



The Dying Patient Act, 2005: Israeli Innovative Legislation

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One of the most difficult moral, cultural, religious, and legal issues in medical ethics is the treatment of the dying patient. In the past few decades the dilemma has intensified for various reasons: the enormous advances in medicine and technology; the change in the patient-physician relationship from a paternalistic to an autonomous approach; the greater involvement of various professionals in treating the dying patient (specialists, nurses, social workers, students, laboratory technicians and others); economic changes due to the very expensive treatments and technologies, and social changes with a significant decline in the role of the physician. In Israel, various policies, guidelines and declarations have been proposed in recent years; but the situation has been confusing, with physicians not knowing what was allowed and what not, acting inconsistently, and often not discussing decisions with patients, next-of-kin, or other health-care professionals, and not documenting life and death decisions [1].

There are varied approaches around the world concerning the dying patient [2,3] and many countries are still battling with these issues. We feel that the development process and the actual Israeli Law may provide useful insights for other countries and for the professionals.

Israeli Legislation – the process

A detailed and comprehensive law regulating the treatment of the dying patient was enacted on 6 December 2005 by the Knesset (Israeli Parliament). The legislation was the product of six years of intensive professional and public debates and discussions. On 20 February 2000, a national committee was appointed by the Minister of Health to enact a law regulating all matters concerning the dying patient, with one of the authors (A.S.) serving as chairman. The Committee comprised 59 individuals, all specialists and high-ranking professionals in their fields, representing the entire spectrum of relevant views. No member was a political or otherwise interested appointment. The multidisciplinary Committee was divided into four subcommittees: a) A medical/scientific subcommittee, including physicians, nurses, social workers and sociologists. The physicians represented all fields of medicine dealing with dying patients (intensive care, palliative medicine, cardiology, geriatrics, anesthesiology, psychia-

try, pediatrics, neonatology, rehabilitation, oncology, neurology, hospital management). b) A philosophical/ethical subcommittee, including philosophers, medical ethicists and clergy from different religions. c) A legal subcommittee, including judges, lawyers, professors of law, and legal advisors of relevant ministries. d) A subcommittee representing *Halakha* (Jewish law), including rabbis and physicians who were well versed in matters of medicine and *Halakha*. All debates and discussions of the Committee were closed to the media. All the members made a serious attempt to reach as wide a consensus as possible despite previously held strong opinions and the very difficult and emotionally loaded issues at stake.

On 23 May 2004, the proposed law of the Committee was accepted by the Israeli government and on 6 December 2005 it was finally legislated by the Knesset as “The Dying Patient Act.”

The Committee was successful in reaching a wide consensus on almost all issues related to the dying patient, despite the inherent complexity of the subject, and despite the deep differences of opinion between members of the Committee. The only significant dissenting opinions were on the issue of withdrawing continuous treatment (i.e., ventilator) and withholding food and fluid from a non-competent dying patient not yet defined as being in the final stage. Although in principle there remains disagreement on these issues, with a minority opinion accepting the principle that there is no difference between withholding and withdrawing any therapy, the Committee managed to minimize the practical disagreement by accepting the concept of a timer attached to a ventilator [4].

The Law – highlights

Fundamental assumptions

- The majority of people do not want to die; on the other hand, the majority of people do not want to suffer at the end of life and they do not want their lives to be prolonged artificially.
- Every person is assumed to want to continue living unless proven otherwise; in case of reasonable doubt one should err in favor of life.
- Every adult person is assumed to be competent unless proven otherwise.

- The definition of a minor in this Law is a person under 17 years of age.
- A dying patient is defined as one who will die within six months despite medical therapy; the last two weeks of expected life are defined as the final stage.
- From a philosophical point of view neither the value of life nor the principle of autonomy is an absolute value. Hence, there ought to be a balance between these principles, based upon the value system of Israel as a Jewish and democratic state. There is a need to determine the boundaries of prolonging life versus the avoidance of unjustifiable and unwanted suffering.
- Decisions concerning dying patients should be based solely on the medical condition of the patient, his or her wishes, and the degree of their suffering. No other factors should be considered when deciding how to treat the dying patient.
- In the case of an incompetent patient at the time of the required decision, the Law strikes the following balance:
- Commission of acts that hasten death is prohibited, whereas omission of life-sustaining therapies is permissible.
- Sanctity of life overrides autonomy by prohibiting any action that intentionally and actively shortens life (i.e., active euthanasia or physician-assisted suicide), even if these acts were previously requested by the patient.
- On the other hand, the principle of autonomy overrides sanctity of life by permitting the withholding of treatments if this was the wish of the patient.
- The Law distinguishes between two types of treatments: the first is continuous life-sustaining therapies (cardiac pacemaker or respirator), which cannot be stopped because this is viewed as an act that shortens life. The second is intermittent life-sustaining therapies (dialysis, chemotherapy, radiotherapy), which can be stopped if they are directly related to the dying process. Terminating intermittent or cyclic life-sustaining treatments is viewed as omitting the first or next treatment rather than committing an act of withdrawal.

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Treatment modalities

Several values are involved in treating dying patients. These include the value of life, the principle of autonomy, beneficence, non-maleficence, and distributive justice. The basic dilemma is how to strike a balance between the sanctity of life and the principle of autonomy. Almost no one advocates accepting an extreme and absolute position concerning either the value of life (i.e., prolonging *any* life by *all* means at *all* times and at *all* costs, even when it adds only pain and suffering) or the principle of personal autonomy (i.e., accepting autonomous wishes for active euthanasia of healthy people or non-terminally ill patients). Hence, there is an obvious need to decide on where the line between these values should be drawn. Any distinguishing boundary line, however, is debatable. Therefore:

- When sanctity of life and autonomous patient wishes both require prolonging life, they should be respected even if the patient's request seems to be futile by the conceptions of the caregivers, unless it is harmful to the patient or others.
- When the autonomous wishes of the patient demand shortening of life and hence are in opposition to the sanctity of life, it depends on the current status of the patient:
- If the dying patient is competent and refuses any treatment, including food and fluids, he or she should not be forced against their wishes, however they should be encouraged to change their mind; thus, the respect for autonomy and human dignity takes priority over the respect for value of life. This, however, does not include active euthanasia or physician-assisted suicide, which are prohibited by overriding societal values even if the patient autonomously requests them.
- The Law prohibits the withholding of food and fluid from a currently incompetent dying patient for the following reasons: the value of life in such situations overrides the previous autonomous wishes of the patient which are now unknown; food and fluid are regarded as a basic need of any living being, rather than a form of treatment; socially and emotionally there is a fundamental difference between food and fluid and other life-sustaining treatments; dying of starvation and dehydration is regarded in Jewish philosophy as an indignity to life; withholding food and fluid is unrelated to the dying process and hence is regarded as a form of euthanasia.
- When the patient approaches the final days of his or her life, defined by the Law as less than two weeks, it is permissible to withhold food and even fluids, if such was the clear wish of the patient before becoming incompetent.

At this final stage of life, food and even fluids may cause suffering and complications.

- Based upon the notion of the dignity of man and upon the moral requirement to alleviate pain and suffering, the Law requires providing palliative care according to current medical standards to the patient and to his or her family. This includes palliative treatment that might unintentionally shorten life, based on the principle of double effect.

Procedural aspects

The Law requires appointing a senior physician as the responsible health-care provider. The tasks include:

- Establishing the medical situation of the patient
- Analyzing all relevant facts and documents together with all other experts and decision makers
- Establishing the wishes of the patient
- Identifying the close person who should take part in the decision-making process
- Formulating a detailed plan of treatment
- Documenting all the decisions in a clear and explicit manner
- Informing all relevant parties of the decisions.

The Law establishes various mechanisms verifying that advanced medical directives are the calculated wishes of the now-incompetent dying patient, including the following:

- A detailed form, attached to the Law, to be filled out by any competent person at any time in life with the aide of a physician or nurse
- Renewal of the statement every five years
- Reevaluating the statement when a serious illness is diagnosed, with the aide of an expert physician in the field of the actual ailment
- Establishing a national registry of advanced medical directives. The registry's responsibility includes sending reminders every five years to the owners of the advance directives to verify whether or not they have changed their minds about the directives. The registry also serves as a source of information whenever an incompetent patient is admitted to a hospital and it is unknown whether there is an advance medical directive, or what is stated in it.

Testimonies about the incompetent dying patient's wishes by family members or friends known to be emotionally related to the patient can be accepted by the responsible physician.

The Law establishes institutional ethics committees as a problem-solving mechanism. It also establishes a National Ethics Committee as an authority of appeal and with the mandate to solve more difficult problems as well as establishing policies. These committees are composed of experts in the fields of medicine, nursing, social work, psychology, law, and ethics, as well as the clergy. This mechanism is meant to avoid the involvement of courts in a matter that is better dealt with by a multidisciplinary group of experts rather than by strict legal procedure.

Types of patients

The Law relates to several categories of patients and establishes the medical and social attitude towards them. The fundamental criterion to be included in this Law is the life expectancy of the patient – i.e., one who is suffering from an incurable medical condition and his or her life expectancy, even if medical treatment is provided – is no more than six months.

The Law deals with the following categories of patients who fulfill the basic definition of a dying patient according to the Law:

- Adult (17 years and older) competent patient
- Adult patient currently incompetent who was previously competent
- Adult patient who has never been competent
- Minor, i.e., less than 17 years old.

The Law does not relate to the following categories of patients: Terminally ill patients whose life expectancy is longer than six months, and newborn infants, particularly extremely preterm born babies.

Summary

The new Israeli Dying Patient Act is based on principles and processes that have achieved a wide consensus despite the fact that it is a very complex and emotionally loaded issue. It provides clear balancing approaches between opposing values as well as explicit mechanisms for issues that were previously not provided for in Israel or were unclear. These include mechanisms for providing autonomous patient decision making when incompetent in "real time," with legally binding advance medical directives. These include methods of verifying the real and informed wishes of the patient or the appointment of a surrogate decision maker, a national registry of advance medical directives to optimize the validity of these wishes, legally binding palliative care as a citizen's right, clear guidelines for physicians to know what is permitted and what is not in treating terminally ill patients, the appointment of a senior physician with clear directives of his or her responsibilities toward the dying patient, and dispute resolution including the innovative establishment of a National Ethics Committee composed of experts in all relevant fields.

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