obligation to treat patients and casualties. However, members of a medical team who are themselves injured are of no benefit to the cause. Injury to the medical team is liable to come from the act that caused the event or from the persons who caused the event. In predictable states of risk (war, epidemic, work in a hazardous environment) the medical team and their managers are obligated to initiate and execute reasonable preparations (exercises, protective equipment, immunization, etc.) in order to be capable of operating in a hostile environment. In the absence of proper advance preparations for the situation encountered by the medical team (for example, the absence of protective equipment against an infectious biological generator) the team shall act to the best of its judgment in order to help the casualties, without affecting their capability to help other casualties as well.

States of emergency involving numerous casualties that take place in different regions
The event usually commences in an area that is not a medical facility. It is also likely to involve an intermediate stage—a temporary improvised medical facility at a less than optimal level. It will continue in the process of transferring the casualties. It will end in a proper medical facility. The special nature of the first three situations is that the potential for violent injury to the team
is more real than in an orderly facility, and this should be taken into account.
The entry of a medical team to the line of fire: In the event of risk to life, the physician, together
with the security entities, shall estimate the risk involved in entry to the location of the event
versus the obligation to save lives. When speaking of a potential for injury not caused by
humans, the same principle applies.

**Educational aspects**

a) Part of a physician's basic professional training must include treating casualties in a
multi-casualty event.
b) The involvement of medical schools staff in the planning and updating of the studies is
essential, as is that of physicians engaged in this field on a daily basis.
c) Medical schools should offer continuing education programs for medical personnel,
nurses, and paramedics on the subject of multi-casualty events.
d) Medical schools and other institutions of the medical community are committed
to education of the community and para-medical personnel regarding the medical
aspects of coping with a multi-casualty event. Physicians will lead the writing of
treatment protocols and the planning of education programs on the subject.
e) Physicians will take steps to promote capabilities of the system and the community to
treat casualties in a multi-casualty event and to promote understanding of the medical
system during such events.

**Ethical principles in a biological event**

a) The allocation of preventative treatment resources within the medical system:
A physician shall not participate in decisions regarding the allocation of limited
resources on a non-medical basis, such as age, sex, race, religion, nationality, economic
or social status.
In situations in which there is preventative treatment (such as immunization) for a
biological event, the system is obligated to offer such treatment to the medical staff.
If there are insufficient means of preventative treatment for the entire medical staff,
the health system shall specify the order of priority for giving the treatment. This shall
be done in consultation with medical specialists in the field and subject to the rule that
treatment will be offered to those in the highest level of danger, such as the relevant
researchers and laboratory workers, the medical staff most exposed to the contagious
patients, and the epidemiological staff.
b) The physician's obligation to treat infectious patients:
1. If a physician refuses to accept the treatment offered to him, and does not have
a contra indication, this shall not exempt him from his obligation to appear in his
place of work and treat persons affected by the event.
2. If the physician has a contra indication to the treatment, he shall be entitled to decide
whether he wishes to treat persons affected by the event and under which conditions.
c) The limits of the risk that the physician is obligated to take in the treatment of infectious
patients:
1. If the system has supplied the physician with the required means of protection, has trained him and furnished him with the knowledge required for optimal functioning in the given situation, the physician shall be obligated to function as required, and shall give treatment.

2. If the system is unable or does not wish to supply the aforesaid means, the physician is not obligated to endanger himself beyond the limits that he sets for himself voluntarily and with his colleagues and specialists in the subject.

d) A patient who endangers the public and/or the medical staff:
1. A distinction should be made between a patient who endangers society and one who only endangers the staff giving the treatment. The laws of the State and the relevant regulations are obligated to give the means to deal with both situations, in other words, to prevent the patient from becoming a danger either to society or to the staff giving the treatment.

The Public Health Ordinance specifies instructions regarding reporting of an infectious disease and the prevention of the spread of the disease amongst the population. The Ethics Board of the Israeli Medical Association has published a position paper regarding the transfer of information to the medical staff about an infectious disease. These instructions are also valid for a member of the medical staff who has contracted a primary disease or from a patient. The Ethics Board of the Israeli Medical Association has published a position paper that addresses an incompetent physician and the obligation of reporting him.

e) Medical confidentiality
The laws and regulations related to protection and immunity of medical information apply also during an epidemic.

42. Medical tourism
Published in July 2014

The Information Revolution has revolutionized medicine. Digital-savvy patients can access any relevant medical information within minutes and make their own decisions about the medical treatment they want. The modern healthcare consumer can go online and quickly and easily find a highly reputed and expert physician to address his medical issue. Patients today know the physician’s face, professional history and personal past prior to meeting him in person.
Affluent patients can reach an expert anywhere in the world within hours. Millions of patients now cross international borders in pursuit of healthcare that is better or cheaper than where they live. Cross-border medicine, or “medical tourism” as it is called, has become a medical, social and economic issue that concerns many countries, including Israel.
As the American journalist and author Thomas L. Friedman expounded in his book “The World is Flat,” cyber space facilitates the free flow of information, people and money from anywhere to anywhere around the world. We live in a new world of “connected vessels” that react quickly to any disparity between two points on earth. This is true for all economic markets, including
the medical market. The motivating forces in the medical field are the quality of medical care, its price and its availability in the home country versus the destination country. Smart advertisement and marketing, along with accessible transportation and organization, induce millions of patients throughout the world to pursue the medical solution they believe best suits them and their needs.

The Israeli healthcare system has been facing increasing difficulties during recent years: The shortage of physicians, nurses and beds available to the public has reached a dangerous level, and is expected to become even more acute in the coming years. The waiting times for an expert physician or a surgery room are often intolerable, and the crowding of in-patient departments does not allow for human contact and appropriate medical care. The duration of hospitalizations continues to shorten, making this reality doubly disturbing.

The high professional level of Israeli medicine attracts tens of thousands of medical tourists to the country, generating revenues of millions of shekels every year. The public healthcare system in Israel desperately needs this money, but the risk involved is no less significant. It is plainly visible that a temporary tourist receives preferred treatment in every public hospital he enters in exchange for his money: personal escorts, shortened lines in the medical maze and priority in examinations, imaging and operation rooms. These will always come at the expense of the less fortunate locals who cannot compete with the wealthy tourist.

The Ethics Board held several discussions on this complex topic. The following position paper attempts to define the appropriate balance between encouraging medical tourism in order to gain resources for improving the quality of public healthcare, and the basic obligation to uphold the rights of citizens to primacy in access to healthcare in Israel.

The position paper:

1. The public healthcare system is meant to serve the health and well-being of the citizens of the country, in accordance with the National Health Insurance Law.
2. On the one hand, medical tourism can serve to improve the quality of healthcare services provided to citizens. On the other hand, it can consume public healthcare resources that are already limited.
3. Therefore, the appropriate balance should be found between these two conflicting interests.
4. Services given to medical tourists should be based on personnel, infrastructure and equipment that is set aside for them, in order to avoid taking up resources currently allocated to treating the citizens of the country.
5. Services provided to medical tourists should not delay the diagnosis or treatment that citizens are entitled to during hospitalization or ambulatory care.
6. Medical tourists should not be given preference in the public healthcare system when selecting the medical staff, quality or duration of treatment or the conditions of hospitalization.
7. The rights of the medical tourist should be upheld and protected since, as a tourist, his rights are more vulnerable. The hospital will confirm in advance that the patient is able to make the payments necessary for the intended treatment and will not cease life-
saving medical treatment simply because the medical tourist ran out of funds.

8. Physicians should choose freely whether to extend their working hours for medical tourism. Physicians should not be compelled to practice in this framework against their will.

9. The wage earned by physicians working in medical tourism, beyond their regular work in the public healthcare system, should be determined proportionately to the amount the medical tourist is charged for the treatment.

10. A national independent public monitoring committee should be established with inspection and enforcement authorities in order to oversee the operations of public hospitals in the field of medical tourism. It should ensure that funds are directed to improving public healthcare around the country, and not only in those facilities capable of supplying medical tourism. The establishment and regular operation of this committee is a necessary condition for maintaining medical tourism in its current format.

11. The issue of medical tourism is inseparable from the urgent need to solve the severe shortage of beds and staff in public hospitals.

12. The Ethics Committee views with concern the continuing decrease in government investment in public medicine in the areas of staffing, infrastructure and medical equipment and calls for immediate rectification of this situation.

43. The Joint Ethical Forum of the IMA and medical tourism companies

Published in November 2014

Members of the Steering Committee:
The Ethics Committee: Dr. Tami Karni-Chair, Dr. Elinor Goshen, Dr. Zecharia Kleinbaum, Dr. Yoav Luria, Dr. Israel Eilig, Dr. Constantin Katz, Adv. Gili Shilat, Adv. Keren Eldar, Tali Barzilai, Karen Mashiach-Zwang.
Representatives of the medical tourism companies:
Association of Medical Tourism Companies in Israel-Dr. Andrei Matzayev, Yevgeny Vasileyev, Dr. Yelena Kravyev, Magdev Radislev, Adv. Natalie Klachevski
iMER-Ilan Tamir, Adi Yakobovitch
GLOBAL medical organization-Adi Norman, Ran Dotan
Definitions:

a. "Medical tourist": a person who comes to Israel to receive healthcare services from Israeli medical institutions, whether public or private, and who isn’t entitled to healthcare services under the National Health Insurance Law – 1994 (hereinafter: “the medical tourist” or “the tourist”);
b. "Medical tourism company": a corporation or person engaged in medical tourism (hereinafter: “the company/companies”);

c. "Physician": a certified physician licensed to practice medicine in Israel;

d. "Physician-in-charge": a physician from a medical tourism company who is in charge of formulating the treatment proposal based on the tourist's medical record and information, and is the tourist's primary care physician;

e. "Medical escort": a person who accompanies the tourist during medical treatment, on behalf of a medical tourism company, a hospital or the tourist;

f. "Treatment team": the entire medical and administrative team that manages the needs of the medical tourist in Israel, including the physician-in-charge, the medical escorts on behalf of the medical tourism company and the physicians who provide medical treatment;

g. "Practice of medicine": examination of the sick and injured, diagnosis, treatment, prescription of drugs, medical counseling, medical treatment and follow-up, and all other services usually provided by a physician;

h. "Medical information": information directly concerning the physical or mental medical condition of patients or their medical treatment;

i. "Medical examinations": medical examinations the medical team needs to perform on the patient in order to receive a full clinical picture and determine treatment;

j. "Medical institution": a hospital, clinic or lab recognized by the Ministry of Health;

k. "Public hospital": a public hospital as defined in the National Health Law – 1994;


Goals:

a. Defining a joint ethical code for physicians and medical tourism companies that will regulate their collaboration in providing medical tourism services.

b. Formulating rules for providing medical treatment to medical tourists in Israeli medical institutions, in a way that upholds the principles of medical ethics: autonomy, beneficence, non-maleficence and distributive justice between tourists and Israeli citizens.

c. Creating a relationship between physicians and medical tourism companies that will facilitate providing quality healthcare services to medical tourists, while upholding the positive reputation of Israeli healthcare and recognizing that medical tourists are goodwill ambassadors for the State of Israel.

d. Establishing a joint forum for physicians and medical tourism companies to receive complaints from patients and refer them to the appropriate bodies for further investigation.

General obligations:

a. Only physicians should make medical decisions regarding the medical tourist.

b. All laws regarding healthcare and medical ethics that apply to Israeli physicians should also apply while treating medical tourists.
c. Representatives of medical tourism companies should receive training in ethical issues, to be decided upon by the Forum for Application of the Ethical Code – a joint forum of the IMA and medical tourism companies.

**Treatment proposal:**

a. An offer to receive the services of a medical tourism company should contain two parts: The first part should list the medical treatments offered to the medical tourist, and the second part should contain the additional tourist services the company provides, such as: a medical escort and translation, lodging in a hotel, transportation, tourism activities, etc.

b. The company should request all relevant medical information from the medical tourist. The company should then provide the physician-in-charge with this information.

c. The physician-in-charge of formulating the treatment proposal for the medical tourist prior to arrival in Israel should check the diagnosis, prognosis and treatments given to the medical tourist.

d. The physician-in-charge should formulate and sign a treatment proposal that will be sent to the medical tourist prior to arrival in Israel. This proposal should include a statement that the medical tourist is required to bring the medical documents upon which the proposal was based.

e. The pricing of the first part of the treatment proposal should be made in accordance with the estimated clinical condition of the medical tourist. The medical tourist should be notified that the price could change as a result of a change in the clinical condition.

f. At the request of the medical tourist, the company should provide additional tourist services, as agreed upon.

g. The company should notify the medical tourist, prior to arrival in Israel, about lodging arrangements while in the country. In any case, the company should be informed about the tourist’s lodging arrangements.

h. The company should explain to the medical tourist that as part of the additional tourist services provided, the tourist’s medical information may be disclosed to people other than medical personnel (such as a medical escort or translator). If medical tourists decide to receive these services, the company should have them sign a medical confidentiality release form.

i. The company should manage the duration of the medical tourist’s stay in Israel efficiently. Accordingly, the treatment proposal should include an estimated likely duration of stay.

j. The company should provide the medical tourist with its contact information, including phone numbers for contacting representatives of the company in urgent cases and/or emergencies. When the company knows ahead of time the name of the medical institution where the medical tourist will receive treatment, it should also state the contact information of the medical institution.
Part E  

Treatment proposal for incurable patients:

a. The physician-in-charge should provide the medical tourist with accurate information about the medical treatment, including the treatment’s ability to substantially change the course of the disease, extend the patient’s life expectancy and improve his quality of life.

b. If the physician-in-charge, after examining all the data, concludes that the medical tourist’s condition cannot be improved – he must make every effort to prevent the tourist from traveling to Israel for treatment.

c. Prior to the medical tourist’s arrival in Israel, the company should reach an understanding with him regarding funding for a return trip to his country, if the medical treatment given in Israel turns out to be ineffective.

Adapting the proposal to the treatment:

a. After sending the treatment proposal and prior to the medical tourist’s arrival in Israel, there should be direct communication between the tourist and the physician-in-charge or a representative of the company.

b. The medical tourism company and the medical tourist should openly discuss the tourist’s expectations, from the first communication until the end of treatment.

c. If the treatment plan changes due to a medical need that arose after the treatment proposal was formulated, the company should notify the tourist and provide explanation and justification for the change.

d. After sending the treatment proposal, the price of treatment should only be changed if the clinical condition of the patient changes, or if the circumstances change in a way that could not be predicted or prevented. If the price changes in these situations, the company should explain the reason for the change to the tourist. If the wage of a physician changes – the new offer should reflect the components of treatment that changed, including those regarding the change in the physician’s wage.

e. The medical tourism company should notify tourists about any change in the treatment plan or pricing prior to their commitment to receive the treatment.

f. Medical tourists should not be obligated to undergo tests they have already done, and which the treating physicians deem to be of good quality, except in cases where there is a clinical justification for repeating a test.

g. The company should try to schedule appointments for necessary medical examinations ahead of time, in accordance with the treatment plan sent to the medical tourist. This rule does not apply to examinations that were deemed medically necessary only after the tourist arrived in Israel.

Medical treatment of medical tourists:

a. The company should assist tourists, to the best of its ability, in adjusting their stay permits to the duration of their treatment.

b. Subject to section h above [under “Treatment proposal”], the company should protect the tourist’s medical confidentiality. The medical information disclosed to the company...
should only be accessible to the tourist's treatment team.

c. The physician-in-charge should oversee the medical treatment given to the medical tourist in Israel and should be familiar with the tourist's medical records created during treatment.

d. The company should compile and keep the tourist's medical records.

e. The company should make sure to convey all medical information to the relevant medical personnel treating the medical tourist, in order to ensure that proper and appropriate treatment is provided and/or continued.

f. The company should maintain the right of medical tourists to receive medical information regarding their condition in a language they can understand, including a summary of treatment and conclusion of treatment by the physician-in-charge and translation of documents when necessary.

**Post-treatment follow-up:**

a. The company should try to connect the medical tourist with a physician in the country of origin for the after-care clinical follow-up regarding the medical issues treated in Israel.

b. The company should, to the best of its abilities, assist medical tourists in receiving a copy of their medical records in order to ensure continuity of treatment and follow-up in the country of origin. If needed, the company should provide tourists with detailed instructions and medical recommendations regarding the period after they leave Israel.

c. The relationship of trust between the treatment team and the patient should continue after the end of treatment, as needed.

**Transferring between medical tourism companies:**

a. Medical tourists may transfer their treatment from one medical tourism company to another, and should be permitted to receive service from any medical tourism company they choose.

b. If a medical tourist asks to terminate his contract with one medical tourism company and transfer to another – the first company should transfer all medical documents it holds to the medical tourist or to the other company, as requested by the tourist.

c. The physician-in-charge should be committed to the continuity of the medical tourist’s medical treatment, even if the professional connection with him ends, and should cooperate with any other physician who also takes part in the tourist’s medical treatment.

d. Medical tourism companies should maintain mutual respect. If a dispute arises between medical tourism companies regarding a tourist who is currently undergoing treatment – the sides should have a respectful discussion to resolve the dispute amicably. In any case, the patient’s health should be the most important value for the companies while resolving disputes.

e. A medical tourism company that receives a medical tourist who was initially treated
by a different company is permitted to request a letter from the transferring company stating that the tourist does not owe it any money.

f. In any case, the tourist’s health should not be compromised, and he should not be denied necessary medical treatment.

**Advertising medical tourism services:**

a. Advertisement on behalf of medical tourism companies, through Internet sites or any other medium, should contain detailed information about the services offered by the company as well as credible and substantiated information regarding the areas of expertise and practice of the physicians the company works with, while maintaining the rules of self-advertisement of physicians in the State of Israel.

b. Alongside the advantages, the advertisement should include information about the risks associated with medical tourism.

c. Physicians and medical tourism companies should do all they can to prevent advertisement that is inappropriate and/or violates the rules of medical ethics, including advertisements that contain partial or false information and/or any advertisement that may mislead patients.

d. Medical tourism companies that use a physician’s name for advertisement should be held to the rules of Israeli medical ethics regarding the advertising of physicians.

e. Companies should show their official name (as it appears in the company’s official documents) and contact information on their website and other advertisements. Companies should avoid creating the impression that their website is also the official website of the medical institution with which they work and should be sure to separate the accreditation of the medical institution from their own accreditation or documents.

f. Advertisements stating the advantages of a certain medical treatment should also present the risks entailed in that treatment. The advertisement should not include a guarantee of the results of the medical treatment provided by the company.

g. Companies should not offer their customers participation in experimental treatment and/or any medical treatment that has not been authorized as an accepted medical treatment in Israel.

h. Companies may use celebrity figures for advertisement purposes, as long as the commercial advertises the services provided by the company. The use of celebrity figures shall be subject to maintenance of their medical confidentiality.

i. The term “specialist” in advertisements should only be used regarding fields recognized by the Scientific Council as areas of specialization.

j. If an advertisement uses the name of an Israeli physician – there should be no use of patients’ images, even with their consent, including their name, picture, voice, recommendation or any part of their body.

k. Companies should avoid any advertisement that may disrespect the profession of medicine.

l. Companies should avoid advertisements that disparage physicians and/or other medical tourism companies.
Providing medical treatment in accordance with the just distribution of resources to Israeli citizens:

- The appropriate balance should be found between developing medical tourism for the good of patients and utilizing the limited medical resources in Israel.
- The same quality of care should be provided to medical tourists and Israeli citizens.
- The rules of medical ethics should apply equally to treatment given to both Israeli citizens and medical tourists.
- Companies should invite a medical tourist to Israel only if there is sufficient capacity and availability for the medical procedures required in the relevant Israeli medical institution.
- Physicians should treat medical tourists in a framework that will not cause a delay in diagnosis or treatment for Israeli citizens, during both hospitalization and ambulatory care.
- Physicians should treat all of their patients, including medical tourists, according to the urgency of their medical condition, especially regarding use of medical equipment that is not readily available (such as MRI machines).
- Physicians should not attempt to give preference to medical tourists in hospitalization conditions or any treatment that is not available to Israeli citizens.
- Physicians should not give preference in treatment to a medical tourist over an Israeli citizen.

Transparency and avoiding conflicts of interest:

General:

- The treatment team should work to better the tourist’s health, without any extraneous considerations.
- Physicians should be transparent and disclose to the medical tourist any personal, financial, professional or other conflict of interest that may be related to his treatment.
- Physicians should refrain from receiving any benefits in the context of medical treatment and should not offer or accept business or personal connections with a medical tourist while they have a patient-physician relationship.
- Physicians should make sure that their work with medical tourism companies does not place them in a conflict of interests with their position in the public institution for which they work, whether as an employee or service provider, or with their ethical and professional obligations towards their other patients. Furthermore, the company and its representatives should not place physicians in a conflict of interests, whether they are aware of it or not.
- Treatment teams should refrain from inappropriately taking advantage of their relationship with the medical tourist in any way, including physically, mentally or financially.
- Treatment teams should refrain from soliciting a medical tourist to receive unnecessary medical treatment, whether another medical treatment or in general.
Transparency regarding payment and the physician’s fee:

a. The treatment proposal should list all components of the payment the company demands, including the various components of the physician’s fee, such as payment for consultation, payment for surgery, etc.

b. The physician’s fee should be charged by the medical tourism company and then transferred to the public hospital. Payment for treatment provided in a private clinic should be transferred by the company to the physician.

c. Physicians should not demand, receive or pay agency fees for referring medical tourists for examination, diagnosis, treatment or sale of medical equipment, or for referring them to health resorts or rehabilitation facilities. Physicians should only be allowed to allocate part of their wage to pay another physician if the latter significantly contributed to the diagnosis or medical treatment of the tourist.

Establishing a Joint Forum for Applying the Code:

a. The signatories to this Ethical Code will establish a Joint Forum (hereinafter: “the Forum”) that will answer questions regarding the application of these ethical instructions and provide interpretation for the rules. The Forum will consist of representatives of physicians and of medical tourism companies. The chair of this forum will be a physician who is a member of the Ethics Board of the Israeli Medical Association, appointed by the chair of the Ethics Board for this position.

b. Each member of the Forum can select a stand-in, subject to the approval of the body they represent in the Forum.

c. The Forum will formulate opinions on questions relating to the application of the ethical rules, both in principle and regarding specific future actions, and will act as a forum for discussing ethical complaints relevant to the field of medical tourism.

d. The Forum will have the authority to review and issue guidelines for any contractual relations between a physician who is a member of the IMA and a medical tourism company, including dealing with violations of the rules stated above.

e. The Forum will discuss the ethical training required for representatives of medical tourism companies.

f. The discussions of the Forum may be carried out in any way the Chair decides, including over the Internet.

g. The Forum will hold at least two meetings a year, in order to clarify issues regarding its responsibilities and authority. These meeting will be scheduled by the Chair.

Ethical Certificate:

a. Medical tourism companies that sign this Code and commit to upholding its principles, are entitled to the Ethical Certificate for Medical Tourism and may use it for branding and advertisement.

b. The Joint Forum will have the authority to revoke the Ethical Certificate from medical tourism companies that do not act in accordance with the Code’s rules, as long as the company is given a chance to present its case.
44. Judicious use of medical imaging

Published in January 2011

**Background**

Medical imaging has been a major contributor to the advancement of modern medicine. Wilhelm Roentgen, a German physicist, created the first medical X-ray image in 1895 – an image of his wife’s hand with a ring on her finger. Seventy-six years later, in 1971, a British company created the EMI Scanner, the first of the 3D imaging devices now commonly known as CT scanners.

An estimated 65-70 million CT scans are performed in the U.S. each year. These scans enable earlier discovery and diagnosis of diseases than previously possible, track the influence of treatment inside the body and reduce the number of surgical interventions required. In these ways, the scans improve the quality of healthcare, lengthen the lifespan and improve the quality of life for many patients.

Along with their substantial medical benefit, imaging tests raise many difficult questions pertaining to medical treatment and healthcare economics.

Ionizing radiation damages the genetic material of the radiated cells, sometimes irreversibly, and may cause malignancies. According to generally agreed-upon assessments, 1%-2% of cancer cases diagnosed each year in the U.S. are caused by ionizing imaging tests. CT scans performed in the U.S. in 2007 (the last year with relevant information) were projected to result in 29,000 cases of cancer.

About 20,000 CT scans are performed in the U.S. every day, with radiation 100-500 times stronger than a regular chest X-ray. A third of patients scanned in 2007 were 35–54 years old and 66% of this group were women. These are the age and sex groups that are at higher risk of cancer resulting from radiation. Due to the cumulative risk to the general population from ionizing radiation, we must reassess and carefully balance the benefits and risks of this radiation.

The financial aspect of overusing imaging methods should also not be taken lightly. The accepted estimate is that 20%-50% of these scans do not yield information that improves diagnosis or treatment and do not affect the life expectancy of the patient – and are therefore unnecessary. Despite this fact, the number of imaging tests is rising at a rate of 10% per year, outpacing the growth in the use of prescription drugs (6%-8%). Since the yearly cost of these tests in the U.S. is $100 billion, it comes as no surprise that government authorities and medical associations have joined in an effort to rein in the increase in overuse of imaging devices.

**Overuse**

There are numerous and complex reasons for the overuse of imaging. Briefly, we might mention physicians’ academic education that encourages being “thorough and comprehensive” when creating a wide differential diagnosis, confirming or disproving every diagnosis on the list – while discounting the practical and prudent side of community healthcare, which is more frugal in nature. This is a culture that rewards for the number of tests, and not for their nature; it is a financial culture that encourages over-paying for procedures, as opposed to consultations and conservative evaluation. Defensive healthcare urges the treating physician to perform excessive examinations, and the radiologist to request further clarifying imaging tests.
The patients, who lack knowledge of the risks entailed in imaging, see imaging tests as a sign of better treatment and insist on their right to undergo these tests, without having to pay for them. Finally, private clinics directly influence consumers through direct marketing and large newspaper ads that play upon the patients’ fears. For example, these clinics encourage widespread ionizing survey tests “for the early discovery of atherosclerosis in the heart, which could cause heart attack and death.”

We must encourage a renewed evaluation and a professional discussion among physicians and the general public regarding the limitations of performing ionizing imaging tests in healthcare, in order to find the appropriate balance between their benefits and risks. The instructions of the Medical Directorate (40/2008) in the Ministry of Health, along with the joint position paper of the Israel Heart Society and the Israel Radiological Association regarding “Guidelines for Computed Tomography of the Heart” (April 2010) – are the first steps towards the necessary change.

**Position paper:**

1. Imaging tests, since they are non-invasive, accessible and carry no immediate risk, are used very often and contribute towards improving medical diagnosis and treatment.
2. Using imaging tests, especially those that include ionizing radiation, should be justified in terms of the immediate gain versus the long-term risk.
3. The risk of cancer as a result of ionizing radiation from a single test is low, but numerous tests on the same patients create a cumulative risk for them, along with health implications for the general public.
4. Patients should be referred to imaging tests, and the tests should be carried out, only if there is a detailed clinical prescription requiring it, and if there is no other appropriate test that does not include ionizing radiation.
5. Extra caution is necessary when using ionizing radiation on children, young adults, women and, in particular, pregnant women.
6. Patients should be notified about the risk entailed in imaging tests, as an integral part of the informed consent for the test.
7. Physicians and the general public should be educated about appropriate use of imaging tests, with a special emphasis on fair and responsible utilization of limited technological and human resources.

**45. Imaging results – Do they go to the physician, the patient or both?**

**Published in March 2016**

**Background:**
The Israel Radiological Association presented a question to the Ethics Boards regarding the daily work of every radiologist. The various imaging tests, including X-rays, CT, MRI, PET CT, isotope scintigraphy, coronary angiograms, etc. are meant to help physicians confirm a diagnosis similarly to lab tests, such as blood tests or pathology. Lately, healthcare culture has changed
so that patients receive lab and imaging results directly, usually via the Internet with a personal code that allows them to see results on a website, sometimes before the treating physician has time to see them. In some cases, the results are mailed to patients. This conduct ostensibly protects the autonomy of patients and allow them to do as they see fit with information regarding their medical condition, including receiving another opinion from a different physician. People have their own interest at heart, so they will usually make sure to continue treatment without delay.

But here’s the rub. This information could include difficult news or indications of sound medical condition, and in both cases patients may misunderstand the results. Without a face-to-face meeting between patient and physician and a proper explanation, patients may suffer from unnecessary anxiety, depression and distress, or conversely, set the results aside without receiving appropriate treatment.

Psychiatrists who are members of the Ethics Board did not point to indications that bad news leads to self-harm where there were no previous suicidal tendencies.

But still, there is a dilemma: To whom does the information belong? Who should receive the imaging results? Perhaps maintaining the autonomy of patients actually requires that the results be given to them during a conversation with the treating physician, explaining and processing the information into a diagnosis and treatment decisions?

We should also mention the technical difficulty in the healthcare system, since sometimes radiologists don’t know who the family physician is, which physician referred the patient to get tested and/or who’s in charge of continued treatment.

The problem is exacerbated during screening tests, such as mammograms. Where should we send the results? Regarding tests that require further radiological analysis – should we always wait for the treating physician’s response or should we notify and call in the patient directly, in order to save time and reach a clear diagnosis quickly, even if “only” to decrease anxiety?

When there are findings in imaging that indicate immediate life-threatening danger to the patient, such as a suspected pulmonary embolism, a bowel obstruction, etc., there is no doubt that the imaging physician must directly inform the treating physician and, if the latter is absent, inform the patient and refer him urgently to continued treatment. However, most cases do not fall under the title of “severe danger.”

This is a complex topic, and clearly no single solution will be found for all cases. Therefore, the Ethics Board has decided to propose the following solutions:

1. In general, imaging tests should only be performed with a physician’s referral. Referring physicians should provide their contact information in order to receive the imaging results.

2. Referring physicians should state the importance of professional accompaniment and interpretation for any imaging test result. We recommend that referring physicians coordinate with patients ahead of time whether they want to receive certain imaging results directly, and if so, this request should be stated in the referral.

3. We recommend that every medical entry contain a note about whether the patient wants to receive the imaging results directly, via Internet or mail, without the presence
of a physician.

4. When received at imaging clinics, patients should be asked again whether they want to receive the results directly. We recommend that imaging clinics add a place to mark the patients’ request on admission forms or on the computer.

5. Imaging results should be returned to the referring physician and the treating physician, and at the same time to patients if they requested it or if this was coordinated with them, as stated above. All patients should receive notification when the results arrive, even if they do not want to receive the results directly, and should be instructed to go to the referring physician.

6. In cases of emergency, patients should be contacted directly, in order to avoid any delays.

7. In urgent cases, there should first be an attempt to reach the referring and/or treating physicians, and if they are not available in real time, radiologists should contact patients directly in order to refer them to continued treatment.

8. In cases where there is no referring physician, such as screening tests, radiologists should act immediately if there is a need for further tests. Patients should be notified ahead of time that they will receive the results directly.

46. Anti-aging medicine

Published in March 2003

Background

The significant increase in the last century to the average life expectancy, and the corresponding improvement in quality of life in the western world, has created a new reality for many persons of advanced age. These people, aged 70 or more, enjoy good health, are active at work and in society, and possess financial means that they are prepared to invest in order to preserve their health. Most of them wish to live for a long time without growing “old”.

Conventional medicine is very involved in this pursuit. In recent years, considerable emphasis has been placed on educating the public about a healthy life style that integrates proper diet, regular physical activity, weight watching, and non-smoking. Early diagnosis and proper treatment of illness also prominently contribute to the extension of life expectancy.

However, medicine and science recognize the fact that old age is a natural and inevitable part of life. Although the biological mechanisms causing bodily aging body are being revealed to researchers, we still lack the possibility of extending the human lifetime beyond its “natural” limits, which are apparently due in most cases to genetic factors.

We have recently witnessed the flowering of a new kind of “medicine”. Like mushrooms after the rain, private “institutes” and “centers” have appeared that engage in “anti-aging”, and promise wonder treatments and perpetual youth for everyone who is interested. These institutes, which have tremendous cash turnovers, engage in treatments whose effectiveness and ability to halt or delay the aging process lack scientific proof. Use of celebrities in the promotion of these “institutes” exploits the innocence of the public.
The mixtures of vitamins, food supplements, exotic mixtures of hormones and medicines of unknown composition, such as the brain improvement formula, are no more than delusion and deception of the public in order to create profits for the owners of these institutes. Some of these treatments are even liable to endanger the health of those using them. These institutes waste considerable financial resources and affect the ability to furnish the general public with reliable medical information regarding the aging processes.

The Ethics Board held a debate on the subject of anti-aging, and its position appears below. Apart from this declaration, the Ethics Board calls on the State authorities to increase supervision in this field and to prevent medical and financial damage to the public.

Position paper

- Aging is an inevitable and natural life process, and it is impossible to deny its existence.
- The process of aging is determined by genetic factors, some of which are still unknown, as well as environmental factors.
- Conventional medicine, which includes education, preventative medicine, and methods of treatment, contributes to the extension of human life expectancy.
- The steep increase in life expectancy has created many persons of advanced age who wish to extend their lives without becoming "old".
- "Anti-aging" medicine promotes this hope in return for considerable sums of money.
- The information available to us indicates that "anti-aging" medicine is not evidence-based, and is scientifically unsubstantiated. This leads to the concern that it is merely exploitation of the lack of knowledge of the general public and the sale of illusions.
- The drugs we know of that are given by "anti-aging" medicine are not effective in extending life expectancy, and some of them are even dangerous to one’s health. There are cases in which the patient is not aware of the composition of the medicines.
- The Israeli Medical Association calls on the public to beware of throwing away its money in a search for eternal youth.

47. Cease fire

Published in May 2007

Background

Increasing social violence unfortunately reflects a sad reality in many aspects of our life. Medicine is not exempt from the list of areas to which this trend has spread, and is even more likely than others to suffer from it.

When human life suddenly lies in the balance, while on the other hand the medical system is overloaded and operates under constraints of limited time and manpower, and consequently sometimes fails to meet the expectations of the patient or his family, an explosive emotional situation is created. Not much is required in order for this situation to erupt into violence, verbal or physical, that will be directed against the medical staff.

Much research has indicated that the incidence of violence in the health services, in Israel and abroad, considerably exceeds the incidence of violence in every other field of public service.
Surveys conducted in Europe and in the US indicate that 50% of physicians reported that violence is a permanent problem in their work environment, and 30% of them were harmed in the year preceding the survey, by physical or verbal violence during execution of their work. A large research project conducted in Israel amongst 2300 workers in 23 emergency wards found that 75% of them were exposed to violence in the year preceding the survey, and 20% of the cases involved physical violence. The damage caused by this violence is clear: attacked physicians report feelings such as lack of motivation, fear, anxiety, depression and humiliation, decrease in productivity in work and frequent absences from work. Physicians who have been attacked tend to develop suspicion towards the patient and regard him as a possible enemy, which destroys the relationship of mutual trust.

The large health organizations throughout the world have adopted a policy of zero tolerance for violence against medical personnel. This policy is implemented by placing special emphasis on problematic places, such as emergency rooms, in which the staff are required to work with maximum speed and effectiveness, and means of monitoring, security and supervision are set up in these vulnerable places.

In addition, there is considerable investment in training the medical staff in early identification of a potential danger, alertness for warning signs of expected violence and means of coping with them. The new approach attempts to neutralize in advance the chances of a dispute occurring with the physician, alongside operation of an uncompromising enforcement and punishment system. However, it is clear to everyone that a constant, large scale investment is required on the part of the State and the employers to ensure the welfare and security of the physicians working for them.

In a society that recognizes the value of strikes as a legitimate weapon of the worker, the prohibition of strikes in a specific sector necessitates providing proper alternatives to deal with their professional hardships. In the absence of such alternatives, the physicians have no choice but to employ the weapon of striking. Shutting down the medical services in response to violence against physicians is not intended to improve their economic welfare, but to guarantee them working conditions free from threats and pressure, something which is not only the concern of the physician, but is a significant public interest.

**Position paper**

- Violence against medical personnel in general and against physicians in particular reflects increasing violence in Israeli society.
- Violence against physicians causes physical, mental, and financial damage to the attacked physician.
- Violence against physicians harms the physician-patient relationship and causes damage to the quality of the treatment given to the general population.
- The State and the employers are obligated to protect the security of the physicians and the workers in their service.
- In the absence of proper protection, physicians are entitled to fight for the right to receive this protection.
- A strike intended to protect the security of physicians is a legitimate means for
influencing public opinion and the employers, and is aimed at causing the legislator to allocate the resources required for protection of the physicians.

- In a society that recognizes the right to strike in employer-employee relations, the prohibition of striking in a specific sector obligates society to present a proper alternative.
- In the absence of such an alternative and in extreme circumstances of physical attacks against a physician, a strike of the medical services is conceivable.
- A strike in the medical services will be proportional, so as to minimize its damage as far as possible.

The Ethics Board and the Israeli Medical Association call on the legislator and the judicial system to adopt a policy of zero tolerance towards the phenomenon of violence against physicians and medical personnel in Israel.

48. The ethics of a physicians’ strike in a labor dispute

Published in March 2013

It would seem that a workers’ strike does not go hand in hand with medical care. The unwritten contract between physicians and the general public demands from us, physicians, to treat patients every hour of every day. Therefore, strikes should not be a part of our professional culture.

Going on strike, a unilateral action taken by physicians against their employers during a financial conflict, is naturally met with harsh criticism.

The main point made against strikes in the healthcare system is that striking is an aggressive move that benefits the powerful side rather than the side of justice, and therefore is immoral. According to those opposed to strikes, striking harms a third party, sick people and patients – an innocent and captive public that cannot decide the fate of the strike. The purpose of strikes is to use the patients to pressure employers and decision makers who do not personally suffer from the strike. All this could harm the public’s perception of medicine as an altruistic profession that lies above the gray reality of labor disputes.

The transition from the Hippocratic age of medicine to the modern age of “managed medicine” transferred the responsibility for the patient from individual physicians to society at large, through employers and the State. Therefore, physicians are forced to direct their frustration with a collapsing healthcare system towards this new target (that is, employers and the State), and sometimes the only choice is to wield the weapon of striking.

There is sometimes a very blurry line between striking to benefit patients and striking to benefit physicians. When physicians strike due to unacceptable hospitalization conditions, overcrowding in the hospital departments, abbreviated hospitalization and rapid turnover of patients, a needed diagnostic or treatment method or even the time allocated to examining a single patient in the clinic, are they striking for their “terms of employment” or are they striking for the benefit of the patients?

Those that support allowing strikes in the healthcare system argue that those opposed to
strikes hold physicians to a higher moral standard, and that physicians, like all people in society, have the basic right to strike in order to better their conditions of employment. They argue further that physicians should not continue providing less-than-optimal care to patients, even if achieving an improved standard of care entails the many short-term difficulties of an ongoing strike. Strikes, according their supporters, will boost the awareness of the public, employers and state authorities to the flaws and deficiencies of public healthcare, which in turn will improve it.

The achievements of the latest physicians’ strike include both an increase in physicians’ income and a dramatic change in the quality and professional personnel in distressed medical professions and in hospitals in the periphery. This serves as further proof that improving physicians’ conditions of employment is inevitably connected to improvements in the quality of care given to the public.

The position paper regarding the ethics of physicians’ strikes as a means [of pressure] in a labor dispute is intended to bridge the inherent tension between the physicians’ commitment to society to provide continuous care and their right to protect their conditions of employment and the quality of the healthcare system in which they work.

**Position paper:**

1. In general, physicians are required to provide medical care to any person at all times.
2. The social contract between physicians and the general public imposes a responsibility on physicians to ensure that the healthcare system is strong and fair, and is able to provide proper and impartial care.
3. Strikes in healthcare services are not only aimed at enhancing the physicians’ conditions, but also at improving the patients’ well-being, since these goals are intertwined.
4. The legitimacy of a strike in healthcare services, therefore, derives from the desire to improve the healthcare system and benefit the patients.
5. There is inherent tension between the physician’s commitment toward society at large and going on strike. Therefore, a strike should always be the last resort after all other avenues have been exhausted.
6. Before striking, physicians should consider, in the specific circumstances, the anticipated damage to third parties versus the benefit to the strikers and the general public.
7. With no other adequate option given by the state or employers, physicians can strike in a proportionate and careful way.
8. During the strike, the provision of emergency healthcare services and other vital services should be ensured.
9. During the strike, the maintenance of systems for monitoring and examining unusual cases should be ensured in order to minimize the harm done to patients.
10. During the strike, a public information system should be in place to provide the public with up-to-date information on the goals of the strike, the demands of the struggle, the actions taken by strikers and their effect on patients.
11. Physicians taking part in strikes are not relieved of their ethical and professional commitments to their patients.

49. Who may be called professor?

Background
In recent years the Ethics Board has been called upon to address the issue of the title "professor" (of medicine), or to be more precise, who is entitled to use this title in Israel.

It should be noted that the degree of Doctor of Medicine is the professional title of every physician. It is intended to indicate that the holder of this title successfully completed medical studies, and that he is certified by the State to treat patients. A physician is entitled to add to his title the additional title of "specialist in..." if he completed recognized training in this field and met the requirements of the Scientific Council of the Israeli Medical Association and holds a certificate of specialization granted to him by the Ministry of Health.

The title "professor" (Prof.) is an academic degree given to a physician who teaches or conducts research in a university. This title has no connection with the treatment of patients.

Although we are certain that a person calling himself "professor" has in fact received this title honestly, in other countries the title "professor" is used in different situations and for various aims. This is liable to mislead the public, especially if the title "professor" is given for teaching for a specified period of time in a foreign university, or if the title "professor" held by the person is not in the field of medicine.

Over the years we have repeatedly encountered complaints from the public on this subject. The general public in Israel regards a person who holds the title of "professor" as a senior and very experienced physician, and frequently prefers him to an "ordinary" physician. One result of this view is that the title "professor" carries with it clear and unambiguous economic advancements. It is therefore easy to understand the feelings of the public that wishes to be certain that the "professor" who came to them is in fact a professor of medicine in accordance with the criteria customary in Israel.

Position paper
- The title "professor" may be borne by:
  1) A physician who has an active appointment and teaches in a faculty of medicine in one of the universities in Israel, and whose name appears on the list of professors of said faculty. (For this purpose, a person shall be regarded as a professor if he bears the title of associate professor or full professor in an academic or clinical track.)
  2) A physician who retired and who holds the title of professor may use this title permanently (Professor Emeritus).
  3) A physician whose major occupation is in medicine in Israel may use the title...
"professor of medicine" conferred upon him abroad, only if the degree has been officially recognized by one of the faculties of medicine in Israel. In all other cases the physician may make use of this title only after he has attached to his name the title "Dr.", while indicating the title "professor" in a separate line, as well as the place and period of time in which he worked as a professor outside Israel (updated May 2009).

4) A physician may make use of the title "professor" given to him in a profession other than medicine, only after he has attached to his name the title "Dr.", while indicating the title "professor" and the field in which the title of "professor" was given in a separate line, and in a way that will not mislead a reasonable person into thinking that the title "professor" was given in medicine (updated May 2009).

5) A physician who bears the title "professor" and who is transferring between two universities in Israel, may use this title for three years from the date of the move.

- The Ethics Board has contacted the four deans of the faculties of medicine in Israel and has received from them the list of the professors of medicine serving in each of the faculties. This list shall guide the Ethics Board in this matter.

50. The best physicians

Published in November 2003

Background
The Ma’ariv newspaper publishes every year a special, festive supplement for Passover, in which it rates “the best physicians available”. This year the rating addressed 41 different fields of medicine, and each field posted the names of ten physicians to which the newspaper had awarded the title “10 in medicine”.

This supplement and its predecessors have justifiably aroused a wave of complaints and protests on the part of many physicians who regarded its publication as a blow to the honor of the profession and, no less so, to all the other excellent physicians who were not included in this list.

It is important to remember that already last year the chairman of the Israeli Medical Association sent a personal letter to Mr. Dankner, the editor of Ma’ariv, in an attempt to persuade him to stop this publication. Dr. Yoram Blachar wrote: “It is a pity that the newspaper erred in the publication of an article that degrades physicians and misleads the entire public”.

The editor of the newspaper did not even bother to reply to this letter. An additional reminder sent in writing two months later also remained unanswered. Another letter in this vein, sent this year by Mrs Yael Bosem, spokesperson of the Hadassah Hospital, also went unanswered.

The Ethics Board held a special debate on this subject and invited the reporter of Ma’ariv who edited the supplement.

Many arguments were conveyed to the reporter. Firstly, the members of the Ethics Board were incensed that the rating of the physicians was done alongside synagogues, ritual baths, cars, cell phones, fitness institutes, pension funds, shopping malls, and other consumer products.
This was enough to cause all of us to feel an expression of contempt for the profession, and displeasure that it had been turned into a consumer product. Tomorrow, Ma’ariv is liable to position us between Krembo and Bamba.

Even worse was the criticism conveyed to the journalist regarding the scientific validity of the data collection on which the lists of physicians were based. The journalist’s explanations of the way in which she asked for and collected data from tens of people, including friends and acquaintances, and even "cross referenced information tens or even hundreds of times" over many months, were not accepted by members of the Ethics Board.

The grave impression obtained by everyone was that the list is based on rumors and social gossip, and meets no scientific criteria whatsoever. In the opinion of all members of the Ethics Board, the list has no validity or significance. As such, it causes great injustice to numerous fine physicians who are not included on it, and may even mislead the public.

With everyone’s agreement, Ma'ariv, by means of its reporter, was requested not to continue this publication. Unfortunately, the journalist, who regards her work as a "social mission", did not accept the position of the Ethics Board.

The current scientific concept is that no individual physician shall be judged on his apparent achievements, since he is only a part, however important, of an entire system. It is therefore important to monitor, using scientific tools, the medical quality of a medical “service” and not of an individual physician, and this information should be presented to the public.

Position paper

- Lists of “the best physicians” have recently appeared in the press.
- These lists have been prepared without any scientific basis, and are based on rumors and social gossip.
- These lists may mislead the public and discriminate against many other good physicians.
- The Ethics Board calls on the community of physicians, directors, and spokespersons of the medical institutions not to cooperate with the editors of these lists.
- There is no significance to the grading of an individual physician, since he is part of an entire system.
- Estimation may be made of a service but not of an individual physician.
- Reliable scientific tools exist for evaluation of the quality of a medical service, and these should be implemented and published.

51. The system for approving tests and treatments in the health funds, and the treating physician

Published in July 2015

Background

At the Ethics Board session on May 5, 2015, members discussed the system for approving tests and treatments in the health funds. The discussion focused on the discourse between physicians directly treating the patients (within a physician-patient relationship), and physicians in charge
of the system for approving tests in HMOs, from a distributive justice standpoint. There is constant tension between the values of medical ethics: the autonomy of the patient, the principles of beneficence and non-maleficence, and the principle of justice. No one principle is always more important than another.

During medical school and their various internships, treating physicians and managing physicians (with most physicians assuming both roles on a daily basis) undergo socialization into the world of medical ethics, which teaches them fidelity to the patients' best interests. The personal autonomy of physicians derives from the need to provide the best care to patients. It is also clear that the smaller the pie and the more deficient the healthcare budget, the more considerations of distributive justice become critical and the detrimental impact on individual health becomes almost inevitable. This causes increasing frustration among treating physicians and even professional burnout, which may in turn also harm the patients' health.

During the Ethics Board discussion, which included treating physicians and managing physicians from the various HMOs, it was clear that all participants act in accordance with the Hippocratic Oath and for the patients' benefit, as expected. The advantage of directives given by managers who are also physicians was emphasized in the discussion, since this ensures that medical-ethical considerations, in accordance with the ethical duties of all physicians, are taken into account. Obviously, there may be disagreements, and it is important to have open medical discussions and efforts of mutual persuasion. Managing physicians must recognize the needs of individual patients, and at the same time treating physicians must recognize the healthcare needs of the general public – namely the just distribution of the healthcare budget and specifically the HMO budget.

A survey regarding the autonomy of HMO physicians was conducted for the IMA in June 2009 by Prof. Avi Degani and Dr. Rina Degani. The poll attempted to evaluate the public's opinion of physicians' autonomy in Israel: the physicians' ability to make professional decisions regarding the treatment of patients, free from any financial or political dilemma dictated by the HMOs. Does the public trust their family physicians? The survey results were as follows:

- 74% of the public stated that they highly or very highly trust their physicians.
- Most people (67%) believe family physicians acquiesce too often to HMO demands to spare expensive treatments and tests.
- Most people (63%) believe the loyalty of physicians lies first with the HMO, and only then with patients.
- Most people (83%) expect physicians to oppose HMOs to protect their patients' interests.

Another question discussed the amount of trust in the public healthcare system when patients need special medical care: Would they prefer to go to a private physician to ensure they receive the most suitable test or treatment because they fear their HMO might deny it? About half of respondents stated that this is a good enough reason to turn to private care.

Responsible managing physicians who properly manage the budget can preserve a high level of public healthcare in Israel, deliver quality and cost-effective care while maintaining proper relations, and further research and advancement. This is possible only if based upon
an understanding of the medical ethical duties for treating patients and for relationships of physicians, including recognition of the constant tension between maintaining the general budget and loyalty to individual patients. There is a risk that under the management of non-physicians, the lack of trust may increase.

**Position paper**

1. Treating physicians should be loyal to patients and present them with options for tests and treatment within “the health basket” and outside it, in accordance with the law and the rules of ethics.
2. Treating physicians should be aware of the limitations of “the health basket” and HMO directives.
3. Treating physicians should match expectations with patients about the need for a certain test or treatment, while bringing attention to the fact that such treatment might not be covered by the HMO.
4. Treating physicians’ requests for approval of treatment should be made in a polite, professional and collegial manner, should include a factual and clear explanation, and should be backed up by professional medical literature if necessary.
5. Physicians in charge of various medical approvals should make decisions based on consistent criteria as much as possible and should explain the grounds for their decisions.
6. Approving physicians should respond quickly and professionally, while taking all the patient’s information into account.
7. Responses to the treating physicians from the approving physicians should also be polite, professional and collegial, and should include the approving physician’s reasoning and identity in order to enable a transparent discussion with the treating physician.
8. Each treating physician should have a clear address for appeals and unusual cases, according to HMO regulations.
9. In cases of appeals, when the approving physicians intend to reject the request again, they should consult with a physician who is a specialist in the relevant field.
10. After the discussions are concluded, the final answer will be given to patients by the treating physician in a way that respects all those who practice medicine.
52. The transfer of information to a medical team regarding an infectious disease

Published in June 2005

Background

A family physician working in a small community contacted members of the Ethics Board with a request for help and advice: How should she behave towards an AIDS patient who wished to maintain confidentiality regarding his illness. The only ones who know that he is a carrier are his wife, this physician, and an additional specialist working in a special AIDS treatment center at a nearby hospital. The maintenance of confidentiality is critical for the patient, who is convinced that if his children or members of his community learn of his illness, it will affect his quality of life, and he also fears social excommunication or even the loss of his place of work.

Unfortunately for the patient, he experienced at the same time heart disease and requested cardiac catheterization. The patient demanded from the physician that his illness be kept secret from the medical staff in the hospital who were to treat his heart disease. His bed in that hospital had been marked in the past with a sign revealing the situation, and only by a miracle, from his point of view, did he succeed in keeping his secret. The patient preferred not to undergo the cardiac treatment rather than risk disclosure of his illness to others.

The physician who contacted the Ethics Board encountered a grave dilemma between her personal commitment to the patient and his wife, towards whom she feels closeness and responsibility, and her other obligations – to preserve the security and health of members of the medical staff who were to treat him in the hospital.

At the debate held in the presence of the physician, there were also representatives of the Ministry of Health, Dr Zohar Mar and Dr Daniel Shem-Tov, as well as two medical specialists who direct treatment center for AIDS patients – Prof Shlomo Mayan from Hadassah hospital, and Dr Margalit Lorber from Rambam hospital.

Data were presented that testify to the very low chances of infection to the medical staff, and regarding the new approach that now encourages AIDS to be regarded as an infectious disease like all others, free of social stigmas. Emphasis was placed on the legislative obligation imposed on physicians to report every AIDS carrier to the Ministry of Health.

It was also emphasized that the obligation of confidentiality for a patient is not absolute in all cases, and in cases in which there is danger to public health, it is permissible to infringe this obligation. At the end of the meeting, the members of the Ethics Board formulated the following rules:

Position paper

- The connection between the physician and the patient is founded on transparency and honesty between the two parties.
- Consequently, the patient shall not conceal from the physician treating him that he suffers from an infectious disease.
- The principle of medical confidentiality and the right to privacy by the patient are not absolute and they are overruled by the principle of preservation of public health,
including the health of the medical staff.

- The physician is legally obligated to notify the Authority of any patient suffering from an infectious disease that endangers public health.
- The working relations between a physician and his professional colleagues and other medical staff are also based on transparency and honesty.
- Consequently, a physician shall not conceal from another physician or medical staff the fact that the patient, sent for continuation of treatment, carries an infectious disease.
- The disclosure shall be made with care and to the required extent, in order to preserve, as far as possible, the privacy and dignity of the patient.
- The hospital shall not overtly indicate the illness of a patient suffering from an infectious disease.

53. **The incompetent physician**

*Published in June 2005*

**Background**

Several applications were made to the Ethics Board regarding the issue of an “incompetent” physician. The ethical issue involved how to bridge between apparently conflicting commitments – preservation of confidentiality on the one hand, and commitment to the public, on the other. One case, for example, concerned a physician who performs delicate surgery. His colleagues noticed that his hands had begun shaking to such a degree that, in their opinion, he endangered the health of his patients. Consequently, the management of the hospital decided to suspend his surgery rights. The physician did not accept the position of his colleagues, and began operating privately, outside the hospital. As expected, he caused damage to some of his patients and his professional colleagues who remained in the hospital had to correct it.

Another case concerned a specialist in internal medicine, who began to suffer from rapid cognitive decline, which affected his judgment and the quality of his medical decisions. In the opinion of his colleagues, he required constant supervision in all his activities in the department, and his functioning as a supervising doctor was very compromised. The physician himself, because of his illness, lacked insight into his deteriorating cognitive situation.

In both these cases, the professional colleagues who treated these physicians and the managements of the medical institutions contacted the Ethics Board with a request for guidance about how to act towards physicians suffering from functional medical limitations. The Physicians Order [new version], 5736-1976, instructs the Director-General of the Ministry of Health to bring before a special medical board any physician who suffers from a “dangerous illness” that is defined as “endangering the health of patients being treated by the physician”. The law does not explain how the Director-General is to know of such a physician and does not impose the obligation of reporting on a physician aware of his colleague’s illness.

Members of the Ethics Board formulated rules of behavior in such cases, striking a balance between the right to privacy, dignity, and freedom of occupation of the incompetent physician, and the obligation for the welfare and health of the public.
Position paper

- An incompetent physician, with limitation of functioning for any reason whatsoever, shall refrain from giving treatment or taking medical responsibility for the health of his patients.
- In the event of doubt, such a physician shall consult with another medical specialist.
- Every physician is obligated to protect patients from an incompetent physician.
- Every physician is obligated to help the incompetent physician and inform him, if necessary, of the gravity of his medical condition.
- The fear of error, social inconvenience, or possible legal action, must not defer the identification of an incompetent physician.
- Identification of an incompetent physician shall be done with extreme caution while giving maximum protection to his privacy and good name.
- Identification of an incompetent physician shall be done by means of a direct application to the Director-General of the Ministry of Health.
- The physician giving notice shall inform the incompetent physician in advance of his intention to notify the Authority of his illness, in an attempt to persuade him to stop working, and where possible, to move to another field of medicine.
- The Director-General of the Ministry of Health shall consider the information that reaches him and shall decide how to act, subject to the provisions of the law.
- The incompetent physician shall be entitled to receive a copy of all the medical information about him furnished to the Director-General of the Ministry of Health, including the identity of the physician making the notice.

54. The prohibition of workplace harassment between physicians

Published in July 2016

Background:
Two senior physicians presented their personal story to the Ethics Board: A new director, who was appointed to the department where they had worked for many years, began preventing them from performing surgeries. They felt disgraced and humiliated, and suffered significant damage to their professional abilities in the operating room. This harms not only them personally, but also the patients they could treat in the future.

The issue of workplace harassment made the headlines in mid-2015, following proposed legislation that would enable compensation without proof of damage in cases of harassment. The explanation of the bill states: “Harassment in the workplace is a common social phenomenon that harms many workers: Studies show that at least one of every four workers in Israel suffers from workplace harassment at some point in their career. Workplace harassment infringes upon workers' human dignity, liberty, well-being, their ability to perform their work and their professional performance. There are cases where the harassment even harms an individual's physical or mental health.”
Workplace harassment has been defined as recurrent behavior against an individual that creates a hostile, demeaning and humiliating environment for them, to the point that hurts their ability to perform their work. The proposed legislation suggested compelling employers to take reasonable measures to prevent such harassment. These measures included creating regulations to prevent harassment and a procedure for filing complaints about workplace harassment, as well as handling complaints and acting to resolve the issue and prevent it from recurring.

Examples of harassment include, as stated above, demeaning or humiliating behavior, screaming, shouting, false accusations, spreading harmful rumors, infringing on privacy, setting unreasonable demands or demands that aren’t relevant to the job, intimidation or threats, crediting a worker’s successes to another person and disrupting a worker’s ability to perform his or her job.

In the IMA’s code of ethics, we have emphasized the responsibility of physician managers, both towards patients and subordinates. This responsibility includes respecting the ethical and professional autonomy of subordinate physicians and helping to improve their professional level.

Regarding professional medical development, the managing physician is committed first and foremost – like any other physician – to the patients’ best interests. This commitment is expressed also in training physicians to adeptly perform all medical treatments that will improve the patients’ medical conditions as much as possible.

The obligation of physicians to impart medical knowledge derives from the Hippocratic Oath. In this framework, managing physicians are required to ensure the training of their subordinate physicians, interns and senior physicians, and to continuously learn from colleagues who have special expertise.

The Ethics Board has decided to raise awareness of a managing physician’s special obligations, derived from medical ethics, with an emphasis on preventing workplace harassment between physicians.

**Position paper:**

1. Workplace harassment is forbidden, harms the dignity of physicians and impairs their performance.
2. Managing physicians, like any other physician, should refrain from demeaning or humiliating another physician in any way, including their manner of expression about or towards that physician.
3. Managing physicians should ensure that subordinate physicians can perform their work and that their medical training, medical abilities and professional level are not harmed, without creating an atmosphere of intimidation and while setting a personal, moral and professional example.
4. Physicians should refrain from joining in harassing behavior towards another physician and should do their utmost to support the victim.
5. Physicians who identify behavior that could be interpreted as harassment should make every effort to inform the harasser that such behavior is wrong.
6. Physicians who identify harassment of a physician, should try to involve the harasser’s superiors.

7. Physicians who identify or undergo harassment are urged to contact the Ethics Board, which will thoroughly examine the issue.

8. The Ethics Board and IMA are committed to protecting physicians, supporting colleagues and helping to prevent further harassment.

55. Physicians’ conduct when changing workplaces

Published in February 2018

Background:
This year, a group of physicians resigned from their jobs due to professional disagreements and a faulty workplace relationship. This event caused a stir in the healthcare system and Israeli public, and the media continued reporting on the issue daily for many months. Everyone lost in the end – the patients, their families, the physicians who resigned, their colleagues, administrators and the Ministry of Health. It was a severe blow to public trust in the healthcare system.

The IMA’s Ethics Board received many communications at the time that expressed extreme positions on one side or the other. Some asked for the Board’s intervention and expected us to demand that the physicians withdraw their resignation, “since physicians cannot abandon their patients.” Others were angry at colleagues who spent time caring for “patients left behind” in the department. Some were furious about the involvement of patients in demonstrations, and others expressed disdain at statements in the media directed against the physicians who had resigned.

The field of specialty of those physicians has suffered from a shortage of specialists. The physicians who stopped treating patients in their specialty comprise a significant percentage of all knowledgeable and experienced specialists in Israel, and their resignation further increased the strain on other physicians in the field.

The resignations created a difficult dilemma due to the inability to provide optimal medical care: Should physicians stay and provide medical solutions at the highest level that resources or medical institutions allow, and not leave their patients? Conversely, when treatment is not optimal due to administrative and financial reasons, are physicians obligated to raise a red flag and even leave their workplace and patients?

In July 2017, the Ethics Board discussed the crisis in the Hemato-Oncology Department at Hadassah and noted the verdict of the labor court that recognized and defined the physicians’ resignation as legitimate. Since the resigning physicians gave six-months’ notice and turned in their letters of resignation three months ahead of time, they should not be seen or described as having “abandoned” their patients. During the passionate public debate, harsh words were used because of the fierce dispute. We remind all physicians of the Oath – “Heed the dignity of your friends for in honoring them you will be honored.”

The Ethics Board published a position paper in 2009 regarding “the obligations of a physician
at the end of physician-patient relationships.” In 2006, they published another position paper entitled “Physicians may inform their patients about their new workplace”. These papers discuss the personal obligation of physicians to their patients. These ethical rules were written as part of the chapter dealing with physician-patient relationships.

According to these position papers, physicians may discontinue physician-patient relationships while adhering to certain rules.

This position paper discusses the relationship between physicians, managing physicians, directors of medical institutions and physicians in the Ministry of Health, and the involvement of patients, their families and the media in the crisis.

Position paper:

- Physicians are allowed to change their workplace.
- Managing physicians are expected to respect physicians who change their workplace, and their wishes.
- Physicians changing their workplace are expected to give notice of their intention to leave.
- Managing physicians may present physicians changing workplaces with the problems that could rise from their leaving, in a conversation or a written correspondence, in a respectful and dignified manner.
- Physicians changing workplaces are expected to help as much as possible with transferring knowledge and providing professional support to their colleagues who remain at the medical institution or to their new replacements, in order to facilitate quality continued treatment for patients.
- In situations of disagreement or dispute due to a change of workplaces, the sides should involve a physician accepted by both sides in order to work out their differences and maintain the dignity of the profession.
- Managing physicians and physicians changing their workplace may not use patients and their families to pressure the physician who is leaving or the medical administration of the institution.
- The media may not be used to insult or attack treating physicians, physicians changing their workplace, replacement physicians, managing physicians or physicians in general.
- Preventing physicians from being employed in medical institutions as “punishment,” to apply pressure or to intimidate – should be condemned. All physicians in every position should protest against this and strive to utilize their knowledge and medical experience for the benefit of the patients.
- The Ethics Board will work to inform and remind those involved in such disputes about the relevant ethical rules.
56. The obligation to publish the name of a physician found guilty in a clarification committee of the Ethics Board

Published in April 2004

The exposure of the name of a physician found guilty in a clarification committee of the Ethics Board constitutes a means of deterrence. The increase in transparency in the disciplinary proceedings of the Ethics Board is compatible with the good of the patient and with the current accepted culture in physician-patient relations. This initiative on the part of the physicians will be welcomed by society and will reduce the public pressure that occurred in other professions. Consequently, members of the Ethics Board decided to impose the obligation to disclose the name of a physician found guilty in a clarification committee of the Ethics Board, whose punishment is suspension or expulsion from the Israeli Medical Association. The recommendation of members of the Ethics Board is to add to the regulations of the Israeli Medical Association, in the section addressing judicial proceedings in the Ethics Board, part two: "hearing proceedings in the clarification committee", section 28: Punishment, paragraph 28.3, the following words:

28.3 "The clarification committee shall be entitled to order publication of the details of the complaint while concealing the name of the person against whom the complaint was lodged, or with publication of his full name in "Medical Time", or in any other media chosen." In the event of a punishment of suspension or expulsion from the Israeli Medical Association, the committee shall be obligated to publish the name of the physician in question.

57. Clinical trials

Excerpted from the position paper published in September 2006

Background

Introduction

Clinical trials are essential for the advancement of medicine, and without them modern medicine in general, and the development of new drugs in particular, would not be possible. The need for new drugs has increased in recent decades, as scientific knowledge has revealed the genetic and molecular basis of most diseases. New drugs and innovative medical technologies contain great hopes, heretofore unknown, for the healing of incurable illnesses. The good of society as a whole dictates that these clinical trials continue to be conducted in the future for the welfare of the human race, its health and increased life expectancy. Along with the clear hopes they inspire, clinical trials on humans present a risk to the patients participating in them. The researchers' wish to develop innovative methods of treatment is liable to distort and erode the legal and ethical frameworks that protect the method of conducting the trials. Economic interests may also be involved. The law and the ethical code are intended to preserve and protect the health and security of those who risk their health in the hope of
finding a cure for their illnesses or even saving their lives. These patients, by their participation in the clinical trials, are likely to also ensure the health and lives of those who follow them. The rapidly changing reality and the advancement of technology, including the progress of medicine, generally increase the desire of researchers to develop and manufacture innovative treatments and drugs. This intention, whether it derives from the desire of the researcher for self-fulfillment and realization of his professional capabilities or from his desire to promote his name and reputation, may lead to the creation of a conflict of interests, in which the welfare of the patient is liable to be opposed to that of the physician. In addition, this changing reality may create new situations in the physician-patient relationship that did not exist even a few years ago. There are physicians who, in addition to their traditional role as healers, simultaneously have research-economic relationships with the pharmaceuticals industry or startup companies. We, as a society, and especially as a profession, are responsible for preventing improper situations and for protecting the patients. Articles in the press on the subject of clinical trials in Israel have recently attracted considerable public interest. According to these articles, which have not yet been examined in the Courts, some physicians have allegedly betrayed the trust of their patients and conducted clinical trials in crude infringement of the law and of medical ethics. Even if all these allegations prove to be false, the social damage caused to the image of the physicians and medicine in Israel is tremendous, and, in particular, threatens the future of clinical research in Israel. The Israeli Medical Association decided, based on deep commitment to the professional and ethical standards of medicine in Israel and to its status in the eyes of the public, to take steps in order to protect the status of clinical trials, to profess their importance and to minimize, as far as possible, any future deviation from the procedure required for their execution. This position paper reflects the position of the Israeli Medical Association, as formulated by members of the special committee convened for this purpose. I would like to thank the members of the committee for the valuable time they devoted to this important subject and for their sensible comments. Special thanks to advocates Gili Shilat and Adva Perry for their significant contribution to the wording of this document, and to Advocate Leah Wapner for initiating this process.

The importance of medical research in Israel
Clinical trials have been conducted in Israel and abroad for decades, and their contribution to the health of patients and to the standard of medicine is clear. The level of clinical research as conducted in Israel ranks us with the most advanced countries in the world regarding the nature and quality of the medical service given to our citizens. Medical research brings great benefit to all participants:

The patient – The patient undergoes close and continuous medical monitoring, and enjoys direct and immediate access to the physicians treating him, both junior and senior, without any financial cost or administrative barriers. The treatment given is subject to constant monitoring, both by the inspection committees of the institution – as set forth in the Public Health Regulations (Medical trials on humans), 5740-1980 (hereinafter: “the public health regulations”) and in the Procedure for conducting medical trials on humans (2006), published by the Pharmacy Division.
of the Ministry of Health pursuant to the public health regulations (hereinafter: "procedure for medical trials"), as well as by the pharmaceutical companies who act in accordance with the strict criteria of the FDA in the US and of the EMEA in Europe.

Most patients who participate in clinical trials receive innovative and advanced drugs many years before these drugs appear on the open market, drugs that may significantly improve their quality of life and health, reduce the side effects that accompany existing drugs, reduce the risks involved in the receipt of existing alternative treatment, and frequently even save their lives. All this occurs without any payment on the part of the patients. Furthermore, in Israel there is a unique commitment on the part of the pharmaceuticals companies to supply the trial drug free to patients who participate in the trial for an additional three years after the end of the trial or until its inclusion in the national drugs basket.

The physician – The physician is exposed to the most advanced information that exists in the field of the research, which improves his capability and grants him a prominent advantage in the treatment of similar patients. Meetings of researchers that include the participation of physicians from various countries expose the physician participating in the research to the most advanced global medicine of the time as well as allowing researchers to create valuable professional and personal links with the international professional medical leadership. Publication of research earns the physician a place of respect among his colleagues, which improves his chances to again serve as a researcher in additional trials, and so on. Furthermore, such a trial obligates strict and methodical recording required for monitoring the patient’s clinical condition, the treatment given to him, and the results. This meticulous recording sets proper standards for any medical documentation that the physician may record in his subsequent professional career. This constantly improving process benefits all those concerned.

The State of Israel – The built-in advantages in clinical trials also apply to the State of Israel as an overall framework. Israel’s participation in multi-national trials is essential for the creation of foreign relations with countries of the world, for Israel’s participation in world medical research and for confirmation of its status throughout the world in the field of medicine.

The health care organizations – These organizations are given the option of granting their patients the most advanced professional medical treatment existing in the world, while at the same time improving the professional knowledge and clinical capabilities of the physicians working for them. This advanced treatment is provided without any financial costs being imposed on the health care organization or on the State.

The pharmaceutical companies – The pharmaceutical companies enjoy clear economic benefits as a result of the development of clinical research in Israel, which leads to the development of innovative drugs and treatments. If more and higher quality clinical research is conducted in Israel, it will constitute an increasingly preferred target for the investment of additional resources for conducting clinical trials.

The general public – It is clear that the public enjoys a variety of advantages inherent in the conduct of clinical research – including more innovative and quality treatment, more advanced technologies, physicians of a higher professional standard, more developed foreign relations between Israel and various countries, and other advantages.
Furthermore, approximate estimates indicate that pharmaceutical companies invest about $300 million in medical research in Israel, and that the lion’s share of this money is re-invested in the national medical system, in the expansion and quality of the clinical activities conducted in it.

Clinical research also permits expanding clinical activities to small hospitals in Israel and to the field of community medicine. In this way, the circle of physicians exposed to the advantages included in these trials expands, and an additional group of physicians is given the opportunity for advancement and improvement, similar to the process existing in the central hospitals.

We can see that there are mutual interests of all the relevant entities regarding the need to conduct and develop the clinical trials conducted in the State of Israel.

■ The legal framework

The legal framework, pursuant to the Israeli legal system, is derived first and foremost from the primary legislation (laws and ordinances), but may also be deduced from secondary legislation (orders and regulations) as well as from international declarations and conventions and from court rulings.

It is incumbent upon us that the legal framework in Israel for conducting clinical trials conforms to the existing international legal framework, as updated from time to time. This coordination is essential in order to permit the State of Israel to participate in the execution of the clinical trials throughout the world.

Furthermore, in an issue of this magnitude we should strive to reach general world agreement regarding the legal framework that we are using.

Clinical trials on humans contain the hope of a cure for patients who will in the future need new drugs or treatments, and we cannot overstate the importance of their contribution to saving lives and advancing medicine and the medical system.

On the other hand, one should not ignore the risk of misuse involved in these trials, especially given the desire of researchers to develop innovative methods of treatment and to advance at maximum speed through the stages of the clinical trials, sometimes, unintentionally, without strictly observing relevant rules. In the current reality, in which the physician becomes an active partner in medical research with the pharmaceutical industry, there may be economic interests, sometimes covert. For example, the advancement of a new technology or its results may influence the academic or economic status of the physician participating in the research.

In light of this, we have an obligation to formulate clear, fully transparent rules regarding medical trials on humans, that focus first and foremost on the safety and health of the patient while protecting his welfare.

The need to formulate ethical rules for conducting medical trials on humans was recognized for the first time after the end of World War II, with the discovery of the evil experiments conducted by the Nazis on humans. The Japanese Army also conducted depraved experiments on thousands of persons using biological weapons, beginning in 1936 and continuing throughout World War II.

Until World War II, no public, legal, and moral steps were in place for the protection of patients taking part in research. The judges in the Nuremberg trials called on the nations of the world to create an international procedure for trials on humans, to be based on “natural morality”, or as
they defined it:

“The principles of the laws of the nations as expressed in accepted behavior between civilized persons, in the laws of humanity and in the public conscience.”

The first recognized document to address the regulation of medical trials on humans was the Nuremberg Code, formulated following the trials of the Nazi physicians after World War II. In 1964, at its 18th General Assembly, held in Helsinki, Finland, the World Medical Association (WMA) adopted recommendations that guide physicians in bio-medical research on humans. These recommendations were collected into an official document, known as the Helsinki Declaration, which replaced the Nuremberg Code.

The Helsinki Declaration was adopted by many countries throughout the world, and formed the basis for laws, declarations, and national directives in a similar spirit throughout the world. The Declaration itself has been revised seven times since 1964, the last time in 2004, in order to adapt it to the changing reality, and it continues to form the ethical and legal basis for the planning, execution, and recording involved in the execution of clinical trials on humans.

The Helsinki Declaration is also the basis for the international guide for the execution of clinical trials formulated in recent years under the name Good Clinical Practice (GCP). These directives are not part of the law, but have been adopted by health authorities in Europe, the US, and Japan. The Israeli Medical Association was involved in the activities of the WMA and participated in the years 2002 and 2004 in the process of updating the Helsinki Declaration.

The wording of the principles of the Helsinki Declaration, as amended in the 29th World Medical Association Assembly held in Tokyo, Japan, in 1975, was codified and implemented in Israel by virtue of the public health regulations. These regulations constitute the legal basis in Israel for the regulation of medical trials on humans, and they were enacted by virtue of section 33 of the Public Health Ordinance, 1940.

The public health regulations specify that a medical trial on humans is defined by the use of drugs, radiation, or chemical, biological, radiological, or pharmacological material contrary to legislation or to the approval given for such use. It also includes situations when the use in question is not customary in Israel for the needs requested, or has not yet been tried in Israel and that may, or is intended to, influence the health, body, or spirit of a person or fetus or part thereof, including the genetic arrangement, as well as the execution of any process, act, or examination in humans that is not customary.

The principles for conducting a clinical trial as set forth in the Helsinki Declaration and adopted by the public health regulations, place emphasis on the good of the individual participants, which prevails over the good of society or the good of science. Furthermore, the principles emphasize the obligation to preserve the wholeness of the body, spirit, and personality of the participant and his privacy.

In addition, there is an obligation to receive the comprehensive, designated informed consent of the candidate to participate in the clinical trial, as detailed below, as well as an obligation to conduct trials in accordance with accepted scientific standards and to estimate the risk versus the benefit in the trial.

In accordance with the public health regulations, medical trials are currently being conducted
in Israel on humans, in accordance with the provisions of the procedure for medical trials on humans, published as aforesaid by the Pharmacy Division of the Ministry of Health in 1999 and last updated in 2006. This procedure regulates the rules regarding these trials in Israel and describes the procedure for filing an application for a medical trial and the requirements for its approval.

In addition, the ethical basis regulating the execution of medical trials on humans is anchored in the International Convention regarding Civil and Political Rights, which states in section 7, that: "A person shall not be subject to torture or to cruel, inhumane or humiliating behavior, or punishment; in particular a person shall not be subject to a medical or scientific trial without his free consent."


In addition, a number of laws have been enacted in Israel that have direct and indirect ramifications on the issue of medical trials on humans, such as the Basic Law: Human dignity and liberty, the Patient’s Rights Law, 5756-1996, and the Genetic Information Law, 5760-2000. The Ministry of Health has also issued a number of Director-General circulars, as follows:

1. A Circular regarding the registration of medical trials in the world database of the NIH (dated 4.9.2005), which states that every clinical trial that meets the criteria set forth in this circular and that is conducted in Israel must be registered by the initiator of the trial in the medical trials database. In the case of a trial initiated by a commercial company, the researcher must ensure the registration of the trial by the company. The Helsinki committee of the medical institution shall not approve a clinical trial that was not registered, unless it accepts the reasons of the researchers for not doing so. The circular also states that in principle, it is possible to register a medical trial in several sites, but the circular requires that the registration be done on the NIH site, with the aim of uniform registration.

2. A circular regarding the supervision and monitoring of clinical trials in medical institutions in Israel (dated 6.3.2005), aimed at guiding the medical institutions in proper monitoring of medical trials. This circular states, inter alia, that the Helsinki committee of the institution is obligated to supervise the clinical trials approved by the committee and by the director of the hospital, and that the researchers responsible for the trial must submit to the committee yearly reports, or more frequently if the degree of risk in the trials is high. They must also submit regular reports regarding adverse events that arise during the trial. The circular also states that the management of the medical institution must appoint a supervisory body for monitoring and checking the clinical trials approved in the institution.

3. A circular regarding guidelines of the supreme committee for medical trials on humans, for the setting up and use of banks of genetic samples (dated 2.1.2005). The guidelines are intended for those who wish to set up banks of DNA samples or to make use of existing banks, and are based on the rules employed in the supreme committee for approval of genetic trials on humans and on the relevant law, including the provisions
of the Genetic Information Law, 5760-2000, the Law for Protection of Privacy, 5741-1981, and the Privacy Protection Regulations (transfer of information to databases outside the country), 5761-2001.

It should be noted that these instructions expressly state that the setting up of a DNA bank does not grant exemption from the filing of an application for approval of genetic research on humans, if the execution of such research is requested after approval of the DNA bank. In addition, the application for research will be determined separately, in accordance with the rules and procedures customary in the committee.

4. A circular jointly issued by the Ministry of Health and the Clalit Health Services, that addresses agreements with commercial entities (dated 19.4.2004) and is aimed at formulating rules for agreements between institutions of the Ministry of Health and Clalit Health Services with commercial entities for the purpose of conducting clinical trials, research, participation in conferences and study days in Israel and abroad, and other connections, within the context of accepted ethical rules. This circular anchors the demand unique to the State of Israel, that the initiator of the research must supply to a patient who participates in the research the drug or treatment that he received during the research, for a period of up to three years, without payment, after the end of the trial, as long as it cannot be received from the health care organization in which the patient is insured, or as long as it has not yet been approved for marketing in Israel and when no suitable alternative treatment exists.

Nonetheless, and notwithstanding the aforesaid, rules for conducting medical trials on humans have not yet been codified in primary legislation in Israel. The Ministry of Health has been drafting a bill on the subject of medical trials on humans since 1997, but no government bill has been submitted.

On December 21, 2005, a (private) bill was published, entitled Medical Trials on Humans, 5765-2005, submitted by members of the Science and Technology Committee of the Knesset. The aims of this bill are to formulate the principles according to which medical trials on humans are to be conducted. For example, the bill states that a medical trial on humans shall be conducted while maintaining the dignity, freedom, and rights of the person. Furthermore, the bill specifies the conditions for conducting medical trials on humans, the definition of the committees for human trials and the method of their functioning, the setting up of a supervision and monitoring committee, consent for participation in the medical trials, and definition of the obligations and rights of all those involved in those trials.

In June 2005 the Israeli Medical Association sent its comments regarding the draft of the proposed law and suggested the addition of sections contained in the revised Helsinki Declaration, since that is the most advanced document in the field of medical trials on humans that is binding on physicians throughout the world. For example, the IMA proposed adding a reference to considerations relating to distributive justice (it shall be justified to conduct medical trials on humans only when there is a reasonable chance that the population on whom the trial was conducted will benefit from its results). The IMA also suggested extended obligations of disclosure regarding informed consent (see details in the part addressing
this subject), extended obligations in connection with publication of the findings of the trial including negative results, sources of financing, conflict of interests, etc. The private bill passed in its first reading on December 14, 2005, before the dissolution of the 16th Knesset. If the rule of continuity will apply to it in the current Knesset (the 17th) it will be sent for a second and third reading.

The position of the Israeli Medical Association is that there is an urgent need for primary legislation on the subject of medical trials on humans, both from a declarative aspect, since it is important for the Israeli Knesset to be the one to address the issue, and from a practical aspect, since the power of primary legislation is greater than that of secondary legislation, is more difficult to change, and reflects a more intensive public debate. It is ironic that in contrast to humans, trials on animals have been secured for several years in various laws. Until completion of the legislation, it is necessary to preserve a balance between giving maximum protection to participants in a trial on the one hand, and the essential need to conduct the medical trials, on the other hand.

**Informed consent**

The obligation to receive a person’s informed consent for every activity related to his body and health, including the use of parts of his body, including organs, tissues and blood samples, is derived from the fundamental principles of a person’s right to his body and the obligation to respect his dignity, rights and freedom. It also stems from the obligation to conduct medical trials on humans in the spirit of the Helsinki Declaration and in accordance with proper clinical practice.

This obligation applies even more strictly to medical trials on humans, since these trials have extensive potential to reveal information concerning the participants in the trial, perhaps his family and offspring and even large populations. In addition, although we are speaking of an action that contains numerous and significant advantages for the patient, we are dealing with a new and experimental drug that also involves an unknown risk that cannot be ignored. In Israel, the obligation to receive informed consent is codified in the Patient’s Rights Law, 5756–1996, in the public health regulations, and in the procedure for medical trials.

The obligation to obtain informed consent, as set forth in the procedure for medical trials, also includes the obligation of the researcher to give the participants information about the medical trials in a clear comprehensible way. Information about the trial includes, inter alia, an explanation of the nature and process of the research, its aim and duration, the average number of participants in the trial, a description of the various processes, and indication of the chances to receive each of the treatments proposed in the trial, including a placebo, if any. It also includes a description of the advantages expected as a result of participation in the trial, a description of the expected risks, and an explanation of alternative treatments, if any. Furthermore, the researcher must inform the participant that he has the right to absolute confidentiality and that his documents will be examined by authorized entities only. In a genetic trial, this right, as well as the participants’ right to privacy, must be emphasized even more.

In the absence of primary legislation that addresses medical trials on humans, the issue of informed consent specific to this matter has not yet been secured by law. The bill includes
the demand to receive the informed consent of every participant in a medical trial conducted on humans, and even describes the type of consent required, the method of furnishing the information to the participant in the trial, the way in which the informed consent is given, and the conditions permitting deviation from receipt of the informed consent. The principle regarding the receipt of informed consent for participation in a clinical trial as specified in the Helsinki Declaration, last revised in 2004, obligates broader disclosure regarding the method of obtaining the informed consent than is included in the bill. The Israeli Medical Association proposes that the Helsinki Declaration, including its integrated system of checks and balances, be adopted as a single unit. In addition, its position is that the principles appearing in the revised wording of the Helsinki Declaration, including the broadened obligations for disclosure in connection with informed consent, and the increased stringency of the requirements for formulating informed consent, should be codified in primary legislation. For example, the IMA feels that the law should include the principle as set forth in section 22 of the revised Helsinki Declaration, according to which every participant in the trial shall be given information regarding the sources of financing of the trial, the connections between the researcher and the company managing the medical research, the researcher's involvement in the proposed research and any potential conflict of interests. In addition the trial participant must be informed, in language comprehensible to him, that research in which a commercial company is involved contains a chance for a profit by said company. He should also be informed whether the physician involved is a research agent who receives financial remuneration for his services from the commercial company conducting the research.

In the law should include the principles of section 23 of the revised Helsinki Declaration, which mandates extreme caution regarding the informed consent of the patient when there are relations of dependency with the practitioner, in which case it must be verified that the consent is not given in any way under any pressure or threat whatsoever. In such cases, a practitioner who is not involved in the research and who has no connection with the relationship between the physician and the patient, must be the one to obtain informed consent.

Finally, section 11 of the Helsinki Declaration from 1975 (which is codified in the public health regulations) states that in the case of a legally incompetent participant, the medical treatment shall be requested and received from the legal guardian, in accordance with the national legislation. When physical or mental incompetence makes it impossible to obtain informed consent, or when the person used for the research is a minor, the responsible relative shall grant permission instead of the person used for the research. The Israeli Medical Association also advises including reference to section 24 of the revised Helsinki Declaration, which gives broader protection to participants who are unable to give their consent. The section states that research on these groups shall only be conducted if the research is vital for the advancement of the health of this specific population, and only if it is impossible to conduct the research with participants who are legally competent to give informed consent.

The Israeli Medical Association believes that primary legislation should also include the rule currently found in the procedure for medical trials referring to populations in special conditions.
According to this rule, whenever the researcher has doubt regarding the competence of the participant to give informed consent, and the researcher knows that a legal guardian has not been appointed for the participant, the researcher must obtain the evaluation of a psychiatrist or geriatrist who are independent of the research. Furthermore, when speaking of a participant who is a minor, the researcher must give an explanation of the trial in accordance with the minor's understanding.

### The Helsinki committees

The execution of medical trials on humans in Israel comes under the supervision of the Ministry of Health by means of the Helsinki committees in the hospitals. In every hospital the Helsinki committee comprises the most senior physicians and researchers in the institution, representatives of the public (clergy or lawyers), and representatives of the hospital. In 1990, a requirement of the Director-General was added to include in the committee a senior pharmacist, so that the considerations of the committee would also include his/her professional skills and considerations.

The members of the committee serve on a voluntary basis and receive training in the rules of management of clinical research. The members of the committee are appointed by the management of the hospital and approved by the Director-General of the Ministry of Health. The Helsinki committees act in accordance with the procedure for medical trials of the State of Israel. This procedure corresponds to the rules for clinical research of the European Union and the rules for research of the American FDA.

Every proposal for research on humans is submitted to the Helsinki committee of the institution for approval. The committee focuses mainly on the good of the patient and on the potential risks and benefit to the patient as a result of participation in the research. Special emphasis is placed on giving a detailed explanation to the participant in the trial and to his signing an informed consent form, in which all the details are given of the trial and its ramifications. In addition, every participant in the trial is insured with special insurance.

When dealing with a trial that includes administering an experimental drug, the initiator of the trial must undertake to supply the drug to the patient for up to three years after the end of the trial or until the drug is included in the national drugs basket. This provision for supplying the drug even after the end of the trial is unique to the State of Israel.

After approval by the Helsinki committee of the institution, the proposal for research undergoes additional discussion and approval by the Ministry of Health, except in the case of a "special" trial (within the meaning of the fourth supplement of the public health regulations). Finally, the director of the hospital in which the trial is conducted approves the research.

Section 15 of the procedure for medical trials obligates the head researcher to report within 48 hours to the chairman of the institutional Helsinki committee and to the director of the institution regarding any case of death or a serious adverse event. An adverse event refers to an unexpected incident, in which one cannot exclude a connection between it and the use of the research product. The head researcher must also report within 48 hours to the chairman of the institution Helsinki committee only, regarding a malfunction to a medical accessory/ instrument of the trial that has ramifications regarding the safety of use and effectiveness of the equipment.
In the event of death, the chairman of the institution Helsinki committee examines the notice immediately. If he reaches the conclusion that there is no connection between the event and use of the research product and/or the patient’s participation in the trial, he must report the event and this conclusion to the Helsinki committee and to the Ministry of Health within 30 days. In contrast, if the chairman of the institution Helsinki committee cannot rule out a connection with use of the product or participation in the trial, he must notify the director of the institution immediately.

In such a case, the director of the institution must appoint an examination team to discuss the matter within 14 days. Depending on the conclusions of the examination team, he may order the continuation of the trial or, alternatively, recommend to the Helsinki committee to halt the trial. The Helsinki committee shall notify the director of the institution and the Ministry of Health of the conclusions of the discussion of the examination team and of its own decisions.

In adverse safety events that do not involve death, the researcher is obligated, pursuant to section 15.1.2.2 of the procedure for medical trials, to update the Helsinki committee regarding continuation of treatment of a patient following an incident, and the Helsinki committee shall discuss the reports and their ramifications on the participants in the trial and indicate this in the protocol of their meeting. The Helsinki committee is obligated to send to the Ministry of Health their reports and conclusions, including the possible connection between the event and the person’s part in the trial, within 30 days, or upon sending the protocol of the next meeting.

In contrast, in the case of reports received by the Helsinki committee from the initiator of the trial, the Helsinki committee is exempt from sending them to the Ministry of Health, since the obligation of reporting lies with the initiator.

In order to improve the system for supervision and control of the conduct of the medical trials on humans in the State of Israel, the Ministry of Health, in the Director-General circular issued dated 6.3.2005, ordered the setting up of a monitoring system. In accordance with this circular, a body must be set up in every institution whose function is to monitor the execution of the medical research and to verify that the research is conducted in accordance with the customary strict criteria.

The function of this monitoring system is to verify that patients who participate in the trial have received an adequate explanation of the trial and have duly signed the informed consent forms, that the trial was conducted in accordance with all the rules of good medical practice, and that every side effect was reported in a timely fashion to the Helsinki committee. The Director-General circular is in its infancy, and consequently the time has not yet come to evaluate to what extent it has actually been implemented.

As a result of the ongoing improvement in the conduct of clinical trials in Israel, including the setting up of permanent monitoring entities, professional training of the researchers and raising the standard of functioning of the Helsinki committees, the system of medical trials on humans in Israel now complies with the strictest international criteria, recognized by the FDA. Together with the trend for constant improvement, and although most clinical trials comply with the existing rules, there is still room for improvement. For example, most medical trials in Israel are “multi-center international research”. Such a trial is conducted in several hospitals
at the same time in Israel. In such circumstances, duplication and complications are liable to result, since each medical center is required to approve the same research, by means of its own Helsinki committee, separately and in parallel to the other centers. This is so even after the research has undergone all the relevant stages of approval and even after it has been approved as a multi-center trial by the Ministry of Health. This results in unnecessary work that takes up valuable and protracted time for approval of the trial.

The position of the Israeli Medical Association is that the investment of considerable time for the approval of clinical trials is not necessarily a guarantee for the quality of the approval process and is even liable to be harmful. Particularly with multi-center research, the process for receipt of the approvals must be made more efficient and the time required for conducting the trial must be reduced, and steps taken to simplify the process.

Consequently, when a trial has been approved in a specific institution in all its stages, and approved by the Ministry of Health as a multi-center trial, the institution Helsinki committees of the additional institutions in which the multi-center trial is requested should avoid discussing all the ethical aspects of the trial that have already been addressed by the first institution, and should instead make use of the recommendations and conclusions of the Helsinki committee that discussed the trial and approved it in the first institution. This will not only shorten the time of the processes for approval of the trial, but will also contribute to the creation of uniform rules regarding the execution of the same trial in the various institutions.

In addition to the institution Helsinki committees, there is a independent, supreme Helsinki committee, whose composition, legal quorum, and ways of appointment are specified in the public health regulations. This committee’s function is to provide an opinion regarding trials related to the human genetics, artificial fertilization of a woman, and other subjects the Director-General of the Ministry of Health raises, including trials regulated by the Genetic Information Law.

The medical trials procedure also establishes a central committee for medical trials on humans, appointed by the Director-General of the Ministry of Health, which advises on the subjects of medical preparations, medical devices and instrumentation/ medical equipment, products containing living cells and tissues from a human source and xenotransplantation, or any other subject to be decided upon in the future.

The Israeli Medical Association calls for the formation of a supreme Helsinki committee to serve as a multi-disciplinary steering committee for the discussion of any ethical, medical, legal, philosophical, social, or other question that may arise from time to time during the approval and execution of any kind of clinical trial. This committee should comprise representatives from various disciplines who are specialists in a variety of fields and possess the suitable qualifications to provide an answer to the questions and issues that may arise. This will serve to formulate uniform, final, and binding rules for the execution of every clinical trial, in any institution whatsoever, to be consistently updated in accordance with the needs and questions that arise.

The position of the Israeli Medical Association is that its representatives should be included in this supreme steering committee. In the light of the active participation of the Israeli Medical
Association in the revision of the Helsinki Declaration in recent years, its representatives will be able to reflect for the members of this committee the international situation related to clinical trials and the changes taking place from time to time in the international documents related to clinical trials.

In addition, the Israeli Medical Association will, by means of its professional associations, be able to place senior physicians in every field of medicine at the disposal of this committee. By means of its Scientific Council the Israeli Medical Association will be able to increase the training of physicians in the professional knowledge required for execution of clinical trials, and by means of the Ethics Board the Israeli Medical Association will also be able to assimilate the ethical code required in these trials.

The Israeli Medical Association holds that the work of the members of the Helsinki committee in the various committees should be regarded as an integral part of their routine work. This recognition will permit members of the committee to devote the time required to study the requests before them and to judge them with familiarity with the scientific background material. This recognition will indicate the considerable importance that the public in Israel attaches to the work of the committee, and its vital role, as well as the expectation that members of the committee will carry out their jobs in the most professional manner possible.

**Physician training**

The Israeli Medical Association attaches great importance to activities in the field of medical education, qualification of specialists and research grants in order to train physicians to conduct clinical trials. Consequently, the Israeli Medical Association has begun acting in the following three fields:

The Israeli Medical Association, by means of its Scientific Council, has initiated joint activities with the Association of Deans of Medical Schools, with the aim of including the relevant subject matter for conducting medical research on humans in the study programs of the four medical schools in Israel. The aim is to have the mandatory curricula in all the medical schools include courses in ethics, management of medical research, and the study of good clinical practice (GCP) in medical research.

The Israeli Medical Association, by means of its Scientific Council, has initiated the preparation of a course in the ethics of medical trials and the methodology of clinical research, including familiarity with the regulatory frameworks of the research and with GCP. The Israeli Medical Association will take steps to make these studies mandatory so that every resident in the State of Israel will be obligated to undertake these studies and pass exams in them during his specialization.

The Israeli Medical Association has initiated a change, according to which starting from a specific date in the future, only a physician who has undergone recognized additional studies in GCP and has received a certificate from an internationally recognized body may become a head researcher in a trial. Furthermore, the Israeli Medical Association is taking steps to ensure that on a later future date, every researcher (and not only the head researcher) who participates in a clinical trial will have received such training.

The aim of this training program, including its various stages, is to obligate physicians to
assimilate throughout their professional career, beginning at the outset, (whether during their academic years, their practical work, or when conducting a medical trial) the rules to be observed when involved in a medical trial on humans. Apart from these steps, the Israeli Medical Association shall specify a transition period in order to permit all the physicians to become familiar with these new rules of qualification.

■ Enforcement

As set forth above, the issue of medical trials on humans has still not been addressed by primary legislation, with the existing legal basis for regulation of the issue found in the public health regulations, enacted by virtue of the Public Health Order. The Order includes a provision for punishment according to which a person infringing one of its provisions is liable to six months imprisonment or a fine.

The private bill for Medical Trials on Humans, 5765-2005 specifies punishments for conducting trials contrary to the law. Among other things, the bill states that a person who initiates, conducts, or permits conducting a medical trial on humans in contravention of the law shall be liable to one year's imprisonment or the payment of a significant fine (and in the case of a corporate initiator – a double fine). In the case of a high risk trial, the penalty shall be increased to three years’ imprisonment. It is also proposed that infringement of the law will also constitute an infringement of the Physicians Order and the Psychologists’ Law, and punishment shall be determined accordingly.

The position of the Israeli Medical Association is compatible with the trend to increase the penalties imposed on those infringing provisions related to medical trials on humans. The Israeli Medical Association is convinced that the full strictness of the law should be implemented against physicians who infringe the law or the public health regulations and the existing provisions regarding clinical trials. Such infringement harms the public's trust in physicians and medicine.

Consequently, when it has been duly established that a physician has infringed these rules, he shall not receive the protection of the Israeli Medical Association. The Israeli Medical Association is convinced that it is important to have criminal sanctions whenever there is infringement of the relevant rules, and that it is necessary to grade the gravity of the various offences, to evaluate every infringement on its own merits, and to determine the appropriate punishment in accordance with the gravity of the offence. Furthermore, when speaking of the gravest offences, even heavier punishments than those proposed in the private bill should be imposed.

The Israeli Medical Association believes that it is necessary to strengthen the mechanisms for the supervision and monitoring of research, starting from the proper allocation of resources and positions, through the determination of clear, specific rules to define the types of trials requiring more frequent supervision and monitoring and, finally, providing effective enforcement mechanisms. In addition the obligation for reporting as set forth in the law, described above, should be strictly observed and the committee should be empowered to impose sanctions on a head researcher who does not report in a timely fashion, even during the interim period until the legislation of suitable regulations in the subject.

The Israeli Medical Association regards the participation of patient representatives and
representatives of the Association for Civil Rights as vital for the various processes taking place in connection with the issue of medical trials on humans in general, and in all matters related to supervision and monitoring, in particular.

**Summary and recommendations**

The continuation of clinical trials in Israel is an interest shared by patients, physicians, and the medical establishment in Israel.

Clinical trials benefit the patients participating in them and allow them the most advanced means of treatment and therapy in the world, years before these means are included in the national drugs basket, all this under skilled and close medical monitoring and without any cost on their part.

The physicians also benefit from clinical trials: They are exposed to a unique medical field in which they significantly increase their knowledge and acquire valuable clinical skills. The execution of trials obligates the existence of a strict and inflexible system of regular transfer of information to the patients, medical documentation and monitoring, while maintaining very strict international standards.

The exposure of researchers in Israel to additional researchers from other countries opens a window for them onto the most advanced international medicine, while creating professional and social connections with the international medical leadership.

The State and the medical organizations also benefit from the execution of clinical trials. The trials also permit the peripheral hospitals and community physicians to participate, and thus benefit from a high academic standard. The State and the health care organizations benefit from medical manpower possessing improved clinical capabilities, who acquire better insight and diagnostic and treatment capability for the patients. The professional knowledge acquired during treatment of the patients who participate in clinical trials is used, in the final analysis, for better medical treatment of the entire population.

Let us not forget the important economic value of the clinical trials conducted in Israel. Based on accepted estimates, the pharmaceutical industry invests about $300 million a year in medical research in Israel. This is a very small share, not exceeding 0.3% of the entire international investment in medical research, which totals $100 billion every year.

We need to utilize the advantages existing in the medical system in Israel and international recognition of its quality, in order to turn Israel into a preferred destination for international pharmaceutical companies. This is an attainable goal.

The contribution of patients who participate in trials to the advancement of medicine and science is endless and is worthy of appreciation and esteem on the part of each one of us. In return, we must guarantee that the clinical trials are conducted in strict observance of all the applicable laws, regulations and ethical rules in Israel.

We must also guarantee to the patients that the trials will be conducted with full academic freedom, without any influence by the pharmaceutical companies, with full transparency, and while preserving the freedom to publish all the results of the research, even if they do not meet the expectations of those who initiated or financed it. In this way, we shall act in accordance with the mandatory directions published and recently updated by the International Association
of Editors of Bio-medical Journals (ICMJE).

In order to advance the execution of clinical trials in Israel, the Israeli Medical Association proposes the following steps:

1. **Education and assimilation of the medical culture of GCP and the relevant ethical rules:**
   a) The Israeli Medical Association, by means of its Scientific Council and in cooperation with the association of deans in Israel, shall take steps to include the subject of clinical trials, including the principles of GCP and the relevant ethical rules, in the mandatory study program of the medical schools in Israel.
   b) The Israeli Medical Association, by means of its Scientific Council and its scientific associations, shall take steps to establish a national central course to teach the principles of GCP and the relevant ethical rules. Every resident during his period of specialization shall be required to participate in this course and pass a final examination.

2. **Obligatory further studies for researchers:**
   a) The Israeli Medical Association, in cooperation with the Ministry of Health, shall take steps so that starting from an agreed date in the future, every head researcher in a clinical trial shall be obligated to undergo a GCP course and possess a GCP certificate awarded by an internationally body recognized and qualified for granting such a certificate.
   b) The Israeli Medical Association, in cooperation with the Ministry of Health, shall take steps so that starting from an agreed date in the future, every researcher in a clinical trial (not only the head researcher) shall be obligated to undergo a GCP course and possess a GCP certificate awarded by an internationally body recognized and qualified for granting such a certificate.

3. **Change of the structure and functioning of the Helsinki committees:**
   a) Steps shall be taken to improve the efficiency of the various Helsinki committees, especially in cases of multi-center research, and to reduce the period of time required for approvals of clinical trials in general and of multi-center clinical trials in particular.
   b) The work of the Helsinki committee members shall be regarded as an integral part of their routine work.
   c) Steps shall be taken to set up a supreme Helsinki committee that shall serve as a multi-disciplinary steering committee for the purpose of discussion of and response to any ethical, medical, legal, philosophical, social, or other question that may arise during approval and execution of a clinical trial, and that shall comprise representatives of the various disciplines.

4. **Enforcement**
   a) The Israeli Medical Association shall cooperate with the Ministry of Health in order to enforce the laws, instructions, and ethical directions during execution of clinical trials in Israel.
   b) A physician who has been duly proven to have infringed the rules of this system
shall not enjoy protection from the Israeli Medical Association.
c) The gravity of the infringements shall be graded and sanctions to be employed against a physician who infringes the relevant rules shall be specified in accordance with this grading.
d) A physician who has been found guilty by a court of such an infringement shall be brought before a clarification committee of the Ethics Board.

5. Primary legislation
a) The Israeli Medical Association calls for addressing the subject of clinical trials in primary legislation as soon as possible.
b) The Israeli Medical Association calls to adopt in primary legislation the principles embodied in the Helsinki Declaration, as updated from time to time, since this is the most advanced document in the field of clinical trials that obligates physicians throughout the world.

58. Comments by the Israeli Medical Association on the bill for Medical Trials on Humans, 5767-2007

Published in 2007

Introduction
The Israeli Medical Association welcomes the regulation of the issue of medical trials on humans, as part of the bill for Medical Trials on Humans, 5767-2007 (hereinafter: "the bill"), after waiting for many years, during which the Israeli Medical Association repeatedly emphasized the vital need for regulation of this important and material issue as part of primary legislation.

Clinical trials are essential for the advancement of medicine, and without them, it would be impossible to develop new drugs and technologies that promise great hope. At the same time, we must preserve and protect the health and safety of the participants in clinical trials while strictly observing the obligation to obtain the informed consent of the participants in the trial. Therefore, it is essential to have a clear legal framework and ethical rules covering the execution of the trials. It is important to remember that we are speaking of an extremely dynamic subject, one that constantly raises throughout the world varied and complex ethical, moral, medical, philosophical, social, and legal questions requiring a suitable answer, especially in light of the development of technology. The field of pharmacogenetics, which has grown over the last several years, is an example of one such development that contains within it complex issues, for instance regarding special and vulnerable populations, such as pregnant women, children, and others.

This constantly changing complexity, as well as the increased exposure and participation of the State of Israel in numerous instances of multi-center and multi-national research, obligates the State to adapt itself to international norms and rules and to act in accordance with existing international standards existing in the field, as well as to create legal mechanisms that will permit flexibility and the adoption of dynamic rules.

In recent years the Israeli Medical Association has acted in the international arena and has formed
part of the working team that updated the Helsinki Declaration in the framework of the WMA, whose current president is the chairman of the Israeli Medical Association, Dr Yoram Blachar. Now, prior to the debates of the committee regarding the bill, the Israeli Medical Association has contacted both the WMA and other international organizations in order to receive their comments regarding recent developments in the field.

Summary of selected comments from the position of the Israeli Medical Association regarding the bill. (The full position may be found on the website of the Israeli Medical Association.)

- The Helsinki Declaration, as updated from time to time, should obligate every medical trial on humans.
- The definition of sensitive populations should be extended to include additional populations such as soldiers, and to strengthen the protection of populations of this kind.
- The definition of a medical trial shall not include the collection research data that is not in itself a trial.
- The relevant definition for use of a placebo, as set forth in the Helsinki Declaration, shall be adopted.
- Discretion regarding the recommendations for approval of a medical trial should be left to the trials committee, which possesses the ethical authority to do so. Under no circumstances should the director of a medical institution approve a trial that has not been approved by the trials committee, not even for special, noted reasons.
- The issue of insurance in medical research on humans must be addressed.
- The protections regarding the giving of informed consent should be expanded, especially for sensitive populations. For example, we recommend to adopt the relevant sections from the Helsinki Declaration that address the importance of giving informed consent to a practitioner not involved in the research where there is a dependent relationship between the patient and the physician, and to verify that consent was not given, in any way, under any pressure or threat. In addition, in cases of doubt regarding the competence of the participant to give informed consent, and when the patient has no legal representative, the researcher must receive the evaluation of a suitable professional who is independent of the research.
- The institutional trials committee should have discretion to exempt retrospective research on existing pathological samples from the need for informed consent, while receiving approval that sufficient material remains from the pathological sample for future needs. These researches are very important and form in most cases a foundation stone for prospective research.
- The information furnished to the research participant in order to receive his informed consent should also include relevant information for men, in cases in which the drug or the treatment are liable to influence fertility or increase any risks, similar to information furnished to pregnant or nursing women and to women of childbearing age.
- In selected research, in which no special risk exists for the participants, the local trials
committees should continue to be authorized to approve the research in order to prevent significant harm to the advancement of the research and to the health of the patients, since a requirement to receive approval from the Ministry of Health is liable to significantly and unjustifiably delay the approval of such research.

- The composition of the institutional trials committee (the Helsinki committee) should be changed so that it may function in the best possible way and as professionally as possible. Its members should include professionals from the fields of biostatistics, epidemiology, molecular biology, and the laboratory.

- The legal arrangement, according to which one of the representatives of the supreme trials committee of the Ministry of Health will be the chairman of the Israeli Medical Association or his representative from the Israeli Medical Association, should remain in effect.

- Steps should be taken to secure in legislation the possibility of an institution being aided by the medical trials committee of another institution. In practice, there are currently institutions that do not have their own trials committee, such as medical institutions with a small number of researches, and consequently they are aided by an institutional trials committee belonging to another medical institution.

- One of the most significant difficulties in the State of Israel in the field of medical trials is the slow and protracted approval process. This situation is created both because of the great load imposed on members of the committees and because they work on a voluntary basis. In order to improve the quality and standard of the medical trials and the advancement of research in general in the State of Israel, the work of the members of the institutional committees should be regarded as an integral part of their routine work. Such recognition will permit members of the committee to devote the time required for study of the approvals and to become familiar with the scientific background material. It will also indicate the great importance that the public in Israel attaches to the work of the committee and its vital function, and the expectation that the members of the committee will fulfill their duty in the most professional way possible.

- A multi-disciplinary steering committee should be set up for discussion of ethical, medical, legal, philosophical, social, and other questions regarding medical research, in order to create uniform, finalized, and binding rules. The committee should include representatives of the Israeli Medical Association, which has been involved in updating the Helsinki Declaration in recent years, and which, by means of its professional associations, the Scientific Council and the Ethics Board, will reflect the relevant international situation picture.

- The scope of the unit for supervision and monitoring of research in Israel should be formulated. In order to prevent any fear of possible conflict of interests, the head of the supervision unit should not be permitted to actually conduct medical trials on humans.

- The ethical obligation existing in the State of Israel to provide the research drug to participants for up to three years after the end of the medical trials should be left in
effect, barring exceptional circumstances. The Director-General of the Ministry of Health should not have discretion to grant sweeping exemptions ahead of the trial. Instead, it should be expressly determined in advance when the granting of such an exemption will be permitted. The fact of the exemption and the reason for it shall be included in the informed consent.

- No excessively sweeping limitation shall be imposed on the number of innovative activities that are not part of medical trials on humans, in order to avoid harming, for “procedural reasons”, in an arbitrary and unjustified manner, patients who require the innovative activity. Rather, proper supervision and monitoring mechanisms should be created.
- Increased obligations of disclosure should be imposed on the researchers in connection with the publication of the findings of the trial, including negative results.

59. Clinical trials on humans – “stakeholders” in clinical trials

Published in September 2004

Background
The current economic reality dictates extreme changes in the physician-patient relationship. The traditional role of the physician is expanding. In addition to his being a practitioner and a healer, in recent years the physician has become an active participant in medical research, in close cooperation with pharmaceutical and start-up companies. Conditions are created in which the advancement of new technology is likely to influence the economic status of the physician participating in the research. In this new reality, in which commercial considerations are apparently liable to overshadow scientific truth, we are obligated to formulate clear rules for the status of a “stakeholder” in the medical research.

Position paper
- Clinical trials are essential for the development and advancement of medicine, and consequently their continued existence should be supported.
- The development of new medical instrumentation or of a new drug involves financial means not available to the hospitals or the physicians.
- Because of this need, business partnerships are created between the hospitals and physicians, and commercial entities.
- Such a partnership should be regarded positively, since it is a means for advancement of the standard of medicine.
- Clinical trials conducted under the management of “stakeholders” are permitted, but obligate increased caution regarding the safety and health of the patients participating in the trial.
- A clinical trial managed by a “stakeholder” shall be conducted solely in a medical center in which there is an institutional Helsinki committee and with additional supervision by the Helsinki committee of the Ministry of Health.
Part E

- A clinical trial managed by a "stakeholder" shall be conducted with maximum transparency of all the economic interests behind the trial, including those of the medical institution and the physicians participating in the trial.
- The patient shall be told of all the other alternatives existing for treatment of his illness, and he shall be given details of all the risks and chances of the proposed experimental treatment.
- No charge shall be collected from the patient as long as the competent authority has not declared that the trial treatment has been proven.
- The director of the medical center in which the trial is conducted by the “stakeholder” bears dual responsibility for its proper execution.

60. Clinical trials on humans – the use of a placebo
Published in September 2004

Background
The advancement of medicine frequently obligates execution of medical trials on humans. Such trials contain a hope and relief for those patients who will need in the future the new drug currently in development. However, we cannot disregard the risk involved in these trials to those exposed to an experimental drug or to an innovative technology, before their effectiveness and safety are proven. Modern human society has decided, following the terrible criminal acts perpetrated by the Nazi regime, to formulate rigid criteria that permit the conduct of trials on humans only with the preservation of the health and safety of the lives of every participant in the trial. The Helsinki Declaration of the WMA from 1964, and an additional series of declarations by this organization, have created the ethical basis required for conducting trials on humans. The Helsinki committees operating in Israel in hospitals and in the Ministry of Health are derived from the said international declarations and commitments.

The use of a placebo in clinical trials has recently been the subject of sharp ethical debate, so that the WMA was forced to publish in 2002 clarifications of section 29 of the original Helsinki Declaration, that refer to the use of a placebo. The major feature of this debate is the need to bridge the gap between the existing requirements to compare every new treatment with the best treatment currently in use, and the needs of modern research, which sometimes obligate the use of a placebo, while causing possible risk and suffering to the patients.

The Ethics Board has discussed this subject and adopted the spirit of the WMA’s decision.

Position paper
- Clinical trials are liable to expose the patient to treatment with less effective drugs and/or to treatment with a placebo.
- The good and safety of the patient participating in the trial must take precedence over any other consideration, including the good of society or of science.
- In general, every new medical means should be compared in diagnosis, prevention, or treatment against another effective and proven means already in existence.
In general, the use of a placebo should be permitted only in cases in which there is no other medical means whose effectiveness has already been proven.

The use of a placebo in clinical trials is permitted in the following special circumstances:

1) When proper and weighty scientific methodological reasons obligate the use of a placebo in order to measure the effectiveness of the new medical means.

2) When the trial tests means of prevention, treatment, or evaluation of a mild medical problem, during which no real suffering or medical damage will be caused to the patient.

3) The use of a placebo in clinical trials in which the informed consent of the patient cannot be obtained, including from psychiatric patients, obligates greater caution and the development of special additional rules. This should be done alongside the development of a supervising and monitoring mechanism of the Helsinki committee and of the management of the medical institution approving the trial.

61. Genetic research in large populations

The decision in the Israeli Medical Association to set up a committee to address the subject of genetic research followed a series of events related to genetic research in Israel, which raised fundamental questions regarding the conducting and management of genetic research, especially in designated large populations. These questions are new, and it was impossible to find existing answers in legislation or accepted ethical codes.

Recently, a commercial company began collecting blood samples, on a large national scale in an attempt to map the genes of hereditary illnesses in members of a specific ethnic group. The subject aroused considerable public interest and led to a sharp debate on the sensitive issues surrounding the confidentiality of genetic information, the genetic marking of an ethnic group, commerce in genetic information, and the status of the physician vis-a-vis the commercial company conducting the research on the one hand and the individual patient on the other hand.

As a result, the Ethics Board of the Israeli Medical Association decided to set up a multi-disciplinary committee of specialists, to formulate recommendations regarding the conduct of genetic research on large populations and the treatment of the results obtained.

At the outset, the committee wishes to emphasize that the discussions held and the summary presented in the report do not refer to the activities of any specific company or researchers. The entire report should be read as containing recommendations and directions both for the entities that engage in genetic research, with emphasis on physicians, and for the entities who determine policy, with the aim of formulating rules with a binding normative weight.

Thanks are due to the members of the committee for the considerable time that they devoted to the discussions, for their sensible advice, and for their contribution to clarification of the complex subjects on which this document is based. Special thanks are due to Advocate Assaf Toib, the legal advisor of the Ethics Board, for his faithful help in drafting the first version, and to members of the legal department who helped him, to Prof Zvi Borochovitz and to Dr Carmel...
Definition of the major terms in the report

The following are definitions of major terms used in writing the report:

- **Population** – All individuals associated with a group of persons having a common denominator.
- **Large populations** – Persons associated with a population group that contains a large number of individuals having a common denominator (ethical, medical, or other).
- **Genetic test** – A test of DNA or its products of a person, for the characterization and comparison of DNA sequences or research on the genetic material of the person, in order to locate tendencies to a specific illness or for confirmation of a diagnosis of a genetic illness.
- **Population genetics** – Research on the degree of variation in a group of individuals.
- **Genetic material** – A gene, genetic products or functioning, or analysis of DNA or chromosomes.
- **Genetic research** – Research in which tests are made of a gene, genetic products or functioning, or analysis of DNA or of chromosomes, for the purpose of location or negation of a mutation connected to a genetic illness.
- **Genetic information** – Information obtained as a result of genetic research.
- **Ethnic group** – A group of persons recognized as such on the basis of unique characteristics, such as blood, genealogy, language, culture, or nationality.

The aim of the report

The document is primarily intended to formulate rules of ethical conduct for physicians who participate in genetic research. The report also contains recommendations related to research physicians conducting the research, on one hand, and commercial companies that engage in genetic research on large populations, on the other hand. We are aware that these can only serve as recommendations for the commercial companies, but their acceptance will considerably facilitate cooperation with the medical community and, in the final analysis, will advance genetic research.

The report was written before legal tools for regulation of genetic research on large populations were formulated. We hope that this report will advance the process of formulating normative rules for what is "permitted" and "forbidden" in genetic research and will form a basis for legislation that will lead to regulation of this subject.

The starting points for the recommendations of the committee

The recommendations of the committee are based on the following starting points:

- **a)** The committee recognizes the importance of genetic research and calls on all entities to take steps to advance it.
- **b)** Genetic research in large, specified populations, in contrast to research on individuals, creates a new set of ethical, moral, and legal issues that did not exist until now.
- **c)** Therefore, concomitant with the rapid development of genetic research, we must prepare the ethical and legal tools required for supervision of this research.
d) The committee recognizes the aspiration of commercial companies engaging in research of this kind to enjoy an economic profit, provided that the good of the public is also maintained, including improvement of medicine and medical research.

e) In genetic research conducted on large populations, care must be taken to respect the rights and privacy of the patient or individual being researched, and to avoid the creation of a negative characteristic (stigma) regarding the entire population researched.

f) It is best to conduct genetic research in large populations in cooperation with the medical community and to regard physicians as partners to the research, and not merely the suppliers of samples.

g) The advancement of bio-medical research obligates global cooperation including the transfer of information and samples between various countries. Limitations should be set for the transfer of such information when dealing with information regarding large populations of residents.

General principles

1) Genetic research on humans, like any other research, shall be subject to both the law and the ethical code and shall obligate the receipt of all the obligatory approvals, including approval by the supreme Helsinki committee for genetic trials on humans.

2) The public should be informed about genetic research being conducted on large populations. Such publication will ensure transparency, supervision, and public discussion of the research. Exceptions are those cases in which the very act of publication may harm the entity conducting the research or the population being researched.

3) Residents of the State are not a “national resource” or the “property” of the State, and neither is their blood and the genetic material derived from it. However, the State is a “stakeholder” in genetic information related to its population. This leads to the right of the State to formulate rules for the management of the research and the use made of the genetic information collected.

4) Every publication of the results of genetic research conducted on large populations shall be done with maximum sensitivity in order to prevent negative characterization or stigmatization of the population being researched.

5) For the benefit of overall human knowledge, the publication of the results of the genetic research should be encouraged even if they do not meet the expectations of the researchers or the commercial company conducting the research.

Setting up a statutory entity for genetic research

The committee calls on the State to set up a statutory entity for genetic research whose functions shall be:

1) To approve the execution of genetic research in general and on large populations in particular.

2) To supervise execution of the genetic research, including scientific supervision and
confidentiality of the accumulated information.

3) To formulate the rules for transfer of the overall genetic information and its secondary uses, as a scientific or economic asset, to a third party, including multi-national pharmaceutical companies.

4) To formulate rules for approval of the purchase or merger of a commercial company conducting research with other companies and entities in cases in which there is concern that the genetic information collected will be misused.

5) To specify a period of time for execution of the research, at the end of which the information shall enter the public domain.

6) To formulate rules for saving the genetic information and the blood samples in the event the activities of the researchers or of the commercial company conducting the research cease.

7) To take steps to set up a national DNA bank that will be available to the medical and scientific community in Israel.

8) To verify that blood samples and genetic information will not be destroyed at the end of the research or on dissolution of the company, and that they will be transferred to the national DNA bank in accordance with the rules to be formulated.

9) To verify that if the company conducting the research is purchased during or after the trial by another company, the purchasing company shall assume all the commitments assumed by the first company regarding management of the research and the genetic bank held by it.

Informed consent for medical trials and genetic research

The obligation to receive informed consent for any action connected to or affecting one’s body, or for use to be made of parts of one’s body, including organs, tissues, and blood, is derived from a person’s rights over his body. This obligation applies even more stringently in connection with medical trials and genetic research. Genetic research has broad potential to expose private information about a participant in a trial, his family, offspring, and ethnic group, and even about large populations about which, until now, it was impossible to collect genetic information.

1) As part of the process of obtaining a patient’s informed consent for execution of genetic research, the patient shall be permitted to choose one of two options:

a) The granting of “general consent” – Sweeping consent given for every future research use of a sample taken from the research subject, without the need to return to him to receive repeated consent, provided that every research conducted based on the material collected aims to advance science and medicine. This general consent shall not be given by minors and/or legally incompetent persons and/or their guardians.

b) The granting of “individual consent” – Consent by the person researched for execution of a specific research or trial or in a specified field, so that in the event of expansion of the research or the execution of new research, application must be made again to the person researched in order to obtain his consent for the new
research. Without such renewed consent, no use may be made of the information received and/or of the samples.

2) Clinical trials involving persons lacking legal competence to give informed consent shall be performed only in the absence of alternative research groups. Such a case requires the informed consent of the guardian responsible for the legally incompetent subject. An additional condition for research on legally incompetent groups of people is that the research seeks to advance the health of the "population represented" by such people.

3) Research in large, specified, population groups obligates the entity conducting the research to obtain, in addition to individual consent, also "collective informed consent". This consent may be given by the "natural" leaders of the said group.

4) Informed consent shall also be given for the manner in which the information is stored: as unidentified information or as coded information that may be identified.

The obligation of disclosure by a physician taking part in the trial

1) As part of the process of obtaining informed consent, a physician involved in a clinical trial shall inform the research subject of his degree of involvement in the proposed research. The physician may be involved in the research as follows:
   - Research physician – A physician who actively participates in the execution of the research over its entire length.
   - A physician who participates in the research – A physician who makes an intellectual contribution to the planning of the trial, its execution, and the analysis of its results, but does not accompany the research during all its stages.
   - A physician who is a research agent – A physician who constitutes an "agent", who transfers the genetic sample to a commercial company for the purpose of the research.

2) The research subject shall be informed, in language comprehensible to him, that the research in which a commercial company is involved contains a chance for financial profit by the company.

3) The research subject shall be informed that a research agent receives financial remuneration for his services from the commercial company conducting the research.

4) The research subject shall be informed of the precise aims of the research and its ramifications, if any, on the research subject, his family, offspring, and the population group to which he belongs.

5) The research subject shall be informed if there is intent to transfer the information or samples collected to any third party whatsoever, during or after the trial.

6) The research subject shall be informed of the personal benefit to him and to his family, if any, which will emerge from his participation in the research.

7) The research subject shall be informed at the end of the trial of the results, including drugs or medical technologies developed during the trial. In the case of an unidentified examinee, this shall be done by publication in a daily newspaper.
Medical confidentiality

1) Information regarding a person who participates in a trial may not be furnished to anyone else, including members of his family, unless his express consent has been received:
   • To reveal the very fact of his participation in the research.
   • To reveal the personal results received from the research.

2) A person who participates in a trial shall be informed confidentially by his physician of the results of the research affecting him personally, if this research was done using identified DNA.

3) Both the research subject and members of his family reserve the right not to know the results of the trial and its ramifications on him and on his family.

Expansion of the genetic research

Sometimes the need arises to expand the medical research by adding additional relatives, expanding the use of a sample beyond that agreed in advance, or including an additional research entity in the examination of an existing sample. In such cases, the following actions shall be taken:

1) Any change to the scale or aims of the trial obligates advance approval from the Helsinki committee that approved the original trial.

2) The research subject himself shall appeal to additional relatives where relevant. With the subject’s consent, his physician may do so instead.

3) Expansion of the use of a sample beyond that agreed in advance obligates the receipt of renewed informed consent in those cases in which only “individual”, rather than "general", consent was given.

4) The transfer of information and samples between academic-public research entities is permitted without limitation as long as the information is transferred for the advancement of science only and subject to the consent of the research subject.

5) The transfer of information between commercial entities obligates approval by the supreme Helsinki committee for genetic trials on humans, and, in the future, approval by the statutory authority to be set up for this purpose.

6) The removal of genetic information that originates in large populations, from the State of Israel, shall be permitted only after receipt of approval from the supreme Helsinki committee for genetic trials on humans, and in the future, approval by the statutory authority.

Participation of physicians in the research

1) Physicians who participate in the conducting of the research shall be entitled to access to the information collected in the research.

2) Every physician who participates in the research shall be entitled to conduct a dialog with his colleagues to the research or with the commercial company conducting the research, in which he may put forward proposals and ideas of his own regarding the research.
3) In general, a connection with a physician who is a "physician participating in the research" is preferable to a physician who is a "physician agent".

4) Remuneration for a physician employed in an academic or public institution who participates in the conducting of genetic research shall be given solely by means of the institution employing him. A physician who works privately shall be entitled to receive remuneration for his contribution to the research.

Rights to the genetic information
An increasing part of genetic research focuses on epidemiological genetic research on large populations. This fact has broad significance that goes beyond the level of the individual and may influence a large number of populations up to the level of the State itself. Naturally, research of such magnitude obligates different treatment from that which was customary until now. Consequently:

1) The State is forbidden to trade in genetic samples or genetic information, similar to the prohibition to trade in organs for transplanting.

2) The collection of genetic information and samples within the State is possible thanks to the cooperation of citizens of the State. Although this contribution does not give title to the State, it creates a link to the information.

3) The State has the right to prohibit use of the genetic information and to set limits for its use, including the formulation of rules aimed at protection of populations and groups of individuals.

The fruits of the genetic research
The balance required between the economic interest of the commercial company conducting the research and the welfare of the community obligates the formulation of new rules that will secure both parties.

1) It is proper that the community cooperate with the commercial company conducting the research for advancement of medical research and medicine.

2) The community that contributes the human resources constituting the basis for the genetic information shall be entitled to demand remuneration from the fruits of the research.

3) The remuneration for patients who participated in the trial, except in the case of research in unidentified DNA, shall be as far as possible the supply of free drugs or medical technologies, the products of the research.

4) The remuneration for the general community shall be a financial one, as an agreed proportion of the research budget or its income.

5) Financial remuneration shall be given for advancement of medical research of those medical or research institutions that participated in the trial or for advancement of public health.

6) The economic remuneration for the State shall be stipulated in advance and shall not be on a voluntary basis.
62. Trials on animals
Published in June 2002

Background
The Israeli Medical Association is committed to the advancement of medicine and medical research for the welfare of Israeli society. Medical and scientific research is conducted in part by means of trials on animals. This is necessary in order to understand the biological mechanisms operating in the human body. It is also necessary to test the effectiveness and safety of new medical technologies on animals before their implementation in humans. Furthermore, such trials are required for teaching and qualification in medical studies.

Restriction of scientific and medical research based on animal trials, beyond that currently specified in the law, will harm the development of medicine and will prevent the public in Israel from receiving advanced medical treatment.

Research on animals arouses opposition on the part of organizations acting on behalf of animal rights. This opposition is understandable and must be taken into account, and the proper balance struck between such opposition and the needs of medicine and science and the good of the human race.

Position paper
- Trials on animals are essential for the advancement of medicine and for the good of the human race.
- Consequently, the Israeli Medical Association supports these trials.
- Trials on animals shall only be done within the framework of the existing law (Cruelty to Animals Law, 5754-1994), as enacted from time to time.
- Trials on animals shall be conducted only in the absence of a suitable alternative.
- Trials on animals shall be conducted after approval from the competent authorities.
- In every trial, use shall be made of the minimum possible number of animals. The animals chosen should be drawn from the lowest developmental level that would allow the conducting of the trial.
- In every trial, effort shall be made to minimize the suffering caused to the animals during and following the trial.
- Every trial on animals shall be done in accordance with the accepted international standards (NIH/ NRC and/or regulations of the national council for trials on animals).
- Steps should be taken to explain the position of the Israeli Medical Association and the medical community, to increase the cooperation and consent of the general public, and to prevent additional restrictive legislation.
63. Ethical rules in scientific publications
Published in January 2006

Background
The public recently became aware of an unfortunate and embarrassing case in which a research article was accepted for publication despite the fact that the research had apparently never been conducted. When the authors of the article were asked to take assume responsibility for its contents, one of the authors, a department head, replied that he did not know what they were talking about. According to him, while standing in the lobby during a professional conference, he gave his written and signed consent to the publication without bothering to check to what he was committing himself and without actually taking any part in the work. This was the sad climax of a sorry, ongoing reality that is further reflected in complaints received by the Ethics Board, whereby the list of authors of scientific articles does not always reflect their actual contribution. This is an expression of the tradition in which the department head is always regarded as the author of an article in any work published from his department, even if he took no part in it.

The editors of leading medical journals throughout the world are now conducting a very important campaign intended to preserve public trust in the scientific truth published in these journals. The boundaries of the struggle go beyond the framework of this position paper, but in order to protect the status of medicine in Israel, we saw fit to reiterate to physicians in Israel what is and what is not proper in scientific publication.

I would like to thank the members of the subcommittee of the Ethics Board, Dr. Tami Karni (chairman), Dr. Elinor Goshen, Dr. Danny Harduf, Dr. Baruch Chen, and Prof. Adi Shani, who drafted and wrote the first version of this document.

a) General introduction
All those who engage in scientific and medical research are obligated to absolute intellectual integrity. This integrity is intended to preserve the rectitude of the research and its professional standard on the one hand, and to preserve the trust of the public in the scientific information published, on the other hand.

This basic obligation has made the status of an author in a scientific publication in the current culture especially sensitive. The status of “author” has become a major tool by means of which the researcher’s professional and academic capability is judged. The number of articles published currently determines the status of the researcher in the scientific medical community to which he belongs, serves as a major tool in his progress up the university ladder, and constitutes virtually the sole measurement tool for awarding research grants and the salary derived from them.

The change that has taken place in the current nature of research, which obligates cooperation between large and numerous research groups, has also led to numerous difficulties in determination of the location of each “author” in the long list of names of all the participants in the research.

The status of an “author” is not a gift from heaven. It expresses scientific and social
responsibility that the author takes upon himself. Besides the professional credit and the social recognition, this status also contains a commitment to take responsibility when things don’t work out properly, such as when the information furnished transpires to be incorrect; when the findings cannot be repeated; or when the conclusions presented are found to be exaggerated and unsubstantiated. Consequently, the status of “author” grants great honor together with great responsibility. Medical research requires tremendous investments, most of which come from the pharmaceutical industry. This industry has its own agenda that does not necessarily correspond to that of the research physician. In this bitter reality, several cases have unfortunately been recorded in which commercial and economic considerations of the entity financing the research have taken precedence over the scientific truth, and have led to the distortion or concealment of medical information from the public, so as to serve the needs of the financing entity. An urgent need has arisen to redefine the reciprocal relations between the medical academia and the pharmaceutical industry, so as to preserve the academic freedom of the researcher.

The ethical code appearing in this document is intended to solve some of the problems. This is not a complete document and it addresses a limited number of subjects related to medical articles. In our opinion, it will be necessary to complete and revise it in the future, and to adapt it to the changing reality.

We suggest that all the readers examine the appendix “Uniform instructions for the publication of articles in bio-medical journals”. This important document was first published by a group of editors of bio-medical journals originally called “the Vancouver Group”, which, over the course of time, became the international committee of bio-medical journals editors (ICMJE). In recent years, this committee has published a number of revisions to its basic document. The latest version, written in October 2004, appears on the website: www.icmje.org.

b) Authors of a scientific-medical article

The definition of an ”author” of a medical article is now clear, and has been well defined by the international committee of bio-medical journals (ICMJE).

According to this definition, a person shall be regarded as an ”author” if he meets the following conditions:

1) He made a real contribution to the conception or planning of the basic idea on which the research is based, to analysis of the results or to the giving of significance to or interpretation of these results.

2) He wrote the article or introduced material changes into it, while adding new, genuine intellectual content.

3) He gave final approval of the article for publication.

4) In cases of multi-center research with a large number of researchers, the researchers must choose from amongst themselves those directly responsible for the published work. These researchers must themselves meet the definition of “author” in accordance with the aforesaid agreed criteria.

5) The mere provision of financial support, the simple collection of information or samples, or “general supervision”, do not themselves award the right to the status of
“author”.

6) Each of the authors of an article must be a real participant in a substantial part of the research, so that he can face up to criticism by his professional colleagues and by the public of material parts of the scientific publication.

These rules clarify that the status of an “author” cannot be a gift or honor awarded to a specific person by virtue of his position only. For example, it is improper to offer the status of “author” to a department head only because he is the head, if he made no material contribution to the research as set forth above.

The order of appearance of the authors in the research article must be determined in advance and with the agreement of all the researchers. It is customary that the author whose contribution to the research was the greatest and most decisive should appear at the head of the list. Next will appear the author whose contribution was second in value, and so on. It is customary that the last author in the list is the senior researcher, in whose laboratory or under whose direct supervision the research work was conducted. The last author of the article must also meet the criteria of “author” as set forth above. The status of the last author must not be awarded as a gift or honor for the said person.

1) Every author must carefully read the entire article, before its publication, and agree both with the form and contents of his own part and with the parts of the other authors.

2) No article shall be sent for publication without the criticism and agreement of all the authors.

3) Every author is personally responsible for the contents and conclusions of the entire article. Every author must be prepared to defend the contents of the article published in his name, including both his part and that of his colleagues in the article.

4) All other participants in the work, whose contribution to it does not reach the level of “author”, shall be referred to separately in the acknowledgements.

5) The authors shall briefly indicate the contribution of each author on a special form, to be attached to the article at the time of its submission to the editors of the journal. This shall appear in a footnote to the article.

6) No researcher shall permit his name to appear as the author of an article unless he meets the required conditions as set forth above.

c) Duplicate (redundant) and salami publications

- Duplicate publication – the repeated publication of an article, which clearly overlaps a previous article already published. Such overlapping may occur when there is a clear-cut resemblance to the fundamental hypothesis on which the research is based, the characterization of the sample, the identity of the patients, the research methods, the results of the research or its conclusions.

- Salami publication – the slicing up of data received from a single research and dispersing them in several different journals or on different dates, with the intention of increasing the number of articles.

Duplicate and salami publications damage and distort scientific truth and are consequently prohibited.
The damage caused by these publications is very great. It is sufficient to cite the waste of resources caused by publication at the expense of other original articles, the waste of time of the reviewers of these articles and the creation of an artificial load of information that has no proper purpose. It is also important to note that duplicate publication is liable to lead to medical bias in meta-analysis of evidence-based medicine. Furthermore, publications of this kind frequently involve legal problems of the copyright theft. Worst of all, such articles permit misguided academic advancement because of apparent “achievements”.

The authors shall declare that the article submitted for publication is original and has not been submitted in parallel for publication in another journal, and that the relevant information has not already been published somewhere else.

Duplicate or salami publication is permitted in the following cases:
In large-scale epidemiological or clinical research, whose results cannot be published at that time, or that address difficult research questions.
In a previous publication of the research as part of an abstract submitted for a scientific conference, provided that the editor of the journal is aware of the previous publication.
In a duplicate publication in different languages intended for different readers and with the knowledge of the editors.

d) Conflict of interests

The trust of the medical community in particular and of the wider public in general regarding the truthfulness of medical research obligates transparency and clear knowledge that the information published is free of any overt or covert bias, and that those who conducted the research were free of any conflict of interests.

A conflict of interests exists when the “author” of the article, the institution in which he works, or the “reviewer” of the article have personal interests liable to influence the results of their scientific work. Such a conflict of interests is also liable to exist when the “author” or the “reviewer” are convinced that such a conflict of interests will not influence their capability of scientific judgment.

Reciprocal financial relations are the major reason for a conflict of interests in medical research. This includes employer-employee relations, especially in the case of a pharmaceutical or hi-tech company, which holds shares or securities of a commercial company that has an interest in the results of the research, the receipt of “consulting fees” or financial remuneration for lectures made on behalf of the said commercial entity involved in the research, etc.

A conflict of interests is also liable to exist in other circumstances, including the existence of personal relations with other researchers, academic competition, and intense emotional involvement in the research.

The absence of integrity and transparency in the medical information published will necessarily lead to lack of trust towards the researchers, the journal publishing the article, and medicine in general.

Consequently, every researcher who publishes a medical article must fully and honestly reveal and expose every possible conflict of interests that may influence his judgment. This directive...
applies both to reviewers of medical articles and to the writers of editorials in medical journals.

**e) The academic independence of the researcher**

A significant part of medical research is currently conducted with the direct financing of commercial companies. This form of financing has a dangerous potential to bias the results of the research in accordance with the economic interests of the entity financing the research. In order to preserve the academic independence of the medical research and its status in the eyes of the general public, the ICMJE has recently issued stricter instructions, according to which the researchers must avoid signing research contracts which contain any restriction whatsoever regarding the absolute freedom of the researchers when conducting the research. In accordance with the new instructions, every researcher who contacts a journal with a request to publish research must declare that he had full access to all the information collected in the research. In addition, he must declare that he was able to independently process the information collected, that he was given full freedom to write and publish the article, even if its results do not fulfill the expectations of the entity financing the research and that he bears personal responsibility for the accuracy of the information published. The head researcher is also required to specify the part of the entity financing the research, if any, in these processes. This declaration by the researcher regarding full academic freedom is now routinely required in every article submitted for publication, together with a declaration regarding a possible conflict of interests, as set forth above.

In order to prevent concealment from the public of "negative" medical information for the entity financing the research, the editors of the journals decided that beginning July 2005, prior registration of every clinical trial would be required as a necessary condition for its publication in the future. Registration shall be done via a digital website, accessible to the public at no charge. The website shall contain, inter alia, information related to the identity of the illness that forms the basis for the research, the nature of the treatment being tested, and the aims, scope, and identity of the commercial entity financing the trial. The address of the website in Israel is www.clinicaltrials.gov.il.

In September 2005, the Ministry of Health published a Director-General circular that lists the instructions for registration of medical trials in the database. The researchers must comply with these instructions.

**f) Afterword**

Researchers should constantly be cognizant of the great responsibility they bear. They must remember that their fellow physicians who read the article before treating patients will use their work. Consequently, they are obligated to write every word, to consider every sentence, with the maximum possible caution and with the same degree of concern and caution as if they themselves were treating a patient at that very same moment. With that same ethical commitment, they must fulfill this important duty with full scientific accuracy, and with intellectual and personal integrity.
64. **Sex selection using in vitro fertilization**

**Background**

Medical technology is advancing so rapidly that a gap is repeatedly created between the astonishing capabilities it places at our disposal and the public opinion regarding their use. It is enough to recall the tremendous uproar and penetrating debate that arose in Israel and throughout the world around the birth of the cloned sheep, Dolly. Suddenly there arose a primeval fear of a future, Orwellian world, in which cloned humanoids fill the streets.

The human race touched the Creator’s throne on one hand, and was filled with awe and fear on the other. It is not surprising that many societies, including Israel, hurriedly protected themselves with legislation intended to halt this frightening vision, even if fundamentally unsubstantiated.

We must now address an apparently “easier” issue, without intervention in the first act of creation, but “only” the pre-determination, by order, of the sex of the newborn. The technology of pre-implantation genetic diagnosis is already available in several medical centers in Israel. Is it permissible? Should we permit specialists to act freely in accordance with their professional capability, when by doing so we cross fundamental values of human society?

It is appropriate to clarify that the technology for determination of the sex of the newborn has been implemented for several years, with broad social agreement, in order to prevent genetic illnesses that exist in linkage with the sex chromosome. Any deviation from this reduced policy is liable to lead us to distant lands such as those of China and India, where fetuses are killed in the first months of pregnancy, after their sex is known, for economic or social reasons, crudely disrupting the demographic balance in those countries.

The Ministry of Health has recently published instructions that permit the selection of the sex of the newborn, for non-medical reasons. In accordance with these rules, permission is given only to married couples who have four joint children of the same sex and for whom the birth of an additional child of the same sex will constitute for them an insufferable mental burden that may cause “material and significant harm to their mental health”.

In the debate held in the Ethics Board, the fundamental values of freedom of the individual and his natural right to determine how his life should be conducted vis-a-vis the good of society in general, and the fundamental values on which it is based, were discussed. In this fine balance, the members of the Ethics Board decided, similar to the ethical positions of large medical organizations in the western world, that the selection of the sex of the newborn is ethically permissible for medical reasons only. However, the members of the Ethics Board saw fit to limit this decision, exceptionally, to a fixed period of time of five years, at the end of which time, the position shall be brought for renewed discussion.

**Position paper**

- The rapid advancement of medical technologies obligates constant re-evaluation of the fundamental values of society.
• Pre-implantation genetic diagnosis currently permits the determination of the sex of the fetus and the diagnosis of genetic illnesses.
• In vitro fertilization done for genetic diagnosis exposes the woman to medical treatments that involve suffering and risk to health, and should therefore be used for appropriate purposes only.
• The selection of the sex of the fetus in in vitro fertilization when done for social, economic, or religious reasons is improper, and is consequently ethically wrong.
• This decision is limited to a period of five years. At the end of this time, it will be necessary to re-evaluate the medical capabilities of determination of the sex of the newborn, the long-term influences of this technology on the baby, and the positions of society and of the legislator in this matter.

65. Intellectual property in the health system

Taken from the position paper of the Israeli Medical Association referring to the report of the inter-ministerial steering committee for regulation of intellectual property in government ministries, dated December 2006

Background
The report of the inter-ministerial steering committee for regulation of intellectual property in government ministries (appointed by the comptroller general in the Ministry of Finance in 2003) was published in December 2006. The committee decided to first address the major services in the government in which there is relatively high potential for the creation of intellectual property. The committee set up a sub-committee for matters related to the health care system in order to formulate principles for taking advantage of the byproducts of knowledge in government hospitals.

An examination of committee recommendations shows that the main player in the system managing intellectual property in government hospitals is none other than the research physician. It is clear that the intellectual property that the State wishes to regulate and commercialize is created by the efforts of the physician. Under these circumstances, a considerable part of the committee recommendations address physicians alone. The Israeli Medical Association has found that the recommendations of the committee significantly harm those physicians who engage in applied research, and some even worsen the working conditions of the physicians. Consequently, the Israeli Medical Association drafted its reservations about the report in its position paper. The following are some of the major failures that emerge from the report, and the position of the Israeli Medical Association regarding them.

The importance and contribution of medical research being conducted in the hospitals
The recommendations of the committee express the fear that encouragement of research in the hospitals will harm the current treatment of patients, or that advancement of applied research will be done at the expense of basic research routinely conducted in the hospitals. The position of the Israeli Medical Association is that this assumption is mistaken, since experience shows that not only is there no basis for the fear indicated by the committee, but that medical treatment and medical research are intertwined. It is well known that hospitals in which medical
research is conducted are those that provide the public with more advanced and higher quality treatments than hospitals in which such research is not conducted.
In addition, it is impossible to separate basic research and applied research. Such separation is anachronistic, incorrect, and inapplicable. Furthermore, applied research can be integrated in the medical treatment of the physician, and develops as a result of the interaction between the physician and his patient.

**The royalties system for research physicians proposed in the report**
The royalties system for research physicians proposed in the report is discriminatory, unreasonable, superficial, and inefficient. The proposed mechanism is a sliding scale in which the rate of royalties to which the research team is entitled decreases with increased income from commercialization of the invention. In accordance with the proposed model, the researcher is entitled to 40% when the income per invention reaches up to NIS 1 million; 25% when the income per invention lies between NIS 1 million and NIS 10 million; 15% when the income per invention lies between NIS 10 million and NIS 20 million; 2% when the income per invention lies between NIS 20 million and NIS 50 million; and 0% (!!!) when the income per invention is more than NIS 50 million. This royalties mechanism discriminates against physicians engaging in research who are state employees, both relative to their colleagues who engage in research in other hospitals and research institutions, and relative to their colleagues who engage in research in academic research institutions.
The proposed royalties mechanism does not award physicians proper remuneration and does not meet the requirements for "reasonable consideration", as set forth in section 135 of the Patents Law, which specifies criteria for the exercise of judgment by the committee for compensation and royalties regarding the consideration due the inventor.
The proposed mechanism is superficial – it does not refer to the number of researchers involved in the research, and there are no rules regarding the proportional division of the consideration between the researchers. In addition, the mechanism is inefficient since in many cases physicians also engage in research in academic institutions in Israel and abroad. A discriminatory and inefficient mechanism will lead to a loss of knowledge and to a brain drain from institutions owned by the State.
The proposed arrangement is liable to cause a physician who wishes to engage, among other pursuits, in research, to prefer to be employed in a hospital that is not owned by the State, because of the discriminatory mechanism. In addition, the arrangement is unreasonable since it is incompatible with the arrangements customary in research institutions abroad.
The artificial separation between the research activities and the activities of the physician in the hospital harm the working conditions of the physicians:
The report specifies rules that apply to a physician employed by the State who engages in applied research. A physician who engages in applied research during his working hours in the hospital shall do so as part of the health corporation and shall be regarded as an employee of the corporation. The worker shall be obligated to clock in as a condition for the receipt of remuneration; the scale of his position in the hospital will be decreased accordingly, as will his salary and social benefits.
The position of the Israeli Medical Association is that this constitutes a significant worsening of the working conditions of the physicians – a part time basis of employment will lead to the loss of salary components given only to a physician working full time. The decision to oblige clocking in is also offensive, cannot be implemented in the profession of medicine and constitutes a blow to the prestige of the profession – professionals of a corresponding status and level are not required to clock in, nor is this customary in other places throughout the world. Clocking in will not increase the productivity of the physician, but will simply increase the cost of his work.

**The question of the ownership of intellectual property created in government hospitals**
The proposed arrangement states that ownership of the products of intellectual property created in government hospitals and in the health corporation will lie with the State. The Israeli Medical Association opposes this ruling and has proposed that ownership should remain with the corporation, with the right for parallel use by the State.

**Waiver by the State of ownership of the invention for the benefit of the researcher**
The report states that when the State is not interested in commercialization of the invention and permits the researcher to commercialize it by himself, the researcher will still be obligated to transfer to the corporation, to the hospital, and to the State, half of the income that would be due them without the waiver. The Israeli Medical Association argued that this is a clearly unreasonable condition.

**Negative incentives for third parties**
The report specifies barriers against commercial companies investing in applied research. The position of the Israeli Medical Association was that in such a situation no commercial company will be prepared to invest in research.

**Prohibition of a physician to consult for a company investing in research**
The report prohibits a physician to consult for a company investing in research. In most cases a company investing in research requires close accompaniment by a researcher during the stages of commercialization of an invention formulated during applied research. The prohibition in the report constitutes disproportional harm to the freedom of occupation, and a significant barrier against companies to invest in government hospitals because of the inability to receive professional consulting.

**66. Medical data mining: risks and precautions**
Published in September 2008

**Background**
The “prescription behavior” of the physician – the decision according to which the physician chooses and prescribes a drug for the patient – has valuable economic significance for pharmaceutical companies. These are unable to market drugs directly to the “consumer” – the patient – and for this purpose they need the professional services of the physician as their “sales representative”.

In the US and Canada, a sophisticated information industry has developed, which sells to the
pharmaceutical companies detailed information acquired from computerized monitoring in thousands of pharmacies, of tens of millions of medical prescriptions that may be linked to individual physicians. The pharmaceutical companies thus collect in a very efficient and sophisticated manner detailed information regarding the medical prescriptions given by the physicians, the great majority of whom are unaware that they are subject to such professional monitoring.

The information supplied to the pharmaceutical companies is liable to expose the physicians to sophisticated means of marketing. When the physician meets with the sales representative of a large pharmaceutical company, the latter possesses detailed information regarding the preferred drugs of the physician. In this way, he can give a “reward” or “punishment”, depending on the condition of the physician and on the economic interests of the pharmaceutical company.

Surveys conducted in Canada and in the US amongst physicians have indicated that most of them are unaware of the acquisition of the information. Most of them have expressed strong opposition to continuation of the monitoring, and have even expressed fears that this phenomenon is liable to harm the academic freedom and purity of the professional considerations of the physicians. The fear has also been raised that medical decisions that are modified following pressure on the part of the pharmaceutical companies are liable to harm the quality of the treatment given to the patients and to cause artificial cost increases in management of the national health systems. Consequently, it is not surprising that in some states in the US and Canada, laws have been passed that prohibit individual monitoring of the prescription behavior of physicians.

IMS Health, a world leader in medical data mining, also operates in Israel and collects information in Israel for the pharmaceutical industry. The CEO of the company in Israel, Mr Benny Daniel, participated in a debate on this subject held by the Ethics Board and explained to its members (and subsequently undertook in writing) that the company is active in the private market only (not in the pharmacies of the health care organizations). In addition, Mr Daniel explained that the company only acquires “aggregated information” and does not acquire individual information regarding single physicians. In this way, he maintains, both the privacy of the individual patient and the privacy and the professional independence of the physician are preserved. We accept this notice and believe that IMS Health Israel will continue to act in this way in the future.

Parenthetically, although not less importantly, it should be recalled that the physician’s “prescription behavior” is a fixed target of the health care organizations. The latter maintain overt, permanent, and computerized monitoring of their physicians. The interest of the health care organization is the opposite of that of the pharmaceuticals company. The health care organization attempts to influence the physician to use the cheapest drugs, generally of a generic or less innovative type, all in order to keep within their limited budgets. However, a separate debate should be held on this and on the issue of the ownership of the medical information in the reciprocal relations between the health care organization and the individual physician.

**Position paper**

- The collection of information regarding the use of various drugs is likely to aid in
the planning and operation of the medical economy, and this is the reason for its importance.

- Information should be collected only in a sample, unidentified way that preserves the privacy and autonomy of both the individual patient and the individual physician.
- Information may be collected from an individual physician only after his informed consent has been received in advance and in writing, including details of the information collected, the aim of the collection and the identity of the entity using this information. Such consent shall be given for a specified period of time only.
- No use should be made of the data collected for the purpose of applying pressure of any kind whatsoever, overt or covert, on the physician, with the intention of changing his prescription behavior.

67. The joint ethical convention of the Israeli Medical Association and the pharmaceutical companies operating in Israel

(from the joint ethical convention published in March 2014)

Members of the steering committee:

Pharmaceutical companies:
Manufacturers Association of Israel: Iris Orad, Anat Savion, Carmel Feldman Abutbul, Dr. Roni Shiloh

Federation of Israeli Chambers of Commerce:
Hana Leidershaider

A. DEFINITIONS
1. Scientific association: A group of physicians in a medical branch recognized as a specialty in accordance with the Physicians’ Regulations (Approval of Specialist Title and Examinations), 5733-1973, who have incorporated for the sake of scientific work and advancing the interests of the medical branch.

2. Scientific society: A group of physicians from at least two different specialty fields, who have incorporated as an independent interdisciplinary society, or a group of physicians from a certain specialty field, who engage in a segment of the specialty branch, and have incorporated as an “association society” under the auspices of the relevant scientific
association for the field of practice of the society and that bears within its name the name of the association to which it belongs.

3. **Workgroup:** A research group or a work group of physicians who are all members of a certain association, who have a defined field of interest within the specialty of the parent association, which they seek to advance. Wherever “the association” is written, the intention for the sake of simplicity is “the scientific association” and/or “the scientific society” and/or “the scientific workgroup”.

4. **Pharmaceutical company:** Any commercial company principally engaged in the development, production, marketing, sale and distribution of pharmaceuticals, medical accessories, medical equipment, complementary products and new medical technologies.

5. **Medicinal product:** A pharmaceutical or biotechnological or other medicinal product marketed by a pharmaceutical company, whether prescription or over the counter (OTC), primarily intended for use following a recommendation or subject to the supervision of a professional in the field of medicine, for the purpose of diagnosis, treatment or prevention of disease, or in order to improve the quality of life of the patient population.

**B. GENERAL PRINCIPLES**

1. The physician may maintain a proper professional relationship with a pharmaceutical company for the purpose of advancing medicine and science.

2. A physician who is in a relationship with a pharmaceutical company shall adhere to his primary obligation to the patient and shall avoid any situation that entails a conflict of interest which undermines this commitment. A physician who identifies a situation of conflict of interest between the pharmaceutical company and a patient shall act with full transparency for the benefit of the patient.

3. The physician shall maintain his professional independence and integrity in any contact with the pharmaceutical company and shall not compromise them on account of any foreign interest.

4. The physician shall disclose any relationship with a pharmaceutical company, whenever it may appear that it could influence his professional views or opinions.

5. The signatories to this covenant undertake to work to assimilate and implement it among the physician community and those employed by the pharmaceutical companies.

**C. CONFERENCES AND CONTINUING EDUCATION PROGRAMS**

**SCIENTIFIC CONFERENCE IN ISRAEL INITIATED BY AN ASSOCIATION:**

1. **SELECTION AND INVITATION OF THE PHYSICIANS PARTICIPATING IN A SCIENTIFIC CONFERENCE:**
   a. The association shall be responsible for the selection and invitation of physicians participating in a scientific conference. The pharmaceutical company shall not select or invite the physicians to the scientific conference, whether personally or through a third party.
   b. Physicians invited to a scientific conference shall be selected according to predetermined criteria published among the members of the association. Insofar
as there is a dedicated entity appointed for this purpose within the association, the invited physicians shall be selected by this entity.

2. **THE PROFESSIONAL – ACADEMIC CONTENT PRESENTED AT A SCIENTIFIC CONFERENCE:**
   a. The content presented at a scientific conference shall deal with professional medical-scientific topics.
   b. The professional content at a scientific conference shall be determined by the association and not by the pharmaceutical company, thus maintaining academic freedom.
   c. The professional content at a scientific conference shall be presented in a balanced and candid manner, without any influence or bias in favor of interests that serve the pharmaceutical company. The content shall be subject to rules requiring transparency and full disclosure. Insofar as there is any connection between the professional content and the pharmaceutical company, it shall be noted in the scientific program as well as at the beginning of the lecture.

3. **THE LECTURERS AT A SCIENTIFIC CONFERENCE:**
   a. The decision regarding the identity of the lecturers and the content of the lectures at a scientific conference shall be the responsibility of the association and not the pharmaceutical company.
   b. The lecturer at a scientific conference shall be allowed to receive, and the pharmaceutical company shall be allowed to give, fair and reasonable payment in consideration of his lecture and he shall be allowed to receive reimbursement in respect of his personal expenses. No reimbursement shall be given in respect of the expenses of a person accompanying the physician.
   c. A physician who lectures at a scientific conference shall present his lecture in a professional, balanced and considered manner and with academic integrity.
   d. A physician lecturing at a scientific conference, who presents a medicinal product, medical technology or medical equipment, shall make certain to mention the relevant regulatory situation of the object of the lecture, including its registration in the register of medicinal products, indications for its use, warnings and restrictions. In addition, he shall make certain to present its advantages and disadvantages, as well as the available alternatives with their advantages and disadvantages.
   e. A physician lecturing at a scientific conference shall be obligated to act with transparency and to adhere to full disclosure. Insofar as the lecturing physician has a connection of any kind whatsoever to the pharmaceutical company, directly or indirectly related to the topic or to the content of his lecture, he shall make certain to mention this at the beginning of his lecturer in a clear and forthright manner, including the type of connection and the name of the relevant pharmaceutical company.

4. **PAYMENT FOR PARTICIPATION IN A SCIENTIFIC CONFERENCE:**
   a. A physician participating in a scientific conference or his employer shall remit payment in respect of the cost of participation to the association initiating the conference or to
the conference company operating on its behalf. The pharmaceutical company shall not be a party to this matter.

b. Participants of a professional conference that includes lodging and/or social activity shall be required to personally bear part of the accommodation costs, including lodging and catering. The association shall be allowed to set the participation amount according to its discretion and/or to exempt certain groups for special reasons to be recorded.

5. ACCOMPANYING PERSONS:
An individual accompanying the physician, who is also participating in a scientific conference, shall pay the full supplement required to cover the cost of his participation in the conference.

6. VENUE FOR HOLDING THE CONFERENCE:
Conferences and continuing education programs shall be held at venues appropriate for hosting a professional conference.

7. SPONSORING A SCIENTIFIC CONFERENCE:
   a. A one-day conference, which does not include lodging, may be carried out under the sponsorship of only one pharmaceutical company. An association seeking to hold a scientific conference that is not one day and includes lodging under the sponsorship of a pharmaceutical company shall be required to obtain financial sponsorship from more than one pharmaceutical company. Accordingly, a pharmaceutical company shall not provide exclusive sponsorship, without sponsorship of another company, to a scientific conference that includes lodging.
   b. A pharmaceutical company’s financial sponsorship of a scientific conference shall be earmarked for the sole purpose of holding the conference and for the scientific – professional content of the conference and not for other purposes.
   c. Insofar as excess amounts remain from the sponsorship money, which were not used for the benefit of the scientific conference, they shall remain in the association’s treasury and shall be used to advance its professional aims. These amounts shall be presented transparently in the association’s balance sheet and on the website of the IMA (Israel Medical Association).

8. DISPLAY STAND:
An association shall be allowed to permit a pharmaceutical company that provides sponsorship for the scientific convention to distribute printed material, designed to further knowledge or professional training, among the physicians participating in the convention. This shall be done in a dignified and appropriate manner befitting the presentation of scientific material. Accordingly, the sponsoring pharmaceutical company shall be allowed to distribute material intended for the physicians participating in the conference only if this material is designed to further knowledge or professional training, including brochures, medical articles and research findings, whether through a display stand or in another manner. This shall be done in a dignified and appropriate manner that befits the presentation of scientific material.
9. **A NON-ACADEMIC PROGRAM WITHIN THE FRAMEWORK OF HOLDING A SCIENTIFIC CONFERENCE:**
   a. The association may incorporate into the conference activity of a cultural nature that is not medical-professional, as long as it is modest and appropriate, not ostentatious and constitutes only a marginal part of the professional program of the conference.
   b. A pharmaceutical company shall not sponsor social or cultural activity in the course of a conference.

10. **REPORTING:**
   a. The association shall be responsible for devising transparent criteria with respect to the selection of physicians invited to the conference and for forwarding a report to IMA on the event and the criteria for selecting the physicians.
   b. The report shall be made by e-mail notification to the IMA Ethics Bureau. This report shall include the name of the initiator of the conference, the name of the sponsoring pharmaceutical company or companies, the venue of the event, the content and the itinerary of the event, the names of the lecturers and the manner of payment to the lecturers, the date of the event, as well as the criteria for selecting the participating physicians.

**A SCIENTIFIC CONFERENCE IN ISRAEL INITIATED AND FUNDED BY A PHARMACEUTICAL COMPANY**

1. **DEFINITION**
   For the purpose of this chapter, a "scientific conference" shall be deemed a conference to which at least 30 physicians are invited or a conference held outside a medical institution.

2. **SELECTION AND INVITATION OF PHYSICIANS PARTICIPATING IN A SCIENTIFIC CONFERENCE**
   The pharmaceutical company shall forward, in advance and in writing, the criteria for selecting the invitees, together with a general program of the conference, for the information of the associations to which the invited physicians belong.

3. **THE PROFESSIONAL CONTENT:**
   a. A physician shall participate in a conference organized at the initiative and with the funding of a pharmaceutical company, when the topic of the conference is medical-professional. Accordingly, a pharmaceutical company shall not organize a conference whose content is not medical-professional.
   b. A pharmaceutical company initiating and funding a conference shall not include entertainment performances therein, other than modest and marginal cultural activity. Accordingly, a physician shall not participate in a conference initiated by a pharmaceutical company if this conference includes entertainment performances.

4. **LECTURERS**
   A lecturing physician at a conference organized at the initiative of a pharmaceutical company shall be subject to all the rules as set forth in clauses 13 (c) – (e) above.
5. **TRANSPARENCY AND FULL DISCLOSURE:**
   a. A physician shall participate in a conference organized at the initiative and with the funding of a pharmaceutical company only if the rules of transparency are observed. The pharmaceutical company shall clearly state that this is a conference it is organizing, both on the invitation to the conference and during the course of the conference itself.
   b. A physician shall participate in a conference initiated and funded by a single pharmaceutical company only if the conference is one day and does not include lodging. Accordingly, a pharmaceutical company initiating a conference on its own behalf shall not include lodging as part of the conference.

6. **ACCOMPANYING PERSONS:**
   a. A pharmaceutical company may invite physicians only, without accompanying persons, to a conference in Israel that it organizes and funds.
   b. A pharmaceutical company shall not fund any expense whatsoever related to the participation of a physician’s accompanying person in professional events that have been organized at its initiative.

7. **PROFESSIONAL MEETING OF A PHYSICIAN WITH A PHARMACEUTICAL COMPANY REPRESENTATIVE FUNDED BY THE PHARMACEUTICAL COMPANY**

   A pharmaceutical company shall not host a physician at a restaurant or at entertainment venues at its expense, unless the entertainment is modest and not ostentatious and is marginal and incidental to giving a lecture or the discussion of significant professional content. Accordingly, a physician shall not agree to participate in an event that includes hosting at a restaurant or at entertainment venues, unless the hosting is marginal and incidental to giving a lecture or the discussion of significant professional content.

**CONFERENCES AND CONTINUING EDUCATION PROGRAMS ABROAD FUNDED BY A PHARMACEUTICAL COMPANY**

1. The invitation of a physician by a pharmaceutical company to participate in a conference or professional continuing education program abroad shall be made through the relevant association or by the employer. The selection of the invited physicians shall be done according to agreed upon, transparent criteria. The pharmaceutical company shall not invite the physician directly.
2. The physician, through the association or the employer, may receive, and the pharmaceutical company may give, partial or full reimbursement of his actual expenses in connection with travel and participation in the conference or in the continuing education program.
3. The physician may not receive funding or the equivalent and the pharmaceutical company is not allowed to fund any activity not directly related to the conference.
4. If dinners are not included in the conference program, a pharmaceutical company may host a medical team at its expense at a restaurant or at entertainment venues, provided that this hosting is modest and not ostentatious.
5. A physician lecturing at a conference abroad shall be subject to all the rules applicable to the lecturing physician at a conference in Israel, including observance of the rules of full disclosure and transparency whenever he has any connection to the pharmaceutical company.

6. ACCOMPANYING PERSONS:
   a. A pharmaceutical company may invite physicians only, without accompanying persons, to a conference abroad organized and funded by it.
   b. A pharmaceutical company shall not fund any expense whatsoever related to the participation of a physician's accompanying person in professional events organized at its initiative.

D. CLINICAL STUDIES

PHYSICIAN PARTICIPATION IN A CLINICAL STUDY FUNDED BY A PHARMACEUTICAL COMPANY

1. The physician shall act with professional discretion and shall put the best interests of the study participant above any other interest.

2. The physician shall take part in conducting a clinical study funded or in some way supported by a pharmaceutical company only if there is an adequate scientific basis for the study. Accordingly, the pharmaceutical company shall not support a clinical study without an adequate scientific basis.

3. The physician shall take part in a clinical study only if the informed consent of the participants has been obtained as required and provided that maximum protection of the participants' rights is guaranteed, including protection of their medical confidentiality and their privacy.

4. The physician shall only take part in a study, including one at the phase IV stage, if all the approvals required have been obtained, including written verification of the commercial relationship, containing the financial consideration that the pharmaceutical company shall pay to the medical institution / association / scientific society, as well as all the requisite regulatory and statutory approvals, including approvals of the competent ethical committee (such as a Helsinki Committee). The written communication shall detail for what the financial consideration is being given.

5. The physician shall take part in a study only if the study has been registered in advance on a publicly accessible public website, insofar as such registration is required.

6. A physician who is not involved in conducting or performing the study shall not receive, and the pharmaceutical company shall not remit to him, payment for the mere referral of patients for the study.

7. The pharmaceutical company shall be responsible for ensuring that the post marketing surveillance studies (phase IV) are conducted on a scientific or professional basis. These studies should not be conducted when the scientific or professional background is scant or absent altogether and the study is designed only as a means to promote the sale of the medicinal product and in order to influence physicians.
ACADEMIC INDEPENDENCE AND TRANSPARENCY IN RESEARCH

1. The physician shall not take part in research if his complete academic freedom is not protected, including free access within reasonable restrictions to the relevant information gathered, as well as the freedom to publish it in any suitable form, save reasonable restrictions that do not compromise the safety of the patients. Accordingly, a pharmaceutical company shall not support and shall not initiate research that does not guarantee the protection of the full academic freedom of the physician and free access to the information gathered, as well as the protection of the freedom to publish it, including adverse results.

2. The investigating physician shall not sign, and the pharmaceutical company shall not have the physician sign, an agreement that could restrict his professional - academic independence or that could restrict performance of the research or the publication of its results, save reasonable restrictions that do not compromise the safety of the patients.

3. The investigating physician shall be required to fully disclose any connection with the pharmaceutical company related to the research, to the appropriate ethical committee (such as the Helsinki Committee) as a condition to approval of the research, as well as to the research participants, and in the body of the publication regarding the research.

4. The investigating physician shall not be part of research or of a publication of research if he and/or his relative have economic connections or interests of which he is aware in the pharmaceutical company related to the research and there is fear of conflict of interest between his connections to the company and his connections to the research. Such participation shall be allowed only if the investigating physician has obtained advance approval from the applicable entities with respect to his involvement in the research or publication, after having indicated his or his relative's economic connections.

5. The physician shall not take part in research, including phase IV studies, if, in his opinion, the research was conducted without a proper scientific foundation, with its principal aim being to further commercial interests of the pharmaceutical company. Accordingly, a pharmaceutical company shall not conduct research without a scientific foundation, with its principal aim being to further commercial interests.

6. The investigating physician shall not receive payment, and the pharmaceutical company shall not allow payment to the physician, which is contingent on the research results.

7. The investigating physician shall not receive, and the pharmaceutical company shall not give the physician directly, any payment / support / consideration in value or in kind for the physician's role as an investigator in the research, other than through the association / the scientific society / the employing institution of the physician.

8. The physician shall not be allowed to receive, and the pharmaceutical company shall not be allowed to give the physician directly, a research grant other than through the association / the scientific society / the employer.

E. BENEFITS, FINANCIAL SUPPORT AND DONATIONS

1. The physician shall not receive, and the pharmaceutical company shall not give the physician, any personal benefit, save gifts of only marginal value that are intended to directly serve
the physician's work or symbolic gifts that are part of socially accepted culture or courteous behavior.

2. A medical institution, clinic or department shall be allowed to receive from a pharmaceutical company and a pharmaceutical company shall be allowed to give, financial support or a valuable donation for the advancement of medical research, for the improvement of care, research and service rendered to patients, or for the reclamation of medical equipment, so long as the receipt thereof does not compromise the professional independence of the physicians who benefit from the support and so long as all the relevant rules ensuring the maintenance of full transparency and documented records in this context are observed.

3. A pharmaceutical company shall not fund, and the physician or the association shall not receive from the pharmaceutical company, full or partial funding for social activities of the medical team, including "fun days" or team building.

4. The receipt of support allowable to a physician or to a medical institution shall not be conditioned on the furtherance of an interest of the supporting pharmaceutical company or any other commercial entity.

5. A physician or association shall not give or demand consideration or another benefit from the pharmaceutical company and the pharmaceutical company shall not give consideration or a benefit for a visit of a medical representative on behalf of the pharmaceutical company to the clinic or department where the physician works.

6. The association or the employer shall be allowed to receive a scholarship, including one for an overseas continuing education program, from a pharmaceutical company for the sake of advancing the professional knowledge of a physician or a number of physicians. The entity receiving the scholarship shall select the scholarship recipients through an awards and scholarship committee. Transparency, equality and fairness shall maintained throughout the selection process. Accordingly, the pharmaceutical company shall be allowed to grant a scholarship intended for a physician or a number of physicians so long as they have been selected by the entity receiving the scholarship and not by the company itself. The scholarship shall not be transferred directly to the physician by the pharmaceutical company, but rather through the association or the employer.

F. PHARMACEUTICAL SAMPLES

1. The physician shall be allowed to receive, and the pharmaceutical company shall be allowed to give the physician pharmaceutical samples, subject to directives of the medical institution, as publicized.

2. The samples shall be marked clearly as physician samples not intended for sale.

3. The physician shall not receive, and the pharmaceutical company shall not give, any consideration for the mere transfer of the pharmaceutical samples from the pharmaceutical company.

4. The physician shall not be allowed to receive, and the pharmaceutical company shall not be allowed to give the physician pharmaceutical samples in commercial quantities.

5. The physician shall not collect any payment from the patient for a pharmaceutical sample.
given to him.
6. The physician, as well as the pharmaceutical company and any representative on its behalf, shall honor the procedures of the medical institution where the samples are distributed.

**G. JOB SLOTS**

1. A commercial entity shall in no way whatsoever fund, directly or indirectly, personnel job slots or salaries of medical institution employees that are not directly related to the research funded by it.

**H. PAID SERVICE TO THE PHARMACEUTICAL COMPANY**

**GENERAL PRINCIPLES**

1. The physician and the pharmaceutical company shall be obligated to confirm any engagement between them in an agreement executed in writing, including an ad hoc engagement.
2. Whenever a physician is employed at a hospital, medical institution or other public institution, the physician shall undertake under the agreement to report to his employer and to obtain the employer's advance approval, if and insofar as the law requires, regarding the engagement between him and the company.
3. The physician shall ensure that an engagement between him and a pharmaceutical company shall not put him in conflict of interest with his position at the institution where he is employed, whether as a salaried employee or as a service provider, or with his ethical and professional obligations toward his patients.

**THE CONSULTING PHYSICIAN**

1. A physician may serve as a paid consultant to a pharmaceutical company and the pharmaceutical company may receive the paid services of the physician, if the aim of the consultancy is to advance medical knowledge, research and the level of medicine in Israel.
2. The physician shall be allowed to serve as a consultant to a pharmaceutical company, whether he serves as a sole consultant or whether he serves as a consultant within the framework of an advisory committee. Accordingly, the pharmaceutical company shall be allowed to receive consultancy services of a physician also within the framework of an advisory committee that consists of additional professionals, which the company shall convene on its behalf.
3. An advisory committee shall consist of up to 15 participating physicians. Participation as a member on an advisory committee is contingent on signature of an agreement between the physician and the pharmaceutical company, which includes, inter alia, notification by the physician to his employer. The physician may receive, and the pharmaceutical company may give the physician, appropriate financial remuneration for the consultancy. The payment shall be commensurate with the professional standing of the physician and the scope of work he performs.
4. The physician may receive from the pharmaceutical company, and the pharmaceutical company may give the physician, in addition to the financial remuneration in consideration of the consultancy services, additional payment constituting coverage of actual expenses
related to the consultancy that he provided to the pharmaceutical company.

5. The physician shall consider whether his paid work for the pharmaceutical company is liable to affect the quality and independence of his medical decisions. Whenever there is fear of conflict of interest, the physician shall decide in favor of his professional independence.

6. The convening of an advisory committee of the pharmaceutical company shall not be deemed a “scientific conference”, insofar as the aim of convening the advisory committee is to receive consultancy services from the consulting physicians.

PHYSICIAN PARTICIPATION IN A LECTURE FUNDED BY THE PHARMACEUTICAL COMPANY

1. A physician may listen to a lecture funded by a pharmaceutical company if the principal aim is to advance the professional knowledge of the physician. Participation as an observer in a lecture does not entitle the physician to any remuneration.

2. A lecturing physician funded by a pharmaceutical company shall disclose at the beginning of his speech, through a slide or clear statement, the nature of the existing economic relationships, if any, between him and the funding company or between him and another company relevant to the topic of the lecture. The pharmaceutical company, on its part, shall require the physician whose lecture it funds to act as set forth in this clause.

3. A lecturing physician funded by a pharmaceutical company shall adhere to professional truth and deliver his speech in an objective, candid, fair, honest and comprehensive manner. The pharmaceutical company funding the lecture of the physician shall not require him to lecture in a manner biased in its favor in any manner whatsoever.

4. A lecturing physician funded by a pharmaceutical company shall use the generic name of the drug in the lecture. However, the brand name of the drug may also be mentioned for the sake of informing the audience of the connection between the names. The physician shall also present in an objective, honest and candid manner the other available therapeutic options in the context of the lecture, along with their advantages and their disadvantages.

5. The physician may receive from a pharmaceutical company, and the pharmaceutical company may give the physician, reasonable remuneration for his participation as a lecturer on behalf of the pharmaceutical company, if he prepared and gave a lecture of professional significance in his field of practice. Presentation of a lecture prepared by the pharmaceutical company is not included within this authorization. A physician may be aided by various background materials that he received from the pharmaceutical company in the preparation of his lecture, insofar as this material was reviewed by him and deemed well-established scientific material. The physician shall also be allowed to receive reimbursement of actual expenses related to the preparation of his lecture.

6. The physician and the pharmaceutical company shall also observe these directives in the context of a recorded lecture, transmitted by any digital means whatsoever to a listening or viewing audience in any location.
I.  ADVERTISING AND PUBLICATION OF MEDICAL PRODUCTS

ADVERTISING BY A PHYSICIAN / ASSOCIATION / SCIENTIFIC SOCIETY
1.  A physician shall not in any way promote or advertise medicinal products within or outside his clinic, and the pharmaceutical company shall not ask of the physician to do so, other than promotion of medicinal products allowable under law by a physician employed for this purpose by a pharmaceutical company, with full disclosure of this fact.
2.  A physician shall not engage in the sale of medicinal products within or outside his clinic and the pharmaceutical company shall not ask of the physician to do so, including a physician employed by the pharmaceutical company.
3.  A physician shall not exert any pressure on a patient to use a certain medical product other than for medical and/or professional reasons.
4.  A physician or association shall not engage in any way whatsoever in the promotion, sale or advertising of commercial products and shall not make their name, academic degree and professional standing available for the benefit of the economic interests of any commercial entity whatsoever. Accordingly, the pharmaceutical company shall not ask of the physician or the association to engage in the sale or advertising of commercial products on its behalf.
5.  In exceptional circumstances, an association shall be allowed to advertise a commercial product if the following conditions are fulfilled cumulatively:
   a.  The advertising is clearly intended to promote health awareness, it would be beneficial to public health and it is not intended to advertise a certain product or technology. In addition, the association believes that there is scientific evidence of the efficacy and safety of the medical product or technology and the topic has been discussed at the board meeting of the association, which documented the resolution that indeed the advertising should be supported.
   b.  The advertising shall be done while ensuring transparency and full disclosure in all matters concerning the name of the pharmaceutical company that provided the funding for the advertising. Medicinal products / technology shall be mentioned by their generic names and their advantages and disadvantages shall be detailed. Concurrently, the therapeutic alternatives should be listed with their advantages and disadvantages.
   c.  The advertising shall obtain prior approval from the IMA Ethics Bureau.

ADVERTISING AND DISSEMINATION OF MATERIAL BY A PHARMACEUTICAL COMPANY INTENDED FOR SALES PROMOTION
1.  A pharmaceutical company shall be responsible to ensure that all promotional material of medicinal products disseminated or advertised by it, in any manner whatsoever, shall be accurate, clear and reflect scientific truth.
2.  A pharmaceutical company shall present promotional material at a professional level and in a manner that meets not only the requirements of the law, but also the highest ethical standards accepted worldwide.
3.  The pharmaceutical company shall be responsible for the fact that information appearing in
any material intended for sales promotion, including properties attributed to the medicinal product, is based on current scientific data and that the manner of its presentation is not misleading. The information must be consistent with the information appearing in the physician pamphlet and not contradict it and must be as approved by the competent legal authority for the medicinal product.

4. The pharmaceutical company representative shall forward academic background material to the physician, including information with regard to the safety of a medicinal product, contraindications, warnings, adverse effects and precautions, subject to any law.

5. The pharmaceutical company shall specify in its promotional material the brand and the generic name of the medicinal product, its active ingredients, as well as the name and address of the company or the agent responsible for marketing the medicinal product.

6. In the absence of regulations or rules directing otherwise, the pharmaceutical company shall specify in the promotional material the approved indications of the medicinal product, its properties and attributes, including significant adverse effects and warnings related to the use of the medicinal product, and shall refer to the marketing company for the receipt of additional information.

7. The pharmaceutical company shall explicitly and clearly indicate the relevant references in the promotional material. References that are not directly based on clinical studies may be indicated, including medical literature and data of the pharmaceutical company, insofar as they are scientifically based and do not contradict the physician pamphlet approved by the Ministry of Health.

8. The pharmaceutical company shall not promote sales, including via mailing or advertising in medical journals, in a manner purporting to be the provision of academic information.

9. The pharmaceutical company shall not conduct any marketing activity of a product not yet registered in Israel. Nonetheless, a pharmaceutical company shall be allowed to convey scientific information, without promotional aspects, while indicating the regulatory status of the medicinal product, subject to the current regulatory rules.

10. The pharmaceutical company shall not promote the sale of its medicinal products via direct contact with the patients, save medicinal products with respect to which the law and/or the regulation so permit.

11. The pharmaceutical company may initiate support programs to increase public awareness of diseases and to raise the level of public understanding of disease prevention, symptoms and manifestations of medical conditions and available treatments, insofar as the information conveyed through the pharmaceutical company is balanced, accurate and reliable.

12. The pharmaceutical company shall not disseminate promotional material without obtaining approval from the relevant professional figure at the pharmaceutical company with suitable scientific background and professional qualifications.

13. The pharmaceutical company shall be obligated to mail promotional material to medical practitioners with a reasonable frequency and scope. The pharmaceutical company shall honor a physician’s request to delete his name from the mailing lists of any advertising
material, including printed material.

14. The pharmaceutical company shall clearly and transparently indicate on its website, if such website includes information relating to a medicinal product, that it is the site of said pharmaceutical company, the identity of the company, and, insofar as relevant, for whom the advertising is intended. The pharmaceutical company shall ensure that the information is tailored to a target audience of physicians, pharmacists, medical practitioners and the public. Insofar as the pharmaceutical company operates in Israel, it shall ensure that the information content appearing on the website is in accordance with the provisions of Israeli law and to the guidelines of the Ministry of Health, and it shall provide relevant information regarding approval of the drug in the State of Israel.

15. The pharmaceutical company shall formulate and maintain procedures that ensure full implementation of these guidelines.

J. MEDICAL REPRESENTATIVES OF A PHARMACEUTICAL COMPANY

1. Marketing and sales personnel of a pharmaceutical company, including staff members involved in some way in the preparation or approval of material intended for sales promotion to be presented to medical professionals, qualified administrative staff or as information submitted to the public, shall be well versed in the provisions of this covenant.

2. A medical representative on behalf of the pharmaceutical company shall undergo suitable training, which shall include learning and becoming familiar with the ethics covenant, and shall possess scientific knowledge to the extent that enables him to provide complete and accurate information regarding the medicinal products promoted by him.

3. A medical representative shall strictly follow the provisions of Israeli law, the rules of the code of ethics detailed in this covenant and the procedures of the medical institution, insofar as agreed between the institution and the pharmaceutical company.

4. A medical representative meeting with a physician shall introduce himself by his full name and by the name of the pharmaceutical company on whose behalf he is acting, clearly and transparently.

5. A medical representative shall ensure that his visit to a physician in the course of his job does not cause any discomfort to the physician, and he shall abide by the rules of the workplace.

6. A medical representative shall ensure the protection of patient privacy and therefore shall not remain in the physician’s room together with his patient, and shall not request any information that might infringe upon the privacy of the patient. Accordingly, a physician shall not allow a medical representative to remain in his room at the same time that a patient is present.

7. A medical representative may convey information to a physician, verbally or in writing, insofar as this information has scientific validity. A medical representative shall provide, at the request of the physician, support for this information.

8. A medical representative shall provide, upon request of the physician, the current physician and/or consumer pamphlet with regard to the medicinal product that he is promoting, as approved by the Ministry of Health, or a website address where the relevant information
may be found.

9. The pharmaceutical company shall bear responsibility for the actions of its representatives pursuant to the rules of this covenant.

10. The physician shall respect the presence of the medical representatives, and protect their dignity in any contact with them.

K. MEDICAL DATA MINING

1. The physician may cooperate in gathering information with regard to therapeutic approaches and the use of pharmaceuticals only if this is done in an unidentified, compiled manner, protecting the privacy and the anonymity of both the individual patient and the individual physician and subject to all provisions of law, including procedures of the Ministry of Health. Accordingly, the pharmaceutical company shall ensure that the gathering of information is accomplished as set forth in this clause.

2. The pharmaceutical company may request information detailed in a written document, which pertains to the use of pharmaceuticals by unidentified patients, and the physician may cooperate in compiling this information, only after advance written consent has been obtained from the physician and from the employing institution. The consent shall include details of the compiled information, the purpose of the compilation and the identity of the entity using this information. Such consent shall be given for a limited period of time only.

3. The physician shall not cooperate in compiling information regarding the use of pharmaceuticals, and the pharmaceutical company shall not compile such information through a physician, if there is an intent to make use of it in order to exert any pressure, overt or covert, on the physician or on his colleagues or with intent to alter their prescriptive behavior.

I. THE JOINT FORUM FOR IMPLEMENTATION OF THE JOINT ETHICS COVENANT

ESTABLISHMENT AND POWERS OF THE FORUM

The signatories to this covenant shall establish a joint forum (hereinafter: “the joint forum”), whose composition and powers shall be as follows:

COMPOSITION OF THE FORUM

1. THE JOINT FORUM SHALL CONSIST OF EIGHT MEMBERS, AS FOLLOWS:
   a. The forum chairperson shall be a physician from among the members of the IMA Ethics Bureau and shall be appointed by the chairperson of the Ethics Bureau.
   b. An additional member shall be a public official with proven and recognized social standing, agreed upon by the parties.
   c. Three additional members shall be physicians from within the Ethics Bureau, to be appointed by the chairperson of the Ethics Bureau.
   d. Three additional members shall be chosen from among the representative entities signatories to this covenant, in the following manner: One representative from the Pharma Israel organization, an additional representative from the Manufacturers
Association and a third representative on behalf of the Federation of Israeli Chambers of Commerce.

e. Each member of the joint forum may appoint a substitute, subject to the approval of the entity that he represents on the forum.

2. IMPLEMENTATION AND ENFORCEMENT:

   a. The joint forum shall have the authority to review, to implement and to enforce, in accordance with the procedures detailed below, any engagement between a physician or a scientific association or society and a pharmaceutical company, as well as any activity of a physician, scientific association or society, or pharmaceutical company, provided that the rules detailed in this covenant apply with respect thereto.

   b. Hearings of the forum may be held in any manner whatsoever, by decision of the chairman of the joint forum, including via the internet.

   c. The joint forum shall hold at least two direct meetings a year, for clarification of any issue related to its areas of authority and responsibility, by decision of the chairperson of the joint forum.

3. OPINION:

   a. At the request of a company that is a signatory to this covenant or a physician or a scientific association or society or a medical institution, the forum shall be allowed to render its opinion on questions involving the implementation of the covenant, including on the question of whether a certain action is permissible in light of the principles of this covenant.

   b. The opinion shall be rendered within 30 working days of the day of receipt of the inquiry.

   c. The forum shall discuss an opinion insofar as it relates to a prospective action, which has not yet been taken.

   d. A final opinion shall not be rendered by the forum unless there is a consensus of at least five members of the forum.

   e. A copy of the opinion, without identifying details, shall be disseminated among the parties signatories to this covenant within 60 working days of the day of delivery of the opinion to the entity that requested the opinion.

   f. A company that acts in accordance with what is set forth in the opinion shall be regarded as having acted in accordance with the rules of this covenant.

4. CONFIDENTIALITY:

   Members of the joint forum shall sign a letter of confidentiality prohibiting use of any information that they obtained in the line of duty outside the forum framework, unless they receive approval of the forum.
PROCEDURES OF THE FORUM

5. Any complaint submitted by a physician or association or scientific company regarding a violation of any of the rules of the covenant by a physician or scientific association or society, shall be governed by the relevant rules as set forth in the IMA Bylaws, Addendum "D", The Ethics Bureau – The Procedures of the IMA Ethics Bureau. Members of the joint forum shall be allowed to submit a complaint regarding any violation by a physician or scientific association or society or medical institution to the IMA Ethics Bureau.

6. Any violation of any of the rules of the covenant by a pharmaceutical company or anyone on its behalf, or a complaint of a pharmaceutical company against a physician or scientific association or society, shall be governed by the rules detailed in Appendix “A” to this covenant, "Procedures of the Joint Forum”.

M. ETHICS SYMBOL

7. The joint forum has selected an ethics symbol, which represents a commitment of a pharmaceutical company to observe the rules detailed in this covenant.

8. A pharmaceutical company that accepts the rules of ethical conduct detailed in this covenant is entitled to use the ethics symbol in its various documents and advertisements, as well as on lapel pins created for its employees.

APPENDIX

PROCEDURES OF THE JOINT FORUM

A. COMPLAINT

1. PERMISSION TO COMPLAIN
   Any person may submit a complaint to the joint forum. The forum chairperson may determine how and whether to hear the complaint.

2. DRAFTING A LETTER OF COMPLAINT
   A complaint shall be drafted in writing and shall contain the following details:
   a) Name of the complainant;
   b) Name of the company or physician or association or society that is the subject of the complaint and/or the entity representing them (the “complainee”), and the address thereof;
   c) Description of the facts constituting the basis for the complaint;
   d) Indication of the clause in the covenant that has been violated, according to the complainant, by the company or physician or association or society and/or anyone on their behalf.

3. JOINDER OF COMPLAINTS
   The chairperson of the joint forum may join together a number of complaints, insofar as they are based on the same facts or on similar facts or on a series of interrelated acts in a manner that they constitute a single event.
The chairperson of the forum may separate between the complaints if he finds that the joint hearing of the complaints would make investigating them cumbersome or difficult.

4. **JOINER OF COMPLAINEES**
   The chairperson of the joint forum may join together a number of complainees included in the letter of complaint, insofar as each one of them was a party to one of the offenses in the letter of complaint, whether as a coparty or in a different manner, or if the complaint is due to a series of interrelated acts in a manner that they constitute a single event. Nonetheless, a complainee should be allowed to object to the joinder or to request a separation of the hearing.
   The forum chairperson may order the holding of separate hearings in relation to each complainee, if he finds that the joint hearing would make investigation of the complaint cumbersome or difficult.

5. **COMPLAINT REGARDING THE VIOLATION OF PROVISIONS OF THE JOINT COVENANT**
   If a complaint has been submitted to the joint forum regarding a violation of any of the provisions of the joint covenant committed by a pharmaceutical company or by a physician or scientific association or society, the forum shall furnish a copy to the complainee.
   If the chairperson believes that there is no need to hear the complaint, since it is baseless, he shall answer the complainant within 30 working days and shall give reasons for his decision, in order to afford the complainant an opportunity to consider how to proceed. If the forum chairperson believes that there is call to hear the complaint, he shall so notify the complainant and the complainee and shall afford the complainee an opportunity to answer in writing to the complaint.
   If the chairperson has determined that the complaint should not be heard, the complainant may request a hearing on this decision before the joint forum. If the joint forum believes that the complaint should be heard, it shall so notify the complainee and shall afford him an opportunity to answer in writing to the complaint.

6. **FURTHER DETAILS**
   The chairperson of the joint forum may request further details and/or documents from the complainant or from the complainee regarding the complaint or the answer, as the case may be, if he deems it necessary to clarify a matter arising therein.

7. **TIME FRAME FOR SERVING ANSWERS**
   If notice has been served on a complainee with regard to the decision of the forum chairperson or the decision of the forum to hear a complaint, as set forth in clause 5 above, the complainee shall answer within 30 working days of receiving the notice, or within such period as shall be prescribed according to the discretion of the forum chairperson. When this period has elapsed and no answer has been received from the complainee, the chairperson of the joint forum may order a hearing on the complaint without the presence of the complainee.

**B. INVESTIGATION OF THE COMPLAINT**
1. If a complaint has been submitted and the chairperson of the joint forum has decided to establish a committee to investigate the complaint, he shall appoint the chairman of the
investigative committee and its members from among the members of the joint forum and shall notify the complainee and the complainant regarding the establishment and the composition thereof.

2. The investigative committee shall consist of a chairperson and four additional members, all of them from among the members of the joint forum. Insofar as possible, the public representative shall be one of the members of the investigative committee.

3. A representative of the relevant organization shall be a member of the investigative committee whenever the complainee company is a member of this organization.

C. SUMMONING LITIGANTS AND WITNESSES

1. SETTING THE HEARING DATE
   The chairperson of the investigative committee shall set the hearing commencement date and shall summon the complainee and the complainant for said date by written notice. Any contact with the parties shall be done in writing.
   The hearing shall be held within 60 working days of the date set for receiving the answer of the complainee.

2. THE RIGHT OF REPRESENTATION
   The parties to a proceeding conducted under this covenant shall have a right to be represented by a third person, including an attorney.

D. HEARING PROCEEDINGS OF THE INVESTIGATIVE COMMITTEE

1. A complaint shall be heard by the investigative committee of the joint forum. The chairperson of the investigative committee shall conduct the hearing.

2. The complainee and the complainant shall be allowed to bring witnesses on their behalf to the hearing.

3. In cases where a pharmaceutical company is either a complainant or a complainee, it shall have an authorized representative on its behalf at the hearing.

4. Minutes:
   a) The chairperson of the investigative committee shall keep a record of minutes of the hearing; however, he may order that someone else record the minutes, or that a record / documentation be kept in another manner.
   b) The complaint, documents submitted and received by the investigative committee and any certificate pertaining to the hearing, shall be attached to the minutes and shall constitute an integral part thereof.

E. PRESENCE OF THE LITIGANTS

PRESENCE OF THE COMPLAINEE

1. A complainee shall only be tried under ethical law in his presence.

2. Notwithstanding the aforesaid, the investigative committee may decide to conduct a hearing without the presence of the complainee, or adjourn the hearing to another date, provided that a summons under clause c.1 above has been served on the complainee. If another date has been set for the hearing and the complainee has not appeared, the hearing shall be conducted outside his presence.
F. RULING
1. EXONERATION DUE TO LACK OF PRIMA FACIE PROOF:
   If the investigative committee has found that the facts of the complaint have not been proven, even prima facie, it shall set aside the complaint.
2. RULING:
   a) At the end of the investigation of the complaint, the investigative committee shall rule with regard to the conduct of the complainee, unless it has decided to set aside the complaint. The ruling shall be in writing and reasoned. The members of the investigative committee shall sign the ruling and copies thereof shall be sent to the complainee and to the complainant. The joint forum shall publish the ruling of the investigative committee within 30 working days of the conclusion of the hearing.
   b) Decisions of the investigative committee shall be made by majority rule.
   c) When a ruling has a minority opinion, all the members of the investigative committee shall sign the majority decision, but the holder of the minority opinion may add his dissenting opinion and his reasons.

G. RECOMMENDATIONS AND SANCTIONS IN RESPECT OF VIOLATIONS OF COVENANT PROVISIONS OR JOINT FORUM INSTRUCTIONS
1. If the investigative committee of the joint forum finds that a complainee or someone on his behalf has violated any of the rules of the covenant or any of the instructions of the joint forum, it may instruct him to rectify the situation and it may impose a penalty of warning.
2. If the investigative committee of the joint forum finds that a complainee or someone on his behalf has violated any of the rules of the covenant or any of the instructions of the joint forum, it shall order the key elements of the proceeding and its results to be posted on the IMA website, with or without disclosing the name and details of the complainee or the person on his behalf, at its discretion.

H. DISTRIBUTION OF DECISIONS
1. Decisions of the investigative committee of the joint forum shall be disseminated only after conclusion of the hearing.
2. A complaint that has been stricken, set aside or dismissed by ruling of the committee shall be disseminated only after receiving written approval of the complainee.
3. Fundamental decisions of the joint forum shall be disseminated to the signatories to this covenant through their representatives who are members of the joint forum.
I. PROCEDURES IN THE ABSENCE OF INSTRUCTIONS

With any procedural matter for which there is no provision in these rules, the chairperson of the joint forum or the chairperson of the investigative committee, as the case may be, shall act in the way they deem best to do justice.

68. The physician as an expert witness

Published in July 2002

Background
The ethics board received a complaint regarding a medical opinion submitted to the Court. The case involved a woman who sued the physician who treated her for medical damage caused, in her opinion, as a result of the physician’s medical negligence. The plaintiff submitted to the Court a medical opinion given by another physician in the same specialty.

The opinion contains legitimate criticism of the medical treatment that the plaintiff received, but also contains many insulting expressions against the physician being sued. I shall quote only a few of them: "The miserable records indicate the poor professional standard of the physician being sued, as well as contempt and lack of professionalism"; "The medical sheet of the operation is confusing, the diagnosis and the headings of the operation are confusing and of a partial nature, the description of the course of the operation is partial, confusing, and illogical"; "The operation report indicates lack of professionalism on the part of the surgeon"; "The summary letter is written in incoherent language"; “All these indicate the lack of professionalism and the negligent approach of the physician being sued”.

The members of the Ethics Board were convinced that this is not a proper way in which to criticize a professional colleague, and that the language used may harm the dignity and status of the physician. The members of the Ethics Board also felt that every physician is entitled to criticize the medical treatment provided by another physician, but should do so in a restrained and relevant manner.

The physician who wrote the offensive opinion was invited to a clarification committee of the Ethics Board, where he apologized for the wording he employed in his opinion.

The members of the Ethics Board decided to write ethical rules for the conduct of an expert physician in the Court. The wording of the proposal was also sent for review and comments by the “Torts forum” at the Israeli Bar Association before its final formulation.

We hope that these rules will guide us in our work and avoid in the future complaints of the type that we discussed here.

Position paper
a) General

- The provision of a medical opinion to the Court is a civil and moral obligation imposed on the physician by virtue of his being a professional in the field. The opinion will constitute evidence in a trial and will aid the judge in determination of the truth and in giving judgment.
- A physician shall agree to serve as an expert witness only in a case in which he believes
that there is a solid foundation for the complaint of the plaintiff or the position of the defendants.

- The provision of a professional, reliable, and objective opinion, based on science and on accepted medical standards, is of value in the specific case in which it is requested and will also lead to improvement of medical treatment in similar cases in the future.

b) The qualifications required from the physician giving testimony

- The medical expert witness shall have the qualifications to fulfill this role pursuant to Israeli law.
- The medical expert shall have the relevant expertise in accordance with the circumstances in which he testifies.
- The medical expert shall be familiar with the level of knowledge and practice customary in medicine and in the various schools of thought, if any, in the field and at the time relevant to the subject of the action.

c) Due diligence

- The medical expert shall indicate at the beginning of his opinion, as required by law, details of his identification, qualifications, and professional and academic status.
- The medical expert shall indicate if he has or had a personal interest with any of the litigants, including the medical institution involved, the insurer, or any of the lawyers involved in the case.

d) Directions for the medical expert

- The medical expert shall objectively, fairly and truthfully provide all the medical and scientific information related to the issue in question, and shall make a reasonable effort to obtain all the documentation relevant to the case.
- If the medical expert found it necessary to rely on medical literature, he shall attach it to his opinion or shall indicate its reference in a clear and correct manner, as is customary.
- The medical expert shall give his professional opinion only after he has examined the plaintiff in the claim. In exceptional cases in which an examination was not conducted, this shall be indicated in the opinion. An opinion regarding a simulation examination or a laboratory examination is possible without examination of the plaintiff.
- The medical expert shall refer to the medical standards customary at the time the cause of claim was created, including all the schools of thought that existed at that time.
- The medical expert shall write his opinion and give his testimony in relevant, modest, and restrained language, based only on the facts and the medical and scientific truth.
- The medical expert shall be entitled to dispute other medical opinions given to the Court. This shall be done in relevant and restrained language. No personal criticism shall be made of other medical experts.

e) Fees

- The payment to the medical expert shall be reasonable and shall be based on the professional status of the expert and the time spent in preparation of the opinion and in giving testimony in Court.
The fee of the medical expert shall not be conditional on the results of the legal hearing.

The medical expert shall not share his fee with anyone else, including the person who referred to him the examinee.

69. **A physician shall not act against anyone in his care**

*Published in December 2004*

**Background**

The issue of the limits of a physician’s loyalty to his patient was brought before the Ethics Board. The complainant wrote that a specific physician had treated his son for about 20 years, since his birth. The medical supervision over these years included periodic medical procedures and regular examinations. The relationship was one of maximum openness and frankness, with full trust in the physician.

The family, for its own reasons, recently decided to submit a complaint of medical negligence against the hospital in which the child was born and against the health care organization in which the family was a member. The treating physician was never employed in these two institutions. The hospital against whom the action was filed contacted the physician with a request to supply a medical legal opinion against the child, the plaintiff, whom he treated over the years.

The family, which sensed that “their” physician was betraying their trust, contacted him personally with a request that he not act against them, but he replied, according to them, that “I strive to disclose the truth and shall continue to act in the service of the hospital being sued”.

The family does not intend to sue the physician in a legal action but it contacted the Ethics Board with a request that his conduct be ethically examined.

The members of the Ethics Board who addressed the question thought that there was an ethical defect in the physician’s conduct, and that his actions cast a shadow over the delicate connection between the physician and the patient and infringed the full trust between both parties that forms the basis of this connection.

**Position paper**

- A proper connection between the physician and the patient is based on full trust between them.
- The preservation of medical confidentiality is a result of this trust.
- Consequently, as a rule, a physician should not act against a person being treated by him nor misuse medical information held by him.
- Sometimes in judicial proceedings, a physician is required to prepare an opinion liable to harm his patient.
- The physician shall fulfill this obligation only if imposed on him by a court ruling.
- The opinion shall be prepared to the best of the physician’s professional judgment and with fairness and integrity.
- The physician shall be exempt from the obligation of confidentiality towards the patient if the latter has consulted him previously only for a medico-legal purpose.
70. Medical confidentiality and medical record privilege regarding psychiatric treatment for victims of violence and sexual assault

Published in May 2018

Background:
The removal of medical confidentiality in cases of mental health treatment of victims of sexual assault raises complex legal, ethical and treatment issues and poses ethical dilemmas for practitioners.
The professional obligations of physicians address, first and foremost, their basic duty to maintain patients' medical confidentiality in order to foster a relationship of trust, which is the foundation of medical treatment. Another basic obligation requires practitioners to be loyal to their patients and forbids harming them. This is grounded in rules of medical ethics dealing with physician-patient relationships and is also mentioned in the chapter regarding physicians and the judicial system. For example, a position paper written in 2004 stated that “Physicians should not act against those who are under their care.”
This principle is clear, accepted and codified in every system in which there are relationships of trust necessary for treatment or representation, where patients are required to expose themselves in order to receive proper treatment. Attorney-client relationships and journalist-source relationships include many protections; how much more so when dealing with life-and-death situations such as in physician-patient relationships, where the physician’s ethical duty to protect the patient should be even more apparent.
Treatment of victims of sexual offenses and the criminal proceedings related to these offenses force the victims to relive their difficult experience. Some victims describe the encounter with the assailant as the “first rape” and the feeling of exposure to evidence collection and treatment as a “second rape.”
Regarding evidence collection, there are clearly defined rules meant to minimize the harm done to victims. Specially trained pediatricians, gynecologists and physicians involved in forensic medicine are entrusted with these duties. Collecting bodily evidence from victims requires their informed consent and the evidence is kept in order to give them time to file a police complaint or press charges. If no complaint is filed, the samples are saved for three months. The members of the Ethics Board think the samples should be kept for an even longer period.
The collection of evidence includes gathering genetic samples to identify the assailant, taking pictures of body parts hurt in the attack, including private regions, and other methods of evidence collection. All these are carried out very delicately with all the sensitivity required in such cases.
These situations are complex and distressing, but are clearly necessary in order to investigate the incident, treat the victim’s complaints and prevent the assailant from repeating such offenses.
Nonetheless, the Ethics Board was recently presented with cases where the police and the prosecution demanded that victims agree to a broad waiver of medical confidentiality regarding psychotherapeutic treatment they received or are still receiving. The contention was that the waiver would allow a more in-depth investigation or strengthen the prosecution’s case. One such case, also covered in the media, was the Kastiel affair, in which a rape victim was required to waive her confidentiality and expose all the records of her treating psychologist. Following this affair, the Israel Psychological Association published a position paper that clarified their strong opposition to the exposure of treatment materials pertaining to victims of sex crimes and violence.

Psychiatrists have approached the Ethics Board on this issue. As a result, we were horrified to discover that victims who decide to undergo mental treatment at a third stage, sometimes long after the actual assault, may experience a “third rape,” exposing their ailing psyche to the police and prosecution, and then occasionally to the defense and the assailant. This course of action is dangerous and harmful. This practice can harm the delicate and complex relationship of mental health patients with their caregiver, and may profoundly damage their trust in people in general. After all, these are situations where a person harmed another person. Mental health caregivers work hard to gain the trust of patients, but they may destroy that trust with their own hands when the details of the sensitive conversations during therapy are exposed to the assailant and those who support him.

The Ethics Board held a sensitive and complex discussion focusing on the social order and the distinctly defined roles of people in various positions in society during such a case and in general. One of the issues raised was the right of those accused of violent assault to a presumption of innocence: The accused are entitled to a fair trial and it is their right to defend themselves with an attorney to the best of their abilities. The role of the police and the prosecutor is to investigate and put on trial criminals with evidence against them. The court’s role is to judge according to the laws of the state and pursue the truth. Between all these stand the victims of the offense, who could be hurt during the investigation and legal proceedings and should be defended as much as possible. The physician’s role is to treat patients in the best way possible and to stand by their side.

Psychiatrists, members of the Ethics Board, added some important professional information. The medical records detailing the feelings and thoughts of patients are not documents that necessarily contain facts or the “absolute truth” about events. Often, they contain a victim’s thoughts, associations to life situations, knowledge, imagination and more. This is the technique of psychotherapy. Therefore, it is doubtful that there is much value in exposing the emotional privacy and the influences of the assault on the victim, while the damage done by the repeated invasion of privacy could harm the victim’s quality of life, severely hurt the mental health treatment process and create a negative incentive for victims to press charges in the future.

The right of patients to privacy is stipulated several times in Israeli law. The Basic Law: Human Dignity and Liberty (section 7) states that all persons have the right to privacy, and that there should be no violation of the confidentiality of their conversations,
The Patient’s Rights Law (section 19) states that a clinician or any other staff member of a medical facility may not disclose any information concerning a patient that came to their knowledge during their services or in the course of treatment. Regarding disclosure of medical information to a third party, the law states that a clinician or a medical facility is allowed to disclose information to another party under conditions specified by the law, including if the patient has given his consent or if the clinician or the facility is so instructed by law.88

The Privacy Protection Law defines publishing any matter relating to a person’s private life, including their medical condition, as an infringement of privacy. The Privacy Protection Law and the Penal Code even define criminal punishment for violating the right to secrecy. According to the Evidence Ordinance (section 49), a physician is not bound to give evidence in legal proceedings on any matter relating to a person who has availed himself of his services, if such matter reached him in the course of his work as a physician, unless that person has waived the privilege or the court has found that the necessity to disclose the evidence for the purpose of doing justice outweighs the interest in its non-disclosure. The Ordinance further states that where privilege is claimed under this section, the claim should be dealt with in camera. If the court decides to hear the testimony, it may hear it in camera.

In other words, the law deals with maintaining physician-patient confidentiality during legal proceedings and stipulates that confidentiality can be waived by the patient or by the court, after it has examined the matter and determined the appropriate balance between investigating the issue and maintaining medical confidentiality. Clearly, the right to medical confidentiality is a substantial right in Israeli law, due to its obvious importance to the relationship of trust between a physician and a patient, which is necessary for comprehensive quality medical treatment. Confidentiality becomes doubly important in the context of psychotherapeutic treatment that includes documenting a person’s innermost thoughts.

The right to confidentiality belongs to the patient; therefore, he may decide to waive medical confidentiality. In absence of patient consent, a judge may obligate the physician to present him with medical records in order to examine them and weigh the importance of the information to the legal proceedings against the damage that may be caused to the patient. In this framework, physicians may explain their reservations and the risk caused to the patient in exposing the medical records.

Thus, the members of the Ethics Board offer the following guidance to psychiatrists in treating patients:

1. Physicians should consider medical confidentiality a primary value during treatment, and even more so during mental health treatment.
2. Generally, patients are entitled to receive medical information regarding their condition,
including their medical records.

3. Physicians should speak with patients undergoing mental health treatment and explain the implications of waiving medical confidentiality, including the disclosure of information to third parties.

4. Physicians who feel that exposing medical records could hurt the patient should do all in their power to prevent the exposure and, if possible, explain the consequences to the patient.

5. Physicians should exercise discretion and should not directly provide third parties with medical records containing information that they believe could be harmful to the patient if exposed.

6. In certain situations, physicians should demand the involvement of the court, which can then discuss the request to waive confidentiality in camera. Physicians will then be able to present the judge with the level of risk to the patient.

71. Forensic medicine

Published in September 2017

Background:
Forensic medicine is a special medical field that does not deal with treatment, but rather with formulating expert opinions that serve as evidentiary material for investigations and trials. The conclusions in these opinions may be used against the examined person (who could be alive or deceased), contrary to the physician-patient relationship described in the rules of medical ethics.

As chair of the Ethics Board, Dr. Karni invited the head of the National Center of Forensic Medicine to discuss the unique nature of the field and the complex ethical dilemmas facing forensic physicians.

As of now, the only forensic medicine institute is at Abu Kabir in Tel Aviv and operates as a unit of the Ministry of Health, under the Medical Directorate.

Forensic physicians at the Institute of Forensic Medicine conduct examinations and investigate unnatural deaths by performing external examinations of the deceased, imaging tests and autopsies, gathering samples and performing necessary lab tests. All this is done under time pressure due to the sanctity of the dead and the requirement to bury the deceased as soon as possible.

Forensic physicians also perform clinical tests on living people who were involved in incidents of suspected violence or sexual offenses, be they victims of the offense or the suspected perpetrators.

There are currently very few forensic physicians in Israel relative to the number of forensic physicians in other developed countries.

Today it is impossible to receive a counter-opinion to that of the Institute of Forensic Medicine. This becomes significant during criminal procedures where the Institute of Forensic Medicine works closely with the police and prosecution, and defendants can find themselves accused of a severe felony, such as murder, manslaughter or rape, without the option of receiving the
opinion of a forensic physician on their behalf. This infringes upon defendants’ right to protect their innocence and their right to due process.

In the current reality, the institute's work focuses on investigation and trial proceedings, and it works in close conjunction with the police and prosecution. As reflected in the media, over the years, various entities began to see the Institute of Forensic Medicine as part of the executive branch of government, and the border between professional medical judgment and investigative or legal judgment is in danger of being blurred.

According to the head of the National Center of Forensic Medicine, several measures have been taken in the last few years to better define this border and safeguard the professional discretion and independence of physicians, and the Ethics Board commends this.

In this context, we should mention the Ethics Board's position paper entitled “Physicians as expert witnesses.” This paper supports the words of the head of the Institute, stating that the forensic physician's role is to present an unbiased, scientific and professional medical opinion, in order to allow the court to determine the truth and conduct a just trial.

As part of the clinical tests performed by forensic physicians, they examine people suspected of various felonies. When a suspect refuses to be examined, a conflict may arise between the suspect's autonomy and the investigators' stance. In accordance with the rules of ethics dealing with the relationship between physicians and examinees, physicians should not examine anyone who refuses to be examined.

If forensic physicians are requested to provide an opinion based on records of a suspect who refused to be examined, or if there are doubts about the suspect's consent, the examination should not be performed in a “roundabout way” and the forensic physician should not provide an opinion. However, in cases where there is a legal obligation – such as a court order – physicians are of course required to perform the tests.

In addition, suspects are often brought before physicians while handcuffed. In these situations, there are guidelines stipulated in the Code of Ethics and in the Ethics Board's position paper entitled “Restraining prisoners and detainees in hospitals.”

During the meeting, the Ethics Board expressed its deep appreciation for forensic physicians who are steadfast, act in accordance with the rules of ethics and maintain their professional integrity in the face of much external pressure.

**Position paper:**

1. The Ethics Board commends the measures taken to preserve the professional discretion and independence of forensic physicians.

   According to the rules of ethics, physicians may refuse to perform a requested medical procedure if the request goes against their professional opinion, conscience or beliefs.

2. When suspects refuse a test, the autonomy of the examined person may come into conflict with the investigators’ stance. In accordance with the rules of ethics dealing with the relationship between physicians and examinees, anyone who refuses to be examined should not be examined by a physician.

3. If forensic physicians are requested to provide an assessment based on records of a suspect who refused to be tested, or if there is doubt about the suspect’s consent, the test should
not be performed in a “roundabout way” and the forensic physician should not write an assessment.

4. In cases where it is legally required, such as under court order, physicians are of course obligated to perform the test.

5. In cases where suspects are brought for examination while handcuffed, physicians should act in accordance with the guidelines of the Code of Ethics and in the Ethics Board’s position paper entitled “Restraining prisoners and detainees in hospitals.”

6. We encourage training more experts in this field and support a decision to establish another institute for forensic medicine in Israel.

72. The recording of medical expert examinations by the opposing side is forbidden

Published in February 2012

Background:
A plaintiff filed a lawsuit in the Jerusalem District Court demanding compensation for bodily injuries.

One of the defendants, through attorney Gil Atar of Naschitz Brandes & Co., requested to have the plaintiff examined by a medical expert hired by the defendant. The plaintiff agreed only on condition that he would be allowed to record the examination. The expert – a senior psychiatrist – opposed this demand and the issue was brought before the Jerusalem District Court. The court’s decision from March 11, 2010 is presented here in outline form:

Summary of the plaintiff’s position:

a. The examination of the plaintiff by the defendant’s expert is “antagonistic” and may create disagreements between the expert and the plaintiff regarding the course of the test and its results. The recording will allow the court to consider the credibility of both sides and rule on the disagreements.

b. The very nature of the examination is unequal and gives an advantage to defendants. Recording the examination will reduce the inequality and promote judicial fairness.

c. The examined person’s right to record the examination is based on his fundamental right to document any examination he undergoes at his own discretion.

d. Recording an examination is consistent with the principle of the transparency of legal proceedings. Recording examinations is also in sync with the legislative trend of visual or audio documentation of the investigative process.

e. Opposing the recording will encourage surreptitious recordings. There is no legal restriction on such a recording in the Eavesdropping Law since the examined person is part of the examination.

Summary of the defendants’ position:

a. The recording may disturb the examiner and disrupt the course of the examination.

b. The recording may complicate the legal proceedings and open additional fronts.

c. The expert opinion is not the “final word” for the plaintiff since the medical expert can
be interrogated about his opinion.

d. If the plaintiff's examination by the defendants' experts is recorded, but the examination
by his own expert is not recorded, this will create inequality and raise doubts about the
integrity of the defendants' experts.

e. The comparison the plaintiff makes between his case and the obligation to record
interrogations of suspects with mental or emotional disabilities and interrogations of
children is irrelevant.

The honorable Judge Yitzhak Inbar notes in his verdict that “the legal regulations are silent
regarding the right of plaintiffs to make private recordings of examinations” and that “the
question has been discussed several times in rulings by district courts, but their stance has
varied.”

Following a thorough examination of the existing rulings, the court determined as follows:

**Recording an examination requires prior authorization by the court for the following
reasons:**

a. The act of recording may intrinsically entail some disruption of the examination.

b. The surreptitious recording of examinations, even if not a criminal offense, may infringe
upon the expert physician's right to autonomously define the work environment at his
clinic.

c. The surreptitious recording of examinations may create an atmosphere of hostility
and suspicion, and is sometimes inappropriate and dishonorable.

After defining the criteria for exercising its discretion, the court ruled as follows:

**The request to record an examination by a medical expert, a psychiatrist – is hereby
denied for the following reasons:**

a. The plaintiff is an adult and his representative did not present any unique information
supporting the recording of the examination.

b. The plaintiff did not record the expert examination conducted on his behalf and in any
case did not offer to provide the defendants with this recording.

c. We accept the expert psychiatrist's position that claims, among other things, that:
"Bringing a recording device to an examination inevitably means bringing in a distracting
foreign observer who disrupts the flow, comfort and spontaneity of both examiner and
examinee.” The court recognizes the expert physician’s right to “design his or her work
environment in accordance with his or her best judgment and understanding.”

The plaintiff's attorney appealed the Jerusalem District Court's decision to the Supreme Court.
The Israel Bar Association decided to attend the hearing as “amicus curiae” supporting the
plaintiff's position in favor of recording the medical examination.

This case was first brought to the attention of the Ethics Board by attorney Atar in May 2010.
The Ethics Board attributes great importance to the fundamental decision the Supreme
Court will make. A decision requiring that the medical examination be recorded may harm
the physician's status in society since it would imply mistrust and suspicion towards medical
experts. In addition to complicating the legal proceedings, such a decision could create an
incentive for plaintiffs to exaggerate their symptoms during the examinations. On the other hand, this could incentivize physicians to overtest and practice “defensive medicine” even when giving expert opinions to the court.

It is easy to imagine how allowing such recordings could lead to visual recordings of medical examinations, and eventually recordings of every professional encounter between physicians and patients, even outside of legal proceedings. There is no doubt that the effects of this process would not be limited to the judicial system, and the atmosphere of suspicion and mistrust would spread to the traditional relationship between physician and patient – where this effect would be destructive.

The Ethics Board held several discussions on this matter, culminating with a meeting on November 2, 2010 where the following position paper was agreed upon:

**Position paper:**

1. According to the rules of medical ethics, physicians who serve as expert witnesses should act with integrity and complete honesty, in accordance with their objective professional opinion and after making a reasonable effort to obtain all information and documentation relevant to the examinee.

2. The members of the Ethics Board believe that routinely recording or photographing medical examinations should not be allowed, even as part of forensic medicine. Such recordings should only be allowed with the consent of both physician and patient, or during extraordinary circumstances defined in advance by the court.

3. Physicians are not obligated to perform medical examinations in the presence of a recording device or camera if they feel it harms the proper course of the examination.

4. Due to the fundamental importance of this case and following a decision made by the Ethics Board, the IMA also decided to attend the legal proceedings as “amicus curiae” in part to counterbalance the position of the Bar Association and support the position opposing the recording of medical examinations. Attorneys Orna Lin and Barak Calev represented the IMA in these proceedings.

5. On February 1, 2012, in a precedential ruling, Supreme Court justices Rivlin, Danziger and Hendel rejected the plaintiff’s demand (Civil Appeal Authority 2948/10). The court stipulated that in general, the recording of expert examinations performed on behalf of the defendants should not be allowed during tort claims if the defendant or the medical expert oppose it, except in extraordinary cases. However, if the plaintiff, defendant and expert all agree to the recording, it should not be forbidden.

6. This shows that the court accepted the position presented by the IMA stating that: “The suspicion directed towards the medical expert is unfounded. A medical expert is not a mercenary. Medical experts are physicians, and as such they are obligated to present the medical truth and are bound to the rules of medical ethics ... Approving the recording would harm the trust in medicine and turn the physician’s examination room into an interrogation chamber. This approach hurts the public’s trust in physicians and their ability to perform their professional duty.”
73. Privacy in the media
Published in December 2004

Background
The terrible terrorist attack on Israelis in Taba during the recent Sukkoth festival once again raised, in the shadow of the dramatic events, the question regarding privacy in the media. For example, the Yediot Aharonot newspaper published on October 8, 2004, over half the front page, a large close-up photo of a small child in her underwear, bleeding on a stretcher. Additional harsh close-up photos filled the center pages of this issue. It may be assumed that none of those photographed gave their consent to be shown in this way, at such a serious moment in their lives, to the whole world.

The media’s thirst for dramatic documentation does not stop at the entrance to the hospital. The violent conflict with our Palestinian neighbors has, unfortunately, created in recent years many opportunities in which the media have been permitted to record that taking place inside the hospitals in the first moments of treatment of the casualties.

Those supporting the opening of the gates of the hospitals to the media claim that a “propaganda war” is being waged at the same time and that there is national importance to casualties on the Israeli side also receiving appropriate attention. The physicians are unable to influence the behavior of the media outside the hospitals, but we are obligated to respect privacy when this becomes our responsibility.

In an attempt to strike a balance between the public’s right to information and the right of every person to privacy, the members of the Ethics Board have drafted the following rules.

Position paper
- In an event involving numerous casualties, and in other cases, there is public curiosity regarding what is happening in the hospital in which these casualties are being treated.
- This curiosity is far greater when speaking of terrorist attacks.
- The exposure of the casualties to the media sometimes serves the interests of the relatives, the physicians treating the casualties, the hospital, the media, and even the interests of the State itself.
- Consequently, the required balance must be struck between the right of the public to information and the right of each casualty, as a person, to privacy.
- No casualties should be photographed unless their express consent has been received.
- When speaking of a minor who has been injured, the consent of both parents is required.
- Exposure of the casualties to the media shall be done in a way that does not harm their medical treatment or that of other patients located near them.
- The media shall be given no identifying details of the casualties or specific details regarding their medical condition, unless they have given their consent.
74. Digital communication and social media

Background
The Digital Revolution has generated the most expansive freeway of knowledge – the Internet – which in turn created the most accessible physician ever – Dr. Google. With the click of a button, we gain access to tens of thousands of websites offering medical consultation and professional medical information. These websites are available to billions of users every day, including physicians, medical students, patients and the general public. The development and expansion of social media networks such as Facebook, Twitter, blogs, forums and dedicated medical websites have enabled patients to consult with thousands of users with similar medical issues and hardships. These platforms create support groups and safety nets that provide patients with emotional support, inform them about similar cases and their available treatment options and, of course, facilitate learning from others’ experience. Such websites and forums also help develop and promote collegial discourse between physicians who seek advice, share ideas and challenge each other. This leads to a substantial improvement of the medical care provided to patients. This new reality has engendered a new model of care – “collaborative healthcare” – a model that encourages patients and caregivers to be active partners throughout the course of medical treatment, promotes the provision of quality personalized healthcare utilizing the vast amount of available information and makes physicians more accessible to assist patients. However, the availability of medical information has created a complex reality – information that was once exclusive to physicians is now public knowledge. Patients arrive for appointments or treatment prepared and informed regarding both their medical issue and their treatment options. The visibility and accessibility of both physicians and patients in social networks can blur the boundaries of physician-patient relationships. As a result, physicians often encounter patients who question their professional authority and even consider their recommendations a “second opinion.”

These issues, which are surfacing due to the expansion of the digital revolution, have an immense impact on patients’ trust in their physicians and in the field of medicine in general. The Israeli Medical Association – like other medical associations in many modern countries, including the U.S., Canada, Australia and New Zealand – considers it important to formulate medical ethics rules for digital communication and social media. These rules will guide physicians through the many dilemmas they face during their routine, professional and social use of the Internet and digital platforms, with their patients and in general.

Definitions
"Caregiver" or "physician" – as defined by the Patient's Rights Law, 1996.
"Digital communication" – any use of advanced technological platforms including websites, forums, blogs, email and text messages, whether or not connected to the Internet.
"Social media" – websites based around sharing social information online, including Facebook and Twitter.
"Online platforms" – any of the methods of digital communication or social media mentioned
above.
"Advertisement" – including promotional ads, for a certified Israeli physician’s practice or for a medical practice in Israel, that target, according to their format, content or form of advertisement, an Israeli audience and are viewed by them, even if distributed abroad.

**Use of social media – in general**
1. Physicians should maintain a separation and clear boundaries between their professional and personal identities when using social media.
2. Physicians should exercise discretion regarding the personal information they post on digital communication platforms and on social media, and should behave in a manner that dignifies the medical profession.
3. Physicians should avoid posting personal remarks or criticism regarding patients on any online platforms and should not upload personal or offensive content regarding previous or current patients, even if it does not violate the patient’s medical confidentiality.
4. Physicians should avoid forming personal, social and unprofessional relationships with their patients, including sending or accepting “friend requests” on social media.
5. Physicians should regularly monitor and review the information about them visible to patients and should make sure that it is reliable and dignifies the physician and the medical profession.
6. Physicians should not use online platforms to search for information regarding the personal behavior of their patients, including searches meant to monitor their medical condition or motivated by concern for their health.
7. Physicians who become exposed to medical information about a patient online should practice caution and exercise professional discretion regarding disclosing that information to the patient. In these cases, physicians should consider the patient’s well-being and the effect the disclosure will have on the patient-physician relationship of trust.

> Physicians involved in online collegial discourse should refrain from mentioning any identifying information about their patients and should practice careful discretion regarding the content posted on social media, taking extracare to maintain the patient’s privacy and medical confidentiality.”

A physician employed in a hospital posted short stories to her Facebook page regarding patients she had treated in the hospital, and asked for the professional opinions of colleagues who were her Facebook “friends.” The physician detailed the diagnosis and other intimate information regarding her patients. Although the physician did not mention their names, the details she cited were enough to reveal the identity of the patients. This violates the medical confidentiality expected of physicians.

**Caregiver–patient relationships – providing medical information and consultation to patients via the Internet:**
1. Physicians should practice caution, exercise discretion and maintain their patients’ medical
confidentiality and privacy when utilizing digital communication platforms or social media to provide medical treatment or to increase their availability and accessibility to patients.

2. Physicians should not offer personal treatment or medical consultation through digital communication platforms or social media if no prior physician-patient relationship has been established and without receiving explicit, documented consent from the consulting patient.

3. Physicians and medical institutions should include in patients' medical files a consent form confirming the patient's awareness of the risks of receiving treatment via online platforms.

4. When providing medical consultation, physicians should practice discretion regarding the type of consultation requested and their ability to provide a suitable response through online platforms.

5. Physicians should avoid providing medical treatment through digital communication platforms or social media in all cases that require a physical examination or an unmediated observation of the patient's physical or mental state.

6. Physicians involved in providing medical information or consultation to a person who is not under their care, should make sure to provide only general advice and discourage the patient from considering their conversation an alternative to a professional appointment.

7. Professional patient-related material transferred via online platforms should be documented in the patient's medical record just like any other medical information.

8. Medical consultation and information provided and transferred via digital communication platforms and social media are subject to the rules of medical ethics and the law.

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“Physicians should avoid posting personal remarks or criticism regarding patients on any online platforms and should not upload personal or offensive content regarding previous or current patients, even if it does not violate the patient’s medical confidentiality.”

A gynecologist posted on Facebook regarding one of her patients: “My patient is constantly late for her appointments … In response, I’m considering delivering her baby a few hours late.” One of the physician’s Facebook followers took a screenshot of the post and posted it to a Facebook group for women planning to give birth in the hospital where the physician was employed. The post stirred harsh criticism of the gynecologist and the hospital: Patients demanded, through a post to the hospital's Facebook page, that the hospital sanction the physician, claiming that her post represented unprofessional behavior and exposed information that violated physician-patient confidentiality.

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**Collegial discourse online**

1. Physicians should uphold their patients’ dignity and privacy when sharing information, skills, new treatments and research results with their colleagues online.

2. Physicians involved in online collegial discourse should refrain from mentioning any identifying information about their patients and should practice careful discretion regarding
the content posted on social media, taking extra care to maintain the patient’s privacy and medical confidentiality.

3. Physicians should use respectful and collegial rhetoric with their colleagues during any professional discussion online, and should be concise, humble and restrained when expressing their opinion regarding the medical treatment provided by a colleague, while basing their arguments on recognized medical information at the time of treatment.

4. Physicians should make sure the medical information they post online is supported by professional literature and research and is not promoted by financial or commercial interests.

5. Physicians interested in acting based on medical information found online should make sure the information is firmly grounded in medical literature and appropriate research prior to applying it to their patients.

6. Physicians should clearly and plainly state whether the information they post is based on medical research, professional experience or personal opinion.

7. Physicians who identify a colleague’s ethically or professionally inappropriate behavior should notify that colleague.

“Physicians should use respectful and collegial rhetoric with their colleagues during any professional discussion online and should be concise, humble and restrained when expressing their opinion regarding the medical treatment provided by a colleague, while basing their arguments on recognized medical information at the time of treatment.”

A certain medical journal often conducts interviews with physicians from different areas around the country in order to write short articles illustrating a “profile” of sorts. The journal also maintains a Facebook page posting links to articles and papers in order to encourage discussion on the page. One such interview posted to the Facebook page provoked a response by a colleague of the interviewed physician, claiming that the physician is unprofessional and careless and that many times he had to “undo the damage” caused by the physician, who according to him selects outdated and archaic treatment options. Such a comment is inappropriate and offensive.

8. Physicians who identify a colleague’s inappropriate ethical or professional behavior, which persists even after such colleague is alerted to it, should notify the colleague’s superior, the authorities or any other authorized party, at their discretion. Furthermore, physicians who encounter information online that may violate the medical confidentiality or privacy of a patient should take appropriate action to protect the patient and/or the information.

Full disclosure

1. Physicians should maintain complete transparency and should disclose any personal, financial, professional or other conflict of interest that may be relevant to providing medical consultation, information or treatment online.
Online privacy and data security
1. Physicians should safeguard all digital medical information they have regarding their patients and save it in an orderly way.
2. Physicians should use privacy settings that ensure the protection of the personal information and content they post online, and they should limit access to their personal information.
3. Physicians should provide medical consultation or transfer medical information online only via platforms that are protected by a digital security system suitable for the sensitivity of medical information.
4. Physicians should be aware of the legal requirements regarding protection of privacy and abide by them with their patients.

“Physicians should not use online platforms to search for information regarding the personal behavior of their patients, including searches meant to monitor their medical condition or motivated by concern for their health.”

A physician with a private clinic “followed” his patients on the social network Instagram. He had good intentions and only wished to remain in contact with his patients, but as time went on, he began to witness his patients’ “bad habits,” some of which went against his advice. In one instance, the physician encountered a picture of an asthma patient smoking a cigarette at a club. The physician took the liberty of chastising the patient for his behavior, emphasizing the consequences of smoking for asthma patients. The patient was surprised that his physician was aware of details that he had never shared with him.

Advertising and ads:
1. Physicians should adhere to the ethical rules regarding advertising when using the Internet.
2. Physicians are accountable for any advertisement posted on their behalf on the Internet and social media.
3. According to the Physicians’ Regulations (Forbidden Advertisement), 2008, physicians should not advertise online:
   a. on websites containing violent, pornographic or other illegal content or on websites that target minors;
   b. through “pop up” ads, including via links to other websites, banners, etc.;
   c. in violation of section 30A of the Communications Law (Telecom and Broadcasts), 1982; (the “anti-SPAM law”).

“Physicians should avoid providing medical treatment through digital communication platforms or social media in all cases that require a physical examination or an unmediated observation of the patient’s physical or mental state.”

An online platform where users can ask questions on medical topics employs physicians to provide general medical information. In one such case, a user posted
a question asking which product he could use to treat a bothersome medical problem. Several hours later, a physician employed by the platform replied with a recommendation for a specific product, while emphasizing the product’s advantages over similar products on the market. Following this advice, the patient purchased the product in a pharmacy. However, the patient later found out that the product contained an ingredient he was allergic to, and instead of helping his condition, the product made it worse.

4. Physicians may advertise their name, degree, medical training (including recognized specialties), fields of practice, positions, place of employment, clinic hours and contact information.

5. Physicians should ensure that the information they post online and/or on social media is correct and verifiable; they should avoid advertising false or partial information that misleads the public, and should not post advertising information disguised as objective.

6. When advertising online, physicians should not state the advantages of a certain medical treatment without mentioning its risks and drawbacks.

7. Physicians should avoid advertising the success rate of their treatments or guaranteeing the expected results or a cure. Physicians should avoid advertisements praising their skills, knowledge or expertise.

8. Physicians should avoid any online advertising that may harm patients.

9. Physicians should not use online advertisement to encourage the use of medical treatments that are inconsistent with medical directives.

10. Physicians should not induce people to seek medical treatment by arousing fear or anxiety.

11. Physicians should not depict a person’s private parts for advertising purposes.

12. Physicians should not make any use of patients for advertisement, even with their consent, including their name, picture, voice, recommendation and body parts.

13. Physicians should avoid advertising in a way that disrespects the medical profession.

14. Physicians should not feature celebrities or public figures in advertisements, whether they are patients or physicians. For this matter, exploiting friendships between physicians and celebrities for advertising on social media will be seen as forbidden advertising.

15. Physicians should refrain from advertising the prices of medical treatments and from advertising discounts, sales or any other financial benefit in exchange for receiving medical treatment.

16. Physicians should avoid advertising or participating in advertisements for commercial products, whether medical or not. In this context, advertising via social media is regarded as forbidden advertising.

17. Physicians may participate in advertisements intended to promote public health, as long as the advertisement is founded upon scientific information and no commercial names of specific products or technologies are used.

18. Physicians should avoid making advertisements praising or encouraging patients to choose private healthcare over public healthcare.
19. Physicians should avoid making advertisements that emphasize the exclusivity or uniqueness of a certain technique or treatment option.

“Physicians should exercise discretion regarding the personal information they post on digital communication platforms and on social media and should behave in a manner that respects the medical profession.”

A woman in her twenties was hospitalized following an alcohol overdose and lost consciousness for half a day. A physician who knew the patient beforehand and was working in the hospital that day went into her room and took a picture of her restrained to the bed and in a fragile mental state. It later turned out that the physician posted these pictures to his blog, along with his personal interpretation of her condition. Doing so, he exposed himself and the hospital to a lawsuit regarding a violation of privacy and the patient’s right to medical confidentiality.

Examples of violations of the medical ethics rules when using social media

Cases from abroad:

Four nursing students were expelled from college after posting a picture of themselves with a human placenta on Facebook:

Four students who attended a lab course in a medical center in Kansas wanted to share the “experience” with their friends via Facebook. The students asked the instructor for permission to pose for a picture with the placenta and mentioned their intention to post the photo on the social network. According to the students, the instructor did not tell them not to take the picture or that it wasn’t allowed, so they continued to pose with the placenta. The picture was posted on the social network for three hours before they were asked (by the college) to take it down. The director of nursing at the college responded to the incident by saying: “[The students’] demeanor and lack of professional behavior surrounding this event was considered a disruption to the learning environment.” After this serious incident, the students were expelled.

January 3, 2011 dailymail.co.uk

A hospital nurse posted a revealing picture on Facebook – the hospital took disciplinary measures:

A nurse working at a hospital in Northampton, England posted a picture on a social network depicting her raising her shirt and exposing her breasts to a colleague from the hospital. The picture, which was taken inside the hospital where they worked, clearly showed one of the hospital’s patients in the background.

The hospital’s administration decided to take disciplinary measures against the nurse. The administration further decided to ban the hospital staff from using social networks while in the hospital and blocked access to these sites from hospital computers.

October 2, 2008 metro.co.uk
A nurse posted an inappropriate post on Facebook, reprimanding paramedics who were doing their job – and was suspended:
In 2009, an 88-year-old man entered the Holocaust Museum in Washington, DC and opened fire. The motive for the shooting was, apparently, racist.
A nurse working at a New Jersey hospital posted the following on Facebook:

An 88 yr old sociopath white supremacist opened fire in the Wash D.C. Holocaust Museum this morning and killed an innocent guard... Other guards opened fire. The 88 yr old was shot. He survived. I blame the DC paramedics. I want to say 2 things to the DC medics. 1. WHAT WERE YOU THINKING? and 2. This was your opportunity to really make a difference!... And to the other guards .... go to target practice.

One of the hospital employees, who was also a Facebook “friend” with the nurse, took a screenshot of the post and sent it to the hospital administration.
The administration determined that the nurse’s post represents conduct unbefitting medical staff working in a hospital and decided to conduct a disciplinary process. At the end of the process, the administration decided to fire the nurse.


A medical malpractice lawsuit was decided based on the defendant’s medical blog:
A pediatrician was sued shortly after failing to diagnose his patient with diabetes, leading to the patient’s death weeks later. The patient’s family decided to sue the physician, who they claimed had performed the examination negligently and had failed to diagnose the illness in time.
At the same time, the physician had been writing an anonymous medical blog, often describing cases that were under his care. The physician also wrote in the blog extensively about the ongoing lawsuit, while describing his emotions and mainly criticizing the legal procedure, the jury, the attorneys, etc.
In one post, the physician described a meeting he had held with an “expert” who prepared him before his first testimony before the jury and explained that juries usually make decisions in medical malpractice lawsuits based on their impression of the physician’s character. He went on to describe advice he received from that “expert” about how to curry favor with the judges.
As it turned out, these blog entries were detrimental to the physician: Near the end of the defendant’s testimony, the prosecutor asked the physician if he wrote a medical blog and if he was “FLEA” (the pseudonym used for his blog). The physician had no choice but to admit that he was indeed the one behind the blog, which presented the image of an arrogant and snide physician. Once the physician understood, based on the advice he received from his attorneys, that his chances of winning the case were very slim – he agreed to pay a settlement.
May 31, 2007 www.boston.com

Hospital staff were suspended after participating in the Facebook “lying down” picture game during a night shift:
An entire medical team was suspended after its members passed the time during their night shift by playing a social Facebook game. The team, which included seven physicians and nurses, played a game in which they took pictures of each other lying face down on different objects. The staff also took pictures inside hospital rooms while using medical equipment belonging to the hospital.

After finding out, the administration decided that even though the Internet game had not harmed hospital patients in any way, the staff's conduct was inappropriate and therefore they would be subject to an internal disciplinary process.

September 9, 2009 theguardian.com

75. Telemedicine
Published in January 2007

Background
The rapid development of information technology that has occurred over the last decades has led to a significant change in the traditional professional relationship between the physician and the patient. What began many years ago as a simple phone reply to a patient’s request, and later became a reply sent by fax, has now become an impressive capability of transmitting digitally, in real time, very complex bio-medical information of all kinds. There is no longer a need to visit the physician in order to receive his opinion regarding the results of a test and to hear his instructions for continuation of the treatment.

The new technologies permit physicians to remotely acquire complex and vital medical information and to meet the medical needs of their patients, without the latter being obliged to spend valuable time in a meeting with the physician. The rapid exchange of medical information permits the patient to remain in his natural surroundings, while taking a larger and more responsible part for the management of his health. Without doubt, the use of telemedicine will increase and we must prepare ourselves for it.

Apart from the technological problems, relating to the quality and reliability of the medical information, its methods of transmission and security, new ethical problems arise that are unique to the mutual relations, digital in nature, between a physician and a patient who are not situated in the same room and do not see each other. It is impossible to address in a brief paper all the ethical issues related to the digital management of telemedicine. This position paper is consequently intended to present the major features and arouse broader discussion and additional thought amongst physicians, health care organizations, and the general public.

Position paper
- The development of information technology currently permits a remote professional connection between a physician and a patient.
- Despite its advantages, telemedicine creates a new ethical and legal reality, and changes the traditional medical connection based on a personal meeting between the physician and the patient.
- Informed use of telemedicine may improve the professional connection with the
patient and the treatment given to him.

- There is a need for both the physician and the patient to identify one another with full certainty when a remote professional connection is established between them.
- The physician has a professional responsibility for the quality of the treatment in telemedicine, and consequently he must consider whether the medical issue in question is suitable for such a connection, and if he possesses information that permits him to give a proper professional answer.
- In cases in which a physical examination of the patient or a direct impression of his mental condition is required, the physician will not make use of telemedicine.
- Telemedicine shall be conducted in accordance with all the laws and ethical rules of conventional medicine.
- Telemedicine should be employed only under technical conditions permitting the preservation of medical confidentiality, security of the medical information, and its documentation.

76. Advertising and publicity (*)

Introduction
Recently, the Israeli Parliament passed a bill that regulates the subject of advertising by professionals. The bill permits specific professionals\(^9\), among them physicians, to advertise themselves more widely, as opposed to the limited way permitted until now.

The bill was passed against a background of basic rights that were granted legislative validity following the enactment of the Basic Law: Freedom of Occupation\(^{91}\) and the Basic Law: Human Dignity and Liberty\(^{92}\), which marked the opening of a new era, in which the right of the individual to advertise himself was recognized in principle. In light of this, the Knesset reached the conclusion that it was no longer appropriate to sweepingly prohibit self-publicity of physicians. Nevertheless it is important to remember that this subject lies at the heart of medicine, and that the physician-patient relationship is a special one, differing from any other relationship existing between a service provider and a customer.

The patient is, a priori, dependent and lacks information that would permit him to evaluate by himself the nature and quality of the treatment he requires, and consequently, he is almost totally dependent on the physician treating him.

Furthermore, there is concern that granting an option of uncontrolled advertising will lead to rampant competition between physicians and medical institutions, which will in turn lead to a cheapening of the medical profession, and will, in the final analysis, also cause harm to patients.

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90 Midwives, lawyers, psychologists, optometrists, veterinarians and dentists
Consequently, a new law has been enacted, that attempts to confront the aforesaid concerns. The new law replaces sections 11-14 of the Physicians Order.

The new law
The following is the wording of the law that was passed:

Limitations in advertising
11.

a) A licensed physician shall not, directly or indirectly, advertise his occupation in a way that may be misleading or that may constitute harm to the dignity of the profession or that contravenes the regulations enacted pursuant to sub section (c).

b) The Minister of Health, in consultation with the Israeli Medical Association and with the approval of the Knesset Constitution, Law, and Justice Committee, shall be entitled to designate types, forms, and ways of advertising:
   1. That may be misleading.
   2. That may constitute harm to the dignity of the profession.

c) The Minister of Health, in consultation with the Israeli Medical Association and with the approval of the Knesset Constitution, Law, and Justice Committee, shall be entitled to designate the types, forms and ways of advertising that may harm the public, and are therefore prohibited.

d) No person may create advertising for the occupation of medicine or for the occupation of a licensed physician, that, were it created by a licensed physician, would have been prohibited in accordance with the provisions of sub section (a).

e) A licensed physician, whose occupation is advertised by someone else, must make every effort to prevent the said person from acting contrary to the provisions of sub section (d); a person infringing this provision shall be liable to half the fine as set forth in section 61(a)(1) of the Penal Code.

f) If a person infringed the provision of sub section (d) regarding a specific licensed physician, it is presumed that the said physician violated his obligation pursuant to sub section (e), unless the physician proved that he made every effort to fulfill his obligation.

Interpretation of the law

Prohibited advertising
In general, the law uses general terms: misleading, harm to the dignity of the profession, harm to the public, whose purpose is to permit flexibility in enforcement of the prohibitions regarding prohibited advertising. Over the course of time it will be possible to see what interpretation is given to these terms.
Misleading and harm to the dignity of the profession

Section 11(a) and (b) of the law states:

Limitations in advertising

"11.  
a) A licensed physician shall not, directly or indirectly, advertise his occupation in a way that may be misleading or that may constitute harm to the dignity of the profession or that contravenes the regulations enacted pursuant to sub section (c).

b) The Minister of Health, in consultation with the Israeli Medical Association and with the approval of the Knesset Constitution, Law, and Justice Committee, shall be entitled to designate types, forms, and ways of advertising:

1. That may be misleading.
2. That may constitute harm to the dignity of the profession."

The right of the physician to advertise himself is balanced with two interests that the legislator saw fit to emphasize:

a) Prohibition of misleading advertising.

b) Prohibition of advertising that causes harm to the dignity of the profession.

Prohibition of misleading advertising

At this stage it is impossible, as set forth above, to define what action falls into the category of "misleading". However, it is clear that the intention of the term "misleading" refers, in general, to the supply of incorrect information or the supply of partial information that creates an incorrect impression. This may be demonstrated by the following examples:

- Indication of the rate of success of a specific treatment/ practitioner in the advertisement – the reader of the advertisement will in general lack the means to estimate the real success of the practitioner. (Did he treat serious or light cases, which cases did he choose not to treat, the number of treatments on which the data presented are based, etc.)
- Advertising that focuses solely on praising the skill, know-how, and professional qualifications of the physician.
- Advertising presented on behalf of the physician as an image advertisement, that may apparently be regarded as the public as an objective article.
- Apparently innocent advertisements, that are related to a business interest of the physician presenting them.
- Advertisements that indicate an academic degree or specialty not recognized in Israel.

Prohibition of harm to the dignity of the profession

Further to what was said regarding prohibited advertising, the term "the dignity of the profession" is also a general term that, over the course of time, requires interpretation. Nonetheless, it may be generally determined that we are speaking of information that may harm the medical profession overall, and an individual physician, more specifically. We shall give a few examples below:

- Advertising in which the tariffs are given for the proposed medical treatments – the fear
exists that publication of the tariffs will lead to cheapening of the medical profession and to a price war in which emphasis will be placed both by the physicians and the patients on the price of the treatment and not on its quality.

- Advertising that expresses contempt, slander, and negation of the qualifications of other physicians.
- The form of the advertising, the color, size, and location of the advertisement are liable to harm the dignity of the profession.
- The advertising means – because of harm to the dignity of the profession, advertising in the form of flyers distributed to the public, telemarketing, billboards, and offers to give medical treatment by means of correspondence, are prohibited.

Prohibition of harm to the public
Section 11(c) of the law states as follows:
"c) The Minister of Health, in consultation with the Israeli Medical Association and with the approval of the Knesset Constitution, Law, and Justice Committee, shall be entitled to designate the types, forms and ways of advertising that may harm the public, and are therefore prohibited.

The term “harm to the public”, like the terms presented above, is a general term that will be interpreted over the course of time. However a number of examples may be given that demonstrate the harm to the public:

- Advertising that encourages the consumption of unnecessary medical treatment.
- Advertising in which use is made of the name or picture of patients who recommend the treatment.
- Advertising that praises a specific medical treatment without indicating its risks and disadvantages.

Other provisions of the law
Section 11(d) of the law states:
"d) No person may create advertising for the occupation of medicine or for the occupation of a licensed physician, that, were it created by a licensed physician, would have been prohibited in accordance with the provisions of sub section (a).

This section states that the advertising restrictions which apply to physicians, also apply to persons who are not physicians (and to companies) when advertising the occupation of a physician or of the practice of medicine.

It seems that the aim of this section is to prevent the bypassing of restrictions on physician advertising by using another entity that is not a physician.

Section 11(e) of the law states:
"e) A licensed physician, whose occupation is advertised by someone else, must make every effort to prevent the said person from acting contrary to the provisions of sub section (d); a person infringing this provision shall be liable to half the fine as set forth in section 61(a)(1) of the Penal Code, 5737-1977.”

This section states that in addition to the restrictions applying to advertising itself, the physician...
is obligated to prevent someone else, who is responsible for advertising the physician, from advertising contrary to the limitations set forth in the law.

It should be noted that a person infringing the provisions of this section is liable to criminal sanctions in the form of a fine.

Section 11(f) of the law states:

“f) If a person infringed the provision of sub section (d) regarding a specific licensed physician, it is presumed that the said physician violated his obligation pursuant to sub section (e), unless the physician proved that he made every effort to fulfill his obligation.”

The law states that in the event that a third person advertises on behalf the physician contrary to the restrictions existing in the law, it is presumed that the physician for whom the advertising was made infringed his obligation as set forth in sub section (e), viz: the physician did not prevent the advertiser from acting contrary to the restrictions on advertising. The meaning of this presumption is that the physician is the one who must prove that he made every effort to prevent the advertisers from acting contrary to the restrictions as set forth in the law.

Conclusions

The legal situation in the wake of the new law is that self-advertising by physicians is permitted, subject to the restrictions that the advertising will not be misleading, does not harm the dignity of the profession, and does not harm the public.

Over the course of time each of these terms will be given its own interpretation.

77. Prohibition of advertising on the radio or television

Published in August 2009

Background

The provision of medical treatment is not the same as any other “consumer product”, and because of the unique nature of the profession it is not similar to other “independent professions”. The very existence of medicine is based on full trust between the patient and the physician, since there is a tremendous difference in knowledge between the two. Furthermore, the patient’s dependency on the physician is absolute, so much so that he places his life in the other’s hands. The patient possesses no reasonable means of measurement to estimate or compare the quality of the treatment that he requires, or the qualifications, experience, knowledge and professional skill of the physician who offers him this treatment.

In the consumer culture that currently exists, can we choose the physician who treats us in the same way as we choose washing powder or a cell phone – under the influence of expensive and effective advertising in which the physician has invested money? Is it proper for us to permit the marketing of medical treatment as we permit the marketing of every other consumer product? Section 11 of the Physicians Order [new version], 5736-1976, imposes strict restrictions on advertising for physicians. To quote: “A licensed physician shall not directly or indirectly engage in advertising of his occupation that may be misleading or harm the dignity of the profession”. Unfortunately, there are some physicians who do not respect the law and thus harm the dignity
of the profession. Recently, there have been cases of crude self-advertising of physicians over the radio. If we do not halt this phenomenon from the start we shall sooner or later reach a situation in which the weather forecast on the television will be accompanied by an advertising plug promoting the physician who sponsors the forecast.

The members of the Ethics Board felt that advertising and publicity on the radio or television are improper and harm the dignity of the profession, and they have consequently forbidden such advertising in this position paper.

Position paper
- Medical treatment is not similar to any "consumer product" or to any other service supplied to the public.
- Medical treatment is based on full trust between the patient and the physician under conditions of differences of knowledge that make it difficult for the patient to choose the physician or the medical treatment that matches the needs of the patient.
- The selection of the physician or medical treatment should not be influenced by self-advertising of the physician over the radio or television.
- Personal advertising of physicians by means of broadcast media harms the dignity of the profession and erodes the physician's status in society.
- The physician shall not advertise himself by means of radio or television and shall not permit self-publicity over these media channels.

78. Marketing disguised as academia

Published in October 2006

Background
In contrast to other professions, medicine constantly arouses great interest in the public. Research has indicated that the public consumes more medical information in the media than information from any other field, including politics and defense. The explanation given is that medicine is practical and touches upon each and every one of us.

It is not surprising that this yearning for information has been identified by both advertisers and pharmaceuticals companies. We are thus recently witness to the amazing growth of various kinds of "health supplements", which accompany most of the newspapers in Israel. These supplements combine powerful economic interests: the newspaper enjoys considerable income from the pharmaceutical companies, and the pharmaceutical industry receives a stage to promote the medical products that it markets.

In accordance with the law, the pharmaceutical companies are forbidden to directly advertise to the consumer the drugs that they manufacture, and, in particular, the law prohibits the advertising of drugs that are not included in the drugs basket in Israel. Consequently, the companies contact physicians, most of whom have a senior, influential professional status, to "academically" present the advantages of their medical product. In this way, the pharmaceutical companies seemingly evade the legal prohibition by using the physicians as a means of covert advertising without the physicians being aware of their part in this process. Since this
phenomenon is increasing, the Ministry of Health submitted a complaint to the Ethics Board, with a request to intervene in this matter.

The members of the Ethics Board who discussed the subject attempted, in the rules that appear in the following position paper, to strike the required balance between the obligation to supply the maximum amount of medical information to patients regarding every existing medical treatment, whether or not included in the basket, and the preservation of scientific truth. This can be done by furnishing balanced and restrained information not intended to serve the economic interests of any commercial entities whatsoever.

The physician is required in such publicity to employ due diligence regarding any connection he has with the relevant pharmaceutical company. In addition, physicians are required not to exploit this forum for personal publicity that deviates from the provisions of the law and the ethical code, and are required to assume responsibility and to evaluate the statements presented in their name before their publication.

**Position paper**

- The advancement of medical knowledge supplied to the public is currently done, in Israel and abroad, by means of information channels and in the popular press.
- The physician’s obligation, pursuant to the law, is to inform the patient about any treatment existing for his illness, even if such treatment is not included in the drugs basket.
- In medical articles intended for the general public, care should be taken to adhere to the scientific and medical truth existing at the time of publication.
- Every publication should indicate simultaneously and in a considered manner the other treatment options existing for a specific illness, while maintaining the correct balance between these options.
- In these articles, the generic name of the drug, and not its commercial name, should be used.
- Sweeping recommendations that serve the interests of commercial entities should be avoided in these articles.
- All such articles should include due diligence regarding any possible conflict of interests which the physician may have and regarding any connection between him and the pharmaceutical company or the manufacturer of the medical technology that he refers to in the article.
- Such articles should not be exploited for self-publicity, except within the restrictions specified in the law and in the ethical code regarding publicity and advertising.
- It is proper for the physician to approve things brought in his name before their publication.
Part E

79. The physician and social media

Published in December 2009

Social networks, primarily Facebook and Myspace, are transforming the way in which physicians and patients communicate. We must begin formulating rules of conduct for physicians in this new virtual space.

Until recently, the medical space where physicians and patients meet was well-defined, with clear and obvious boundaries: Patients would meet physicians in clinics or hospital wards. Outside these recognized physical boundaries, there was little or no interaction between them. This situation preserved the distance necessary in those years to protect the status of the physician.

Newly developed forms of communication have rapidly and dramatically altered the availability of physicians, and substantially narrowed the professional distance between physicians and patients – to the point of blurring the boundaries between “formal” and “familiar.”

The first of these developments was the pager (or beeper), which allowed patients to track their physicians outside the physical boundaries of their office through an intermediary. The development of cell phones along with text messaging technology (SMS) made physicians even more accessible, almost at any place and at any time, and the physician's personal and private spheres began to overlap. Email created another medium for physicians and patients to remotely exchange medical information, without patients needing to physically meet their physician. All these forms of communication include only two parties: the physician and the patient. Therefore, the privacy and medical confidentiality of patients could be easily maintained.

Social networks have overturned this discreet reality and sparked social discourse regarding the future of the traditional physician-patient relationship in the new age of vast social transparency. In these networks, primarily Facebook and Myspace, tens of millions of people participate in growing chains of “friendships.” Social media allows all people to present themselves as they choose, and to display their personal lives in text and photos as much as they want. Everyone can select their friends in the network, while personalizing the level of exposure, detail and intimacy of their daily life presented to these friends.

A quick Google search showed that an online article published on CNN.com in September 2009 entitled “Should you ‘friend’ your doctor on Facebook?” provoked tens of thousands of comments. This is a new cybernetic reality, and we need to formulate rules for proper conduct for physicians in this new reality.

What about the hierarchy?

The cybernetic space enables patients to gather information on their illness, but also on their physicians. Patients occasionally do this prior to meeting a physician, during treatment or after treatment. Should physicians accept requests to join the friend circle of a patient under their care? Conversely, should physicians invite patients to join their friend network? Will the professional hierarchy be maintained when patients become “network friends,” who can continuously observe the private life of physicians, and are exposed to the family and social
events physicians take part in? Will the professional authority of physicians be maintained after patients have seen them, for example, dancing while intoxicated at a private party? This could happen even if the physician is just a “friend” of a “friend,” who posted the physician’s picture without his knowledge.

It is easy to understand that patients seek to be close to their physician, and consciously or unconsciously strive to form bonds of friendship outside the boundaries of the clinic. Patients believe that if they succeed in doing so, physicians will be nicer to them and that they will receive more attention during their next visit.

Physicians are split on this matter: Some consider the Internet an additional means of professional communication with patients, despite the inherent difficulty in maintaining medical confidentiality online. They see the Internet as a place where they can advertise themselves and attract new patients. This approach is grounded mainly on financial motives. Most physicians, however, refrain from exposing those under their care to their social network. The main fear is that the line may be blurred between the physician’s professional and private lives, and that they will be excessively exposed to their patients. Many physicians also refrain from providing medical counsel online for additional reasons: The necessary time investment without compensation, the inability to preserve proper professional accountability and the fear of resultant medical malpractice lawsuits.

There is no doubt that in the coming years this social-digital reality will alter the interaction between physicians and patients. We must begin to formulate proper rules of conduct for physicians in this new virtual social space.

Should we define a sweeping rule: “Whatever should not be said or done in front of patients in the ER should not be uploaded to social networks?”

The following position paper is our initial attempt to deal with this new reality.

**Position paper:**

1. Physicians should carefully consider whether they desire to share their social network with people under their medical care.
2. Physicians should refrain from discussing personal medical issues regarding people under their medical care on social networks. These issues should be discussed, under the defined restrictions, via the personal email of the physician.
3. Physicians should refrain from mixing their personal and professional lives on social networks.
4. Physicians should practice caution regarding the textual and visual content uploaded to social networks on their behalf, in order to maintain their status and professional dignity and in accordance with the proper rules of conduct for physicians.
5. Physicians should not use social media for self-advertising contrary to the rules for media advertisement and should not advertise any other party.
80. Physicians in the media – freedom of speech versus professional dignity

Published in August 2014

Background

The subject of physicians’ statements in the media was brought before the Ethics Board during a sensitive time and amid a violent conflict, which began with the kidnapping and murder of three teenage yeshiva students and the kidnapping and murder of an Arab teenager from Shuafat. The Ethics Board was presented with several examples of political or social statements made by physicians who expressed their opinions publicly – both through electronic and written media and through social media and the Internet in general. The complaints filed with the Ethics Board link the physicians’ statements to a fear that they may not fulfil their duty to treat and provide optimal professional care to all patients regardless of their background. Is there any truth to this assumption? Is the Ethics Board allowed to make a decision limiting freedom of speech based on this fear? Isn’t expressing political and social positions an integral part of civil behavior in a democratic country?

In some of the examples discussed by the Ethics Board, it was emphasized that regardless of the views the physicians expressed, they provided devoted treatment to anyone in need of their medical specialty. It was noted that people from the other side who were injured in war or sick and sought medical care in Israeli hospitals during the fighting received professional treatment, free of any discrimination.

Freedom of speech is part of the right to liberty and allows expressing positions and exchanging opinions out of mutual respect for each side’s autonomy and the possibility of trying to convince another person in the framework of the democratic regime that society strives to create. As Voltaire said: “I disapprove of what you say, but I will defend to the death your right to say it.” What happens, then, when the method of free expression or its content may hurt a patient’s trust in physicians and their professional dignity?

The Ethics Board members were asked to express their opinion and determine the right balance between maintaining the right of freedom of expression and the duty of physicians to maintain their profession’s dignity, while preserving the trust relationship and impartial attitude towards patients. The main question was: Is it appropriate to limit physicians’ freedom of expression, which is a fundamental right for individuals in a democracy, in order to protect these principles?

Position paper

1. Physicians are entitled to freedom of expression as are all of the State’s citizens.
2. We recommend that physicians consider their words when expressing themselves in the media and in general, along the lines of “Sages, be careful with your words” (Avtalyon, Mishnah: Avot.)
3. Physicians should act with responsibility, consideration, respect and patience when speaking in general and especially in the media.
4. Physicians should practice restraint in any framework pertaining to their profession or workplace.
5. Physicians should not abuse their status by presenting their opinions as if they were based on their medical knowledge.
81. Quality measures for physicians
Published in March 2006

Background:
In recent years, there have been rapid changes in Information Technology (IT), along with the creation of new reliable and available tools for evaluating the quality of medical care. These have induced the major medical insurance companies in the Western world to propagate an innovative process in which physicians are financially rewarded for the quality of medical care they provide. In the UK, for example, the accepted estimate is that these direct benefits amount to a third (!) of the average salary of physicians. This change is not meant to punish the “bad guys” and reward the “good guys.” Rather, it is meant to fundamentally change the professional behavior of each and every physician in the accepted direction of better healthcare – including both routine healthcare and preventative medicine- for those under their supervision. Implementing financial rewards is meant to hasten this change, in order to provide the public with safer and more efficient healthcare. Thus, changing traditional work habits of individual physicians will engender profound structural change in the level of care given on a national level, while reducing the chances for mistakes or neglect. It should be noted that behind these changes is also a distinct financial interest for insurers to save as much money as possible on the operating expenses of the healthcare system. At the same time, we should remember that quality measures that are not adapted to the characteristics of the treated population may divert physicians from treating people of a low socio-economic status, who tend to have low health awareness and compliance, in favor of treating stronger populations. This would make the proposed change fail at its main objective. Conversely, incentivizing “quality of care” instead of “quantity of care” would improve the overall level care given to the whole population. Such a fundamental change in the work culture of physicians and the awarding of “certificates of excellence” for exceptional performance cannot be done without a corresponding fundamental change, which is just as important, in the work conditions of physicians – a significant decrease in the workload piled on them by the insurer and relieving them of tasks that are not medical in nature, with marginal medical added value.

In this unique decision, the members of the Ethics Board authorized financial rewards for physicians who are outstanding in their quality of diagnostic and medical care and interpersonal relations, as stated in this position paper. The main concern of the Ethics Board is that these changes should be done transparently and with complete cooperation with physicians, along with a corresponding change in their work conditions; the motivating force throughout this process should be the patient’s clear interest and safety – and not deepening the pockets of the insurer.
Position paper:
1. Maintaining the health and safety of patients is a fundamental value in medicine.
2. Therefore, we should strive to maintain the highest professional level of medicine possible.
3. Evidence based clinical guidelines and quality measures are recognized tools for improving the standards of medicine.
4. These tools should be developed in every field of medicine by the relevant scientific association.
5. Clinical guidelines and quality measures shall be determined by scientific and medical considerations, for the benefit of the patient, and unencumbered by financial pressures.
6. An employer may examine the clinical performance of a physician in his employment, so long as this is done according to recognized, accepted measures, with full transparency and after giving advance notice.
7. An employer may give incentives, including financial incentives, to a physician whose standards of medical care are especially high. Incentives shall not be given for the purpose of limiting expenses.
8. The satisfaction of patients with the professional and personal attention given them by the physician may also be a measure.
9. The provision of incentives to physicians will be possible only once employers, including the sick funds and the Ministry of Health, recognize the need and obligation to provide physicians with a work environment that enables quality medical services in accordance with this paper.

82. Whistleblowing: Exposing corruption in the healthcare system

Published in October 2012

The healthcare system operates in pronounced conditions of inequality, since physicians hold all the professional information. Patients suffer from physical and mental distress and the troubling uncertainty about whether the treatment they are receiving is truly necessary. Furthermore, healthcare does not operate as an ordinary “consumer market” and patients cannot make comparisons regarding the necessary treatment and its cost. The “second opinion” culture only slightly reduces this disparity.

In a financial system that rewards physicians by the amount of work done, physicians are placed in a structured conflict of interest where they are encouraged to over-test and over-treat, especially when dealing with invasive tests or operations. Under these conditions, are recommendations made by physicians purely professional?

There are a multitude of “players” in the field of healthcare – patients, physicians, HMOs, hospitals, drug companies and manufacturers of medical equipment. This tangled web sometimes makes it hard to draw the fine line between corruption and innocent mistakes.

“Corruption” in the healthcare system means performing actions that are illegal or violate professional ethics, actions that are a clear waste of resources, actions that represent behavior
unbefitting a physician, actions resulting from a lack of professional competence, actions that are motivated by interests other than those of the patient, including the financial interests of physicians.

According to accepted estimates, in the U.S. alone the costs of corruption and fraud in medicine reach a sum of $12-23 billion a year. This is an indisputably enormous sum, covered largely by the U.S. government.

The “Lincoln Law” of 1863 allows any person to expose any act of corruption against the U.S. government and rewards the “whistleblower” who exposes such corruption with 15-25% of the sum collected in fines imposed for the corrupt action.

According to data published in medical journals, in the years 1996-2005 the U.S. collected $9 billion in fines after exposing healthcare corruption. In 2010 alone, about $2.5 billion was collected in such fines. Interestingly, although only 4% of complaints were against drug companies, their fines amounted to 40% of all money collected.

A study conducted with 42 “informers” against drug companies found that 85% of them were or had been employees of the drug companies with “inside information” that led them to expose the corruption. The average investigation time was about five years. For every dollar invested in the investigation, the U.S. government received $15. False accusations filed for revenge or retribution involved thousands of dollars of fines paid by false accusers.

Complaints are submitted to external parties despite the fact that this is ostensibly a breach of loyalty and a betrayal of the organization. Therefore, a complaint must pertain to an action the whistleblower regards as either illegal or immoral, contrary to the fundamental values of the whistleblower or the organization itself. Most whistleblowers initially try to solve the problem within the organization and only turn to the authorities as a last resort. A minority of whistleblowers filed their complaint for their own protection, motivated by fear of a future lawsuit.

The results of the exposure are unpredictable and depend on the balance of power between the whistleblower and the organization, the professional culture of the organization, its financial power and especially on the effect the exposure will have on various position holders and the head of the organization. Many whistleblowers experienced counterattacks by the organization, including personal smears, threat of firing or actual firing, social seclusion in the organization, demotion to junior positions and countersuits for “information theft.”

Whistleblowers pay a very substantial personal price, including prolonged emotional stress, legal fees, the destabilization of the family framework, loss of employment and difficulty finding future employment. Even the average $3 million compensation offered to whistleblowers was not perceived as sufficient compensation for the time spent in legal proceedings, the suffering and the side-effects of the lawsuit.

Whistleblowers should be seen as part of the oversight mechanism for the national healthcare system, and as such should be provided with as much protection as possible, including safeguarding their position.
The Ethics Board discussed this issue and agreed on the following position paper:

1. Physicians who discover acts of corruption in their healthcare system should act to expose them.

2. Corruption in the healthcare system means performing actions that are illegal or violate professional ethics, actions that are a clear waste of resources, actions that represent behavior unbefitting a physician, actions resulting from a lack of professional competence, or actions that are motivated by interests other than those of the patient.

3. Direct managers in charge of the administrative body where corruption took place should be notified.

4. If managers fail to take proper action, or if there is a distinct fear that managers are involved in the corruption, the appropriate state authority should be informed about the corruption.

5. Physicians should consider whether to share the uncovering [of corruption] with patients, according to the circumstances of the situation.

6. The IMA and the Ethics Board will defend any physician who exposes with pure intentions acts that a manager, the authorities or a court prove to be corrupt.