A Jewish Perspective on the Refusal of Life-Sustaining Therapies: Culture as Shaping Bioethical Discourse

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A Jewish Perspective on the Refusal of Life-Sustaining Therapies: Culture as Shaping Bioethical Discourse

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Cochrane’s excellent target article (2009) is based on a few ethical and legal assumptions that are currently accepted as “bedrock” principles in Western medicine and bioethics, such as patient autonomy and the right to refuse medical interventions. From this point of departure, he tries to push the envelope further by arguing in support of a practice that is currently “not widely recognized” (47), that of withdrawing ‘natural’ feeding, even from incompetent patients. His main concern is the pressure created by what he considers to be a misconception regarding the need to use a “window of opportunity” (47) to die and the life-and-death decisions made under this pressure. In order to assuage the fear of patients or their surrogates regarding the possibility of “being stuck with life” (47) he argues elaborately that there is no ethical distinction between stopping tube feeding and stopping feeding by hand.

This commentary will not discuss his arguments. Rather, it will highlight the significant cultural gap between Cochrane’s (2009) point of departure for expanding the scope of patients’ rights at the end of life, and the recent Israeli experience in the same area. Cochrane’s concern about “being stuck with life” (47) was one of the major driving forces behind the recently enacted Israeli Dying Patient Law (Ravitsky and Prawer 2008), a detailed and comprehensive law regulating the treatment of the dying patient which was the product of 6 years of intensive public debate and in-depth discussions of a professional national advisory committee (Steinberg and Sprung 2006).

However, within the Israeli context this concern was framed differently. Whereas Cochrane takes it for granted that patients have the right to withdraw life-sustaining therapies and focuses his argument on the right to withdraw ‘natural’ hydration and nutrition, the Israeli debate had a dramatically different point of departure. Israel defines itself as a “Jewish and democratic state” and attempts to integrate a liberal democracy with Jewish values. Although in many ways it is part of the Western medical world, it “deviates considerably from Western norms in certain fundamental respects” (Glick 1997, 955), in particular in rejecting the overriding ethical priority of individual autonomy and in placing an enormous emphasis on the value of human life. The Israeli Dying Patient Law is thus based on ethical and cultural assumptions derived form Jewish law (Halakha) and Jewish values.

Jewish cultural and religious values are the reason that the distinction between withdrawing and withholding life-sustaining interventions is very much alive in Israeli society (Gross 1999). Prior to the enactment of the law, patients and physicians were often concerned about starting ventilation, for the exact same reasons outlined by Cochrane (2009). Their fear, however, focused on “being stuck with life” (47) on a ventilator, i.e. not being allowed to withdraw the intervention once it started. This fear had the alarming effect of pushing some patients to withhold ventilation even when they could have still benefitted from it, thus shortening their lives. One of the main objectives of the long and complex
legislative process that Israel embarked upon was to prevent such circumstances.

Although in the past two decades bioethicists and legislators in most Western countries have rejected the distinction between withdrawing and withholding therapy, they have still acknowledged that psychologically and emotionally the two are not equivalent. Contrary to Cochrane’s (2009) view that the ‘psychological difficulty argument’ is novel in the context of withdrawing ‘natural’ feeding, this argument has been made repeatedly for years regarding the withdrawal of any life sustaining therapy. For example, the British Medical Association (1999) stated that “many health professionals, as well as patients, feel an emotional difference between withdrawing and withdrawing treatment. This is likely to be linked to the largely negative impression attached to a decision to withdraw treatment, which can be interpreted as abandonment or ‘giving up on the patient.’”

The typical Western response to the psychological reluctance to withdraw therapy has been to dismiss it as an emotional reaction that does not withstand the test of moral reasoning, which is precisely what Cochrane (2009) is now arguing with regards to ‘natural’ feeding. In Israel, however, this reluctance is taken seriously, both as a psychological concern and as reflecting a real substantial ethical difference between withdrawing and withholding. The Israeli law does not dismiss the distinction as a psychological/social phenomenon that can be overcome by educating the public and the medical community, but rather makes great efforts to resolve the tension between the demands of individual autonomy (the right to withdraw therapy) and those of Israeli values that echo the Halakhic approach (the reluctance to allow withdrawal). It proposes actual solutions to this tension, solutions that are unique and provide a striking example of the way culture shapes public policy.

Regarding ventilation, the law requires the installation of timers on ventilators in order to transform what is considered ‘continuous therapy’ into ‘discrete therapy’, with the assumption that not renewing a therapy that has been interrupted can be defined as withholding it. This solution addresses both the psychological difficulty of medical staff and family members, and the Halakhic requirement that the procedure leading to the ethically desired outcome be acceptable in and of itself. From the Halakhic perspective, the difficulty of accepting withdrawal is not based on the notion that the life of a suffering dying patient should be prolonged at all costs, but rather on the opposition to human intervention to terminate life. Finding the appropriate means to an ethically acceptable end is therefore a substantial, not just a cosmetic, solution (Ravitsky 2005).

The approach of the Israeli law to the withdrawal of nutrition and hydration is also unique. The law states: “The caregivers of the terminally ill patient (…) will make a reasonable effort to persuade him to receive oxygen, nutrition and hydration, even by artificial means” (Ravitsky and Prawer 2008 [Article C, section 15(b)]). While the law respects the right of a competent dying patient to refuse nutrition and hydration, it introduces a legal requirement to persuade. This requirement allows the principle of autonomy to prevail, while paying homage to the value of life.

Whereas the law does not emphasize the distinction between ‘artificial’ and ‘natural’ nutrition and hydration, it does place great importance on the distinction between competent and incompetent patients. In the case of incompetent patients, contrary to Cochrane’s (2009) argument, the sanctity of life overrides the principle of autonomy and nutrition and hydration must be provided even if the patient previously requested otherwise. For incompetent patients, the Israeli legislator chose to ‘err on the side of life’ for a variety of reasons, some of which Cochrane argues against: the emotional and symbolic difference between nutrition and hydration and other life-sustaining therapies; the fact that nutrition and hydration are regarded as a basic need of any living being rather than ‘therapy’; the fact that death of starvation and dehydration is seen as violating human dignity; and the fact that nutrition and hydration are unrelated to the illness which underlies the dying process and withdrawing them is therefore regarded as a form of euthanasia (Steinberg and Sprung 2006).

The stark difference between the Israeli struggle with the distinction between withholding and withdrawing therapy and Cochrane’s (2009) point of departure which dismisses the distinction altogether, provides an illuminating illustration of the notion that bioethical discourse must be understood within the context of cultural, religious and social attitudes. By this I do not mean to promote a relativistic theory of bioethics, but rather to emphasize that within what is ethically permissible, different societies approach ethical analysis and policy making through their own cultural lenses and therefore often reach different conclusions and solutions.

The Israeli Dying Patient Law may seem—from a Western liberal perspective—as not expressing adequate respect for individual autonomy. Within the society that created it, however, it is seen as a progressive law that guarantees patients’ rights while respecting deeply rooted cultural attitudes and traditions.

All cultures struggle to find the appropriate balance between respect for patient autonomy and respect for human life. A range of possible practices stretches between these two values, e.g. active euthanasia, physician-assisted suicide, withdrawing hydration and nutrition, withdrawing artificial life support, withholding care. Different cultures strive to find their ‘ethical comfort zone’ which is then expressed in legislation and regulation. Even if we agree that certain practices found at the very extremes of this spectrum are unethical (e.g. involuntary euthanasia on one hand and forced treatment of competent patients on the other), there are still different points along the way, around which societies may ethically choose to construct their public policy.
REFERENCES


