

End-of-Life in Israel: A Case Report

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Introduction

Our palliative care team, working within the framework of an oncology ward in a major Israeli hospital, recently cared for a 73-year-old married male with advanced stage liver cancer. A retired engineer and father of two grown children, professionals, he and his family are Jewish by faith and members of the Conservative/Masorati (Israeli branch) movement, one of the three main streams of Judaism. Members of this movement, as opposed to that of Jewish Orthodoxy, perceive Judaism as an evolving religion; canonized texts may be reinterpreted in order to adapt practice to different life contexts [1,2]. In the context of end-of-life, for example, mainstream Jewish Orthodoxy would prohibit withdrawal of mechanical ventilation if it resulted in an individual's immediate demise (which is tantamount to hastening death and prohibited according to medieval codes of law). A significant number of conservative rabbinical authorities, with a broad following, would permit it since the individual is being kept alive by technological means and its withdrawal is merely removing the impediment to death [3-5].

The aim of this discourse is to present the approach our team took to treating and nourishing this patient in the specific context of his faith, illness state, personal wishes, the concerns of his family, and the Israel Dying Patient Act, 2005 [6,7]. The latter stipulates the legalities of care at end-of-life (i.e., the point at which the estimated life span is six months) by which all the country's health facilities must abide. The Act was drafted by a committee of 59 experts representing all sectors of Israeli society in terms of culture, religion, and profession. It reflects the vector of consensus regarding issues of care for the dying without the dissenting opinions. For the most part, the law is in line with the mainstream Jewish Orthodox position [8,9].

The Case

Our patient presented at the emergency department of the medical center with abdominal pain (exacerbated after meals), profound weakness, constipation, and a ten-pound weight loss incurred over the past month. The CT scan that he had undergone one and a half weeks prior to his arrival revealed multiple suspicious nodules in the liver. His wife reported that up until the last two weeks her husband was still going to work. He then experienced a sudden deterioration; stopped eating due to poor appetite and the discomfort it caused, became bed bound, and was unable to perform any activities of daily living. Home-care nurses administered intravenous fluids (500 cc/day) in order to maintain hydration.

After admission to the Oncology ward, our patient underwent a biopsy which confirmed the diagnosis and poor prognosis. As is often the case with liver cancer, the disease process was discovered in our patient at a very late stage. The liver is a central multi-tasked vital body organ; its failure, in this case, was due to the presence of substantial malignant tumor tissue which was incompatible with life [10-12]. A port-a-cath was inserted for the administration of

chemotherapy scheduled for the following week. While hospitalized, the patient ate only small morsels of food and his wife requested that a feeding tube be inserted. Poor appetite, nausea, and sense of fullness are classic symptoms of this cancer.

The patient was evaluated by a psychiatrist and found competent to make his own decisions; he initially agreed to small doses of chemotherapy and minimal oral feeding. Within a few days, however, he deteriorated and at that point refused both treatment and any form of nourishment, including tube feeding. Our patient was then transferred to a hospice where he died six days later.

Retrospective evaluation of this case, as it was reported in the medical records and recalled by the care team, uncovers several lacunae. Before addressing these and their import to the analysis of the case, its legal and ethical context as reflected in the Dying Patient Act, 2005 will be presented.

The Israel Dying Patient Act, 2005

The Act opens with two essential premises: 1) individuals at end-of-life want to continue to live, and 2) individuals at end-of-life are competent to make their own decisions. These premises have practical import. With respect to the first, it implies that care must be taken to neutralize overt or covert pressure, either from the care provider or family sources, which might lead the individual to decline treatment for the prolongation of life. This premise not only directly protects the sanctity of life but also indirectly protects the individual's freedom to exercise his/her autonomy. The second premise directly protects autonomy; it is waived only if an appropriate health professional attests to the individual's lack of competence to make a specific end-of-life decision. The first premise is waived if the individual makes it clear that he/she does not want to continue to live or has explicated this wish in an advanced directive. In such a case, and in the presence of physical or psychological suffering, the Act permits withholding, and in most cases, withdrawing life-prolonging treatment (e.g. surgical procedures, dialysis, chemotherapy); mechanical ventilation need not to be initiated [6,7,13].

For the sake of comparison, it is important to point out the relevant Recommendation of the Council of Europe No. 1418/1999 on the "Protection of the human rights and dignity of the terminally ill and the dying," which were reiterated in the Recommendations of 2009: "...in the event where no previous expression of the patient's will is available the right to life shall not be breached. To ensure their right to life shall not be breached, a catalogue must be prepared of therapeutic procedures that must be provided under any circumstances and that must not be neglected" [14].

Although Israel is not a member of this council, its Act stipulates as mandatory (to ensure that their right to life shall not be breached), the ministering of basic care, which includes nutrition and hydration, oral or enteral during the end-of-life period (six months, as delineated by the law). These are perceived

by the Act as means of sustenance for the remaining vitality of the dying individual, rather than as medical treatment. They may not, however, be coerced, as this would negate a central aspect of dying with dignity which the Act is attempting to ensure [6,13].

It is important to point out that during the last two weeks of life fluids suffice, as withholding nourishment at this stage of the illness process will not hasten the individual's demise; he/she will die sooner of the illness itself [15]. With respect to nutrition and hydration, the Act reflects the Jewish Orthodox position. Some Conservative rabbis, however, perceive enteral nourishment as artificial and classify it as medical care which may be withheld during the months of end-of-life [5,16].

While, unlike the Israeli Act, leading nursing organizations such as the Hospice and Palliative Nurses' Associations define enteral nutrition and hydration as medical treatment, they clearly iterate in their position statements the right to request enteral nutrition at end-of-life in the context of maintaining cultural sensitivity [17]. A distinction has been made by these associations between artificial nutrition which should be provided if the patient deems it beneficial, and other forms of "medical care" which may be denied the patient if they are deemed non-beneficial according to the professional's assessment. This is remarkable as many ethicists claim health professionals are not obligated to acquiesce to a request for "non-beneficial" treatment [18,19]; why therefore would this not apply to enteral nutrition?

In this vein, whereas in most countries and in all of the United States individuals may make a general request in their advanced directive with respect to withdrawal of all medical treatment, individuals who choose to decline artificial nutrition and hydration must state so explicitly, as it is fundamental to life and mandatory for survival [20–22]. It appears that artificial nutrition and hydration are not universally equated with other kinds of medical care; this allows for better appreciation of the position held in their regard by the Israeli Act. For the sake of completeness, it should be mentioned that the Act also incorporates palliative care, the alleviation of physical and spiritual suffering as mandatory treatment [6,7,13].

Analysis of the Case

As previously pointed out, this case, as reported in the records, does not address a number of important points. Although by law the patient would need to be informed of treatment options, including chemotherapy, it is unclear what information the patient and family were given regarding its ability, at this late stage, to have any effect on the progress of the disease. It is possible that they were well informed regarding the poor prognosis, but that the patient and/or family were still in denial as to the gravity of the condition as the downhill course was so steep. It is not known what the sons felt or understood and to what extent they were engaged by the team. We can only wonder if the patient agreed to therapy under pressure from family members or whether it was his own autonomous decision. It would have been important for a palliative team to ascertain the level of understanding and acknowledgement of the situation by conversing with the patient and family [23,24].

It should be pointed out that according to the Dying Patient Act, 2005 [6], family members do not have an independent say regarding patient care; their wishes are to be taken into account only as they represent the autonomous wishes of the patient in situations where the patient is not competent to voice them. In our case, the patient was found to be competent for purposes of making decisions about his healthcare and the family had no legal standing. It is nevertheless true that family members influence patients' decision making. It is important to support the family members so that they may support the patient, but also with respect to their

own suffering as they accompany the patient through the dying process [25].

According to the Dying Patient Act [6], it was certainly not mandatory to administer chemotherapy to this patient, who fell well within the category of end-of-life as stipulated by the Act. As a member of the Masorati sector of Judaism, the patient would also be well within the bounds of his religious faith to decline extraordinary treatment, which chemotherapy certainly is, at this stage of the disease [3–5]. There is no information regarding the presence of a spiritual figure, such as a rabbi, or whether the patient was given an opportunity to express his emotions and experience closure with himself, his family, and other significant others. No mention is made of pain treatment and hydration. The latter is delineated as basic care by the Israeli Act which needs to be maintained unless contraindicated. All these are critical elements of care which deserve attention.

With regard to nourishment, the patient was not able to eat and refused enteral feeding. His prognosis was grave and life expectancy was very short, within the two weeks (or so) time frame stipulated by the Act as the very end of life [6,7]. As such, it was unnecessary, according to Israeli law, to insert a feeding tube. It is important to point out that, in this specific case, because of the anticipated complications and suffering related to enteral feeding – due to the nature and location of the malignancy – it would probably not have been indicated even prior to this point in time. According to Jewish tradition and the Israeli Act, avoiding undue suffering is an integral part of end-of-life care [7,13].

Conclusion

In Israel, which is a relatively conservative country culturally and religiously when compared with the rest of the western world, life itself often trumps quality of life: sanctity of life is uppermost in the hierarchy of values [26]. In this case, however, life could no longer be sustained. Withholding chemotherapy and enteral feeding were within the legal limits of the Act because the patient was so close to death and declined this care. Chemotherapy could have been withheld even if the life span was estimated at six months. The patient's autonomy was essentially respected and he was spared painful therapeutic measures.

The lacunae in the care process warrant more careful attention to record keeping. Complete records are an important part of care and, through their analysis, future care can be improved. Storey, O'Donnell, and Howard (2002) recommended the use of a tool kit which facilitates a comprehensive log of the palliative care journey through which we take our patients and families [27].

Conflict of Interest

The authors declare that they have no conflicting interests with respect to this article. Both authors have same input in preparation of this manuscript.

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