**Virtual Mentor**
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## Clinical Case

### End of Life and Sanctity of Life

Commentaries by Rabbi Edward Reichman, MD, Sandra Gadson, MD,
Lerwut Wongsarnpigoon, MD, Nihal S. Gooneratne, MD, and
Ananda Wickremaratne, DPhil

Ethel Jones is an 82-year-old nursing home resident with a longstanding history of heart failure, who is now hospitalized in the cardiac ICU for the third time this year. She is a retired teacher, with 4 children and 8 grandchildren. She did not list a religious preference when admitted to the hospital. The attending cardiologist, Dr David Rosenberg, is a heart failure specialist, and is an active member of an Orthodox Jewish congregation.

On day 3 of her hospitalization, Mrs Jones developed a fever, which was subsequently determined to be caused by a MRSA line infection from a venous catheter. On day 4, her renal function began steadily deteriorating, until her serum potassium reached dangerous levels.

She has been unconscious for 2 days, and, according to hospital records and her children, she has no advance directives to guide end-of-life care. Dr Rosenberg requests a family conference with Mrs Jones's children (her husband is deceased) to discuss their mother's prognosis and the appropriate next steps in treatment.
"I'm afraid that your mother's health is steadily deteriorating," Dr. Rosenberg tells Mrs Jones's family. "She has a serious infection that has failed to respond to traditional antibiotics."

"How did she get this infection, doctor?" Mrs Jones's daughter Jennifer asks.
"That's a good question. It's likely the result of an IV line we placed during her admission," Dr Rosenberg replies. "Your mother's infection is caused by a resistant strain of staphylococcus that is common in intensive care units and hospitals, but we have more aggressive antibiotics we can use. I should also tell you that her kidneys are failing, and we'll need to begin dialysis to ensure that her electrolytes and fluid status are kept at normal levels. Despite this, I think there's a strong possibility she'll pull through."

At this point, Mrs Jones's eldest son Franklin interrupts. "Look, doctor," he says, "My cousin was on dialysis for years, and, until he died, he was really miserable. I don't want my mom to have to go through that at this age. I think enough is enough. She's been in the hospital 3 times this year alone."

"I understand your concern," Dr Rosenberg says, "but you should realize that your mother may not require long-term dialysis. Her kidneys may recover, but at this stage,

dialysis is the only solution left to correct her electrolyte imbalances. If we don't lower her potassium, she'll likely develop a fatal arrhythmia."

Franklin looks at the rest of the family, who are shaking their heads. "Honestly, I think you shouldn't treat her any further. Even if it's not permanent, starting dialysis just isn't a path we want her to start on. And the 'aggressive antibiotics'—I don't see any reason to pour more substances into her already tired body. It's obviously her time to go. Can't you just give her something to make her comfortable?"

Dr Rosenberg pauses for a moment and then tells Franklin. "We fully intend to keep her comfortable and continue treating her pain. As you know, I'm committed to doing what's best for your mother. But in good conscience, I can't stop treating your mother as long as there are reasonable courses of action that I could take to preserve her life. According to the principles that guide my practice of medicine, I cannot withhold life-saving treatment from any patient—especially antibiotic therapy and temporary dialysis, both treatments with uncontroversial efficacy."

**Commentary 1**
by Rabbi Edward Reichman, MD

*One who sustains the life of but one human being is considered as if he has saved an entire world.*
? Babylonian Talmud, Tractate Sanhedrin, 37a.

As Dr Rosenberg invokes Jewish law in his approach to his patient, it behooves us to discuss how Jewish law would address this case.
1) Would Jewish law indeed require dialysis for Mrs Jones?
2) If the law requires dialysis for Mrs Jones, can Dr Rosenberg, according to Jewish law, impose his religious beliefs on others?
3) Does it matter that this patient is not of the same faith as Dr Rosenberg and does not subscribe to the same religious teachings?

While the voice of Orthodox Judaism is not monolithic and, indeed, a plurality of approaches within accepted boundaries is the norm, one can nevertheless distill immutable principles and values deriving from the Bible, Talmud, and legal codes, which inform the discussion and guide the decisions of rabbinic authorities. Debate and nuanced textual interpretation are hallmarks of Jewish legal discourse. While herein we discuss particulars of a fictional case, any actual case of Jewish medical ethics must be presented to the proper rabbinic authority.

A number of legal principles serve as the foundation for decisions in the field of Jewish medical ethics. One such principle is the sanctity of life and the obligation to preserve it. The concept of quality of life has different meaning in the Jewish tradition, and life, be it sentient or not, is of infinite value. This does not mean that life need be perpetuated at all times and at all cost. According to many rabbinic authorities, there are limited circumstances where specific treatments may be withheld. A full treatment of this area of law is beyond the scope of this essay, but the discussions of withholding treatment are generally restricted to patients suffering from terminal, untreatable

conditions, who are enduring intractable suffering. The specific treatments that can be withheld are debated, but all agree that nutrition, hydration, and oxygen (not necessarily intubation) should be provided to all patients and are not subject to refusal. One is therefore not permitted to withhold food, even if insertion of a feeding tube is required for its delivery, as this is considered basic human sustenance to be provided to all people. Terri Schaivo, for example, according to Jewish law, would not be considered to have a lesser quality of life than this writer. She did not suffer from a terminal, incurable disease, and withholding food would clearly not have been permitted according to orthodox Jewish tradition.

Mrs Jones's medical condition is not discussed in great detail, but for our purposes, I will assume that Mrs Jones has an acute, potentially reversible infection complicated by renal failure, which could theoretically be reversed with antibiotics and temporary dialysis. In such a case, Jewish law would likely require that dialysis be performed, inasmuch as Mrs Jones would surely die without it. If Mrs Jones were suffering from end-stage metastatic cancer and developed irreversible renal failure, a strong case could be made according to Jewish law to refrain from dialysis.

Having established that according to Jewish law dialysis would be indicated, is Dr Rosenberg obligated, according to this same law, to impose his beliefs on others? The answer here is a decided "no." Even if the patient were of the same faith and subscribed to his religious beliefs, Dr Rosenberg would not be required to coerce therapy. The reason is clear from another exercise in legal analysis: American law forbids treatment against a patient's will, and Dr Rosenberg could theoretically receive legal, ethical, and professional censure (not to mention the criminal consequences) for violating a patient's rights and bodily integrity. This could lead to the loss of livelihood and profession for Dr Rosenberg, and would preclude him from assisting in the aid and treatment of future patients. Furthermore, Jewish law places great emphasis on respect for the law of the land where one lives and would disapprove of the violation of American law, with some theoretical exceptions.

As stated above, Jewish law does not require a physician to coerce therapy, if it would result in the loss of profession and livelihood. This concept applies, however, only in a situation where Dr Rosenberg performs no Jewish-legally prohibited actions that would lead to the demise of the patient. In this case, Dr Rosenberg is simply refraining from performing dialysis, but performs no specific action that leads to the hastening of the patient's death. He is permitted the nonaction to preserve his profession and livelihood.

One could envision a theoretical circumstance where Dr Rosenberg is asked to perform an action to hasten the patient's death. For example, if the family wishes to disconnect a patient from a ventilator, that is an action which will lead to the patient's demise. Here, too, one might argue that Dr Rosenberg should not impose his religious beliefs on the family, and he should therefore accede to the request and disconnect the ventilator. In this case, however, Jewish law would not allow Dr Rosenberg to disconnect the ventilator, even if his profession were at risk, because this scenario requires Dr Rosenberg to perform a Jewish-legally prohibited act. (While one could

argue that disconnecting the ventilator is not hastening death but rather allowing nature to take its course, Jewish law thinks otherwise, and focuses on the causality. This action will undoubtedly lead to the death of the patient.)

Although coercion would be out of the question according to Jewish law, Dr Rosenberg could suggest a compromise approach, whereby he encourages the family to allow antibiotics and dialysis on a trial basis. As the antibiotic therapy and the dialysis are discrete treatments, and not continuous, as is a respirator, there would be no problem for Dr Rosenberg, as established above, to discontinue them if the family later requested such. Indeed, if the family is told that there is a chance of recovery with this regimen, but, if it fails, they will have the option to later discontinue the treatments, there might be greater chance of agreement between Dr Rosenberg and the family. The family may take great comfort in the assurance that all efforts were made to treat their loved one, and the possible subsequent guilt of withholding potentially life-saving treatment would be alleviated.

*Rabbi Edward Reichman, MD, is assistant professor of emergency medicine, Montefiore Medical Center, Albert Einstein College of Medicine, New York, NY.*

**Commentary 2**
by Sandra Gadson, MD

This case is that of an 82-year-old woman who resides in a nursing home. She has a history of congestive heart failure and severe cardiac disease with 3 hospitalizations in 1 year for similar complaints.

During the last admission she developed line sepsis with methicillin-resistant staphylococcal aureus, is now starting to develop acute renal failure, and is unconscious.

The doctor wishes to continue with different antibiotics along with temporary dialysis. There is one son who relates the past experiences of a relative on dialysis, and he seems to feel that antibiotics and dialysis are futile. It is clear that this conflicts with the treatment recommendations, but it is unclear whether he has the authority to make decisions that could terminate his mother's life prematurely.

**Advance Directives?**
All too often cases like this are complicated by the lack of an advance directive. "Advance directive" is a term that refers to an individual's spoken and written instructions about future medical care and treatment. Advance directives can be used if the patient is unable to make his or her own decisions. Stating health care choices in an advance directive helps family and physicians understand a person's wishes about his or her medical care. In some cases advance directives list individuals who will serve as health care agents.

With all of our training and expertise as doctors, we are first to do no harm. In this case a change of antibiotics and a temporary dialysis does no harm. It could potentially

make a difference in Mrs Jones's outcome. In a case with no advance directives, health care choices are usually made by the family member whom the physician is able to contact. In situations such as this, where several family members are involved, the best approach is to gather all the siblings together and ask them to decide on 1 person to serve as spokesperson for the family. From that point on, talk only with that individual.

The physician should explain to the family that their mother has congestive heart failure, complicated now by line sepsis and acute renal failure. He or she should say that the suggested plan of treatment is short-term and will cause no discomfort and should try to make the family understand that congestive heart failure, sepsis, and acute renal failure are not necessarily long-term and are treatable with antibiotics. Short-term hemodialysis is needed to cleanse the blood of toxins and to remove excess fluid that contributes to congestive heart failure.

A primary goal of hemodialysis in this case is the resolution of Mrs Jones's altered mental status, in order to get her to directly participate in the decision making process. If Mrs Jones does not respond after this treatment, then a neurological consult is in order. If her clinical condition continues to deteriorate, bringing about clinical brain death, then options for withdrawal of treatment would be appropriately discussed with the family.

Clinical medicine more and more is becoming an issue of the value of life. How do we define "value"? How can a physician put a value on a life? We cannot and should not decide who lives and who dies. There are many temptations: medical care can become costly; insurance companies want to keep costs down; many people cannot afford health insurance. There are also pressures from outside the house of medicine. Yet, life is sacred and important, and our mission as physicians is to give the best possible care to our patients without judgment of race, financial background, education, or gender.

In our years of training, we must develop a sense of compassion, a sense of concern and empathy. A good thing to do is remember the Golden Rule, *Do unto others as you would have them do unto you* (Luke 6:31).

If you put medical expertise, knowledge, and skill together with compassion, your outcomes will be acceptable. In the case at hand, if you have followed this patient and feel that she can improve with additional treatment, then that should be considered.

*Sandra Gadson, MD, is a practicing nephrologist and founder of Northwest Indiana Dialysis Center. She is also president-elect of the National Medical Association, Washington, DC.*

**Commentary 3**
by Lerwut Wongsarnpigoon, MD

The conflict between the family and the physician in decision making concerning the end-of-life care for Mrs Jones is a common occurrence in medical practice. A

psychologist colleague told me of the problems she and her siblings had with her mother's attending physician when she was hospitalized for multiple complications of terminal cancer. Her mother and the children had requested that further treatments be discontinued. The attending physician insisted on continuing aggressive treatments to combat the infections and other organ failures.

**The Family's Decision**

It is common for physicians and patients to disagree over when treatment can appropriately be withheld or withdrawn if they come from different faith traditions that have different ways of viewing life and death. Because faith traditions view the sanctity of life and the meaning of death differently, physicians and patients who do not share the same religion often disagree over medical treatment near the end of life.

Let us consider the case of Mrs Jones from a Buddhist's perspective, for example. A Buddhist is by definition an individual who aspires to live his or her life according to the teaching of the Buddha. Mrs Jones and her family are not known to be particularly religious, so let's suppose that they are Buddhists in the same sense as people who profess to be Christians, but do not actively participate in church attendance or activities. They would at least be familiar with some of the basic tenets, or Dhamma, of Buddhism. They would see "death as a normal process, a reality that will occur as long as ones remain in this earthly existence" [1].

Death can be perceived as a process resulting from the impermanence of life itself. For those who believe in rebirth, death is not the end of life, but simply a transition [2]. Death is the last of the "Three Messengers": Old Age, Sickness, and Death, [3] that one will encounter along the course of one's life. Buddhists are admonished to constantly contemplate the facts that:

1. We are subject to old age and cannot escape it.
2. We are subject to disease and cannot escape it.
3. We are subject to death and cannot escape it.
4. There will always be dissolution and separation from all that we cherish.
5. We are owners of our deed (karma), whatever deed we do, whether good or bad, we shall become heirs to it [4].

Mrs Jones's children seem to be assessing her condition in a manner consistent with the principles described above. In Buddhist terms, they are holding to the "Right View," the first aspect of the Noble Eightfold Path that understands the true nature of existence as consisting of suffering, impermanence, and non-self (insubstantiality) [5]. This does not mean that they are fatalistic or nihilistic, only that they see things as what they truly are in a more detached way.

**The Physician's Decision**

The dilemma facing Dr Rosenberg is much more daunting and complex. Let us consider what a Buddhist doctor would do, assuming that he is fully aware of a Buddhist's beliefs and subscribes to the Dhamma.

Any physician endeavors to treat his patients with compassion, a concept essential to Buddhism. His goal is "to overcome sickness and relieve suffering. The Hippocratic philosophy of medicine declares that nothing should be more important to a physician than the best interest of the patient who came to him for care" [6]. A Buddhist physician in Dr Rosenberg's shoes would be aware of the same principles we discussed earlier. He may be struggling with a major question, however? whether withholding further treatments for Mrs Jones constitutes a violation of the First Precept, which exhorts us to abstain from killing or destroying life. There are additional important criteria that a Buddhist physician needs to consider regarding the First Precept. It is noted that for a killing to be considered a *fait accompli*, it has to meet 5 criteria:

1. There is a living being, in this case, the patient.
2. An awareness that it is a living creature.
3. There is an intention to kill.
4. One must make an effort to kill.
5. The living being dies [7].

There is no doubt that criteria 1, 2, and 5 would be met if further treatments were withheld. One can forcefully argue that a physician in Dr Rosenberg's circumstances harbors no intention to destroy the life of Mrs Jones, and indeed, he strives to treat her with compassion. If he chooses to stop treatment now, he is actually not making any effort to harm or to prolong the suffering of the patient. He probably makes the dying and passing of Mrs Jones more humane. It appears from this reasoning that the First Precept is most likely not being violated.

There are yet other relevant criteria to guide and determine the degree of karmic demerit stemming from the action of destroying a life. One has to consider whether the living being is big or small; useful to others or dangerous and offensive; whether the intention (to kill) is full of hatred, malice, or good will; whether there is an elaborate preparation and deep conviction to harm with no consideration of outcome and consequences, or whether the deed is done in a blind rage [8]. A critical point of which a Buddhist physician needs to be fully cognizant when he decides to continue treating Mrs Jones is whether he is really concerned about what his colleagues think or any criticism he may face. This situation is succinctly described by physician-author Sherwin Nuland in the final chapter of his book *How We Die* [6].

Finally there comes a time when the physician in Dr Rosenberg's situation has to take a step back and wonder why he does not follow the "Middle Path," one of the most important practices that enabled the Buddha to attain enlightenment. In such practice he needs to avoid all extremes in the care of Mrs Jones? that of total neglect on one end and ceaseless efforts to keep her alive at the other. He could then assume an attitude of "equanimity," a gracious state of poise and neutrality, where one admits that it is thus beyond one's power to do anything to avoid the inevitable death of Mrs Jones.

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*Lerwut Wongsarnpigoon, MD, is a psychiatrist in Northbrook, IL, and is of the Buddhist faith tradition. He works in both in-patient and outpatient settings, and part of his practice involves the deaf and hard of hearing population.*

**Commentary 4**
by Dr Nihal S. Gooneratne, MD, and Ananda Wickremaratne, DPhil.

As a physician and a philosopher raised in the Buddhist way of life our thoughts are as follows:

When life begins and the precise point of its termination have been subjects of much debate and ethical concern these days. In Buddhism, life begins not at the point of birth, but in the act of copulation successfully accomplished. The fetus however incomplete is viewed as life *in posse,* in the most ample sense of that term. There is no difference in the gradually unfolding life processes and their potential, and the achieved fact. One leads to the other. Consciousness is part of the potential.

In relation to this particular patient, the larger Buddhist idea of karma also comes into play. In Buddhism, karma is not action per-se but the thought (*cetana*), which is the parent of all actions, good or bad. The baby that has achieved birth, is a product of a positive wholesome thought the parents entertained. Considering all of the above, there is a sanctity attached to all living beings, be they human or animals or even microscopic organisms, which according to Buddhism have a right to live, regardless of scientific taxonomies about single, multiple, or complex order of cells in life forms. A number of implications follow. First that all life is, to use a religious word, sacred, and worthy of respect. Much as each one of us is a member of a family, according to Buddhism each person is a separate individual in terms of previous karmic conditioning. Secondly, given the intrinsic sanctity of life and the implications that follow, nobody has the right to take away life, since karmically each person's life is his own. It follows that third parties, whether they are friends or family of a person who is gravely ill, must exercise great ethical care in coming to a decision. Ideally, in ancient societies and until recent times, what we call life, namely the natural progression and

degeneration of any organism, took as it were a preordained course. Death was a natural expectation in traditional premodern cultures, east or west, accepted with commendable fortitude and grace. We wish to emphasize that in this age of spellbinding medical technologies and their potential, it is easy to forget that death is a natural eventuality which has traditionally been accepted by the dying person as well as by the family, relations, and friends. In eastern religious philosophies as well as in medieval Christian Europe before modernization, the process of life itself was a calibrated preparation for death. A famous Christian saying in medieval time was "Memento Mori," remember that you must die.

These 2 emerging elements seem to be paradoxical. First, there is the natural inclination of all organisms toward the perpetuation of life and, secondly, the acceptance of death as a natural process.

How does all this affect the choice we have at hand—whether to artificially prolong the life of a sick person by modern methods or to let nature take its course?

In many cultures this would be a new question, calling for redefinition of existing religio-cultural norms. It puts a grave burden of enormous ethical implications on those who have the responsibility of coming to this difficult decision. For a relative at the bedside to decide that life support systems should be discontinued is, in terms of Buddhism, an arbitrary and ethically indefensible position. The idea that by doing so, we end the prolongation of suffering is subjective and is not altogether a scientifically defensible position. In this particular case and in recent cases highlighted by the media, there seems to be a sharp division in professional opinion among those who have the competence to come to some form of judgment. Indeed, from a Buddhist point of view the resolve to terminate life is a paradoxical, violent act of taking away someone's life, especially when that person is a human being.

In Buddhism, to be born a human person without the debit of physical or mental handicap, is a privilege which should not be taken for granted. As a result of negative karma, a being may be born in cosmic worlds of woe, in situations of limbo, or as an animal, conditions which the being concerned has no power to alter or abbreviate until the karmic force is expended. There are 2 reasons why great value is placed on the human condition and its potentialities. First it is only as human beings that we can fully understand the central problem of *dukkha,* or suffering, in all its deep existential dimensions. Secondly, it is only in the human condition that we can work out our salvation to end suffering and achieve nirvanic transcendence to break the cycle of birth, and death, and birth again, in an endless, remorseless samsaric round.

In a finely balanced conundrum such as this, the better ethical decision might be to continue with life support systems until nature takes its course. By our phrase "nature takes its course," we mean the natural end of the patient's karmic continuity force. In fact what rationally seems to be a matter of decisions is, one way or another, a reflection on how karma works. The very people who take these decisions are, unbeknown to themselves, agents of karma, according to Buddhism. Logically in the Buddhist paradigm, those who take such decisions create karma for themselves.

The difficulty here is one of trying to integrate 2 virtually incongruent worldviews into a single meaningful synthesis or paradigm. For example, in a natural Buddhist context the dying person, as a result of a lifetime habituation, accepts death as a part of the process of the volatility and impermanence of all things. Life support technologies in themselves cannot be blamed or thought to be the key player in dramas of this nature. The key players are those who consciously, deliberately, and volitionally take decisions one way or other. Compassion in Buddhism is naturally associated with the support and perpetuation of life organisms, conditioned, of course, by the impermanence of all things. In no way can it be argued from a Buddhist perspective that taking the decision to withhold treatment is somehow deeply ethical or compassionate and is in the best interest of the patient.

*Nihal S. Gooneratne, MD, is an attending staff radiologist in the Department of Imaging at Christ Hospital & Medical Center in Oak Lawn, IL. He is also a clinical associate professor of radiology at University of Illinois in Chicago.*

*Ananda Wickremaratne, DPhil, is a professor in the Department of Theology at Loyola University in Chicago.*