



Towards a Jewish Bioethic: The Case of Truth-Telling

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TOWARDS A JEWISH BIOETHIC: THE CASE OF TRUTH-TELLING

A QUESTION OF TRUTH

While telling the truth rarely needs a defense, in the context of clinical medicine it can be fraught with controversy. Specifically, concern that awareness of the gravity of one's own condition can itself be detrimental has dissuaded many a physician from sharing the prognosis, clinical course, or even the very diagnosis with a terminally ill patient.

Such was standard in the United States until approximately 40 years ago, when the issue of physician secrecy was revisited by the lay and medical communities.¹ Today, the consensus position, at least in the Western hemisphere, has flipped, with contemporary bioethics championing patient autonomy as the highest value in medical decision-making and transparency as its basic prerequisite.²

In contrast to the monumental shift in attitude towards disclosure in Western health care systems, halakha, it seems, has been consistently described as quite wary of sharing negative health information with a patient. Nevertheless, an active debate has emerged about whether a more open policy towards patient-physician communication can be sanctioned within the bounds of the halakhic tradition.

The actual halakhic material relevant to the topic of truth-telling has been analyzed quite extensively in numerous responsa and articles in the past.³ Broadly speaking, as in many halakhic debates, there is a fairly

¹ Antonella Surbone, "Telling the Truth to Patients with Cancer: What is the Truth?" *The Lancet Oncology* 7 (2006), 944-950.

² Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 5th ed. (Oxford: Oxford University Press, 2001), 283-290.

³ See Avraham Steinberg, "Disclosure of Illness to the Patient," *Encyclopedia of Jewish Medical Ethics*, vol. 1 (Jerusalem: Feldheim Publishers, 2003), 317-328.

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circumscribed body of evidence that defines the boundaries of the conversation. While the interpretation of certain sources remains hotly contested, most of the controversy revolves around questions of relevance, applicability, and normative weight.

Indeed, it is these questions that interest me most here. My intention is not to survey the halakhic material or delve into specific halakhic sources, nor do I have any novel evidence to bring to the table. Rather, I seek to step back and analyze the contours of the debate. What kinds of arguments are being made, and what extra-textual commitments do they represent? Moreover, what do we expect of the halakha when we present it with modern ethical dilemmas and demand of it a clear and firm response? Lastly, how does halakha incorporate (or not) evolving sociological and psychological assumptions of the medical community that have slowly drifted away from the more traditional models represented in halakhic literature?

While I will offer a specific opinion on the subject of truth-telling, I hope that my comments can transcend this narrow issue and provide perspective relevant to the entire arena of “Jewish bioethics.” There is no doubt that at the heart of Jewish bioethics lie “*havayot de-Abaye ve-Rava*,” the essential substance of our halakhic *mesorah*, and that any foray into Jewish ethics that is not fundamentally grounded in that realm can be only marginally connected to Judaism. At the same time, what exactly we seek from the words of Hazal in this context may at times be different from the goals of halakhic discourse that *yoshevei bet ha-midrash* are used to. Finally, I believe that the issue of truth-telling inevitably touches on subjects that in one sense are not halakhic but at the same time are fundamental to the identities and internal dynamics of different halakhic communities: the scope of authority, the balance between autonomy and paternalism, and the tension between truth and power.

IN DEFENSE OF THE TRUTH

Simply put, deciding whether to disclose or conceal medical information boils down to a consideration of the potential risks and benefits of each option. The risk, of course, is the possibility that the patient’s condition can deteriorate further from hearing upsetting information. Advocates of withholding information point to multiple halakhic sources that underscore how psychological distress can cause biologic harm.⁴ What, then, are the possible benefits of disclosure? For modern bioethics, the primary

⁴ See, for instance, *Shabbat* 128b and *Mo’ed Katan* 26b.

motivation to disclose is out of respect for the patient's autonomy. At the root of individual autonomy is knowledge, which impels clinicians to inform and empower their patients by sharing medical information as fully as possible. Jewish commentators, on the other hand, have noted the absence of autonomy as a core value in classic rabbinic literature.⁵ For some authors, the possible "halakhic" benefit of medical disclosure lies in *Shulhan Arukh, Yoreh De'ah* 338, which enjoins a companion to instruct a perilously ill patient to confess.⁶ Only one who is aware of the severity of his or her prognosis is in a position to confess, especially as mental status may deteriorate well ahead of death.

For many commentators, then, the halakhic calculus is quite simple. We have, on the one hand, the possibility of somehow shortening a lifespan, pitted against the obligation to confess before death. As even "*safek pikuah nefesh*" overrides almost any halakhic concern, the imperative to protect the patient outweighs his or her obligation to confess, and the halakhic presumption favors silence, or even deception. So compelling is the need to preserve hope in order to sustain a patient, argues Kunin, that "if this requires placebos or other means so that he does not lose hope, then this must be encouraged."⁷

Of the critiques that have been leveled against this position, many resort to pragmatic arguments against the proposed risk-benefit calculation. Specifically, they point out a variety of circumstances unique to the modern medical context that may make concealment even more dangerous for health than disclosure, including:

1. The need for patients' informed participation in their own medical therapy.
2. The risk of accidental disclosure by an unwitting member of the health care team.
3. The reality that many terminal patients will ultimately learn of their diagnoses on their own.

⁵ Avraham Steinberg, "Informed Consent," *Encyclopedia of Jewish Medical Ethics*, vol. 2, 554-555; R. Zev Schostak, "Is There Patient Autonomy in Halacha?" *Assia Jewish Medical Ethics* 2:2 (1995), 22-27, available at <http://www.medethics.org.il/articles/JME/JMEB1/JMEB1.7.asp> (accessed May 25, 2009).

⁶ See R. Mordechai Halperin, "Telling the Truth to the Ill" [in Hebrew], *Assia* 42-43 (1987), 5, available at <http://www.medethics.org.il/articles/ASSIA/ASSIA7/R007012.asp> (accessed May 17, 2009); R. J. David Bleich, *Judaism and Healing*, augmented edition (Jersey City: Ktav, 2003), 31-32; and Joshua Kunin, "Should Patients Be Told the Truth about Their Illnesses: Jewish Perspectives," *Israel Medical Association Journal* 4 (2002), 737-741.

⁷ *Ibid.*, 740.

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4. The possibility of increased public distrust of physicians if they are suspected of deliberately withholding information.⁸

While we might characterize some of these arguments as more substantive and others as more technical, as a group they do not directly attack the halakhic reasoning that I outlined above. Rather, they simply alter the risk-benefit ratio by adding in external, pragmatic considerations that the sources above do not relate to. If the specific pragmatic pressure disappears in any given case, then, we return to the underlying halakhic presumption of concealment. Thus, Dr. Abraham S. Abraham rules in his *Nishmat Avraham* that one should disclose information as long as life-sustaining treatment is available. For conditions that are untreatable, however, such as the final stages of cancer, the physician should not inform the patient of his or her condition “in the vast majority of cases.”⁹ And while some of the more systemic considerations I listed may always persist, the essential contention that the halakha is fundamentally wary of disclosure remains untouched.

More recently, Drs. Alan Jotkowitz and Shimon Glick have, by my assessment, more directly countered the conventional position held by recent halakhic literature. After summarizing the common view of truth-telling in Jewish ethics, they write:

We beg to differ from this traditional approach, which is based on the primacy of beneficence, for two reasons. The fear of the danger in receiving the bad news does not seem to be supported by the current medical evidence. . . . In addition, based on our previous analysis [of autonomy], the patient is the one primarily responsible for his or her welfare and can best decide how he or she will react to the information.¹⁰

Jotkowitz and Glick essentially make two points in rejecting the commonly held bias against sharing negative health information. First, they

⁸ See Abraham S. Abraham, *Nishmat Avraham*, vol. 2 (Jerusalem, 1993), *Yoreh De'ah* 338:3; Shimon Glick, “Telling the Truth to the Ill,” [in Hebrew] *Assia* 42-43(1987), 8-15, available at <http://www.medethics.org.il/articles/ASSIA/ASSIA7/R007015.asp> (accessed May 17, 2009); R. Gary Joseph Lavit, “Truth Telling to Patients with a Terminal Diagnosis,” *Journal of Halacha and Contemporary Society* XV (Spring 1988), 94-124; and R. Yigal Shafran, “Telling the Truth to an Ill Patient about his Status” [in Hebrew], *Assia* 42-43(1987), 16-23, available at <http://www.medethics.org.il/articles/ASSIA/ASSIA7/R007023.asp> (accessed May 17, 2009).

⁹ *Nishmat Avraham*, *Yoreh De'ah* 338:3.

¹⁰ Alan B. Jotkowitz and Shimon Glick, “The Physician Charter on Medical Professionalism: A Jewish Ethical Perspective,” *Journal of Medical Ethics* 31(2005), 404-405.

claim that modern clinical investigations have not substantiated the supposed medical risk of truth-telling.¹¹ Second, they suggest that navigating the risk-benefit balance in question does not really fall into the domain of the physician at all. Patients should ultimately be in charge of their own medical care and will make their own determinations about whether truth-telling is helpful or harmful in their own individual cases; physicians should follow their lead.

To be sure, Jotkowitz and Glick are by no means champions of disclosure under all circumstances. To the contrary, they have cautioned the medical community to respect cultural differences regarding truth-telling and to tread carefully in the area of patient communication.¹² At the same time, their overall stance is a striking departure from the conventional wisdom about Judaism and truth-telling. The novelty of their position lies not, I emphasize, in their support of sharing diagnoses and treatment plans with patients. Many others have similarly pushed for a change in practice on the basis of the pragmatic concerns I listed earlier, including Dr. Glick himself, who wrote a compelling article some twenty years ago advocating disclosure.¹³ What is noteworthy is that they seem to quietly sweep aside the classic halakhic concerns, suggesting that modern medical knowledge and a reshaping of the physician-patient relationship have rendered past rabbinic statements functionally obsolete.

Here, I think, is where the more interesting discussion begins. Not, heaven forbid, because I or others dismiss or disparage intricate halakhic analysis of rabbinic source material, but because in this case its conclusions seem so intuitively unsatisfactory. I speculate that for many God-fearing clinicians actively engaged in patient care on a daily basis, there is a vague sense of distance from many Jewish commentaries on truth-telling. The chaotic structure of health care delivery, the contemporary downsizing of physician privilege and authority, and the way in which health and disease play out in real time and with real people all make many halakhic discussions of truth-telling seem downright anachronistic. Their basic assumptions about medicine and medical practice seem fundamentally off, and to offer pragmatic explanations for why it is acceptable to share medical information only papers over an essentially ill-fitting description of medicine. Indeed, as God-fearing clinicians, we do not dare suggest that a segment of halakha is outdated, and yet we wonder if there is some way to more fundamentally update a halakhic

¹¹ See also Lavit, "Truth Telling to Patients with a Terminal Diagnosis," 120-124.

¹² Alan Jotkowitz, Shimon Glick, and Benjamin Gezundheit, "Truth-Telling in a Culturally Diverse World," *Cancer Investigation* 24(2006), 786-789.

¹³ Glick, "Telling the Truth to the Ill." The core of Dr. Glick's later statements can be found in this article as well.

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description of medicine. Do Jotkowitz and Glick offer a solution? Can we justify their assertions within our understanding of the immutability of the halakhic system?

MIND AND BODY IN HALAKHA AND MEDICINE

Regarding truth-telling, R. J. David Bleich writes that “Jewish law is particularly sensitive to the debilitating effects which mental stress may have upon an enfeebled or moribund patient.”¹⁴ While undeniably true, this very observation opens the door to more questions than it settles. It is not a statement about the intrinsic value of either mental health or physical wellbeing within the halakhic system, but rather an assertion about the causal relationship between the two. What does it mean for halakha to be “particularly sensitive” to this causal mechanism? Can we interpret this as some kind of normative statement, by which halakha is encoding a particular conception of the dynamic between mind and body? Or does it simply reflect and incorporate a pre-modern understanding of the natural world in which psychology and biology blend seamlessly together, a view that is neither distinctively Jewish nor essentially “halakhic” in any way?

Regarding the interplay between psychology and biology, the gap between the outlook of Hazal and the perspective of contemporary medicine is multi-dimensional. First, whereas Hazal breathed and functioned in an essentially Aristotelian world that took the seamless unity of both existence and knowledge for granted, modern science operates within a fractious intellectual outlook that utterly forbids the mixing of spirit and material substance. Accordingly, while Hazal might have embraced spiritual or psychological explanations for disease, contemporary medicine insists upon organic theories. Stress as the basis for stomach ulcers has been replaced by bacterial infection; Freudian descriptions of neurosis have given way to hormonal imbalances in the brain. The same holds true for the hypothesis that any degree of mental distress can be lethal for a fragile patient. What for Hazal might have seemed intuitive to the point of obvious is at best eyed with wariness by modern medicine and at worst with derision.

One might think that we could settle the issue by just studying the evidence, but here lies the second level of dissonance: Scientific outlook has evolved not only in terms of what kinds of causal explanations it entertains, but also in terms of what kinds of reasoning can bolster or undermine

¹⁴ R. Bleich, *Judaism and Healing*, 28.

a particular suggestion. The last thirty years have seen a dramatic shift away from relying on intuitive thinking or expert opinion and towards an insistence on rigorous, “evidence-based medicine,” in which medical practice is grounded in empirical data about actual, observed effects of therapies on people. Over and over, medicine has found that supposedly self-evident truths about medical practice have not withstood the test of a clinical trial, in which different groups of people are followed to see if a particular risk factor or intervention correlates with a difference in their respective outcomes. It is in this spirit, I imagine, that Jotkowitz and Glick are unmoved by the arguably sensible concerns of the rabbinic literature, as contemporary studies have not borne out the supposed risks of disclosure.

I hesitate in labeling Hazal’s position as archaic or even pre-modern because in many ways it persists as a dominant worldview today. Many lay people, and doctors, continue to embrace a traditional understanding of the mind-body relationship and resist what they regard as a constricting materialization of health and disease. At the same time, the contemporary perspective of medicine cannot be dismissed as an intellectual fad, as in so many ways it constitutes a natural progression of increasing scientific rigor within clinical medicine. We can no sooner ignore Jotkowitz and Glick’s insistence on hard evidence of harm from truth-telling than we can turn our backs on much of medicine’s recent advances. Moreover, this represents where clinicians “are at,” each to a more or lesser degree, and accounts for any communication barrier between physicians and the halakhic literature with regard to disclosure, on the one hand, and at times between physicians and families, on the other.

Should halakha adjust its own thinking as a result? It seems obvious that a halakhic ruling that emanates from a particular historical scientific standpoint should be subject to emendation, as long as it preserves its truly normative dimension. That is, of course, unless one believes that the mind-body dynamic described by Hazal actually constitutes part of the received tradition itself—which brings us back to the initial dilemma. One cannot update the medical basis for halakha unless one can clearly delineate what is purely medical and not indeed halakhic.

Lest one think I am making a mountain out of a molehill with regard to the fairly narrow question of truth-telling, I believe that the nature of the rabbinic mind-body philosophy has much broader consequences. For example, R. Moshe Feinstein maintained that a physician should not pass over a terminally ill patient for admission to an intensive care unit in favor of a more curable patient who arrived at the hospital subsequently, as such a decision could be emotionally crushing, and thus dangerous, to the original patient. Though the more curable patient may suffer as a

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result, neglecting the original patient would actually translate into an active form of endangerment, according to R. Feinstein, and therefore be even more intolerable. In a slightly different vein, R. Feinstein ruled that the treatment of pain can override a Biblical injunction, as a patient who is experiencing pain will very likely succumb earlier to his or her disease process. In yet another case, R. Feinstein cautioned against administering medical treatment against a patient's will, as the stress of the coercion itself could harm the patient.¹⁵

In all of these cases, how did R. Feinstein arrive at his medical conclusions? Do they derive from some sort of “*Sod Hashem li-re'av*,” (Psalms 25:14) or do they simply represent a *posek's* best efforts to engage the complex, foreign reality of medical care? If the latter, should we subject these rulings to empirical testing, such as looking for a correlation between coercion and mortality? And if our results were to contradict R. Feinstein's assumptions, could we confidently relegate his overpowering authority to the purely normative realm and claim that one of his rulings no longer applies?

Coming back to the limited question of truth-telling, I think that Jotkowitz and Glick's position presents a challenge. To be sure, one need not necessarily accept their conclusion. One could maintain that their read of the medical literature is skewed, or that the literature itself is too shallow to date to conclude that disclosure cannot possibly be harmful. At the very least, though, Jotkowitz and Glick challenge us to rethink the mind-body relationship in halakha, and with significant potential consequences. As a point for comparison, some authorities believe that *metsitsa* (drawing blood from the circumcision wound) can no longer be performed on the Sabbath because it is no longer believed to be therapeutic. Would they similarly question a caretaker's right to violate the Sabbath to provide emotional comfort, as in the Talmud's famous example of heeding a blind, laboring woman's request for a candle¹⁶? Truth-telling, it seems, is only the tip of the iceberg.

TRUTH AND EMPOWERMENT

The second point that Jotkowitz and Glick raise – that the physician-patient relationship has evolved to favor more patient autonomy – is both different and the same. It is different in the sense that this is not a scientific

¹⁵ *Iggerot Moshe, Hoshen Mishpat 2:73.*

¹⁶ *Shabbat 128b.*

or quasi-philosophical claim, but merely a sociological observation about Western medicine, and a fairly mundane one at that. And yet this claim, too, represents something of a departure from past rabbinic writings about medical practice. While rabbinic literature never codifies a particular orientation towards physicians and their mode of practice, many recent authors presume one. Consider the following passage from R. Yechiel Michel Tukatchinsky's *Gesher Ha-Hayyim*:

Once the physician has done his part, and placed before [the patient] the laws of medicine and the ways of nutrition and behavior—the patient is duty-bound to obey the doctor's orders, no less if not more than the laws of the *Shulhan Arukh* concerning the prohibited and the permitted, as a commandment of the Torah, "And you shall take great care of your souls."¹⁷

For R. Tukatchinsky, the physician commands complete authority in the realm of health and disease, equivalent to that of a *posek*. The force of his or her medical advice parallels that of a halakhic ruling — "no less if not more than the laws of the *Shulhan Arukh*." In this version of health care, there is little room for patient advocacy, for questioning or rejecting a proposed course of treatment, for expressing one's preferences, or for actively managing one's own health care. Moreover, there is certainly no need for a patient to learn about his or her disease process, treatment, or prognosis, as the patient contributes nothing to the clinical decision-making. As such, several contemporary texts about medicine and halakha state that patient consent for all but experimental treatments is unnecessary according to Jewish law, as the patient cannot refuse medically indicated therapy.¹⁸

In countering this position, Jotkowitz and Glick rely on the remarkable, perhaps undervalued work of the late Benjamin Freedman, whose posthumously published *Duty and Healing: Foundations of a Jewish Bioethic* provides a refreshing, alternative voice to the world of Jewish bioethics. Freedman, a respected clinical ethicist until his untimely passing at the age of 46, was deeply troubled by what he perceived as a widespread, paternalistic paradigm of medicine in contemporary rabbinic texts—less for its essentially ethical assumptions than for its medical ones. While clear-cut, irrefutable medical advice may indeed be compulsory, argues Freedman,

¹⁷ R. Yechiel Michel Tukatchinsky, *Gesher Ha-Hayyim*, 2nd ed., vol. 1, (Jerusalem, 1970), 29.

¹⁸ Benjamin Freedman, *Duty and Healing: Foundations of a Jewish Bioethic* (New York: Routledge, 1999), 152-155.

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the very concept in modern medicine is an illusion. Rabbinic discussions of consent and autonomy, according to Freedman, often portray the following description of medical decision-making:

The patient's illness has been diagnosed correctly and unequivocally by his physician. The diagnosis is objectively, or at least intersubjectively, true, in the sense that all other doctors would arrive at an identical diagnosis. The prognosis is equally certain. There is one single effective treatment for this disease, recognized as such by all other doctors. The treatment is unambiguously indicated; for example, it is without serious side effects. Without the treatment the disease will continue or worsen; with it, the patient will be healed.¹⁹

Amongst individuals who have fortunately not had to familiarize themselves with the inner workings of modern medicine, this description might not immediately raise eyebrows. For more experienced insiders, though, whether as practitioners or patients, this view is at best patently false and at worst absurd. For, as they know, by Freedman's description,

From the doctor's point of view, every aspect of care is riddled with uncertainty, guesswork, creative insights that leap beyond the evidence, and conscious as well as unconscious trade-offs. Diagnosis is almost always presumptive, rather than conclusive, and at each point in medical investigation there always remains more that could be done to refine the diagnosis: a new test to run, an old test to check. Every treatment option carries with it the risks of side effects, which need to be weighed against the risks associated with alternative treatments and the risk of not treating at all. Treatment recommendations are constantly shifting, in response to factors ranging from new clinical studies to reimbursement patterns and patient demand. Many current standard treatments have never had their safety and efficacy scientifically established; some, which have been validated, are soon superseded by new and promising treatments or cast into the shadow of previously unsuspected late-onset side effects.²⁰

Add to this the unavoidable biases, competing interests, and real limitations of all-too-fallible human doctors, recently publicized in bestselling books by none other than doctors themselves. As Dr. Atul Gawande, a surgeon, writes:

¹⁹ *Ibid.*, 164.

²⁰ *Ibid.*, 165.

What you find when you get in close, however—close enough to see the furrowed brows, the doubts and missteps, the failures as well as the successes—is how messy, uncertain, and also surprising medicine turns out to be. The thing that still startles me is how fundamentally human an endeavor it is.²¹

One only begins to recognize how subjective a business medicine can be when several different consultants weigh in on a given case, each with a different area of specialization, and provide fundamentally discordant accounts of what is wrong and how to fix it. Worse, they may sometimes make little effort to reconcile their collective incongruities, leaving it to the patient to make sense of his or her situation. In other words, doctors do not resolve medical uncertainty; they exacerbate it. Rather than simplify medical decisions, the involvement of a physician adds another layer of complexity, as physicians themselves constitute just another variable in the guessing game of health care.

Finally, as Freedman notes, the uncertainties of medical treatment do not disappear as therapeutic options fade and death becomes inevitable; they intensify. Which aggressive, life-supporting measures should be taken, and in what context? With what cost to the patient, whether in terms of side effects, discomfort, or risk? Every step of medical care is riddled with decisions, and every medical decision entails some element of ambiguity.

Who should hold ultimate authority in sifting through all this uncertainty and making concrete choices? Certainly not the physician, for the simple reason that many of the unknowns lie in areas to which the physician cannot claim any special expertise.²² The physician may know the pathophysiology of terminal cancer, but whether this dying patient belongs in a hospital, a skilled nursing facility, or at home with loved ones and hospice nurses is as much an existential question as a medical one. Moreover, it is a deeply personal question, filled with nuance and laden with emotion, and belongs to no one but the patient. Even loving and committed families can sometimes misjudge patients' own preferences, as Freedman so richly illustrates with cases from his own files. In fact, health care decisions are so crucial and delicate, argues Freedman, that the patient is obligated to manage his or her own situation out of the very same concern for self-preservation that R. Tukatchinsky leaned upon. No

²¹ Atul Gawande, *Complications: A Surgeon's Notes on an Imperfect Science* (New York: Picador, 2002), 4. See also Jerome Groopman, *How Doctors Think* (Boston: Houghton Mifflin Co., 2007).

²² See Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York: Dodd, Mead, 1970).

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one knows your body like you do; no one can dictate its care like you can. And for that you need candor.

To be sure, a patient can certainly delegate responsibility, deciding that either a family member or a physician should control all medical information, including diagnosis and prognosis, if the patient so wishes, and make decisions on his or her behalf. But intentional deferral is no less an exercise of self-determination than active engagement in one's medical care.

Is there something un-Jewish, or anti-rabbinic, about this attitude? I don't think so. Ramban first compared a physician to a *posek*, but specifically in order to highlight their respective needs to function in the face of uncertainty, rather than to emphasize their authority. Just as ambiguity should not paralyze the rabbinic decisor, so too must it not haunt the physician who genuinely seeks to heal. Moreover, the guesswork of medicine cannot forbid the physician from practicing, writes Ramban, for, if so, then patients themselves could not seek out medical care.²³ For Ramban, then, the uncertainties of medical practice belong as much to the patient as they do to the physician. R. Tukachinsky's description, in contrast, likely reflects characteristically mid-twentieth century reverence for physicians more than any rabbinic tradition. Subsequent Jewish writings, however, have not kept pace with their own social contexts.

No *posek* better captures the intensely personal nature of medical decision-making, perhaps, than R. Moshe Feinstein. R. Feinstein was asked by physicians if they must force treatment upon an unwilling patient. R. Feinstein responds that compulsion may be warranted only if the treatment poses no risk at all to the patient. However, "If the medicine itself poses some risk but the doctors are accustomed to give this medicine when the patient has a dangerous illness, *even though the danger of the medicine is much less than that of the illness* (emphasis added), then under no circumstances should the patient be compelled."²⁴ In other words, according to R. Feinstein, assessment of risk is a personal matter. Physicians must respect any subjective concern about risk by the patient, even if standard medical practice considers this level of risk acceptable (In R. Feinstein's words, "much less than that of the illness"). As almost any significant medical intervention will carry a certain trade-off of risk and

²³ *Torat ha-Adam, Kitvei Ramban*, ed. R. Charles Chavel, vol. 2 (Jerusalem: Mosad ha-Rav Kook, 1964), 41-44.

²⁴ *Iggerot Moshe, Hoshen Mishpat 2:73*, as translated by Benjamin Freedman, *Duty and Healing*, 168.

benefit, then, in practice physicians should almost always defer to the patient's judgment.

The implications for truth-telling are two-fold. First, to state the obvious, good decision-making requires access to information. It calls for an honest assessment, open communication, and full (yet compassionate) disclosure, especially as the clinical situation evolves and especially as treatments fail. Kunin's contention that "the idea that patients are owed a basic right to know has no basis in Jewish law"²⁵ may be correct, but irrelevant, as disclosure is still mandatory as a way of empowering a patient to manage his or her own situation, even as death approaches. For the same reason, I object to Kunin's conclusion that "when the patient is terminal and there is no therapy that can be offered . . . rabbinic opinion endorses lying" and even the use of placebos.²⁶

Of course, even if managing one's own health is a personal responsibility, according to Freedman, it should not be a burden. Thus, a patient who is overwhelmed or distressed by information can elect to direct it elsewhere, such as to family members, or to nowhere else at all. But to assume such from the outset, especially when it involves prejudices of age, gender, or medical condition, robs patients of their most important advocate in health care—theirself. Even patients with dementia often take surprising interest in their care. As Jotkowitz et. al. summarize, "Recent research has shown that, for the most part, patients would like to know the diagnosis and prognosis of dementia but that family members are often much more reluctant to have them learn the truth."²⁷ Every patient deserves an opening discussion that clarifies how much he or she does or does not want to learn and helps the clinician feel out what tone, direction, and depth further conversation should take.

But what if disclosure carries uncertain risk for harm, as many recent commentators worry? If we follow R. Feinstein's guidance, the patient's own subjective weighing of risk should direct medical management, even if it does not conform to the party line. If a patient can reject conventional medical therapy out of concern for risk, I suggest that he or she can also conclude that ignorance and silence, or, worse, lies and

²⁵ Kunin, "Should Patients Be Told the Truth about Their Illnesses," p. 740. Contrast with Shimon Glick, "Telling the Truth to the Ill": "If an ill person asks for information from a physician regarding the status of his health, it is his elementary right (*zekhut*) to know."

²⁶ Ibid.

²⁷ Alan B. Jotkowitz, A. Mark Clarfield, and Shimon Glick, "The Care of Patients with Dementia: A Modern Jewish Ethical Perspective," *Journal of the American Geriatrics Society* 53(2005), 882.

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placebos, are more threatening than open communication. Thus, Jotkowitz and Glick contend, “the patient is the one primarily responsible for his or her welfare and can best decide how he or she will react to the information.”²⁸

For the same reason, I hesitate about R. J. David Bleich’s statement that recent research into the effects of truth-telling is “essentially irrelevant” because “the *possibility* [emphasis in original] of adverse reaction is sufficient reason for eschewing a policy of full disclosure.” R. Bleich continues, “Jewish law is concerned with the foreshortening of even a single human life. Accordingly, in this, as in other areas of Halakhah, the possibility of hastening death in at least some patients must be the determining consideration.”²⁹ Is the mounting data describing the safety and benefits of disclosure not enough to at least generate a “*leidat ha-safek*” about its ramifications in any particular circumstance? And if so, rather than retreat to a blanket “*safek le-humra*” stance, should we not leave the matter up to the individual patient to consider and negotiate? According to my understanding of R. Feinstein’s responsum, no doctor or *posek* can dictate to a patient how to weigh the relative risks of various medical options, and I personally do not see why the choice of candor versus deception should be any different.³⁰

TRUTH AND POWER

Having made my case, I must admit that the process was somewhat akin to the Dubner Maggid’s famous metaphor of painting a bull’s-eye around an arrow. Ultimately, the strength of my conviction that patients deserve a chance at the truth flows less from any particular argument and more from a visceral aversion to all forms of paternalism. I have learned this aversion—in good faith, I hope—from *mori ve-rabbi* R. Aharon Lichtenstein, who consistently displays a deep reluctance to make decisions for others, and I have observed the same in other students of the Rav as well. This

²⁸ Jotkowitz and Glick, “The Physician Charter on Medical Professionalism: A Jewish Ethical Perspective,” p. 405.

²⁹ *Judaism and Healing*, 29-30.

³⁰ I readily admit that R. Feinstein himself may not have agreed with my own conclusions regarding truth-telling. For a discussion of R. Feinstein’s position on truth-telling, see Abraham S. Abraham, *Nishmat Avraham, Yoreh De’ah* 338:3 and R. Yigal Shafran, “Telling the Truth to an Ill Patient about his Status.” Paradoxes aside, I think that the application of R. Feinstein’s general principle regarding patient preferences to the subject of disclosure is still valid.

tendency, I believe, stems from multiple sources. On the one hand, it represents a fundamental belief in free will as not just a mandatory catechism, but as a celebration of both the privilege and the challenge of charting one's individual course and owning its consequences. But more than that, this lack of enthusiasm for writing the destinies of others reflects a conviction that life decisions are intensely personal and, as such, call for personal responsibility. No one else can fully sort out the nuances of personal background, context, or predilection that influence a significant decision, nor does anyone else need to live with the outcome.

I have embraced this message with regard to the spiritual domain, and I have similarly carried it with me into my practice of medicine. I could no sooner orchestrate the deception of an ill but curious patient than I could dictate whom he should marry or where he should go to shul. Perhaps in medicine the stakes are greater, but that, for me, is all the more reason to involve the patient, not less. Moreover, I am genuinely uncomfortable with the power that comes with exclusive knowledge. I don't believe I am entitled to it by dint of my position, nor do I enjoy wielding it. And I believe that I am not alone among clinicians.

I think these are healthy instincts, and I would advise those who advocate for widespread deception of patients to be careful what they wish for. Physicians who see themselves as benevolent dictators and who all too easily invoke secrecy and deception sound far more threatening to public health and wellbeing than truth and openness ever could be. After all, let us remember exactly what inspired the patient autonomy movement in the United States in the first place. It grew not out of zealotry for the independence of patients, but out of a long history of physician entitlement, overreaching, and occasional outright abuse. An emphasis on truth-telling is part-and-parcel of a practice of medicine that has overall grown more transparent and more accountable to the population it serves, and I am not sure that it is in our interest to suggest a reversal of that trend.

With this I come back to paternalism. It is not just that I don't want to be a paternalistic doctor; I don't think I can be within the contemporary health care system. Paternalism, if we take its Latin root seriously, means acting as a father. A small part of fatherhood is getting to manipulate one's children with white lies; a far more dominant piece, however, is embracing an utterly exhausting concern for their wellbeing. Perhaps paternalism can reasonably survive in certain hasidic circles or the like, where a central authoritative figure virtually adopts his flock with full and selfless devotion, but not in medicine. Gone are the days of midnight house calls and of following a patient from cradle to grave. Instead, we

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have an unending series of hand-offs from doctor to doctor, a parade of trainees and support staff that shuffle through a patient room or leaf through a record, and transient relationships dictated by the whims of insurance coverage. How cruelly ironic would it be if the overarching commitment and devotion of paternalistic medicine had evaporated but the secrecy and deception survived!

CONCLUSION: WHENCE JEWISH BIOETHICS?

Rather than summarize my points in conclusion, I want to highlight what I have omitted. I have not delved into the discrepancy between the “*keri*” and “*ketiv*” of Kings II 8:10 as other authors have,³¹ which has Elisha either disclosing or hiding knowledge of Ben-Haddad’s imminent death. I have also not analyzed the wordings of the various commentaries to *Yoreh De’ah*, *siman* 338, about exactly when one should direct an ailing patient to confess, for clues about truth-telling. It is not for lack of interest; to the contrary, “for your Torah is my delight” (Psalms 119:77), and I remain a *yeshiva bahur* at heart who finds hidden joy in the minutiae of religious texts. Rather, I sincerely don’t believe that such deliberations would yield a definitive halakhic answer to the problem of truth-telling. All of the various extrapolations, deductions, and semantic inferences have not convinced me that there exists a specific legal directive regarding what a physician should or shouldn’t disclose to a patient. In that case, the issue falls instead to our collective Jewish intuition, in part informed by the considerations I outlined earlier.

But should such a result surprise us? After all, didn’t Ramban explain to us that

It is impossible to mention in the Torah all of a person’s actions toward his neighbors and acquaintances, all of his commercial activities, and all social and political institutions. So after He had mentioned many of them . . . He resumes to say generally that one should do the good and the right in all matters.³²

³¹ R. Yigal Shafran, “Telling the Truth to an Ill Patient about his Status;” see also R. Shafran’s response to a letter by R. Shelomo Korah, *Assia* 45-46, 178-181, available at <http://www.medethics.org.il/articles/ASSIA/ASSIA7/R007036.asp> (accessed May 17, 2009).

³² Commentary to Deuteronomy 6:18, as translated by R. Aharon Lichtenstein in “Does Judaism Recognize an Ethic Independent of Halakhah?” *Leaves of Faith: The World of Jewish Living*, vol. 2, 40.

In this passage, Ramban seems to explicitly reject what has sometimes been termed “halakhic positivism,” the belief that hard, legal imperatives are wholly self-sufficient in determining appropriate behavior.³³ According to halakhic positivism, halakha and Jewish morality are synonymous. What halakha dictates is mandatory; what it does not address is essentially amoral, from a Jewish point of view, and therefore unconnected to the Jewish moral experience. In contrast, Ramban tells us that the hope that formal halakha could act as a totally comprehensive ethical code is logically absurd from the outset and that the Law never saw itself as more than a skeleton on which to build, partly through rabbinic enactment and partly through ongoing intuition.

The exact nature and classification of this “intuition” or “moral sense” has been variously described in seminal works by the late R. Walter Wurzbürger *zt”l* and *yibbadel le-hayyim mori ve-rabbi* R. Aharon Lichtenstein, but both would broadly agree on its main feature: that it grow organically from the root skeleton of halakha itself without being self-defeatingly restricted by it. R. Wurzbürger maintains that “the residual influence of halakhic categories of thought can make itself felt outside the relatively limited area to which the law per se is applicable.”³⁴ Accordingly, he exhorts us to “mine the treasures of both Halakhah and Aggadah to extract guidelines for a Jewish ethics which addresses itself to all areas of life.”³⁵ Regarding this nuanced relationship between halakha and Jewish ethics, R. Lichtenstein writes, “relation to the overall halakhic system is important both for the definition of general goals and by way of molding orientation, context, and motivation. . . . The legal corpus here . . . is more guide than commander; but it is vital nonetheless.”³⁶ For R. Wurzbürger and R. Lichtenstein, the practice of Jewish ethics amounts to a balance between imaginative insight and cautious restraint, to paradoxically leaping beyond without quite ever giving up one’s footing.³⁷ Moreover, I

³³ For a characterization and critique of halakhic positivism in ethics, see Eugene Korn, “Legal Floors and Moral Ceilings: A Jewish Understanding of Law and Ethics,” *The Edah Journal* 2:2(2002).

³⁴ R. Walter S. Wurzbürger, “Covenantal Imperatives,” *Covenantal Imperatives: Essays by Walter S. Wurzbürger on Jewish Law, Thought, and Community*, eds. Eliezer L. Jacobs and R. Shalom Carmy (Jerusalem: Urim Publications, 2008), 53.

³⁵ “What is Unique About Jewish Ethics?” *Covenantal Imperatives*, 36. See also R. Walter S. Wurzbürger, *Ethics of Responsibility: Pluralistic Approaches to Covenantal Ethics* (Philadelphia: Jewish Publication Society, 1994).

³⁶ “Does Judaism Recognize an Ethic Independent of Halakhah?” 50.

³⁷ I add here that the dichotomy between strict halakhic positivism and an embrace of ethical intuition does not necessarily fall out along the lines of recognized philosophical camps. One can be a Centrist Orthodox proponent of halakhic positivism,

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would add, it takes dedication, intellectual rigor, and earnestness, as the very suggestion of creatively extrapolating from narrow halakhic material is ripe for abuse.

While halakhic positivism in its extreme form may be difficult to defend, subtler variations of its central tenet abound. In particular, one can agree with Ramban in principle and yet in practice stretch classical texts to such a degree that they actually do seem to dictate objective rules for every conceivable scenario. Whether such a tendency serves the best interest of Jewish ethics or not, however, is questionable. First of all, one reaches limits at which the intellectual gymnastics seem to strain under their own weight. The recruited texts seem so tangential, the logical jumps so numerous, and the conclusions so tenuous that one sometimes wonders if the integrity of the halakhic process itself has been diluted. Second, the imprimatur of “halakha” may be unnecessarily rigid for issues or situations that are better afforded some degree of flexibility and subjective judgment.

Third, even when relevant texts are identified that could genuinely help navigate a perplexing issue, a halakhic positivist bias could fail to extract the right lessons from them. To reiterate, both R. Wurzbürger and R. Lichtenstein stress that Jewish moral intuition does not burst onto the scene *ex nihilo*, but must emerge from a deep and rigorous engagement with the objective data of the halakhic tradition. Here, Hazal’s admonition that “an ignoramus cannot be pious” (*Avot* 2:5) certainly applies, as a presumptuous moral sense afloat without anchor can truly drift anywhere. However, one who is looking for moral grounding and guidance will bring a very different methodology to the text than one who analyzes it narrowly through the lens of halakhic legal reasoning. The former is scavenging broadly for an articulation of values, while the latter squeezes everything through the filter of “ought,” either mandated or forbidden. Thus not only does halakhic positivism impose legal formality where none ought to exist, it also misses a vital opportunity to actually glean the very insights that could inform an authentically Jewish moral compass.

on the one hand, or a *haredi* champion of a broader interpretation of Jewish moral demands, on the other. In fact, R. Wurzbürger specifically notes that both his theory of intuitive ethics and contemporary interpretations of *da’at Torah* are rooted in the same fundamental assumptions (see *Ethics of Responsibility*, 31; “What is Unique About Jewish Ethics?,” 36-37; and “Covenantal Imperatives,” 53). And while I highlight the scholarly writings of two students of the Rav, other rabbinic works have described similar, expansive visions for Jewish life (with regard to both the ethical and the ritual) in a more traditional nomenclature. See, for instance, R. Asher Weiss’s exposition on “*retson Hashem*” in *Minhat Asher*, *Devarim* (Jerusalem, Machon Minhat Asher, 2007), *siman* 51. Thus the possibility of a broad and inclusive dialogue that cuts across conventional communal boundaries exists.

As an example, let us analyze a much-cited text with regard to truth-telling. According to *Isaiah* (38:1), the Prophet visits the ill King Hezekiah and tersely tells him, in God's name, to leave instructions for his household, for he will not recover. The midrash adds, however, that Hezekiah chastised the great prophet for his apparent harshness:

Customarily, when one visits the sick he says, "May Heaven have mercy on you." A physician who visits tells him, "This you may eat and that you may not eat. This you may drink and that you may not drink." Even if [the physician] sees that the [patient] is about to die he does not say to him, "Leave a testament to your household" lest [the patient] faint.³⁸

What conclusions can we draw from this aggadic text about truth-telling? According to R. J. David Bleich, this text carries specific legal weight in endorsing and perhaps even mandating the use of placebos with terminal patients:

Concern lest the patient fall prey to depression or despair and thereby death be hastened is cited by the Midrash as establishing the normative principle governing such situations. Not only must the physician refrain from transmitting information which may perchance have this effect, but he must also continue to dispense advice which has the sole effect of reassuring the patient. He must be solicitous and feign medical aid even though there is no medical purpose in his ministrations. The patient must be advised what to eat and drink—and which medicines to take—not because of the therapeutic effect of such measures, but because the significance of removal of dietary restrictions or total withdrawal of medication is not lost upon the discerning patient. The "placebo effect" of the physician's continued ministrations not only prevents despondency but has a positive psychological value which is beneficial to the patient.³⁹

While the major thrust of the midrash is certainly along the lines of R. Bleich's description, I respectfully concede some hesitation with claiming that the midrash "establishes" a "normative principle." To what degree an aggadic text can have specific halakhic ramifications is a general question. In this particular text, though, I call attention to the midrash's opening words: "*Be-minhag she-ba-olam*," "the custom of the world." In other words, Hezekiah is not holding Isaiah to a halakhic standard, but to

³⁸ *Kohelet Rabbah* 5:6, as translated by R. J. David Bleich, *Judaism and Healing*, 28.

³⁹ *Ibid.*, 28-29.

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one of *derekh erets*. The basis of his critique is not a received tradition or a derivation of complex hermeneutics, but the common sense of common convention, “the way of the land,” indeed, ethical intuition.

And the conclusions, I think, may be different as well. If Hezekiah is actually drawing upon conventions of etiquette rather than policy or law, then his point may have more to do with communication and grace than with the ethics of placebos. Hezekiah, I believe, is commenting on Isaiah’s manner—his bluntness, his emotional distance, his perceived preoccupation with prognosis rather than with “care,” broadly conceived. The midrash’s reference to medical restrictions on diet, in my mind, advocates not so much for “feigning medical aid” as for a continued active engagement with the patient even as the possibility of recovery seems ever more remote. Even the suggestion that a physician should not instruct a patient to “‘leave a testament to your household’ lest [the patient] faint” may actually be reflecting the danger of a cold and heartless pronouncement rather than the danger of disclosure itself. Whether or not a physician (or anyone else) can openly and compassionately discuss the unfortunate course of a disease with a patient, though, especially if prompted to do so, is not necessarily addressed.

If my reading of this text is fair, then the midrash is delivering a poignant and powerful message about communication that contemporary medicine could very much benefit from. It is calling for emotional involvement, extended and gentle communication, and ongoing participation in the minutiae of care—“This you may eat and that you may not eat”—that do not suddenly end just when all treatment options have been exhausted. And while the midrash doesn’t necessarily offer groundbreaking insights in this regard, I believe it provides some balance to the discussion of the Jewish perspective on truth-telling. It reminds us, in the voice of Hazal, that sometimes context and tone take priority over content, and, more generally, that one’s conduct must stand before the bar of “*minhag she-ba-olam*” as well as before that of halakha.

But I fear that these crucial points get lost if we apply an overly rigid, legalistic reading to the text. The result is not just a lack of specific ethical insight about truth-telling, but a reinforcement of the positivist belief that a Jewish ethical intuition will never have much substance to it. Of course, this posture will prove to be self-fulfilling, as you never find what you don’t look for. If every text is read through a narrow, legal lens, then a Jewish ethical intuition will remain impoverished indeed. Not only does halakhic positivism, even after dilution, sometimes overreach in its own supposedly normative conclusions, it also guarantees an empty and shallow ethic by denying such an ethic the chance to grow from the very rabbinic source material that could nurture it most.

The biggest challenge to a broad, Judaic, ethical inquiry, I believe, is not theoretical validation but actual implementation. Even if we accept a distinction between the legal and the philosophical, the halakhic and the intuitional, where precisely this border lies is anyone's guess. When exactly does an attempt at halakhic analysis become so strained that it is better abandoned in lieu of an alternative approach? Moreover, exactly how do we describe and prescribe an appropriate methodology for developing a genuinely Jewish ethical intuition that reaches broadly but stays loyal to the best of halakhic analysis?

These questions, I believe, represent a central riddle for any real attempt to transcend "medical halakha" in the hopes of a true Jewish bioethic. To be sure, in the spirit of classic halakhic discourse, these questions may be best answered indirectly. Just as halakhic decisors derive general principles from established case law, we may better recognize a methodological path for Jewish bioethics once it is well tread by our own footsteps rather than trying to map it from the outset. Either way, whether by program or by cautious experimentation, a deep and probing ethical inquiry asks of those who have been "*meshamesh talmidei hakhamim*" to step out of their comfort zone of legal interpretation and attempt a new kind of project—not quite something different, but something more, something that builds upon the very best of rigorous halakhic analysis by directing it towards a nuanced articulation of distinctively Jewish values. The path to navigate is frighteningly narrow, flanked on one side by the pitfall of overbearing legalism and on the other by the murkiness of ethical superficialities. But, as R. Nahman of Breslov so memorably taught us, "the most important thing is not to fear at all."