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Timers on Ventilators

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NOTE: At the time of publication, author Vardit Ravitsky was affiliated with the National Institutes of Health. Currently March 2007, he is a faculty member in the Center for Bioethics at the University of Pennsylvania.

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Abstract
Is there 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. However, some doctors, patients, and families still find the distinction to have important ethical implications. A proposed Israeli law offers a unique approach that attempts to respect the cultural reluctance to withdraw treatment while finding a practical solution that respects the wishes of patients and families and allows patients to end their lives with dignity. The Israeli case offers important insights for other countries that want to combine their cultural identity and heritage with democratic and liberal values as well as for doctors in Western countries caring for patients and families that espouse different communal cultural traditions.

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Jewish religious law considers human intervention to end the life of dying patients unethical. Timers on ventilators are proposed as a solution to prevent unnecessary suffering

Is there 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.[1] However, some doctors, patients, and families still find the distinction to have important ethical implications. A proposed Israeli law offers a unique approach that attempts to respect the cultural reluctance to withdraw treatment while finding a practical solution that respects the wishes of patients and families and allows patients to end their lives with dignity. The Israeli case offers important insights for other countries that want to combine their cultural identity and heritage with democratic and liberal values as well as for doctors in Western countries caring for patients and families that espouse different communal cultural traditions.

Objections to withdrawing treatment

The standard Western response to the reluctance of doctors and families to withdraw care is to dismiss it as an emotional reaction. The solution offered is to employ rational reasoning and not be misled by the apparent distinction.[2] This approach is difficult 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."[3] Israel defines itself as a "Jewish and democratic state" and attempts to integrate a liberal democracy with a Jewish communitarian approach.

Israel does not share the strong Western, especially Anglo-American, consensus regarding the over-riding 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."[4] 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.[5] 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 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

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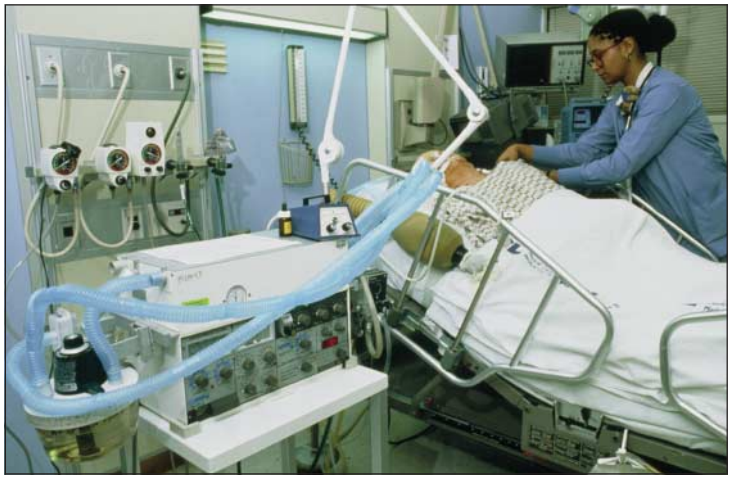

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Under *Halakhic* law dying patients cannot be disconnected from a ventilator

by its symbolic characterisation as extinguishing the candle."[6] 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.[7] 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 treatment

End of life care in Israel is currently not regulated by legislation. To develop a coherent policy and formulate guidelines, Israel's Minister of Health established in 2000 a public committee on the dying patient.[8] The committee, chaired by Professor Avraham Steinberg, 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 submitted to the health minister in 2002. This has been approved by the Israeli ministerial committee for legislation and is currently being sent to the Knesset (the Israeli parliament) as a governmental proposal for legislation.

In reaching a solution, the committee tried to harmonise the Jewish cultural heritage with the autonomy of a dying patient. The philosophical subcommittee, chaired by Professor Asa Kasher, 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."[9] 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, it might cause patients to refuse the intervention for fear of being trapped in a cycle of suffering against their will, thus shortening their lives unnecessarily. Thirdly, 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. Healthcare providers may also be reluctant to start ventilation, knowing that once initiated it cannot be withdrawn.

Permitting termination of continuous care

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."[10]

A second committee was 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.

Bioethical 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?"[11] Will they enable Israeli physicians

Summary points

Jewish tradition maintains a distinction between withholding and withdrawing treatment at the end of life

Any intervention to hasten death is viewed as unethical even if the outcome is ethically desirable

A proposed Israeli law suggests the installation of timers on ventilators as a way of respecting cultural and religious reluctance to withdraw life sustaining treatment

This pragmatic solution would enable doctors to honour the wishes of patients and families to stop mechanical ventilation

to perform in practice what their principles otherwise forbid them from doing, thus eroding a well founded ethical intuition and encouraging wrongdoing?

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 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,"[11] 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.

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Competing interests: None declared.

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One hundred years ago

The puffing paragraph

One of the most frequent of the manifold complaints which are poured into the editorial ear is of the appearance in newspapers of biographical notices of medical practitioners or records of their achievements. The puffing paragraph with which the new journalism has made us too familiar is always objectionable, but in the case of medical men it is often something worse, for it may be false as well as fulsome. In this way it may be misleading to the public as well as harmful to the practitioner, who is made ridiculous by inappropriate praise. There is nothing, indeed, that makes the judicious grieve more than maladroit flattery, which is as embarrassing to the victim as the clumsy caresses of the horse in the fable who tried to emulate the dog's gambols about his master. It may be assumed, on the low but solid ground of enlightened self-interest, that as a rule puffing paragraphs concerning medical practitioners are not inspired by them. Newspapers cannot, as long as the law of libel is not infringed, be prevented from giving information which is considered likely to interest their readers. What, then, is to be done by the doctor on whom a too friendly editor persists in turning the limelight? In a recent issue we mentioned that an American physician had proceeded against a newspaper which had puffed him for injury caused by what may be termed an inverted libel.

Any man may be puffed once or even twice without his knowledge, or even against his will. But if his name constantly appears in the papers he may find it difficult to satisfy his brethren that he is the innocent victim of a malign combination of circumstances. (*BMJ* 1905;i:87)