

FATAL CHOICES AND FLAWED DECISIONS AT THE END OF LIFE

lessons from Israel

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ABSTRACT This article presents a recent disconcerting event that took place at a rehabilitative nursing home in Tel Aviv in light of Israel's Dying Patient Law, which came into effect in 2005. It probes the double effect doctrine as it is relevant to the case at hand and the role of the medical profession and of the family in making decisions at the end of life, and it argues that patients who express a wish to die should receive a comprehensive care assessment that addresses their physical and mental condition before rushing to provide lethal medication. The article concludes by offering some guidelines to help practitioners address the intricate questions they face when patients ask to die.

CASE STUDY

SC was an 80-year-old Israeli woman. She suffered from multiple chronic conditions, including heart disease, pulmonary congestion, chronic leukemia, diabetes, and high blood pressure. She received medication to treat her medical condition. Her pressing problems were shortness of breath and severe pain in her left leg, the result of poor blood circulation. SC resided in a rehabilitative nursing home in Tel Aviv. One night she could not sleep. She sat on her bed, unable

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In memory of my mother, Sarah Cohen (1930–2011).

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to lie down, and screamed with pain. A nurse came and gave her some analgesics with no relief of her pain. The following day the institution's social worker visited her. SC sat in the dining hall with her older sister CA. The social worker asked SC how she felt. SC replied she did not feel well. She was tired and in severe pain. The social worker asked: What do you want? SC answered laconically: To die. The social worker then proposed to categorize SC as a "terminal patient" with the implication that SC would receive from that time only hospice care—that is to say, SC would receive only pain relief medication and no treatment aimed to heal or improve her health. SC agreed. She signed a document to that effect, and her sister CA served as a witness. Shortly thereafter, SC received significant dosages of morphine. She lost her appetite, became bedridden, and quickly lost the ability to communicate. SC became incoherent, confused, and hallucinated. SC, who was not a dying patient, quickly became a dying patient.

This case study poses some serious legal, medical, and ethical questions. In order to address these, I will first reflect on Israel's Dying Patient Law.

THE DYING PATIENT LAW

In 2000, the Israeli Ministry of Health assembled a group of 59 professionals to draft a law to administer end-of-life decision making. The Dying Patient Committee, known also as the Steinberg Committee after its Chair, Professor Avraham Steinberg, worked for two years and submitted its recommendations and draft law to the government. The Committee considered titling the law "The Terminal Patient Law" but the philosophers of the committee objected, arguing that the word *terminal* does not serve the best interests of the patient. They insisted on a lucid end-of-life language, on terminology that would make it clear that the law was applicable only to patients whose death is near.

The Dying Patient Law came into effect on December 6, 2005. The law applies only to patients who were categorized by a qualified physician as "dying," and who have specifically expressed a wish regarding their treatment, either its prolongation or cessation. The law assumes that the majority of people do not wish to die. All Committee members—including physicians, ethicists, and religious authorities—were of the opinion that patients tend to prefer life with medical challenges over death.¹ The law aimed to strike a balance between the principles of value of life and autonomy, based upon the value system of Israel as a Jewish-democratic state. The law stipulates that decisions concerning dying patients should be based on the patient's medical condition, her wishes, and the

¹The Dying Patient Law, Chapter C, section 4 (Dec. 15, 2005). My research conducted in six countries and in more than 30 hospitals and research centers showed that the vast majority of patients cling to life, no matter what. Even in the most miserable conditions, patients opt to live. See Cohen-Almagor 2001, 2004.

degree of her suffering. A “dying patient” is defined as a person who suffers from an incurable illness and who has no more than six months to live even with medical therapy; the last period of two weeks of expected life is defined as the final stage (Dying Patient Law, Chapter D, section 8). The law specifies the means to guarantee that patients have explicitly wished to die. In instances where no instructions have been left, a guardian or a person close to the patient is allowed to make a statement regarding her or his desires. The statement is only advisory and not binding. The law further stipulates that minors under the age of 17 will be represented by their parents on the issue of ceasing treatment. If a conflict between the parents and the physician arises, a committee will rule on the matter (Dying Patient Law, Chapter D, section 28; Barilan 2007).

The law only pertains to patients who are competent or were once competent. It does not apply to post-coma unawareness (PCU) patients, those suffering from severe pain and suffering, non-terminally ill but seriously malformed neonates, or never competent patients (Cohen-Almagor 1997).² The law also prohibits withdrawal of continuous care, distinguishing between intermittent and continuous care. The distinction was made due to disagreements between the philosophers and the religious members of the Committee on the legitimacy of withholding and withdrawing treatment. While the philosophers thought that there was no morally significant difference between withholding and withdrawing treatment, all representatives of religious denominations, without exception, strongly opposed withdrawal of treatment. Thus the distinction between intermittent and continuous care was aimed to address an important aspect of Jewish (Halachic) law. Under Jewish law, patients cannot be disconnected from ventilators (“killing”).

However, there is no problem in not connecting them to such machines (“letting die”). “Continuous treatment” is defined as any form of treatment that is essentially uninterrupted, so that there is no clear distinction between the end of one cycle and the beginning of another. “Intermittent treatment” is defined as treatment that begins and ends in well-defined cycles. Mechanical ventilation is an example of continuous treatment, while intubation, surgery, blood transfusions, dialysis, chemotherapy, radiotherapy, or antibiotics are examples of intermittent treatment. According to the Dying Patient Law, continuous medical treatment may only be terminated for the purpose of medical treatment. While a patient may request not to renew discrete treatment that has been interrupted, he cannot request to withdraw continuous treatment (Gross and Ravitsky 2003; Ravitsky 2005; Steinberg 2001).

The law also distinguishes between primary medical care (medical care to treat the terminal disease itself) and ancillary care (antibiotics for infections, food

²PCU is also termed PVS, persistent vegetative state. I object to this term on ethical grounds and do not believe it serves the patient’s best interests. See Bedell et al. 2004; Cohen-Almagor 1997, 2000b.

and fluids, etc.). Incompetent terminally ill patients have the right to refuse any primary treatment but may not refuse ancillary treatment, while end-state terminally ill patients may refuse either primary or ancillary treatments. Competent patients can refuse food and fluids; incompetent patients will receive food and fluids despite previous contrary statements. This is because food and fluids are regarded as a basic need of any human being; they are not perceived as treatment. unless the attending physicians determine that food and fluids cause harm or suffering. Furthermore, the law explicitly prohibits euthanasia and physician-assisted suicide (PAS); (Dying Patient Law, Chapter D, sections 19–20). Committee member endorsed euthanasia, and only one member supported PAS. The prevailing view was that Israel as a Jewish–democratic state should not allow physicians to practice either. In the future, the prohibition may be reconsidered.

The law also requires the appointment of a senior physician as the responsible health-care provider. The senior physician's 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 comprehensible and explicit manner, and to inform all relevant parties of the decisions. Decisions should be based on medical facts and the patient's wishes (Steinberg and Sprung 2006, p. 1236).

Finally, the Dying Patient Law provides for advance directives. It establishes detailed mechanisms for taking into account the calculated wishes of the now incompetent dying patient. These mechanisms include a detailed form to be filled out by the person with the aid of a physician or nurse; renewal of the statement every five years; reevaluation of the statement when diagnosed with a serious illness, with the aid of an expert physician; and the establishment of a national pool of advanced medical directives (Dying Patient Law, Chapter E).

RELEVANCE OF THE DYING PATIENT LAW TO THE CASE AT HAND

To what extent is the Dying Patient Law relevant to the case at hand? SC did not suffer from any incurable disease: all her ailments were treatable. No senior physician was present in her discussion with the social worker, verifying that she wished to die. No senior physician advised her of a detailed plan of treatment. It seems that her decision was probably related to her continued suffering from pain which was not adequately treated and probably could have been if given the chance. Although the law stipulates that the attending physician should do whatever possible to relieve the patient's pain and suffering by medication, palliative care, or psychological means, no psychological treatment was offered to SC, and no palliative care specialist saw her.

A few weeks prior to the fatal discussion that SC had with the social worker, she completed another form. In that form, SC designated her son RC as her

medical guardian with whom the nursing home medical team should consult should she become incompetent. As RC resided in England, the social worker advised SC to nominate another person, an Israeli resident, as a second medical guardian. This is because the social worker argued that medical directives should be signed in person. They cannot be faxed or delivered orally over the phone. SC then added her sister CA as a second guardian, stipulating that in any event CA needed to consult with SC's son, RC, on any decision concerning SC's health. Copies of this document, with the specific stipulations, were made and given to SC, RC, CA, and the social worker. Yet, only a few weeks later SC was advised to sign another document. RC was not informed or advised, in absolute disregard for the previous agreement and signed advanced directives. Thus, the law was not upheld.

THE DOUBLE EFFECT DOCTRINE

The procedure that the nursing home pursued is known as the "double effect doctrine." The Dying Patient Law says nothing about the double effect doctrine, despite its practice in hospitals and nursing homes. Very little deliberation was conducted in the Committee about the doctrine. The ethical concept of double effect is used to justify medical treatment designed to relieve suffering where death is supposedly an unintended, though foreseeable, consequence. It comes from the double effect doctrine developed by Roman Catholic moral theologians in the Middle Ages, as a response to situations requiring actions in which it is impossible to avoid all harmful consequences. The doctrine makes intention in the mind of the doctor a crucial factor in judging the moral correctness of the doctor's action, because of the Roman Catholic teaching that it is never permissible to "intend" the death of an "innocent person," one who has not forfeited the right to life by the way he or she behaves, for example, by threatening or taking the lives of others (Anderson 2007; Boyle 2008; Cohen-Almagor 2001; Kamm 1999; McIntyre 2001; Quill, Dresser, and Brock 1997; Sulmasy 1999; Woodward 2001).

The double effect reasoning may permit an act causing good and evil when it meets the following conditions:

1. The act considered independently of its evil effect is not in itself wrong. It must be morally good or at least indifferent;
2. The agent intends the good and does not intend the evil either as an end or as a means; however, the agent may permit the bad effect;
3. Application of the doctrine presuppose that some kind of proportionality condition has been satisfied: the agent has proportionately grave reasons for acting, addressing his relevant obligations, comparing the consequences, and, considering the necessity of the evil, exercising due care to eliminate or mitigate it;

4. The good effect must flow from the action at least immediately as the bad effect;
5. The good effect must be sufficiently desirable to compensate for the allowing of the bad effect (Cavanaugh 2006).

In other words, the double effect doctrine applies if the desired outcome is judged to be “good” (relief of suffering); the “bad” outcome (death of patient) is not intended; the “good” outcome is not achieved by means of the “bad”; and the “good” outcome outweighs the “bad.” However, both the intention and the proportionality presuppositions are problematic. It is hard to know, or to prove, what is the doctor’s intention, and the issue of proportionality is tricky, as “proportionate” medication is not easy to evaluate. The double effect doctrine is a practical way to deal with severely ill patients. Some physicians prescribe large doses of medication, knowing that suffering will be lessened but also that life may be shortened. They feel comfortable with what they are doing: they are not breaking the law; they are acting in accordance with their medical understanding and providing solace to suffering patients. However, the double effect doctrine might not be altogether sincere, because there is no clear-cut distinction between treatment administered to relieve pain and suffering and treatment intended to shorten the dying process.

A recent study found a striking ambiguity and uncertainty regarding intentions among doctors. Some were explicit in describing a gray area between palliation and euthanasia, or a continuum between the two. Not one of the respondents was consistent in distinguishing between a foreseen death and an intended death. A major theme was that “slow euthanasia” may be more psychologically acceptable to doctors than active voluntary euthanasia by injection, partly because the former would usually only result in a small loss of time for patients already very close to death, but also because of the desirable ambiguities surrounding causation and intention when an infusion of analgesics and sedatives is used (Douglas, Kerridge and Ankeny 2008; see also *British Medical Journal* 2008; Sheldon 2009; Sprung et al. 2008; Sykes and Thorns 2003).

In the case at hand, the side effect of hastening death was an inevitable or at least likely result of the administration of opioids in order to relieve SC’s pain, not an unwelcomed side effect of providing pain relief in the context of palliative care. However, the *intention* was to kill the patient, because the patient wished to die and the medical team apparently thought that there was no point in prolonging her life. SC confirmed this later on in a private conversation. Thus, the double effect doctrine was misapplied in this case, because less harmful alternatives were available, the intention was not merely to relieve pain, and hastening death was done prematurely, out of proportion to the medical condition of the patient.

SC was a determined, strong-willed person, very energetic and active. Until a few weeks before, she had resided in her own apartment in Tel Aviv, catering for

herself and her personal helper. Overall, she led an independent life. She used to cook, shop, travel by public transportation, play bridge, go to restaurants, meet family and friends. Suddenly she found herself confined to a rehabilitative nursing home, no longer able to climb the stairs to her apartment on the second floor. She could hardly walk, moved about only by a wheelchair, and had to wear an oxygen mask. She found it difficult to cope and to accept the debilitating change. Loneliness, bitterness, and pain became more common than peace, tranquility, and joy. What she needed was psychological counseling that could help her find new meanings in life and a way out of her depression. But instead of appropriate counseling to improve her quality of life and her general mood, the social worker rushed to advise hospice care, which was bound to lead to her death, a death she wished.

THE ROLE OF MEDICAL PROFESSIONALS

The rehabilitative nursing home where SC was residing did not have an in-house psychologist. The social worker assumed this role as well, despite the fact that she did not have any qualifications to provide counseling and appropriate psychological care for patients. This was a major omission that should have been corrected. The nursing home is considered one of the best in the country. Patients there pay a lot of money to receive private care and therapy, but the rehabilitation model is confined only to the physical aspects of the body—the mental and spiritual aspects are neglected. There are strong links between mind and body; caring for one cannot be done adequately without addressing the other. Both aspects of care—physical and mental—are crucial for successful treatment.

The astonishing thing was that SC voiced her death wish only once, and this was enough for the social worker. The role of the social worker as a facilitator is to create an open, safe, caring and supportive space for the patient. But “supportive” does not mean to support all that the patient wants without any questions. There was no argument, no debate, no other choices offered; no asking or evaluating whether SC was depressed and why she wished to end her life. SC expressed a wish to die and then made her fatal choice to accept only hospice care, which meant morphine. I believe that the social worker consulted senior physicians, but none came to speak to SC. No medical professional ever explained her medical condition to SC, outlining the possible options and courses for treatment, and what could be done to address her needs and concerns. Instead of providing reassurances in the value of life, the social worker was quick to agree to terminate the healing treatment.

This situation was a clear violation of Israel’s Patient’s Rights Act (1996), which established the right of patients to be informed of diagnosis, prognosis and treatment related to the medical condition. The Act obligates the patient’s physician to provide the medical information. Although SC agreed to accept only hospice care, she did not fully understand the implications of her consent.

Furthermore, patients cannot be said to give informed consent when they are very depressed, very frail, or confused. Thus, the short conversation with the social worker at the end of which she signed the fatal document cannot be described as one in which the patient gave informed consent (Brennan, 1991; Faden and Beauchamp 1986; Grisso and Applebaum 1998; Maclean 2009; Manson and O'Neill 2007; O'Neill 2003; Switankowsky 1998; Wear 1998). No medical professional provided her hope and assurance that she would be able to overcome the physical challenges. This was a mockery of the healing process and of a careful decision-making process. It is shocking that such a quick procedure could happen in Israel, a country known for its rigorous care and intensive treatment at the end of life.

Medical professionals should resort to the language of hope, especially when dealing with older patients with multiple chronic conditions. The language of hope includes various attributes, among them positive expectations, personal qualities, spirituality, patient's goals, comfort, help/caring, interpersonal relationships, control, one's legacy, and life review (Johnson 2007). Already vulnerable when they learn they have a life-threatening disease or chronic illness, patients can feel bewildered. The power of direct communication, of choices offered, of the language one is using, is profound. The way options are presented can have detrimental effects on the decisions patients make. Indeed, efforts have been made across the medical community to grapple with the language and ethics of hope. A consensus is emerging that all patients need hope, and that doctors are obligated to offer it, in some form or another (Contreras and Kennedy 2009; Hoffman 2005; Nathan 2010). In *The Anatomy of Hope*, Jerome Groopman (2003) forcefully asserts: "Clear-eyed hope gives us the courage to confront our circumstances and the capacity to surmount them. For all my patients, hope, true hope, has proved as important as any medication I might prescribe or any procedure I might perform" (p. xiv).

I believe in phenomenology, that we shape our lives by the words we choose. The invocation of concepts and the terminology we use have significant implications for the care of patients. The medical professionals at the rehabilitation nursing home used the exact language that members of the Steinberg Committee dismissed. Offering to define a patient as "terminal" does not serve the patient's best interest. When a patient is categorized as terminal, the message is one of surrender, of despair. It may seem that the medical professionals are counting the patient's days and are discouraging her from fighting for her life. SC asked to die and immediately was offered to be categorized as "terminal" by a social worker, not even by a qualified physician. This was travesty of adequate medical care.

The medical professional's task is not to hold a clock over the patient's head and count his days. When the destiny of patients is in the hands of medical professionals who seem to have given up, patients cease looking to their caregivers for assistance. Loss of hope diminishes the will to fight for life. I am not saying

that medical professionals should lie: they must report the medical situation accurately to the patients and their beloved people, and not raise false hopes. But they also should not smother the power of life by categorizing patients in terms that may weaken their will to live. (See Cohen-Almagor 2000a, 2000b; Derse 2000.)

In *Garry Lee v. Oregon* (1995), the court said that even for physicians who specialize in treating a terminal disease, no precise definition of “terminal” is medically or legally possible, since only in hindsight is it known with certainty when someone is going to die. And as the Ninth Circuit Court noted in *Compassion in Dying* (49 F. 3d, 1995, p. 590), the terminally ill category is “inherently unstable.”

Moral Conduct, Immoral Conduct, and Amoral Conduct

There is a distinction between moral conduct, immoral conduct, and amoral conduct. *Moral conduct* perceives patients in the Kantian sense as ends rather than means, treating them with dignity, care, and respect. An objective end, Immanuel Kant (1785) explains, is one for which there can be substituted no other end, for otherwise nothing of absolute value would be found anywhere (Jost and Wuerth 2011). We respect patients as autonomous human beings who exercise self-determination. Each individual is perceived as a bearer of rights and a source of claims against other persons, able to make decisions as a free agent. To regard others with respect is to respect their right to make decisions, regardless of our opinions of them. So long as the patient does not harm others, we respect her rights as a person, even if we disagree with her specific decisions and choices.

Immoral conduct is one that is blatantly uncaring, disrespectful, and undignified. Immoral decisions and conduct are in opposition to what is deemed right and ethical. *Amoral conduct* is practiced when people are not aware that they transgress ethical boundaries. They are oblivious to ethical standards as no one ever taught them the philosophical and ethical skills required for the job. They are not sensitive to the fact that their conduct may have deleterious effects on others.

My own research over the past 20 years in seven countries and dozens of hospitals and medical centers shows that a great deal of the medical professional's conduct is amoral in nature. Many medical professionals are superficially familiar with their professional ethical code of practice, as they receive only limited training in it and fail to fully comprehend the intricate philosophical layers underpinning the code. Were they to receive adequate education, pointing to the ethical issues at hand, making them aware of moral quandaries and ways to address and resolve them, the situation could be very different. Medical schools should invest in teaching, planning, and developing medical ethics courses and communication skills programs in undergraduate, residency, and continuing medical education, in order to shape new role-models for the next generation of medical professionals. We need to create a culture of compassion, empathy, and honesty, compassionately diffuse distress and despair, and effectively address systemic barriers to care as they arise (Heritage and Maynard 2006; Kurtz, Silverman and Draper 2005; Sears 2010; Wright, Sparks and O’Hair 2008). Most importantly, we need to edu-

cate physicians to invest time in their patients, to sit (not stand) with them, talk to them at eye level, explain their condition to them in language they fathom, and understand their concerns, fears, wishes, and motivations.

The Dying Patient Law requires certain procedural formalities regarding medical directives. The form must be signed in the presence of two impartial witnesses. In this case, there was one witness, CA, who clearly was not impartial. The form also should be filled in only after the signatory has received medical information from a qualified doctor or registered nurse, who must write down the essence of the information (Dying Patient Law, Chapter E, section 32). SC received no detailed information about her condition from anyone. She suffered for weeks from pain in her leg, but no substantive treatment was given to her designed to heal the leg. Care is the bedrock of medical practice, but all that SC was given was pain-relief medication.

SC's younger son, RC, called his mother from abroad every day, sometimes more than once a day. When he noticed that something was wrong, that he was unable to communicate with his mother as before, he enquired about her condition with the medical staff. No one told him what was going on. At one point, SC told him she was about to die. Alarmed, he called the nurse and asked why his mother spoke in this fashion. The nurse, in response, told him that SC was fine: she seemed to be happy, laughing, eating, and entertaining company. No word was uttered about the new morphine regime.

RC called the attending physician, Dr. N, who described his mother's condition as "stable." Dr. N did not tell him of the new morphine treatment. RC discovered this only a few days later, upon arriving in Israel and after his mother had already left the nursing home.

THE ROLE OF THE FAMILY

SC had two sons. Her elder, YC, resided not far from Tel Aviv. He had problematic relationships with his mother and worked hard as an independent salesman. He visited his mother once a week. Her younger son, RC, had a close relationship with his mother but, as noted, he lived abroad. Apart from him, the closest person SC had was her sister, CA. However, CA was 83 years old, with her own health problems, including severe back problems that inhibited her free movement. CA was put in a very uncomfortable situation. On the one hand, she felt obliged to visit her close sister. On the other hand, each visit was quite difficult. To visit SC, she needed to take a bus, and then walk with her cane. Her conscience did not allow her to remain at home, but her physical abilities were deteriorating. Aiding her sister did not help her own health.

When SC approached CA and said she wanted to die, CA did not try to dissuade her. She was always willing to help her younger sister. SC asked her not to tell anyone: it was supposed to be their secret, conspired with the social worker. SC thought this was for the better. Her older son was not that interested in her;

the other, who was interested, was far away and led his own life with his family. SC found little meaning in life. She explained this to CA, who, instead of providing solace and meaning in life, told her sister: I will join you. She legitimized SC's request and encouraged her to go ahead with her plan. As SC wanted to keep this secret, she had no qualms hiding this development from RC, despite her written obligation to him and the document she had signed in which she pledged to consult and advise him of any medical development relating to his mother.

In many respects, SC put her sister in an impossible situation. RC used to call his aunt CA for updates on a regular basis. Going ahead with the plan meant hiding this development from him, which would destroy the trust between them. But if CA refused her sister, that would entail a clash, something CA wanted to avoid. After some hesitation, she cooperated with her sister. This episode illustrates how dangerous it is to rely on one close relative for such fateful decisions. CA had her own partisan interests that were germane to the case but that did not serve the patient's best interest. Being close to the patient does not necessarily mean that the patient's best interests are being served.

In some respects, this case is reminiscent of that addressed *In the Matter of Spring* (1979) in the United States. *Spring* involved an incompetent person whose wife petitioned the court for an order that hemodialysis treatments, which were sustaining the life of the ward, be terminated. The Springs had been married for more than 55 years. Their son had lived for more than 15 years across the street from his parents' house and had visited them virtually every day during that time. The wife and son had actively cared for the patient's needs since the onset of his precipitous physical and mental deterioration, although the burden that he had imposed upon his family after he developed kidney failure was cumbersome. His wife and son had to transport him three times a week to a private kidney center in another town for five hours of dialysis treatment. Furthermore, Spring's physical deterioration was accompanied by mental disorientation. His behavior at home became belligerent and destructive, and he could no longer care for himself. The crisis in the family increased when his wife suffered a stroke, temporarily losing her ability to speak; the son attributed the stroke to strain and exhaustion resulting from his father's behavior and condition. After Mrs. Spring became well enough to be discharged from the hospital to her home, she could no longer take care of her husband. She needed to devote all her energies to taking care of herself.

At that time Spring was in a nursing home, where his disruptive behavior was controlled through heavy sedation. The wife and son expressed the view that if Spring were competent to voice his opinion, he would wish to have dialysis discontinued, although that would result in his death. The family's view did not rest on any expression of such an intention by the patient, but it was accepted.

It seems that the Spring family was very close-knit. The wife and son found it terribly distressing to see the man they had shared their lives with for so many

years fading away, failing to recognize them, acting brutally, and becoming a different person. They could not cope with this situation. The appeal to the court was made also in order to keep their own sanity, their own lives. It seems that the family sincerely thought that by withholding treatment from Spring, they could preserve his dignity. But the question remains whether Spring himself would have preferred to die (Cohen-Almagor 2001).

Even if we are convinced of a family's commitment to a patient, the family's position should not be obligatory in all circumstances. The family is not necessarily capable of rational decision-making, and even if it is, its interests are not necessarily identical to those of the patient. The patient's best interests should always be first and foremost in our mind (Hardwig 1990, 2000; Jennings 1992; Kushner 2010; Richman 1987).

CONCLUSION

After a few days of receiving the morphine treatment, SC's elder son YC arrived for his weekly visit. He found his mother on the verge of death and enquired what had happened since he last saw her a week ago. When YC understood that she received morphine treatments, he demanded to transfer her to the near hospital. The attending physician insisted that SC had received appropriate care at the nursing home and refused to transfer the patient. YC demanded transfer. After consultation with a senior physician, permission was granted. SC was transferred to the hospital, where the morphine regime was stopped immediately. SC's younger son, who realized that something terribly wrong was going on, arrived the following day. Both sons demanded that their mother receive healing treatment. It took 72 hours for SC's body to clear the morphine. With the appropriate treatment and counseling, SC resumed her will to live. Upon collecting herself, SC failed to understand why the people at the nursing home were so quick to grant her request to die. The mere mention of the nursing home's name became traumatic to her. A few weeks later, SC underwent an operation to open blood vessels in her left leg.

This episode raises alarm bells regarding potential abuse of the Dying Patient Law as it is applied to fragile and vulnerable patients in nursing homes. SC's treatment clearly violated the letter and the spirit of Israeli law and would be considered malpractice elsewhere as well. This episode also teaches us a number of lessons. First, patients may ask to die because life appears to be the worst alternative in the current situation. But the patient should state this wish *repeatedly over a period of time*. We must verify that such a request does not stem from a momentary urge, an impulse, a product of passing depression. We must also verify that the request is not the result of external influences.

Second, we need to arrive at a level of transparency at which proper safeguards for end-of-life medical care can be developed and maintained. At times, the patient's decision might be influenced by severe pain (Ruddick 1997; Schat-

man 2007; Teno et al. 2001; Wall 2002). In this context, the role of palliative care can be crucial, and it need not lead to the patient's death. By palliative care is meant the active, comprehensive, and total care of patients whose disease is not responsive to curative treatment, where maintaining that control of pain, of other symptoms, and of psychological, social, and spiritual problems, is paramount (WHO 1990). One important safeguard should be proper documentation of the use of potentially life-shortening measures, including keeping records on the timing and doses of the drug and the physician's intention at each step. Such documentation may reduce the use of inappropriate large doses of medications to shorten the patient's life given in the guise of relieving pain and suffering (Sprung 2008).

Ganzini and colleagues (2000) report that as a result of palliative care, some patients in Oregon changed their minds about assisted suicide (see also Morrison and Meier 2004). The medical staff must examine whether it is possible to prevent or to ease the pain by means of medication and palliative care.³ The Oregon Death with Dignity Act (13 Or. Rev. Stat. §3.01, 1998) requires the attending physician to inform the patient of *all* feasible alternatives, including comfort care and pain control (Cohen-Almagor and Hartman 2001). If it is possible to prevent or to ease the patient's pain, then the patient's request to die should not be fulfilled; instead, the necessary treatment should be prescribed.

Third, coping with pain and suffering can drain all of the patient's emotional strength, exhausting the ability to deal with other issues. In cases of competent patients, the assumption is that the patient understands the meaning of the decision. A psychologist's assessment is crucial in the process. There should be attending psychologists in nursing homes and hospital wards to speak with patients, discuss their condition, and assess their mental capabilities and ability to make fatal decisions at the end of life. Psychologists can confirm whether the patient is able to make a decision of such ultimate significance to the patient's life, and whether the decision is truly that of the patient, expressed consistently and of her own free will. Most importantly, the role of psychologists is of vital importance in providing comprehensive primary care for patients with multiple chronic conditions. It is worthwhile to hold several such conversations, separated by a few days. The patient's loved ones and the attending physician should be included in at least one of the conversations.

Fourth, it is reiterated that physicians should invest time in their patients. The specialization process is such that physicians see only the organ in which they specialize. Some see only the heart, others the liver, yet others the lungs. No one

³Directive 7 in *The General Manager Circular*, Israel Ministry of Health, no. 2/96 (Jan. 31, 1996) holds: "Doctors must concentrate their efforts on easing the pain, torment, and suffering of the patient, a subject of highest priority in medical treatment, especially when terminal patients are concerned" (p. 12). For further deliberation on pain control mechanisms and their importance, see Doyle, Hanks, and MacDonald 1998; Jost and Mendelson 2003; Morrison and Meier 2004; Quill, Coombs-Lee, and Nunn 2000; Quill, Lo, and Brock 1997.

sees the patient as a whole, as a human being who needs to preserve hope and understand his condition. Physicians need to understand that time is a worthwhile investment, as physician-patient direct communication is crucial in the healing and caring process. "Direct communication" entails verbal communication, active listening, voice management, nonverbal communication, and cultural awareness (McCullagh and Wright 2008; Tamparo and Lindh 2007). Without such communication, patients are in a limbo—uncertain, afraid, not knowing what to expect, victims of their worst speculations and nightmares. On the other hand, positive communication with patients addressing all of the patient's health-related needs and concerns can decrease patient anxieties, increase patient trust, and result in a constructive experience for all involved. The patient must be informed of the situation and the prognosis for recovery or escalation of the disease, with the suffering that it may involve. There must be a free flow of information and coordination between patients and all who provide care for the patients, including specialist physicians, rehabilitation therapists, mental health professionals, home care providers, and social workers (Boult and Wieland 2010). The communication should be two ways, where physicians not only talk but also listen to their patients. What does the patient want? Why does she want this? Listening to the narrative may reveal misconceptions or misunderstanding that can be corrected; alternatively, the narrative may affirm that the patient knows exactly what she wants because of valid reasons.

Fifth, it must be ensured that the patient's decision is not a result of familial and environmental pressures. The patients' motives should be evaluated closely so as to see to what extent they are affected by various external pressures (as opposed to a truly free will to die). A situation could exist in which the patient is under no such pressure, but still does not wish to be a burden on others. Obviously, we cannot say that the feelings of patients toward their loved ones are not relevant to the decision-making process (Casarett 2010; Cohen-Almagor 1996; Hardwig 2005).

Sixth, the decision-making process should include a second opinion in order to verify the diagnosis and minimize the chances of misdiagnosis, as well as to allow the discovery of other medical options. A specialist who is not dependent on the first doctor, either professionally or otherwise, should provide the second opinion. Furthermore, the consulting physician must verify that the patient is capable, is acting voluntarily, and has made an informed decision.

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