

Life-threatening and terminal illness: considerations for hospitalised Orthodox Jewish patients

Abstract

For Orthodox Jewish patients, palliative care in general and withholding and withdrawing treatment in particular pose potential conflicts with some aspects of current religious practice. This article gives an introduction to the relevant cultural context and summarises the relevant principles of Jewish law to help clinicians provide appropriate care for their Jewish patients.

Key words: Life-threatening illness; Orthodox Jewish patients; Terminal care

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Introduction

Clinicians in hospital practice may benefit from understanding the factors pertaining to Orthodox Jewish patients under their care. A common and contentious area is the management of life-threatening and terminal illness. This issue has become particularly fraught for Jewish patients as society has come to accept that quality of life should often take precedence over quantity (Beauchamp and Childress, 2001), a concept that is largely incompatible with Orthodox Judaism, which sees life itself as the primary value. This article informs clinicians of the main issues to be considered in these situations.

The social context

The British Orthodox Jewish community comprises a spectrum ranging from the more strictly Orthodox ('Haredi') to more 'modern' or broader outlooks and practices. The increasing proportion of British Jews who identify as strictly Orthodox makes it important for clinicians to understand the values and issues that are important to this group.

Clinicians need to be aware that it is usual for Orthodox patients and their families to make decisions in close and frequent consultation with their Rabbinic authorities; this is particularly true when it comes to life-or-death issues. The guidelines given here are based on the classical Orthodox sources and are largely agreed across the Orthodox spectrum, although interpretations may vary somewhat among the various Rabbinic advisers in the community.

Among the various faith groups in Britain today, Orthodox Judaism tends to be at the most conservative end of the spectrum with regard to attempts to save and prolong life in general and in terminal situations in particular.

How do Orthodox principles and perceptions differ from current practice?

The approach outlined below is largely compatible with current General Medical Council guidelines (General Medical Council, 2019), and particularly with the More Care Less Pathway review (Neuberger, 2013). In addition, the General Medical Council guidelines specifically recommend that doctors accommodate the cultural and religious ethos of their patients. However, probably partly as a result of experiences before the current General Medical Council guidelines and the recommendations of the Neuberger (2013) review, there remains a level of distrust and suspicion concerning the secular approach among some segments of the Orthodox community. The gap between secular values and practice and those of Orthodox Jewish culture not infrequently leads to tensions. To cite one illustrative example, in a highly publicised case in which a British court ruled against an

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Orthodox Jewish family's wish to maintain the life of their child, accusations of 'murder' and open anti-Semitism followed (Sherwood, 2021). Such regrettable incidents tend to feed the conviction that there is an unbridgeable disparity of values; needless to say, this is not conducive to good clinician–patient relationships. Better understanding of the Orthodox religious perspective on the part of clinicians may improve matters. It is also strongly recommended that clinicians allow an expert Rabbinic advisor to be involved in end-of-life decision making where possible; this often resolves unnecessary conflict by providing patients and families with the reassurance that treatment decisions are being made in line with Jewish law.

Withholding and withdrawing therapy

The obligation to save life supersedes almost all other duties in Judaism, permitting even desecration of the Sabbath and overriding almost all other prohibitions. Despite that, in some situations of terminal illness, treatment may be withheld. However, withdrawing life-sustaining therapy that is being administered in a continuous fashion is forbidden; such actions are indeed considered homicidal in Jewish law (Tatz, 2010a,b).

Therefore, subject to the conditions detailed below, withholding chemotherapy from a patient with widespread metastatic disease would be acceptable. Also acceptable would be the decision, implemented between dialysis sessions, to stop intermittent dialysis. In these cases, death results from the underlying pathology and the failure to prevent it; there are situations in Jewish law where that is permitted.

However, withdrawing ventilation from a patient who is currently dependent on it, or stopping the administration of pressor agents that are being continuously infused to maintain adequate circulation, would be forbidden. In these cases, life is being actively terminated or shortened; that is never permitted.

Required criteria for withholding therapy

When all the following conditions are satisfied, treatment should be withheld:

1. The patient is terminally ill
2. The patient:
 - a. is suffering uncontrollably, or alternatively
 - b. is unconscious with no hope of recovering consciousness.
3. The patient does not want continued treatment.

However, the details qualifying these criteria are critical:

Terminally ill

Terminal illness is defined as a maximum expected survival period of 6 months to a year, and usually much less (Steinberg, 2003). If it is doubtful whether the patient is terminal, the stringent view must be adopted until the doubt is resolved. The default approach must be to regard life as potentially salvageable; the burden of proof falls on the less optimistic opinion.

Uncontrollable suffering

This may be physical or psychological. Psychological suffering, including depression secondary to somatic pain, indicates failure to treat the pain and is not a justification for withholding therapy. Psychological and psychiatric problems need treatment in their own right, undertaken no less aggressively than treatment of somatic problems.

The patient does not want to continue

The patient's wish to allow a lethal condition to take its natural course is relevant only when:

1. The patient is a fully informed mentally competent adult.
2. No safe curative therapy exists. Where the effectiveness or safety of a therapy is subject to dispute among experts, the patient is not obliged to undertake it.
3. Therapy exists but is risky in its own right or extremely painful and the patient refuses such therapy on account of that risk or pain.
4. The patient is not refusing therapy as a result of inadequately treated pain, depression or other ameliorable suffering or any external coercive pressure.

Unconscious or incompetent patients

1. If an unconscious or incompetent patient has previously expressed the desire for cessation of therapy in such circumstances and there is no reason to think that this opinion may have changed, that opinion is valid.
2. Where the patient is not known to have expressed a personal opinion but the family can testify that the patient would have wished for cessation of therapy, such testimony can constitute valid proxy. Even if the family does not know what the patient would have wanted they are entitled to decide on the patient's behalf – most people rely on close family to act in their best interests and this trust tacitly empowers family members as de facto proxies. This applies only where there is no reason to suspect that the family may be acting from inappropriate motives. Where the patient is a minor, the parents' opinion can substitute for the patient's in such cases; parents are the usual guardians here.
3. Where it is not possible to ascertain a patient's wishes and there is no relevant proxy, it may be assumed that the patient would not want suffering prolonged when that suffering is so great that a clear majority of people would respond thus.

Analgesia in patients with life-threatening or terminal illness

Unavoidable significant risk accompanying analgesia is acceptable in life-threatening circumstances because it is an assumption of Jewish law that in such circumstances the pain is not innocuous; severe pain may add to the danger of the underlying pathology. Therefore, relieving severe pain (and alleviating anguish, despair and depression) is not only humane but also therapeutic. Consequently, a measure of risk is acceptable in the course of treating the pain, as it would be in treating the disease itself. However, the analgesia must be administered only with the intention of relieving pain, not to terminate life, and narcotics must be titrated expertly against the pain to provide adequate analgesia with minimum danger.

Withholding fluids, nutrition and other basic needs

Permission to withhold therapy does not include withholding staples such as adequate fluids and attention to electrolyte balance, nutrition and oxygenation (Bleich, 1998). Basic needs that have been necessary over the long term may not be stopped when the patient becomes terminally ill; those are staples for that patient and there is no reason to stop them now. Withholding food for long enough will certainly lead to the patient's death, regardless of the acute clinical situation, and that is not allowed; a patient may never be starved or dehydrated to death.

In some current healthcare settings, it is common practice to cease provision of food and fluids to terminally ill patients. The undoubted result is that, in many cases, the specific cause of death is starvation or dehydration rather than the underlying pathology. That is unacceptable in Orthodox Judaism; guaranteeing death by starvation or dehydration is not a Jewish option.

However, in an imminently terminal situation where a patient will clearly die from the underlying disease process sooner than a lack of nutrition would cause any harm, food may be withheld. There is no obligation to attempt feeding a patient who is not absorbing and who indeed may be harmed by such efforts. (This is not the case with liquids: attention should be given to basic fluid and electrolyte balance until the last stages of life.)

Where oral feeding is impossible or dangerous, feeding by nasogastric or another route should be instituted. A feeding enterostomy should be performed if it would be the best clinical solution. It is good practice to institute such measures in good time and not wait until the patient is too ill or malnourished. In Orthodox Jewish institutions, enterostomy is often performed pre-emptively (for example in cases of dementia) while the patient is fit enough; oral feeding then continues with the enterostomy tube in situ until such time that enterostomy feeding becomes necessary.

Ventilation

Where the patient is terminally ill and mechanical ventilation has not been started, it need not be instituted provided that all the conditions for withholding therapy have been met. Where mechanical ventilation has been started, it may not be stopped while the patient is dependent on it. (Withdrawal of ventilation in patients with brainstem death is beyond the scope of this article.)

Dialysis

A terminal patient who is dying from other (untreatable) causes and whose renal function deteriorates as part of the overall terminal process need not be dialysed. Where renal failure is the specific clinical problem and is reversible, it should be treated.

Antibiotics, other drugs and blood products

As a general rule, intercurrent problems such as infection in terminally ill patients should be treated. Where a drug or other therapy will itself add a significant new danger (eg a poorly tolerated drug or relatively major surgical intervention), its use may be discretionary. Drugs (such as pressors) do not need to be given to a patient in the final stages of the dying process where there is no hope of recovery and the drug will not change the overall clinical picture (although a continuous infusion that is already running and is maintaining life may not be actively stopped).

Risky treatment in desperate situations

Where therapy is available for the treatment of an otherwise terminal condition, but only at the risk of worsening that terminal situation if it fails, the therapy may be given, but only at the patient's discretion (Tatz, 2010a,b). Such therapy may be curative if successful and lethal if it fails – if unsuccessful the patient will die sooner than the natural duration of their disease; nevertheless such therapy is allowed in Jewish law.

The risky option is allowed even when the chances of success are less than 50%. Where success is more likely than failure, the patient should choose the therapy (although coercion may not be applied); where the mortality of the therapy is greater than 50% it remains discretionary for the patient. There is a range of Rabbinic opinion on how small the chance of cure must be to render such therapy forbidden: according to some authorities even a 'distant' chance of success in an otherwise hopeless situation is enough to allow it; some require a chance of success of at least 20% or 30%. This is an area for judgment by competent Rabbinic authority in individual cases.

Extreme old age

Age has no bearing on the obligation to treat; old age is not an acceptable reason to abandon patients in Orthodox Judaism. Even in extreme old age all available therapy must be given, subject to the above conditions.

Resuscitation

Resuscitation should be attempted except where the criteria given above for cessation of therapy are met; in such cases it should not be done.

Conclusions

Orthodox Jewish patients in life-threatening and terminal medical situations have some concerns that are specific to their religious and cultural ethos. In general, these are usually related to the extreme value placed on life itself and a conviction that life should be preserved under most circumstances and certainly never actively shortened. Clinicians can provide better care for these patients by being aware of these issues.

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Key points

- Judaism views the value of life as paramount; quality of life is generally regarded as subordinate to the value of life itself.
- Orthodox Jewish patients and their families who find themselves in the healthcare system are often concerned that their care may be compromised by clinicians' lack of awareness of their values and priorities.
- Judaism does not allow active shortening of life in any way. However, care may be withheld when a patient is terminally ill, suffering greatly or permanently unconscious, and does not (or would not) want to continue active therapy.
- Even in those circumstances, basic physiological and nutritional needs must be met.

Conflicts of interest

The author declares that there are no conflicts of interest.

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