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The dying patient: new Israeli legislation

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Introduction

The moral, cultural, religious, and legal aspects of treating the dying patient are among the most difficult in modern medicine. Although the dying patient has been one of the most prominent problems within medicine since time immemorial, the dilemma has intensified in the past few decades. This is due to the enormous advances in medicine and technology, the change in patient–physician relationship from a paternalistic to an autonomous approach, the greater involvement of various professionals in treating the dying patient, and the economic and cultural changes. Different cultures have different approaches for the dying patient. Israeli society, like other western societies, has struggled with this issue for many years. Various policies, court cases, and declarations have been enacted. Nevertheless, the situation has been confusing, with physicians not knowing what was allowed or not and acting inconsistently, often not discussing decisions with patients, next-of-kin, or other health-care professionals and not documenting life-and-death decisions. As end-of-life practices vary around the world [1, 2] and many countries are battling with these issues, the development process and the current Israeli law may provide useful insights for other countries and various professionals.

Israeli legislation: the process

On 6 December 2005, the Knesset (Israeli parliament) enacted a detailed and comprehensive law regulating the treatment of the dying patient. The legislation was the product of 6 years of intensive professional and public debate and discussion. On 20 February 2000, the Minister of Health appointed one of the authors (A.S.) to head a national committee to enact a law regulating all matters concerning the dying patient. As attitudes and approaches towards the dying patient vary widely and the issue is highly emotionally charged, a multidisciplinary, broad-based committee was established. The committee was composed of 59 individuals, probably the largest ever established in Israel for a specific issue. There were 45 men and 14 women; 56 members were Jewish, 1 Christian, 1 Muslim and 1 Druse. Of the Jewish members, 34 were secular, 17 were Orthodox religious, three were Ultra-Orthodox, one Conservative and one Reform. All members of the committee were experts and high-ranking professionals in their relevant fields, representing the entire spectrum of relevant views. No member was a political or otherwise interested appointment. The committee was divided into four sub-committees: (1) A medical/scientific subcommittee, headed by one of the authors (C.L.S.), composed of 26 members, including physicians, nurses, social workers and sociologists. The physicians represented all relevant fields of medicine dealing with dying patients (intensive care, palliative medicine, cardiology, geriatrics, anesthesiology, psychiatry, pediatrics, neonatology, rehabilitation, oncology, neurology, and hospital management). (2) A philosophical/ethical subcommittee composed of 12 members, including philosophers, medical ethicists and clergy from different religions. (3) A legal subcommittee composed of 13 members, including judges, lawyers, professors of law, and legal advisors of relevant ministries. (4) A *halachic* (Jewish law) subcommittee composed of 7 members, including rabbis and physicians well-versed in matters of medicine and *Halacha*. Each subcommittee discussed all relevant matters from their professional standpoint. Over 20 scientific papers were submitted by members of the committee in order to better understand relevant facts and positions. During a period of close to 2 years (April 2000 to January 2002), intense committee debates occurred. Every opinion and viewpoint was freely expressed and seriously discussed with great mutual respect. All debates and discussions were closed to the media. There was a serious attempt by all members to reach as wide a consensus as possible, despite previously held strong opinions and the very difficult and emotionally charged issues at stake.

The final version of the proposed law was presented to the Minister of Health on 17 January 2002. The minister endorsed the entire proposal. The committee's proposed law was accepted by the Israeli government on 23 May 2004 and was finally legislated by the Knesset on December 6, 2005 as the "Dying Patient Act." Despite the inherent complexity of the subject from medical, moral, philosophical, religious, legal, cultural and psycho-social viewpoints, and despite the deep differences of opinion between members of the committee, the committee reached a wide consensus on almost all issues related to the dying patient. Eighty percent of the members agreed on all the paragraphs of the proposed law, and 100% agreed on 95% of the paragraphs. The only significant dissenting opinions were on the issue of withdrawing continuous treatment (i.e., ventilation) and withholding food and fluid from a dying patient. Although in principle there remains disagreement on these issues, with a minority opinion upholding the principle that there is no difference between withholding and withdrawing any therapy, the committee managed to minimize the practical disagreement by accepting the concept of a timer attached to a ventilator [3].

The law – highlights

Fundamental assumptions

The majority of people do not want to die; on the other hand, the majority of people do not want to suffer at the end-of-life and they do not want their lives prolonged artificially.

There should be a balance between the value of life and the principle of autonomy, based upon the value system of Israel as a Jewish and democratic state. Hence, there is a need to determine the boundaries of prolonging life versus the avoidance of unjustifiable and unwanted suffering.

Decisions concerning dying patients should be based upon the medical condition of the patient, his wishes, and his degree of suffering. No other considerations should matter when deciding how to treat the dying patient, including race, sex, age, economic status, mental status, and life style.

Every person is assumed to want to continue living unless proven otherwise; in case of reasonable doubt one should err in favor of life.

Every adult person is assumed to be competent unless proven otherwise.

A dying patient is defined as one who will die within 6 months despite medical therapy; the last 2 weeks of expected life is defined as the final stage.

Treatment modalities

Several values are involved in treating dying patients. The most important dilemma is striking a balance between the sanctity of life and the principle of autonomy. Since almost no one advocates accepting an extreme and absolute position concerning either the value of life (i.e., prolonging *any* life by *all* means at *all* times and at *all* costs, even when it adds only pain and suffering) or the principle of personal autonomy (i.e., accepting autonomous wishes for active euthanasia of healthy people or non-terminally ill patients), there is an obvious need to decide on where the line between these values should be placed. Any distinguishing boundary line, however, is debatable. Hence, the law is based upon the committee's majority recommendation to strike the balancing line between commission and omission and develop a wide consensus. Therefore, when sanctity of life and autonomous patient wishes coincide, they should be respected even if the patient's request to prolong life seems futile to the caregivers, unless it is harmful to the patient or others. When the autonomous wishes of the patient are in opposition to the sanctity of life, if the dying patient is competent and refuses any treatment, including food and fluids, he should be encouraged to change his mind, but should not be forced against his wishes; thus, the respect for autonomy and human dignity is preserved and overrides the respect for value of life. This, however, does not include active euthanasia or physician-assisted suicide, which are prohibited even if the patient autonomously requests them. In the case of an incompetent patient, the law strikes the following balance: Sanctity of life is respected and overrides autonomy by prohibiting any action that intentionally and actively shortens life, even if these acts were previously requested by the patient. On the other hand, the principle of autonomy is respected and overrides the sanctity of life by permitting the withholding of any treatment directly related to the dying process, if this was the clear and known wish of the patient.

Although the law prohibits stopping continuous life-sustaining therapies, because this is viewed as an act that shortens life, it does allow stopping intermittent life-sustaining therapies. The latter include intubation, surgery, dialysis, chemotherapy, and radiotherapy. Terminating intermittent life-sustaining treatments is viewed as omitting the first or next treatment rather than committing an act of withdrawal. These decisions are founded in the Jewish legal system, where there is no obligation to actively prolong pain and suffering of a dying patient, but any action that intentionally and actively shortens life is prohibited. The withdrawal of a ventilator (a continuous form of treatment), is considered an act that shortens life and is therefore forbidden. As continuing unwanted ventilatory treatment would prolong suffering, the law allows the possibility of changing the ventilator from a continuous form of treatment to an intermittent form by connecting a timer and allowing the ventilator to stop intermittently [3]. This is based on the Jewish legal concept that not only the end has to be morally justified (i.e., the death of a suffering terminally ill patient), but also the means to achieve it ought to be morally correct. Hence, the technology that turns the ventilator into an intermittent form of therapy defines the interruption as an omission rather than commission. This innovative approach is also psychologically helpful to health-care providers who have problems executing the wish of the patient. As to withholding food and fluids from an incompetent dying patient, the law prohibits this act for the following reasons: the value of life in such situations overrides the previous autonomous wishes of the patient, which are now unknown; food and fluids are regarded as a basic need of any living being, rather than treatment; socially and emotionally there is a fundamental difference between food and fluid and other life-sustaining treatments; dying of starvation and dehydration is regarded in Jewish philosophy as an indignity to life, and withholding food and fluid is unrelated to the dying process and hence is regarded as a form of euthanasia. This, however, changes as the patient approaches the final days of his life, where food and even fluids may cause suffering and complications, and hence the law permits abstaining from its administration in the final stage. Based upon the notion of the dignity of man and upon the moral requirement to alleviate pain and suffering, the law requires providing palliative care according to current medical standards to the patient and to his family. This includes palliative treatment that might unintentionally shorten life, based on the principle of double effect.

The present Israeli solution is contrary to most Western countries, where no distinctions are made between continuous and intermittent therapies, actions and omissions, withholding and withdrawing treatments or nutrition and other treatments [4, 5].

Procedural aspects

The law requires the appointment of a senior physician as the responsible health-care provider. His tasks are: to establish the medical situation of the patient; to analyze all relevant facts and documents together with all other experts and decision-makers; to establish the wishes of the patient; to formulate a detailed plan of treatment; to document all the decisions in a clear and explicit manner; and to inform all relevant parties of the decisions. Decisions should be based on medical facts and the patient's wishes. The law addresses the need for advance medical directives or the appointment of a surrogate decision-maker, the relationship of various decision-makers and the establishment of problem-solving mechanisms for a variety of situations. The law establishes detailed mechanisms verifying that advanced medical directives are the calculated wishes of the now incompetent dying patient, including the following: a detailed form to be filled out by the person with the aid of a physician or nurse; renewal of the statement every 5 years; re-evaluation of the statement when diagnosed with a serious illness, with the aid of an expert physician; and establishment of a national pool of advanced medical directives. Every 5 years, reminders are sent to the owners of the advance directives to verify whether or not they have changed their minds about the directives. The pool also serves as a source of information whenever an incompetent patient is admitted to a hospital and it is unknown whether there is an advance medical directive. Testimony about the incompetent dying patient's wishes by family members or friends known to be emotionally related to the patient are also accepted. The law establishes institutional ethics committees as a problem-solving mechanism. It also establishes a National Ethics Committee as an appealing authority and with the mandate to solve more difficult problems as well as establishing policies. These committees are composed of experts in the fields of medicine, nursing, social work, psychology, law, ethics and the clergy. This mechanism is intended to avoid the courts.

In summary, the new Israeli Law for the Dying Patient is based upon a process that achieved a wide consensus on this complex and emotionally loaded issue. It provides explicit mechanisms for issues that were previously not provided for or were unclear. These include mechanisms for providing autonomous patient decision-making when incompetent at 'real time' with legally binding advance medical directives that include mechanisms to verify the real and informed wishes of the patient or the appointment of a surrogate decision-maker; a national bank of advance medical directives to optimize the validity of these wishes; legally binding palliative care as a citizens' right; clear guidelines to help physicians establish what is permitted or not in treating terminally ill patients; the appointment of a senior physician with clear definition of his responsibilities toward the dying patient; and dispute resolution including the innovative establishment of a National Ethics Committee composed of experts in all relevant fields. Although some specifics of the new Israeli law may not be suitable for other countries with different religious and value systems, the consensus process and the explicit mechanisms to help dying patients can be helpful for other countries in building what is best for their citizens.

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