Jewish Medical Ethics

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Outline

1. Tenets of Traditional Judaism That Influence Medical Practice
2. Genetics, Reproduction and Sex
3. Death and Dying
4. Organ Transplantation
5. Triage, Access to Health Care and Resource Allocation
6. Human Experimentation

References

Bleich, J.D.: Judaism and Healing

Dorff, E.N.: Matters of Life and Death: A Jewish Approach to Modern Medical Ethics.


Tenets of Traditional Judaism That Influence Medical Practice

1. Human life is of supreme (infinite) value and is given as a loan from God to the individual.
   - Since life does not belong to the individual, it is not his to give away.
   - No life is more or less valuable than another.
   - Man is the steward of his body.
   - In the face of danger to life or health (*pikuach nefesh*), preservation of life takes precedence over all other commandments (except three: murder, idolatry and adultery).
   - God created an imperfect world which man is expected to strive to perfect (*tikkum olam*) and thereby become a partner with God in creation.

2. Man is created "in the image of God" (Genesis 1:27)
   - The human body must be accorded respect in life and in death.
   - Mutilating, scarring or marring the body in life or in death is forbidden.
   - Deriving benefit from the body in life or in death is forbidden.

   (Note: *pikuach nefesh* takes precedence over these commandments)

3. Man holds "dominion over the fish of the sea and birds of the air and every living thing crawling on the earth" (Genesis 1:28)
   - Man has the right to use animals in his service and for his health and the responsibility of protecting them from all avoidable suffering.
   - Man is given the task on earth of using nature for his benefit and the responsibility of nurturing and protecting it as a steward of God.
   - 'Naturalness' is not a virtue in itself.
4. The physician-patient relationship: Healing as an obligation

Biblical mandates:

- "…you shall surely heal…" (Exodus 21:18-19)
- "Return [it] to him – you shall not hide your eyes [from it]." (Deut. 22:2)
- "Do not stand idly by when your neighbor's blood is flowing." (Lev. 19:17)
- "…and your brother shall live with you…" (Lev. 25:36)

Differing values:

- **Civil society**: medical care represents a *contractual relationship* that gives priority to autonomy and consent of the patient (emphasizes *rights of the patient*).

- **Judaism**: medical care represents an *obligation* of the physician that goes beyond a contractual relationship and gives priority to the duty to heal (emphasizes *obligations of the physician*).

Obligations rather than rights:

- **Patient**: obligation to tend to the body given him by God
- **Physician**: obligation to heal
- **Society**: obligation to see to it that healing proceeds in the best way for most patients
Sexuality, Reproduction and Genetics

1. "Be fruitful and multiply" (Genesis 1:28) *(Pru u'rvu)*

- sexual relations:
  
  **primary purpose**: procreation

  **secondary purpose**: sexual pleasure is a gift to be accepted from God with thanks - "...when husband and wife unite in holiness, the Divine Presence is with them" (Talmud)

  need for ritual purification *(mikveh)* a symbol of God's gift

  sex forbidden outside of marriage

  evolution over the centuries (concubines, polygamy, monogamy)

  - "pointless destruction of human seed a grave violation" *(onanism)*
  
  homosexuality:

  - abhorrence of homosexual conduct
  
  - sympathy for those 'afflicted'

  - importance of still unresolved role of genetic basis

  homosexual conduct is to be deplored and "resisted by all means possible"

  (minority view: not a matter of choice - "when a person is compelled…the All Merciful One frees [him from any punishment]" (Talmud); see carefully reasoned exposition of this view by Rabbi E.N. Dorff)

2. Contraception

- forbidden except for considerations of *maternal* (not fetal) health and well-being

- concern over contraception not only on *halakhic* grounds, but also as serious threat to survival of Jewish community (lowest birth rate of any group in the Western world)

- if contraception indicated, there is a sequence of preferred methods:
3. Fertility

"Judaism is generally sympathetic to treatments which allow an otherwise infertile couple to conceive, but opposed to use of donated sperm or ova which breaks the genetic connection between parents and child and introduces confusion at basic levels of identity and relationship" (Shulman)

- medical intervention to assist with fertility generally encouraged, with some exceptions:
  - artificial insemination - husband (AIH): fully allowable
  - artificial insemination - donor (AID) (or sperm bank): forbidden because of risk of incest, lack of valid of genealogy, problems of inheritance
  - in vitro fertilization (IVF) - husband: fully allowable (developing ovum may be tested for genetic abnormality and discarded or used for research - rationale below)
  - IFV - donor: forbidden

4. Surrogate, Host or Incubator Mothers

- controversial, undecided
- implantation of IVF embryo (maternal and paternal) in host (third party) womb for gestation - problematic (may be permissible if no alternative); problem of use of surrogate mother's body for benefit of another person
- embryo transfer (borrowed ovum)
  - woman donor artificially inseminated (father), resulting embryo flushed from womb and transferred to womb of another woman ('mother') and carried to term - unclear

5. Abortion

- beginning of life
  - Jewish view: fertilized ovum, embryo, fetus all represent potential life
  - Catholic view: fertilized ovum, embryo, fetus all have life and soul
• abortion

**Judaism** - permitted for hazard to life or well-being of mother, which takes priority over *potential life* of offspring

**Catholicism** - abortion never permitted and is worse than murder because it kills physical life and a soul that is condemned because it was never baptized

6. Fetal Tissue

• fetus must be protected from risk resulting from research; but tissue from a non-viable fetus may be used

• abortion may not be performed for the sake of 'harvesting' tissue

• no human embryo should be generated solely for research; 'spare' embryos may be used for potentially therapeutic research

7. Gender Selection

• forbidden; class exercise (for extra credit): when is this *halakhically* permissible?

8. Genetic Screening

(see more extensive summary in article by Dr. Fred Rosner)

• genetic information (with varying accuracy and predictive value)
  family history, laboratory tests

• some markers identifiable:
  adult carriers  (Tay Sachs, cystic fibrosis)
  adults themselves at high risk  (Huntington's, some breast cancer, ? Alzheimer
  amniocentesis/newborns  (PKU, cretinism, congenital adrenal hyperplasia)

• problems:
  limitations of tests
  whether to screen for untreatable diseases
  psychosocial effects
  issues of privacy, insurability, etc.
9. Stem Cells

- stem cells: precursor cells with capacity to generate additional cells or tissues of various types:

  - adult stem cells: difficult to obtain; limited capacity (this may be changing)

  - embryonic stem cells: obtainable from aborted fetus, IVF 'spares', or umbilical cord; capacity to generate variety of cells and tissues (currently new embryonal stem cells forbidden by President Bush)

  importance - assist enormously in understanding normal development and disease; potential therapeutic applications in cell therapies ('replacement cells' for regenerative medicine) (Parkinson's, Alzheimer's, stroke, spinal cord injury, diabetes, heart disease, arthritis, etc.)

10. Cloning

- removal of nucleus from unfertilized ovum (contains only half the complement of genetic material [haploid]) and replacement with nucleus from another (non-germ) cell (containing full genetic complement [diploid])

- development of individual without sperm-ovum union and with all genetic information from single individual

- implications - very far reaching
1. Definitions

- **Goses** – an individual who is in the dying process (not expected to live more than 72 hours.
- **T’refa** – gravely ill, but better than goses

2. Defining death itself

- Death as an enemy – or as a part of life
- Cardiopulmonary criteria (cf. Maimonides and “power of locomotion”)
- Neurological criteria
- Brain death controversies
- Balancing definitions of death with organ procurement

3. Valid refusal

- Secular standard
  - Adequate information
  - Voluntariness
  - Capacity
- Rejection of pain-prolonging treatment
- Rejection of treatment that prolongs dying (or causes a “hindrance to departure of the soul”)
- How to balance with *piquach nefesh?*
4. Uses of medical technology

- Dialysis
- CPR
- Ventilators
- Artificial hydration and nutrition (IV, NG, PEG…)

5. Pain management and palliative care; hospice

- Maimonides: pain and suffering as inevitable part of the human experience
- Dorff: Yet pain is not a way to achieve holiness in Judaism
- Growth of hospice, and compatibility with Jewish teaching

6. Assisted suicide, euthanasia

- Distinctions and definitions
- Clearly forbidden
- Valid refusal with palliation as not equivalent to “assisted dying”

7. Role of physician
When Life Becomes Agony, Should Death be Made Easier?

Your 70-year old uncle Joe, who is a wonderful person and has always been your favorite relative, is found to have widely disseminated cancer of the pancreas. Curative surgery is out of the question and he undergoes several courses of chemotherapy with severe side-effects (nausea, vomiting, diarrhea) and no evidence of response. Your uncle and his wife have developed a close relationship with their physician. They decide together to discontinue treatment.

Joe's appetite is poor, he suffers increasingly severe back pain and he becomes progressively weaker and more debilitated. He is taking increasing doses of narcotics, but with little pain relief. Joe begs his physician to hospitalize him so that he can be given better pain relief. The physician prescribes another pain medication in addition to what he is already taking.

Joe's status worsens. He repeatedly discusses ending his suffering by taking a large dose of sleeping pills from a stash that he has saved up. His wife is frantic with anxiety and helplessness and comes to you for advice and help.

(a) What advice would you offer?

(b) What do you think of the possibility that Joe may commit suicide? Is this a morally/spiritually/ethically sound option?

(c) His wife asks for your advice on whether she should assist Joe in doing this. What do you tell her?

(d) What would you like the physician to do? Should the physician help Joe to end his suffering? How?

(d) How do the following descriptive phrases relate to Joe and his wife and physician:

(1) suicide
(2) assisted suicide
(3) 'active' euthanasia
(4) 'passive' euthanasia

(e) Are these measures ever morally/spiritually/ethically appropriate?

(f) Who has fundamental jurisdiction over your body?

(1) in our secular community
(2) in Traditional Jewish law
(g) How does this affect the status of suicide and assisted suicide in these two communities?

Arrangements are made for Joe to be admitted to Baptist Hospital. Joe’s own doctor is seeing patients in the office when he is admitted and sends word that he will see Joe in a few hours. Shortly after Joe is admitted to a room on the medical floor, he experiences a cardiopulmonary arrest. The ward nurses are not familiar with Joe’s situation and summon the ‘Code Team,’ who are successful in resuscitating him. In the course of the resuscitation, an endotracheal tube is placed and Joe is transferred to the Medical Intensive Care Unit for management of his assisted respiration.

Over the next few days, Joe is on intravenous feeding and narcotics. The couple’s only son, from whom they are intermittently estranged, arrives from California, where he is now living. The attending physician raises with Joe’s wife and son the possibility of disconnecting the respiratory assistance device. Joe’s wife is ambivalent about what to do, but the son is adamantly opposed and expresses the view strongly that “everything possible should be done.” Since Joe’s closest relatives are divided, the assisted respiration is continued.

(h) How could this conflict in caring for Joe have been avoided?

Joe is intermittently responsive, showing evidence of continued pain in his back. The doctor prescribes intravenous morphine for pain relief. A dose of 8 mg every 4 hours appears to give him some relief, but this wears off about 3 hours later.

(i) What is your opinion about increasing the dose to 12 mg every 4 hours? To 40 mg?

Joe dies several days later, one of the 50% of Americans who die in an acute care hospital. The bill for his care in the hospital during this final episode, which included 5 days in the Intensive Care Unit, is $14,000, thus contributing to the 50% of all health care expenditures for Americans that are incurred in the last six months of life.
Who Shall Live And Who Shall Die?
Triage, Access to Health Care and Resource Allocation

1. The problem:
   - individual dilemmas - the patient and the physician
   - societal dilemmas - society's decisions concerning distribution of medical resources

2. Individual dilemmas:

   How should priority for health care be assigned among individual patients?

   (a) conflicting guidance in Jewish tradition (Talmud) carefully crafted priority lists (derived largely from the law governing redemption of captives) discussed and debated at length abundant evidence that such lists were largely ignored, with obvious exceptions (relative need, first-come-first-served, repeated needs of those with largely self-inflicted diseases, lottery); example (Dorff):

   Caravans of men are walking down a road and are accosted by non-Jews who say to them: “Give us one from among you that we may kill him; otherwise we shall kill you all.” Though all may be killed, they may not hand over a single soul of Israel. However, if the demand is for a specified individual...they should surrender him rather than all be killed. (Talmud)

   (b) preference for priority guidelines set by society (Dorff):

   Ulla, son of Qoseb, was wanted by the [non-Jewish] authorities. He arose and fled to Rabbi Joshua ben Levi ....[The troops] came, surrounded the city and said: “If you do not hand him over to us, we will destroy the city.” Rabbi Joshua ... went up to him, persuaded him to submit and gave him up [to them]...Now Elijah z'l had been in the habit of visiting him [Rabbi Joshua], but he [now] ceased visiting him. [Rabbi Joshua] fasted....and Elijah appeared and said to him: “Shall I reveal myself to [betrayers] ?” [Rabbi Joshua] said: “Have I not carried out a rabbinic ruling]?” Said [Elijah]: "[This should have been done through others and not by yourself.]"

   Extrapolation (Dorff): "[D]ecisions concerning the scope of health care should not be made by physicians alone....It is also against society's best interests to place the burden of such decisions on physicians, for the doctor must be seen by the patient as his or her advocate with only the patient's well-being in mind."

3. Triage in the real world:

   Visiting Professor: Andrew A. Quartin, M.D., M.P.H., Division of Pulmonary and Critical Care Medicine, Department of Medicine, University of Miami School of Medicine
4. Societal Dilemmas:

How should the burden of the cost of health care be shared?

Who should make decisions concerning the cost and allocation of health care resources?

- the patient and family
- health care professionals
- the community

(a) long tradition in the Jewish community of support for medical care (dating back to medieval Spain), but the community must use its resources wisely

(b) guidance from the Laws of Redemption of Captives:
- community - must set limits
- individual - free to pay without limit

(c) “...community has....the right and the duty to make considered decisions about how it will allocate its resources among its various responsibilities...but there is a mandate (and a moral obligation in Judaism) that everyone have access to health care (Dorff)"

5. "A Jewish Argument for Socialized Medicine" (article by David Novak):

- strong evidence that both physicians and judges (not attorneys) are acting in *imitatio Dei*: “I am the Lord your Physician” (Exodus 15:26) God as "the Judge (ha-shofet) of all the earth" (Genesis 18:25)

- similarities for the Jewish community between administration of justice for all and provision of health care for all and its obligation to do both

- relevance of these traditional Jewish obligations to the general community - for insight and guidance; the Torah was given twice, first in the Wilderness (Mount Sinai) - for all the nations to participate; a second time, just before the Israelites entered the Promised Land, to confirm their obligations

- proposal that '...Jewish ethical tradition has much to offer those who want health care to be based on something (the sanctity of the human person as a being created in the image of God) more morally elevated than the practice of individual autonomy..."
... And When We Die ...

1. Guiding Principles

(a) human body (guf) and soul (nefesh) belong to God; we are merely trustees

(b) the body after death deserves the respect due God's creation (kavod hamet)
   - disfiguring or otherwise desecrating the body is prohibited (nivul hamet)
   - deriving benefit from the body is prohibited
   - even a kohen is required to handle a body if no one else available

(c) prompt and respectful burial required (chevra kadishah)

2. Organ Transplantation

(a) pikuach nefesh takes precedence (no difference or priority for Jew, non-Jew)
   - life to be saved must be 'before you' (hacholeh lefaneinu)
     - not a problem for 'cadaver' organ transplants;
       - but 'organ banks' (bone, marrow, etc.) prohibited by Tradition
   - organ removal must be done with respect
   - Jewish donors underrepresented
     - but organ donation (under appropriate conditions) fully approved
       - and encouraged by Orthodox, Conservative and Reform rabbinates

(b) living organ donors permitted, but not obligatory
   - an act of supreme charity (chesed)
     - must balance benefit with risk to donor, whose consent is, of course, required

3. Special Problems of Heart Transplantation

(a) forbidden to prepare the donor for transplantation surgery

(b) when is the patient dead?
4. Visiting Professor: Joshua Miller, M.D.,
   Professor of Surgery and Immunology
   Co-Director, Division of Transplantation Surgery
   University of Miami School of Medicine

5. Autopsy

(a) requirements as above for kavod hamet

(b) permitted for:
   - legal requirements
   - for information that may save a life (pikuach nefesh)
     defined very narrowly by Tradition (hacholeh lefaneinu);
     organs, tissues must be returned for burial, except for small samples;
     defined more broadly by others
Human Experimentation

1. Guiding Principles:

(a) Jewish tradition - mandated by halachah, with primary emphasis on obligations of both physician and patient to sustain life; informed consent is desirable, but not required: "In the treatment of patients generally, whether the cures are tested or only experimental, the opinion of competent medical experts alone counts, not the wishes of the patient...." Lord Immanuel Jakobovits, Ph.D., Chief Rabbi of Britain

(b) Secular society - mandated by evolving guidelines in Western society (Nuremberg Code, 1949; Declaration of Helsinki, 1964; Belmont Report, 1979), with primary emphasis on rights of the patient (autonomy)

2. Types of Experimentation:

(a) Interventions of proven efficacy (not considered 'experimentation' by current medical criteria)

* Patient is mandated by Jewish traditional halachick principles to accept procedures of known efficacy (refuah bedukah) - patient may not shorten or terminate own life

* Patient has right under current guidelines of medical practice to refuse any intervention, proven or unproven

(b) Interventions of unproven safety and efficacy both Jewish tradition and current accepted practice require risk/benefit assessment

* Jewish tradition - benefit must be to the patient/subject of the study, except if risk is very low; decision made by physician

* secular society - decision in patient's hands; patient's informed consent required
3. Clinical trials:

(a) Phase I (to assess safety)

* according to Jewish tradition may only be carried out if: animal studies show safety and efficacy; expectation of benefit exceeds minimal risk; and patient gives informed consent; participation of children, mentally retarded individuals, prisoners prohibited here and in any clinical trial requiring informed consent

* Western biomedical community: same requirements, except that participation in clinical trials of handicapped patients permitted under special conditions

(b) Phase II (to assess efficacy)

* Jewish tradition - requires possibility of benefit to the specific patient, as well as acceptable Phase I outcomes

* Western biomedical community - does not require possible benefit to the specific patient

(c) Phase III (to assess safety and efficacy in groups of patients)

* both Jewish tradition and Western biomedical community require valid expectation of benefit in the patient (halachah permits therapy which, if ineffective, may foreshorten life; derived in Talmudic discussion of the tale of the four lepers in II Kings)

4. Vexing Issues:

* Is the use of 'placebo' treatment ethical?

* Does the patient have a right to know which of several study agents is being administered?

* Is 'blinding' of the physician or patient ethical?