TABLE OF CONTENTS

ONE

THE SECOND (OR THIRD) OPINION IN JEWISH LAW

COMPOUNDING CONFUSION OR CREATING CLARITY?

Nachum B. Lebovics
Edward Lebovics, MD

I. INTRODUCTION

The American Medical Association Principles of Medical Ethics declares, "The health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance." Physicians are directed to contribute to this alliance by respecting patient rights. One of these is the right to a second opinion.[1] During the bygone era when the paternalistic model of the practice of medicine prevailed, second opinions were relatively uncommon. As patient autonomy emerged as the dominant medical ethical principle in Western countries, mediating between diverse approaches to patient care has become a routine challenge for patients and physicians.

Certainly, any patient who lacks confidence in his or her physician, whether because of a perceived lack of expertise or poor communication, would be well advised to seek care elsewhere. Such a move might be more accurately classified as a transfer of care rather than a second opinion. The first physician's recommendations would be rendered void, and the patient would essentially be starting anew. However, physicians[2] or patients secure in a healthy relationship may reasonably consider

Nachum B. Lebovics is an alumnus of the kollel of Yeshivas Mir Yerushalayim and Yeshiva Shaar HaTorah-Grodno. He is currently a medical student at the Albert Einstein College of Medicine.

Dr. Edward Lebovics, MD, FACP, FACG, AGAF, FAASLD is the Interim Chairman of the Department of Medicine, and the Sarah C. Upham Professor and Director of the Division of Gastroenterology and Hepatobiliary Disease, New York Medical College.

The authors express their profound gratitude to Rabbi Aryeh Millet and Rabbi Eliezer Lebovics, who graciously provided vital assistance in the preparation of this manuscript.

1 "Patient Rights," AMA Principles of Medical Ethics, https://code-medical-ethics.ama-assn.org/ethics-opinions/patient-rights, 1.1.3(g).

2 The *Shulchan Aruch* (*Yoreh Deah* 336:1) prohibits a physician to practice if there is a greater expert present. R. Eliezer Yehudah Waldenberg (*Tzitz Eliezer* 5, *Ramas Rachel* 22:5–6) limits this prohibition to cases when the greater expert is readily available. It also does not apply to conditions whose management is well known and within the competency of the lesser expert.

a second opinion. Common scenarios that would precipitate such a step include an anticipated major but non-emergent[3] intervention, lack of expected improvement in the patient's condition, or a particularly rare or complex condition. The physician or patient may prefer a more experienced practitioner, or the patient's family or clergy may advocate for a second opinion. However, the nature of multiple opinions is such that it may promote confusion rather than inspire confidence.

It is the absolute prerogative of any patient to choose his or her physician, based on the principle of *lo mi'kol rofei zocheh adam l'hisrapos* (one does not merit a cure from every physician).[4] However, when a second opinion is desired, it is critical that a competent practitioner be identified to render the second assessment.

To aid in this endeavor, multiple resources are available, including the referring physician, other physicians, community-based referral agencies, and reputable online resources.

In the absence of direction, even a medically sophisticated patient is vulnerable to misleading heuristics in arriving at the truly optimal management.[5] There is a tendency to favor information that supports one's preexisting beliefs (confirmation bias), or base decisions on the hope for a preferred outcome (outcome bias) rather than acknowledging valid data.[6,7] For instance, consider a condition for which guidelines strongly support an aggressive surgical approach. The patient, fearing surgery, may unconsciously prefer a practitioner offering a conservative alternative unsupported by evidence. While guidelines include flexibility based on the patient's values, such as the priority of safety versus efficacy, a halachically valid decision must nonetheless conform with acceptable standard of care.[8]

This presentation will discuss (1) the permissibility or obligation to pursue higher-level medical care, (2) the evaluation of conflicting medical opinions, and (3) the respective roles of rabbis and physicians in this process.

It must be noted that references in the rabbinic literature to degrees of expertise are not defined in contemporary terms and cannot be assumed to be consistent across different authorities (see n. 70–72).

3 In an emergency, immediate intervention is required, as codified in the *Shulchan Aruch* (*Orach Chaim* 328:2): "For someone who has a dangerous illness, it is a commandment to violate Shabbos. One who acts quickly is praised. One who asks spills blood."

4 *Yerushalmi*, *Nedarim* 4:2; *Ran*, *Nedarim* 41b; *Shulchan Aruch*, *Yoreh Deah* 336:1. This teaching may stem pragmatically from an effective doctor-patient relationship, including the patient's confidence in the physician (*Tzitz Eliezer* 13:56:8) or the intensity of the physician's focus on the case (*Igros Moshe*, *Choshen Mishpat* 2:74:1, although R. Moshe Feinstein's phraseology indicates that the physician's focus and *lo mi'kol rofei* are distinct points). Such an interpretation is reminiscent of the parallel precept *lo min ha'kol adam zocheh lilmod*, based upon which a teacher must accompany his student who committed an inadvertent murder into exile (*Makkos* 10a; see *Ritva* ad loc.), reflecting the *rebbi-talmid* bond that sustains successful learning. Alternatively, *lo mi'kol rofei* may be a metaphysical phenomenon based upon the Talmudic assertion that when a Heavenly decree imposes an illness, the decree includes when, though whom, and by which therapy the condition will be withdrawn (*Avodah Zarah* 55a). Since the cure comes via unique, predetermined practitioners, the patient must be empowered to solicit the physician who can bring about his recovery (see n. 28).

5 See *Tzitz Eliezer* 5, *Ramas Rachel* 22:7–8. For similar reasons, R. Waldenberg admonishes patients against self-medicating (other than common remedies for minor ailments).

6 Ian A. Scott, "Errors in Clinical Reasoning: Causes and Remedial Strategies," *BMJ* 338 (June 2009): b1860. https://doi.org/10.1136/bmj.b1860.

7 Pat Croskerry, "The Importance of Cognitive Errors in Diagnosis and Strategies to Minimize Them," *Academic Medicine*: Journal of the Association of American Medical College 78, no. 8 (August 2003): 775–80. https://doi.org/10.1097/00001888-200308000-00003.

8 The halachic requirement for physicians and patients to adhere to the generally accepted standard of care is beyond the scope of this paper. For full discussion, see, R. Moshe Rotberg, "Halachah's View of the Requirement to Follow the Established Standard of Care," *Touro University/New York Medical College Medical Halachah Annual* 1 (2023): 47–62.

Theological Considerations

From a theological point of view, pursuit of a second medical opinion may depend on the dispute between the *Ramban*[9] and Rabbeinu Bachya ibn Pakuda[10] regarding the balance of *bitachon* (trust in God) and *hishtadlus* (effort).[11] The *Ramban*'s opinion is that the person complete in his *bitachon* need not pursue efforts to maintain his health.[12] However, we, not being on this sublime level, must make efforts consistent with the natural order. Rabbeinu Bachya, on the other hand, believes that health and sustenance are not subject to nature at all. Nonetheless, we are commanded to make the appropriate effort so that God's blessings do not appear miraculous and we escape the dangers of idleness.[13] Thus, the *Ramban* would support a second medical opinion as appropriate *hishtadlus*, a reasonable effort. However, Rabbeinu Bachya, arguably, would reject it as excessive when the cure can be brought about through the first physician without appearing miraculous.[14]

Definitive theological backing for a second medical opinion is found in the *Moshav Zekeinim*,[15] a compendium of writings by the Tosafists, based on the verse "*V'rapo yerapei*." They derive from the double reference to *refuah* that two physicians are involved. Lest one mistakenly assume the failure of the first physician to effectuate a cure indicates that the intention of Hashem is for the patient to remain ill, the second reference to healing teaches that the patient may seek out a second physician. Importantly, according to all opinions, it should be recognized that ultimately, God provides the cure, not human intervention.

II. THE PURSUIT OF MORE-EXPERT CARE

There is no halachic imperative to seek the most expert physician when the patient is satisfied with competent care. R. Yitzchak Zilberstein[16] suggests support for this notion from the Biblical story of Yocheved placing the baby Moshe in a wicker basket.[17] The Talmud explains that she did not use stronger material that would have better protected the child, preferring cheaper material out of a scrupulous avoidance of stolen property.[18] The *Maharsha* adds that use of the wicker basket certainly did not present a danger, for if it did, saving Moshe's life would override any other concern. Rather, Yocheved was not required

---

9 *Vayikra* 26:11.

10 *Chovos Halevavos*, *Shaar Habitachon*, ch. 3–4.

11 See the elucidation of R. Yaakov Kamenetsky (*Emes L'Yaakov*, *Bechukosai* 26:11). We acknowledge Dr. Irving Lebovics for directing us to this source.

12 See *Alei Shur*, vol. 2, pp. 599–601, where R. Shlomo Wolbe limits the *Ramban*'s directive to abstain from medical intervention to Biblical times, when a prophet or priest guaranteed the outcome. See also *Teshuvos Minchas Asher* 1:120. R. Asher Weiss analyzes the *Ramban* in *Vayikra* (ibid.) and in *Toras Ha'adam*, *Shaar Hasakanah*, concluding that in the current era, the *Ramban* would obligate a sick person to seek medical attention.

13 Notably, Rabbeinu Bachya writes that one is required to choose the foremost intermediary (i.e., physician) and then believe that God's decree will be enacted (*Chovos Halevavos*, *Shaar Habitachon*, ch. 4, *Lev Tov*, s.v. "*Lamros*"). The notion that once the desired physician is identified, the patient should no longer intervene is promoted by the Lubavitcher Rebbe, R. Menachem Mendel Schneerson, who wrote, "The Torah gives [a doctor] permission to heal…and this is why people commonly go to doctors and we follow their medical advice. There is nothing else for you to do in this matter—leave that to the doctor. What you [do] need to do, is be confident in Hashem that you will have a long life" (*Igros Kodesh*, vol. 5, pp. 156–58).

14 This proposition would have to maintain that when obtaining the initial consultation, choosing the greatest expert is the appropriate conduct to minimize the appearance of a miracle. However, the pursuit of subsequent opinions may be excessive *hishtadlus*. This cannot be a strict rule. It would not apply when a second opinion is standard practice, such as if the first physician suggests a second opinion or offers no treatment.

15 *Shemos* 21:19.

16 *Shiurei Torah L'Rofim* 2:89, pp. 170–71.

17 *Shemos* 2:3.

18 *Sotah* 12a; see *Rashi* there.

to spend money for an added level of protection.[19] The same applies to a patient. It is true the *Birkei Yosef*[20] states that a patient is required to pursue the most expert physician, lest he be liable for injuring himself. However, R. Eliezer Yehudah Waldenberg points out that the *Birkei Yosef* appears to be referring to a past era when healers required no licensure. His instruction would not apply to modern times when physicians require state certification to practice.[21]

A remarkable anecdote is told of the distinguished *dayan* R. Yechezkel Abramsky, which demonstrates the prerogative of a patient to decline a second opinion. R. Abramsky took ill and was under the care of his local doctor. His attendant urged him to seek an expert opinion from a renowned professor. R. Abramsky responded by asking his disciple why nobody boarding a plane asks for the credentials of the pilot. He provided the answer: "Because the pilot is on the plane with you. My personal physician is enduring my illness with me."[22]

While there is no requirement to seek a higher level of care, a patient may choose to do so. This applies to a *choleh she'yesh bo sakanah* (a dangerously ill patient) even if doing so involves violating Shabbos. R. Zilberstein quotes a source for this ruling[23] from the Mishnah that states that we summon a "*chachamah*" from outside the *techum* (the distance of two thousand *amos* from dwellings beyond which travel is forbidden on Shabbos) to deliver a child on Shabbos.[24] The *Tiferes Yisrael* comments that the Mishnah's use of the term *chachamah* for midwife, as opposed to the more common term, *meyaledes*, implies that even if a midwife is present, a more expert practitioner may be summoned.[25]

In a case involving a child in need of open-heart surgery whose parents sought to transfer from the care of a competent surgeon to a renowned expert surgeon, R. Shlomo Zalman Auerbach ruled that a donation to the child's care qualifies as charity if the anticipated outcome would be significantly better ("*yatzliach gadol b'harbei*") and thereby be considered *pikuach nefesh*.[26] While "significantly better outcome" was not defined in this case, R. Auerbach elsewhere opines that the benchmark for *safek pikuach nefesh* is that which most people would fear and avoid.[27] However, this standard is applicable to designating funds as charity. Regarding violation of Shabbos to access a higher level of care for a *choleh sheyesh bo*

19 *Chiddushei Aggados Sotah* 12a, s.v. "*Teivas*." See also n. 27 and 28.

20 *Yoreh Deah* 336:4.

21 *Tzitz Eliezer* 5, *Ramas Rachel* 22:5.

22 This well-known story is referenced in *Toras Hayoledes*, supplement to ch. 7, *siman* 12, p. 486. Of note, R. Moshe Feinstein advises that if choosing between a physician who is a *yerei Shamayim* and a greater expert who is non-observant, one should choose the greater expert (*Igros Moshe*, *Yoreh Deah* 4:8:1). R. Shlomo Zalman Auerbach (*Shulchan Shlomo*, *Erchei Refuah*, vol. 1, pp. 98–99) rules that for care on Shabbos, an observant physician is preferred; if the non-observant physician has greater expertise or is the only physician available, though, it is permissible to go to him. R. Waldenberg writes that while, all things being equal, a Torah-observant physician is preferred, the priority is that the patient be comfortable with the choice of physician because *lo mi'kol rofei zocheh adam l'hisrapos* (*Tzitz Eliezer* 13:56:8). For the same reason, R. Feinstein advises that if a greater expert does not know how to cure the illness, one should still consult physicians of lesser reputation who may provide an effective treatment (*Igros Moshe*, *Choshen Mishpat* 2:74:1). Regarding seeking assessment regarding fasting on Yom Kippur, R. Yosef Shalom Elyashiv (*Toras Hayoledes*, ch. 3, n. 1) and R. Nissim Karelitz (*Chut Hashani*, *Shabbos*, vol. 4, p. 252) write that an observant physician is preferred, but if unavailable, a non-observant physician can be relied upon (see also n. 32).

23 *Shiurei Torah L'Rofim* 2:88, p. 164. Of course, no specific source is needed when seeking a higher level of care falls under the rubric of *safek pikuach nefesh* or *yesuvei daata*, which always permit violation of Shabbos (see n. 28 and 29).

24 *Shabbos* 128b.

25 *Shabbos* 18:33 (*Yachin*). From the discussion in *Shabbos* 128b and commentaries there (see *Rashi* and *Rashba*), it emerges that this source permits at most the violation of *techum Shabbos*.

26 *Shulchan Shlomo*, *Erchei Refuah*, vol. 1, p. 74. See further discussion in *Shiurei Torah L'Rofim* 2:88, pp. 165–66.

27 *Minchas Shlomo* 2:29 (in later editions, 2:37), s.v. "*U'l'inyan*."

sakanah, R. Zilberstein rules that one may act in the same manner as one would on a weekday.[28]

At first glance, it is paradoxical that a patient is not required to seek a higher level of care yet may violate Shabbos if he chooses to do so. This seemingly defies the axiom that one may not override Shabbos to achieve a goal that is not even a required mitzvah to begin with. This enigma can be explained based on a principle championed by R. Asher Weiss. In some cases, the Torah affords a person the option as to how to proceed. It is a person's decision that will either trigger obligations or not. For example, a terminally ill patient with only short-term survival prospects and suffering from severe pain may opt for no further life-prolonging therapy. Halachah would then not require intervention to save him. However, if the patient requests that all measures be taken to prolong his life, halachah would demand intervention, even overriding Shabbos. Similarly, a patient may decline a higher level of care when under the care of a competent physician. Yet if he chooses to access a renowned expert who may provide a significantly better outcome, the decision generates an obligation to access such care, even if he must violate Shabbos to do so.[29]

III. EVALUATION OF CONFLICTING MEDICAL OPINIONS

The primary Talmudic source for resolving disputes between doctors is the case of evaluating whether a sick person may fast on Yom Kippur.[30] The rulings relevant to this discussion are as follows:

- If one physician says the patient must eat and one says he may fast, or it is two versus two, the patient must eat, based on *safek nefashos l'hakel* (we are lenient if there is even a doubtful threat to life).[31] The opinion of an expert gentile[32] is accepted in this matter. This ruling applies even if the physician(s) advocating the strict position that the patient may fast is a greater expert.[33]
- If two physicians or the physician and the patient[34] say the patient may fast, and a single physician says he must eat, he must fast.[35] This is based on *ein devarav shel echad b'makom shenayim* (a single opinion in opposition to two or more is discounted). However, if the single physician advocating the lenient position that the patient must eat is a *muflag b'chochmah* (a preeminent expert), the patient must eat.[36]

---

28 *Shiurei Torah L'Rofim* 2:88, p. 165, based on *Shulchan Aruch*, *Orach Chaim* 328:4; see *Mishnah Berurah* and *Biur Halachah* ad loc.

29 *Teshuvos Minchas Asher* 1:117. See also R. Yosef Aryeh Lorincz, *Mishnas Pikuach Nefesh* 1.

30 *Yoma* 83a.

31 *Orach Chaim* 618:2.

32 The *Mishnah Berurah* (618:6) writes (based on *Rama*, *Orach Chaim* 328:10) that only an expert gentile physician is considered. The *Mateh Ephraim* (618:2, *Ketzei Hamateh* 618:3) decries the lack of sensitivity of gentile and non-observant Jewish physicians of his day for the importance of fasting on Yom Kippur, referencing several responsa. He concludes that the credibility of the physician is ultimately dependent on the assessment of the *posek*. The *Biur Halachah* (618, s.v. "*Choleh She'tzarich Le'echol* cites the *Mateh Ephraim*.

33 *Rama* 618:2 and *Mishnah Berurah* 618:8. R. Elyashiv concurs with this ruling (*Kovetz Teshuvos* 3:68). However, see *Mateh Ephraim* (618:2, *Elef L'Mateh* ad loc.), who references a dispute in this matter. The *Magen Avraham*, quoting the *Bach*, rules in accordance with the *Ramban* that in a case where the two sides are equal in number, if a preeminent expert (*muflag b'chochmah*) says that the patient may fast, we follow his opinion even *l'chumra* (see n. 43 for further elaboration of the *Ramban*). The *Mateh Ephraim* amplifies that the position of the *Rama* that we do not follow the *muflag l'chumra* presupposes that the *meikil* is an expert as well, just less so than the *muflag*. If the *meikil* is a "simple" physician, his opinion is discounted when opposed by a *muflag*. The *Mateh Ephraim* concludes that the ruling is ultimately dependent on the assessment of the *posek* (*ha'davar taluy bi'ros einei ha'moreh*).

34 *Mishnah Berurah* 618:9; when the patient has a physician supporting his opinion, his desire to fast is not attributed to emotional reasons.

35 *Orach Chaim* 618:3.

36 *Mishnah Berurah* 618:10.

- If two physicians say he must eat, even if one hundred physicians (and the patient) say he may fast, the patient must eat.[37] This is based on the principle of *ein holchin b'pikuach nefesh achar ha'rov* (we do not rely on a majority in matters of threat to life).
- If the physician is familiar with the condition but is in doubt whether fasting will lead to danger, the patient must eat based on *safek nefashos l'hakel*.[38] If the physician is unfamiliar with the condition, his opinion is discounted.[39]

Majority Opinion vs. Superior Expertise

This *sugya* is the source of a fundamental dispute amongst Rishonim about whether the majority opinion (*rov minyan*) or superior expertise (*rov chochmah*) prevails. The *Ran* writes that the use of the term *beki'im* (experts) in the Mishnah[40] implies that expertise is prioritized over numbers, both for leniency and stringency.[41] Therefore, if a single physician with superior expertise contends that the patient can fast, and two lesser experts say he must eat, the *Ran* rules that the patient must fast.[42] The *Ramban* disagrees, asserting that majority prevails over expertise. As such, we instruct the patient to eat based on the opinion of two experts, even if a preeminent expert says that he can fast.[43]

The *Rambam* has a third view. He writes, "If some physicians say he needs [to eat], and some say he does not need, we follow the majority or the greater experts."[44] The phrase "we follow the majority or the greater experts" is widely understood to reflect a hierarchy of factors.[45] The numerical majority opinion is reckoned first for both leniency and stringency. In essence, the *Rambam* maintains that the concept of *trei k'mei'ah*, that two valid witnesses are weighted equally to a hundred, is not relevant in this context.[46] Only if the advocates of each side are equal in number does the side with superior expertise prevail.[47]

Although fundamental, this debate about *rov minyan* versus *rov chochmah* has limited practical applicability for the Yom Kippur situation. The *Rama* rules that two lesser experts who require the patient to eat prevail over two superior experts who say he may fast because of *safek nefashos l'hakel*.[48] The *Shaar Hatziyun* interprets the ruling of the

37 *Orach Chaim* 618:4; *Mishnah Berurah* 618:11.

38 *Orach Chaim* 618:5; *Mishnah Berurah* 618:14.

39 *Orach Chaim* 618:6.

40 *Yoma* 82a.

41 *Yoma* 4b in the *Rif*'s pagination. The *Ran* references the Talmudic passage explaining why Beis Shammai practiced according to their own rulings despite their adversary, Beis Hillel, being the majority: "When do we follow the majority? In a case where the disputing parties are equal in wisdom to one another. Here, however, Beis Shammai is sharper than Beis Hillel, and therefore, they acted in accordance with their own opinion even though they were in the minority" (*Yevamos* 14a).

42 The *Ran* adds a cryptic phrase—that this ruling is true "if it is clear to us that the superiority of his expertise outweighs the larger number of the others."

43 *Toras Ha'adam*, *Shaar Hasakanah*, cited by the *Tur* in *Orach Chaim* 618. The *Ramban* marshals support from the practice of the Sanhedrin, where rulings were established by the majority regardless of the relative expertise of the judges. Accepting that this proof is inconclusive, the *Ramban* concedes that (1) a preeminent expert (*muflag*) prevails if the two opinions have an equal number of advocates, and (2) one superior expert overrides multiple lesser experts if the superior expert rules *l'kula* in a case of *sakanas nefashos* (though there is some ambiguity on this point in the words of *Ramban*).

44 *Hilchos Shevisas Asor* 2:8.

45 See *Maggid Mishneh* ad loc.

46 The *Noda B'Yehudah* (*Tinyana Even Ha'ezer* 57) explains that logically, if two observations are opposed by one hundred, the error should be attributed to the two outliers. For matters of testimony, a *gezeiras ha'kasuv* dictates *trei k'mei'ah*. However, this novel principle cannot be extended to any other context. See n. 51.

47 Thus, the *Rambam* prioritizes *rov minyan* over *rov chochmah* even more than the *Ramban*, who at least favors the superior expert if he is lenient in a situation of *sakanas nefashos*.

48 See n. 33.

Rama to apply even if the physicians advocating that the patient may fast are superior in both numbers and expertise, because the doctrine of *ein holchin b'pikuach nefesh achar ha'rov* dictates to be lenient.[49] However, as will unfold, the principle of *rov minyan* may be operative for medical decisions where neither option is inherently stringent or lenient. Thus, the ruling of the *Rama* cannot be construed as a rejection of the *Rambam* (that majority rules) for situations where *ein holchin b'pikuach nefesh achar ha'rov* does not apply, such as in patient management decisions, when both options present risk to the patient.

The Role of Certainty in the Physician's Assessment

The doctrine of *ein devarav shel echad b'makom shenayim* is central to the conclusions to be drawn from the *sugya* and requires elaboration. The rule of *trei k'mei'ah* is ordinarily limited to testimony.[50] For practical assessments, *rov deios* (the majority opinion) is generally relied upon. Nevertheless, with regard to matters of life and death, we revert to weighting two opinions equally to a hundred.[51] Many understand this to be based on *ein holchin b'pikuach nefesh achar ha'rov*.[52] The *Mishnah Berurah*[53] expounds that the source for this is the verse, "*Va'chai ba'hem*—And you shall live by them,"[54] which directs that Torah's commandments never lead to the loss of life. Even a remote possibility of danger warrants leniency. It follows that the doctrine of *ein devarav shel echad b'makom shenayim* indicates that a single expert opinion ordering the patient to eat is so thoroughly discounted by the presence of two contradicting opinions that it does not even register as a remote risk. When to apply this novel doctrine warrants further analysis.

A critical consideration in understanding *ein devarav shel echad b'makom shenayim* is the degree of certainty of the physician's assessment.[55] It would seem reasonable that if the determination is based on direct observation, the physician's report carries the weight of *vadai* (certainty). Such may be the case for many diagnostic assessments, for example, when based on the patient's frailty.[56] However, if the physician's determination is based on analysis and probability assessment, his words are an *umdena* (an estimation). Such assessments introduce a degree of doubt and are given the status of *safek*

---

49 618:11.

50 See n. 46.

51 Whether this ruling remains true at the end of the *sugya* is the subject of debate amongst Rishonim. The *Rosh*, *Rif*, *Ran*, and *Ramban* maintain that this ruling is final. This opinion is codified in *Orach Chaim* 618:4. However, the *Rambam* (*Hilchos Shevisas Asor* 2:8) and *Rashi* (*Yoma* 84b) understand that the final ruling is that we rely on the majority opinion even when evaluating matters of life and death. Accordingly, if two experts say the patient needs to eat and three say he can fast, he would be prohibited from eating.

52 See *Orach Chaim* 329:2, based on *Yoma* 84b. An alternative explanation for the Talmud's ruling weighting two opinions equal to one hundred is given by the *Ramban* (*Toras Ha'adam*, *Shaar Hasakanah*). He writes that because two experts are sufficient to generate a concern for *sakanas nefashos*, we need not inquire further. Once further expert opinions are not necessary, they can be ignored.

53 329:5.

54 *Vayikra* 18:5.

55 See R. Ahron Lopiansky, "The Roles of Medical Expertise and Rabbanim in the Pandemic," *Touro University/New York Medical College Medical Halachah Annual* 1 (2023): 87–97. R. Lopiansky defines certainty narrowly, conferring the status of *vadai* only to information that is verifiable as fact, such as water boiling at 100° C.

56 Frailty has emerged as a major predictor of outcome for a variety of illnesses and interventions (see Martin A. Makary, et al., "Frailty as a Predictor of Surgical Outcomes in Older Patients," *Journal of the American College of Surgeons* 210, no. 6 (June 2010): 901–8. https://doi.org/10.1016/j.jamcollsurg.2010.01.028.). Until recent years, frailty was assessed subjectively by observation alone. Now, it is usually measured by simple bedside maneuvers (dominant hand grip strength, time to do five chair stands, and seconds holding the three-position balance).

(uncertainty).[57] Therapeutic decisions[58] are generally based on assessment of risk and benefit versus the alternatives and as such would be categorized as *umdena*. However, this formulation is not overtly expressed in the *poskim*.

The *Chasam Sofer* and others consider all medical assessments to be *umdena* and, as such, *safek*. They interpret the *sugya* of fasting on Yom Kippur to be referring to the assessment of the physician(s) as a *safek*.[59] It would follow that the principles deduced from that *sugya*, particularly *ein devarav shel echad b'makom shenayim*, indeed apply in a *safek* situation, even for *safek pikuach nefesh*. According to the formulation of the *Chasam Sofer*, if two physicians disagree in *umdena* and they are of equal stature, a third opinion would invoke *ein devarav shel echad b'makom shenayim* and would be decisive, even though the majority opinion is itself considered only a *safek*.

The opinion of R. Elyashiv regarding the physicians' assessment in the Yom Kippur *sugya* is quoted in two places and reflects a nuanced approach that assigns certainty to some medical assessments. One source addresses the question that if the physicians' assessment regarding fasting on Yom Kippur is considered *safek*, why is a *safek pikuach nefesh* of a single opinion (that the patient must eat) discounted by two opinions that themselves are merely *safek*?[60] R. Zilberstein quotes R. Elyashiv as responding that the medical opinions referred to in this *sugya* are considered *re'iyas einayim*, direct observation, and thus are treated as *vadai*.[61] It is reasonable to assume that physicians of Talmudic times were assessing *chulshah* (frailty) by direct observation. The implication is that an assessment of two physicians in *umdena* would not prevail over a single physician's *umdena* of *safek pikuach nefesh*, contrary to the view of the *Chasam Sofer*.

In a different context, R. Elyashiv is quoted as interpreting the *sugya* in a similarly nuanced way. A question is raised why the opinion of a *mumcheh* (expert) does not override two other opinions even to impose fasting, given the halachah that a physician may not even practice if a greater expert is present.[62] Here, R. Zilberstein quotes R. Elyashiv as responding that when the diagnosis is in question, indeed the opinion of the *mumcheh* prevails. However, in the Yom Kippur *sugya*, the diagnosis is clear and undisputed. The issue is only the risk of fasting. For this determination, the *mumcheh* is not

---

57 See *Teshuvos Yehudah Yaaleh* 2:193, who derives from *Rashi* (*Sanhedrin* 78a, s.v. "*Amduhu L'misah*") that following an assault, the court assesses whether the trauma inflicted was deadly, implying that a physician's assessment is not acceptable to impose the death sentence on the defendant.

58 Physicians are aware that diagnostic findings, whether by history, physical examination, laboratory studies, or imaging, entail analysis of sensitivity, specificity, and predictive value of the data. Nevertheless, arguably, halachah may recognize diagnostic evaluation, when unequivocal, as an observation, in contradistinction to therapeutic decision-making, which is a prediction of outcome. Yet, the supposition that therapeutic decisions are all *umdena* and categorized as *safek* needs elaboration. R. Waldenberg (*Tzitz Eliezer* 8:15:7:19) writes that if two physicians disagree on the therapy on Shabbos of a patient, one advising an intervention requiring Shabbos violation and the other one advising a therapy not requiring Shabbos violation, the physician promoting the therapy not requiring Shabbos violation cannot be forced to provide the therapy requiring Shabbos violation, because his therapeutic recommendations are given with definitive knowledge, not presumption. At first glance, it seems that R. Waldenberg is attributing certainty to a therapeutic recommendation. However, R. Waldenberg clearly is referring to certainty by conviction, not by direct observation. While such conviction may be sufficient to forbid violation of Shabbos by that physician, it may not establish a *vadai* status. Alternatively, R. Zilberstein suggests (*Shiurei Torah L'Rofim* 3:221, p. 66) that perhaps a physician's conviction by which he assumes the awesome responsibility of placing a patient at potential risk assigns to that opinion the status of *vadai* (see n. 64).

59 *Teshuvos Chasam Sofer*, *Yoreh Deah* 158. Similarly, see *Teshuvos Panim Me'iros* 1:12 and *Tzitz Eliezer* 5:11:2.

60 R. Waldenberg is not bothered by this question. He explains that even though the principle of *al pi shenei eidim yakum davar* (facts are established by two witnesses) applies to testimony and not *umdena*, Chazal extended the principle to *umdena* for *pikuach nefesh*, attributing a single opinion (when opposed by two) to *b'didami* (conjecture) (*Tzitz Eliezer* 5:11:2).

61 *Toras Hayoledes*, supplement to ch. 54, *siman* 68, p. 551.

62 See n. 2.

considered to have greater insight. Such analysis is *shikul ha'daas*, medical judgment, and is open for all to express, even in the presence of a greater expert.[63] In this case, *shikul ha'daas* is assigned the status of *vadai*,[64] clearly extending the designation of *vadai* beyond direct observation. The implication is that in the case of *umdena*, *ein devarav shel echad b'makom shenayim* would not be invoked, again contrary to the position of the *Chasam Sofer*.

R. Zilberstein provides two illustrative examples:[65] (1) A patient is in the recovery phase of hepatitis. The *mumcheh* says it is safe for the patient to fast, while another physician says the patient must eat. As the diagnosis is not in question, and the disagreement concerns the safety of fasting, the expert's opinion is overruled, and the patient must eat. (2) A patient complains of chest pain, and a physician raises concern of coronary insufficiency. The *mumcheh*, however, states that the symptoms are due to acid reflux. In this case, the diagnostic acumen of the expert prevails, and the patient must fast.

Extending to Patient Management Disputes

In the *sugya* of Yom Kippur, several fundamental principles are operative: *safek nefashos l'hakel*, *ein holchin b'pikuach nefesh achar ha'rov*, *ein devarav shel echad b'makom shenayim*, and *rov deios* versus *rov chochmah*. Furthermore, the same rules employed to resolve disputes between physicians regarding fasting on Yom Kippur are applied to violating Shabbos.[66] However, a critical question to address is to what extent these rules are generalizable to resolving disputes amongst physicians in medical practice. In the cases of Yom Kippur and Shabbos, the issue is danger to health versus violating a prohibition. There is a clear *tzad kula* (lenient alternative, viz., the patient may eat on Yom Kippur or may violate Shabbos) and *tzad chumra* (strict alternative, viz., the patient may not). In medical practice, the issue is between two management options, such as whether to treat or observe, treat medically or surgically, etc. Both sides entail health risks and benefits. *Safek nefashos l'hakel* and *ein holchin b'pikuach nefesh achar ha'rov* favor neither option.[67]

R. Zilberstein rules that in disputes regarding patient management, if a preeminent expert (*muflag*) is present, his opinion prevails.[68] If two physicians disagree and neither is a *muflag*, even if one is a greater expert, a third physician should be consulted whose opinion will be decisive. If a third

63 *Shiurei Torah L'Rofim* 2:100, p. 230. R. Zilberstein reiterates this interpretation in the context of a toddler who is seen sipping from a peculiar bottle on Shabbos (*Chashukei Chemed*, *Sanhedrin* 69a). Two observers say the bottle was labeled "bleach," and one hundred say it was labeled "beer." May Shabbos be violated? He suggests that the doctrine of *trei k'mei'ah* applies to an *umdena*, as in the Yom Kippur *sugya*, where the diagnosis is clear, and the issue is only the danger of fasting. However, in the case of the child, where the issue is the accuracy of the observation (albeit not testimony), it is implausible that the one hundred observers are wrong (see n. 46), and, perhaps, Shabbos may not be violated. Of note, R. Zilberstein expresses this point in several places in terms of the diagnosis being clear and undisputed. However, on one occasion, he refers to the diagnosis and treatment being clear (*Shiurei Torah L'Rofim* 2:100, p. 230), creating a degree of ambiguity.

64 Letter from R. Zilberstein to the author. The designation of the physician's opinion as *vadai* appears to be case-dependent. R. Zilberstein wrote that perhaps the novelty of *ein devarav shel echad b'makom shenayim* is that a physician's conviction by which he assumes the awesome responsibility of placing a patient at potential risk by, for example, allowing a patient to fast or allowing a woman to continue a dangerous pregnancy, establishes the opinion as a *vadai*. Thus, a position that takes the safer approach may be designated as *safek* (see *Shiurei Torah L'Rofim* 4:221, p. 66; see n. 58). However, R. Zilberstein concedes that, in practice, R. Elyashiv did not accept this ruling (see ibid., p. 69).

65 *Shiurei Torah L'Rofim* 2:100, pp. 231–32.

66 *Beis Yosef Orach Chaim* 328:10.

67 There are medical management disputes for which *safek nefashos l'hakel* and *ein holchin b'pikuach nefesh achar ha'rov* indeed apply. See R. Zilberstein (*Shabbos Shabboson*, pp. 172–74, *Shiurei Torah L'Rofim* 4:221, pp. 65–69) for a discussion of management of pregnancy when two physicians advise termination for maternal safety and one physician allows for continuation of the pregnancy.

68 *Shiurei Torah L'Rofim*, 1:9, pp. 121, 126. This ruling is in accordance with the *Magen Avraham*, *Mateh Ephraim*, and *Mishnah Berurah*. See n. 33 and 36.

opinion cannot be obtained, the greater expert prevails.[69] This ruling follows the *Rambam* that the numerical majority prevails, and expertise is considered only if the number of opinions on each side is equal.

The question of how to assess expertise remains to be addressed. There is no definitive source associating the status of *muflag* or *mumcheh* with contemporary rankings of medical expertise. R. Shmuel Yehudah Kauder, writing some two hundred years ago, opines that all physicians of his time were considered *mumchim*, as they were tested by the greatest physicians appointed by the government.[70] The same applies today. R. Yehoshua Leib Diskin is quoted as defining expertise by consensus in the community.[71] R. Zilberstein suggests possible correlates,[72] such as greater seniority, greater number of physicians serving under him, more extensive training, or greater acceptance in the medical community (the latter based on the *Rambam*).[73]

Elsewhere, R. Zilberstein discusses whether in a patient management dispute, one expert overrides two other physicians. He quotes from R. Elyashiv that if the expert discerns features of the condition not appreciated by other physicians, his opinion is accepted. If the observations of all the physicians are the same but the expert is relying on his greater experience, the opinion of the majority prevails.[74] This ruling reiterates the aforementioned position of R. Elyashiv that the supremacy of the *mumcheh* is limited to superior diagnostic acumen. Furthermore, this ruling does not run counter to the *Rambam*'s priority of *rov minyan*. The *mumcheh* prevails when presenting a diagnostic finding, because his assessment is in the realm of *vadai*, unopposed by any other *vadai* opinion. Again, this analysis appears to limit the role of greater expertise to diagnostic, but not therapeutic, deliberations. Thus, the role of the greater expert is narrow.

In conclusion, R. Zilberstein rules that for disputes in patient management between two physicians, (1) if one is a preeminent expert (*muflag*), his opinion should be followed; (2) in the absence of a *muflag*, a third physician should be consulted whose opinion prevails; (3) if a third physician cannot be consulted, the opinion of the more senior of the two physicians prevails; and (4) if the two are of equal stature, *shev v'al taaseh adif*,[75] the passive approach prevails.[76] For cases of two physicians versus one greater expert, if the greater expert is reporting an observation not appreciated by the other physicians, his opinion prevails. If he is relying on greater experience, though, the majority rules.[77]

IV. MAKING DECISIONS IN PRACTICE

When disputes between physicians occur, to whom should the vulnerable patient turn for adjudication: a rabbi or a physician? Operationalizing the halachic principle of *rov minyan* or the designation of *mumcheh* or *muflag* may be challenging in practice. Classifying a recommendation as based on diagnostic acumen or probability assessment may be subject to interpretation.

---

69 Ibid., pp. 123, 126.

70 *Teshuvos Olas Shmuel* 108.

71 *Chashukei Chemed*, *Yoma* 82b.

72 Ibid., pp. 124–25.

73 *Hilchos Mamrim* 2:2.

74 *Asusa*, Elul 5766, pp. 106–7.

75 See *Eruvin* 100a and *Tosafos*, *Rosh Hashanah* 28b, s.v. "*Lo Ne'emar*." Notably, R. Zilberstein quotes R. Moshe Shternbuch and R. Dov Berish Weidenfeld as ruling that the passive approach prevails when one physician believes that a therapy will be beneficial and the other opines that it will be harmful. However, if one physician states that a therapy will be beneficial and the other feels that it will be neither beneficial nor harmful, the therapy should be undertaken (*Toras Hayoledes* 8:5, n. 10, p. 83).

76 *Shiurei Torah L'Rofim* 1:9, p. 126.

77 See n. 74.