Jewish Medical Ethics and Halakhah

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Jewish doctors through the ages have always prided themselves on their devotion to the welfare of their patients and on their high moral standards. At an early stage they rejected the Christian theological position that suffering was ennobling and that illness should be accepted as divine punishment. The sages of the Talmud overwhelmingly insisted on the physician's right to heal the sick against any such theological argument [1]. We may read the "ethical wills" left by medieval Jewish physicians such as R. Judah ibn Tibbon, that inspire the next generation to continue to care for their patients with compassion and humanity [2]. And in our own era, as victims of the organized medical cruelty of the Nazis, for us Mengele has become the Jewish metaphor for the negation of medical ethics [3]. The Nuremberg Code and its progeny, the Helsinki Convention, were nourished by the the Jewish suffering on the altar of medical racial science.

Jewish Medical Ethics has become a new academic discipline in its own right, starting with the publication of a book by that name by the Chief Rabbi of Britain, the late Lord Immanuel Jakovits, in 1959 [4]. There is a Journal of Jewish Medical Ethics published by the Institute for Medical-Halakhic Research at Shaarei Zedek Medical Center, a religious hospital in Jerusalem (this journal, Anna, is subtitled "Jewish Medical Ethics" in the English edition, and "Halakhah and Medicine" in the Hebrew edition). There are also countless courses on the subject. In honor of the founder of the movement, there is a Jakobovits Institute of Jewish Medical Ethics at Ben-Gurion University of the Negev. Not only was the founder a rabbi, but the vast majority of the active scholars in the field are Orthodox and committed to the halakhah (Jewish religious law) and its dictates, several of them simultaneously practicing as active medical doctors. A prime example is Prof. Abraham Steinberg whose encyclopedic contribution [5] was recently publicly recognized with the award of the Israel Prize. However, the vast majority of Jewish doctors today do not see themselves as subject to the dictates of the halakhah, and this may well have been true in earlier times too. Where then is the place for a Jewish medical ethos aside from the rulings of religious law?

In the current issue of IMAJ, Dr. Kunin presents a halakhic perspective on truth-telling in medicine [6]. However, the halakhic debate on this subject allows for more voices than Dr. Kunin lets us hear. Indeed halakhic debates are typically multi-layered. In recent years, two diametrically opposite halakhic positions have been presented on this particular subject – one categorically forbidding the doctor to tell painful truths to patients, and the other instructing that the patient should be told as much as can be tolerated [8-9]. These dissenting voices, however, are only heard within the confines of the halakhic debate. Once the subject is aired outside the Orthodox camp, a monolithic, ex cathedra, statement is typically presented for the rest of the Jewish and non-Jewish world. It is therefore not surprising that the non-halakhic Jewish doctor today finds little space for his own moral judgment within the public debate, and only the voice of the halakhah is heard as the true representative of Jewish Medical Ethics. This disenfranchisement of the non-Orthodox Jewish doctor is potentially dangerous to the future of the moral standards of Jewish medicine.

Halakhah, as a system of law, strives towards authoritative rulings as the culmination of its theoretical debates. Sometimes these rulings are unchallenged, but more often than not there will be a minority opinion that is less authentically halakhic even if it is not accepted as binding by those committed to Orthodox Judaism. It is into this space that a very few non-halakhist have ventured, most notably the late Dr. Benjamin Freedman of Montreal [10,11], but their work does suggest that a more nuanced approach to Jewish medical ethics is possible [12].

Dialogue between the halakhists and other ethically sensitive Jewish doctors and philosophers has the potential to re-harness the great traditions of Judaism to the progressive world of contemporary scientific medicine and public healthcare systems. There are, however, considerable problems along the path towards such a dialogue, since the rules of discourse are so vastly different in the worlds of halakhic and secular scholarship. Whereas the halakhah is based on absolute, immutable, divine sources, and its scholars see themselves as guided by divine inspiration [13], secular ethics admits to its fallible and human nature and welcomes free enquiry and open criticism [14]. The proponents of halakhah who could foster a fruitful ethical dialogue with secular Jews must be capable of accepting free criticism of their most hallowed creed. Given the enormous range of opinion within halakhah, this mission should not be impossible.

References
1. Babylonian Talmud, Bava Qama 85a.
Wireless Capsule Endoscopy – Pros and Cons

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**Key words:** wireless capsule endoscopy, intraoperative enteroscopy, gastrointestinal bleeding

In their article on wireless capsule endoscopy in this issue of IMAI [1], Dr. Fireman and collaborators, who reviewed the literature on the subject, concluded that the capsule “is likely to become the front-line procedure in the detection of small bowel diseases.” However, the discussion ignores most of the critical issues related to the capsule and to small bowel investigation.

The authors cited a study where capsule endoscopy detected more lesions than did other modalities. The clinical significance of these lesions and the impact on outcome is not clear. There is no information about the outcome of such patients: did they undergo surgery, if so, what were the findings during surgery and during the post-operative follow-up? There is no discussion on the failure of the capsule to localize lesions within the small intestine.

A detection of arteriovenous malformation by the capsule will require intraoperative enteroscopy for better localization and resection. However, were we to use an intraoperative enteroscopy, the need for the capsule would be unclear since one could move directly into intraoperative enteroscopy. Intraoperative enteroscopy is an accepted technique in patients with serious gastrointestinal bleeding, and the use of capsule endoscopy would merely increase the cost with no additional benefit. The time for reading the examination of the capsule is between 1 and 2 hours. This is quite a heavy load for the gastroenterologist. It will limit the number of examinations possible and will incur considerable costs, thus precluding more extensive use of the capsule.

Nonetheless, capsule endoscopy is a technological breakthrough that allows us to directly study the entire small intestine. The amentarium available today for studying the small intestine is limited. A barium study of the small bowel is not sensitive enough, especially for mucosal lesions. Push-enteroscopy is invasive and is associated with discomfort and occasionally complications. It investigates only the proximal portion of the small intestine. The endoscopic capsule, however, provides an excellent view of the small intestine and is safe and well tolerated. Mucosal lesions such as erosions, ulcers, and arteriovenous malformations can be seen clearly. In the case of obscure gastrointestinal bleeding, a negative study will justify a repeated upper and lower gastrointestinal endoscopy before we can consider intraoperative endoscopy.

At the present time however, capsule endoscopy cannot replace any of the other investigative procedures of the small bowel. Investigation of the small intestine should include enteroscopy, X-ray studies, and capsule endoscopy. The number of capsule studies performed worldwide is still small and it is too early to appreciate the sensitivity and specificity of this procedure. The limited information currently available, however, is quite promising.

**References**


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