Withdrawing Treatment at the End of Life: A Jewish Approach

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Modern medicine is one of the greatest successes of the past century. It eradicated a few life-threatening diseases, almost doubled the average life expectancy in many developed countries and can, to date, effectively treat numerous conditions. As a result, we have learned to trust it and rely on it. Moreover, most of us will put ourselves in the hands of healthcare providers in one of the most vulnerable times of our lives – the time of our death. While performing wonders for us during our lives, modern medicine has the power to harshly intervene in the painful and intimate process of dying. It can prolong suffering and sometimes makes it difficult to preserve human dignity in face of the inevitable.

‘End-of-life decision-making’ and ‘the right to die with dignity’ have become some of the most controversial issues in bioethics in recent years. While many questions about biomedical technology seem to be futuristic or esoteric, end of life questions touch on the lives of every individual. Many people find themselves struggling with them while going through the painful process of taking farewell from a loved one, years before they are confronted with their own death. End-of-life questions thus tend to fuel an intense public debate in many countries, a debate based on cultural narratives and moral values, often stemming from a religious background.

One of the questions that have been preoccupying this ongoing public debate is whether there is a distinction between withholding and withdrawing medical treatment at the end of life. In the past two decades, courts and bioethicists in most Western countries have rejected this distinction. Already in 1983, an American court acknowledged the right to withdraw treatment arguing that “each pulsation of the respirator or each drop of fluid introduced into the patient's body by intravenous feeding devices is comparable to a manually administered injection or item of medication”\(^2\). The argument allowed one to see that withdrawing treatment, a contentious idea at the time, is nothing more than refusing treatment, an already well founded moral and legal right.

However, some doctors, patients, and families still find the distinction to have important ethical implications. The standard Western response to the reluctance of doctors and families to withdraw care is to dismiss it as an emotional reaction. For example, in a

\(^1\) Parts of this paper have been previously published as “Timers on Ventilators” in the British Medical Journal Vol. 330, pp. 415-417, 19 February 2005.

\(^2\) Barber v. The Superior Court of Los Angeles County. 1983. 147 Cal. App 3d 1006.
document titled “Withholding and Withdrawing Life Prolonging Medical Treatment: Guidance for Decision Making”, published in 1999 by the British Medical Association, the distinction is explicitly rejected: “Although emotionally it may be easier to withhold treatment than to withdraw that which has been started, there are no legal, or necessary morally relevant, differences between the two actions. (...) In fact, withdrawal of life-prolonging treatment is often morally safer than withholding it.” The solution offered is to employ rational reasoning and not be misled by the ‘apparent’ distinction

This approach is challenging for individuals or cultures who take the distinction seriously. Israel is a case in point. Although in many ways Israel is part of the Western medical world, it “deviates considerably from Western norms in certain fundamental respects” Israel defines itself as a “Jewish and democratic state” and attempts to integrate a liberal democracy with a Jewish communitarian approach. It does not share the strong Western, especially Anglo-American, consensus regarding the overriding ethical priority accorded to individual autonomy. Traditional values that Judaism shares with other religions are also at play. These place an enormous emphasis on the value of human life up until the moment of death and on the religious notion of life as belonging to the creator and not to people.

Hence, the Western liberal emphasis on autonomy does not always prevail. Rather, the “communitarian dialogue pushes ... to alter the individual’s preferences to better harmonize with the collective voice” In Israel, this collective voice is shaped by a religious heritage that is partly based on values stemming from Jewish religious law, called Halakha. The rich and diverse Halakhic literature encompasses more than 18 centuries of intellectual discourse about most aspects of human life, including bioethics.

A Jewish Perspective

Within Halakhic literature, withholding treatment at the end of life, generally perceived as a permitted non-interference in the natural process of dying, is traditionally distinguished from interventions involving direct contact with the body or immediate environment of the dying person—for example, the withdrawal of treatment that has already started. This distinction stems at least in part from the religious approach that humans should not have an active role in the dying process, which should remain in the hands of God. Jewish religious

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law does not approach the issue from a consequentialist perspective, where the moral value inheres only in the end result. Rather, the procedure leading to the outcome has independent moral value.

The *Halakhic* literature reasons using a metaphor of the dying person as a “flickering candle”, and the idea that one should not be “placing one’s finger on the candle”. In his book *Alternatives in Jewish Bioethics*, Noam Zohar notes that “this clearly excludes an understanding of the forbidden hastening of death in consequentialist terms: the deed’s wrongness is not determined by its result - namely, the fact that the patient is dead at a certain earlier moment - but rather by its symbolic characterisation as extinguishing the candle”\(^8\). This means that withdrawal of treatment is perceived as forbidden even if the death of the patient at that point in time is an ethically appropriate outcome.

In this cultural context withholding is acceptable but withdrawing is not\(^9\). Consequently, an individual’s request to withdraw life sustaining treatment, such as mechanical ventilation, is perceived by many as conflicting with this traditional approach. Patients may request not to be connected to a ventilator, but they cannot ask to be disconnected once treatment has been initiated. This approach delineates limits imposed even on the autonomy of competent adult patients. Israel thus faces the challenge of respecting personal autonomy and the right of individuals to choose how and when to end their lives, while taking into consideration traditional values that sometimes demand limits on these choices.

**Regulating End of Life in a Jewish-Democratic State**

To develop a coherent policy and formulate guidelines, Israel’s Minister of Health established in 2000 a public committee on the dying patient\(^10\). In the introductory remarks to the proposal, Prof. Steinberg – the committee’s chair – writes: “The committee’s assumption is that from a social and a national point of view, it is appropriate to reach solutions for the problem of end of life care, based on a wide consensus, while balancing the conflicting values which underlie decision making processes in this area. In the state of Israel there is a unique need to reach agreement based on its value system as a Jewish democratic state”\(^11\).

The committee reflected professional expertise and included representatives of most Jewish denominations, as well as the larger minority groups within Israeli society. Other than a few dissenting opinions, a wide consensus was reached among all groups, and a proposal was

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11 Report of the “Public Committee Regarding the Patient at the End of Life”, page 7.
submitted to the health minister in 2002, followed by the enactment of a detailed and comprehensive law regulating the treatment of the dying patient in 2005.

In reaching a solution, the committee tried to harmonise the Jewish cultural heritage with the autonomy of a dying patient. A philosophical subcommittee suggested a distinction between continuous and discrete treatment as a way of translating the traditional distinction between withdrawing and withholding into clearly defined terms. According to the proposal, “not continuing discrete treatment” is perceived as withholding, whereas “not continuing continuous treatment” is perceived as withdrawing.

The proposed law defines continuous treatment as “any form of treatment that is essentially uninterrupted and admits of no clear distinction between the end of one cycle and the beginning of another”, and discrete treatment as “treatment that begins and ends in well-defined cycles”. Mechanical ventilation is an example of continuous treatment, while blood transfusions, dialysis, or drug treatment are examples of discrete treatment.

According to the proposed law “it is forbidden to terminate continuous medical treatment ... when the termination may lead to the death of the patient, whether competent or not competent. However, it is permitted to terminate discrete treatment”\(^\text{12}\). Patients may therefore request not to renew discrete treatment, but they cannot request to withdraw continuous treatment, such as mechanical ventilation.

The disturbing result may be that patients will remain connected to ventilators against their will. This presents extreme difficulties. Firstly, as a matter of principle, it would restrict the range of choices individuals have unfettered control over. Secondly, in case of doubt it may lead to a decision not to connect, because the patient herself or family members would rather avoid the possibility of a prolonged suffering and loss of dignity, than gain a few more hours, days or weeks of life. This is true not only for patients and their families, but may also be relevant to healthcare providers. As the British Medical Association points out, “there is a risk that the perceived difficulty of withdrawing treatment could lead to some patients failing to receive treatment which could benefit them. (…)ome health professionals may be reluctant to start treatment in the mistaken belief that, once initiated, the treatment cannot be withdrawn”\(^\text{13}\). Finally, since the need to connect a patient to a ventilator is sometimes urgent and unexpected, decisions would be made in haste, without appropriate discussion among family members.

**Permitting the Withdrawal of Treatment: An Original Solution**

The committee thus sought a solution that would resolve the tension between the demands of individual autonomy and those of Israeli communitarian values that echo the *Halakhic* approach. Instead of attempting to “educate” the medical community and the public to


disregard the distinction between withholding and withdrawing treatment, committee members opted to devise a technical solution. Since the main practical issue is that of withdrawing mechanical ventilation, they came up with the idea of transforming the continuous into discrete by installing timers on ventilators, with the assumption that “not renewing treatment that has been interrupted can be defined as withholding treatment”.  

A second committee was thus established with the goal of developing delayed response timers. These will allow a ventilator to be set for a limited time (such as a week), at the end of which it will be turned off without human intervention. This would allow time for appropriate discussion among patients, family members, and healthcare providers. The discussion may result in a decision to extend the operation of the ventilator for a time determined by medical need or by the wishes of the patient or the family, or in a decision to let it turn off at the set time, providing the patient is under appropriate sedation. Such timers are being developed, but before they are put into clinical use their safety will have to be tested in an ethically approved clinical trial.

Timers have been in use for decades as a technical solution to reconcile centuries of Halakhic law with the use of modern technologies. For example, according to orthodox Halakha, turning electric devices on and off is forbidden during the Jewish Sabbath. Orthodox Jews use timers to regulate operation of electric devices in advance, thus preventing the need for active intervention.

**An Ethical analysis**

What is the bioethical meaning of this proposed solution? If the reluctance to disconnect a patient from a ventilator is based on the belief that the act is ethically wrong, timers could be perceived as deceptive devices meant to disguise an unethical act as a legitimate one. In such a case, a mechanical device that transforms what is in essence withdrawal into what externally looks like withholding has controversial ethical implications. Do timers represent the “displacement of ethics by trickery”? Will they enable Israeli physicians to perform in practice what their principles otherwise forbid them from doing, thus eroding a well founded ethical intuition and encouraging wrong doing?

Timers are not a ruse to an unethical outcome. According to Jewish religious law, even if the outcome is ethically desirable, the procedure leading to it may still be forbidden. Hence, the termination of continuous treatment is perceived as ethically prohibited not because it leads to an ethically wrong outcome but because it uses an ethically questionable procedure to achieve that outcome, as in the case of using tainted evidence to achieve a justified conviction. The difficulty of accepting withdrawal is not based on a belief that the life of a

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suffering dying patient should be prolonged at all costs but on a cultural approach that is ethically opposed to human intervention to terminate life.

Consequently, creating an alternative procedure allows the Halakhic legislator to overcome the obstacle and proceed towards achieving the desirable outcome. Finding an alternative procedure to a desirable outcome is a typical Halakhic approach. It allows adaptation to changing circumstances without requiring the Halakhic legislator to contradict legal principles or precedents.

By converting ‘commissions’ into ‘omissions’, timers are meant to enable healthcare providers to overcome a procedural obstacle to achieve an ethically justified outcome. Moreover, they may allow them to overcome a possible emotional difficulty of terminating life supporting treatment. They also enable people with diverse attitudes and values to reach a suitable pragmatic consensus. Timers should therefore be perceived as an appropriate way of bridging the gap between the ethically justified outcomes of respect for individual autonomy, avoidance of prolonged suffering, and death with dignity, on the one hand, and communitarian cultural values on the other.