IMPACT OF RLIGION ON DECISION MAKING IN RESPIRATORY INTENSIVE CARE PRACTICE.

ESSAY

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Abstract

Objective*:* Medical care for the dying or terminally ill patients by families and health care professionals is a challenging task especially when religious values, practices, and beliefs influence treatment decisions for those patients. Recent research has shown that the religious affiliation of both physicians and patients markedly influences end- of- life decisions in the intensive care unit in the entire world. The world's major religions' standings on withholding and withdrawing of therapy, on hastening of the death process when providing pain relief and on euthanasia are described. Religious perspectives on advance directives, nutrition and hydration, do not resuscitate/do not intubate (DNR/DNI), and extubation are often unfamiliar to the medical community. This review also discusses the influence of religion on practice of medical staff and family perception.

Design*:* The review is based on literature research and perspectives of ethicists in countries where religious rulings do influence secular law.

Results*: Not* all religions have distinct rulings on all the above-mentioned issues, but it is pointed out that all religions will probably have to develop rulings on these questions. The importance of patient autonomy in the Western world is not necessarily an issue among other ethnic and religious groups, and guidelines are presented with methods to uncover and deal with different ethnic and religious views.

Conclusion*:* Many religious groupings are now spread world-wide (most notably Muslims), and with increasing globalization it is important that health-care systems take into account the religious beliefs of a wide variety of ethnic and religious groups when contemplating end-of-life decisions.

Keywords: Ethics, Religious methodologies, Intensive care, Euthanasia, End of life, Withholding/withdrawing of treatment, Influence.

LIST OF CONTENTS

INTRODUCTION

Beliefs regarding end-of-life care, including those of withholding and withdrawal of medical intervention, vary widely between different religions. Recent research has shown that the religious affiliation of both physicians and patients markedly influences end-of-life decisions in the intensive care unit. ***(Bülow et al., 2008)***

All healthcare professionals need to have some insight and knowledge into the beliefs of the major faiths they are likely to encounter, in order to be culturally sensitive to what their patient's wishes may be, and so that discussions and management can be targeted appropriately. ***(Carlet et al., 2004)***

Muslim jurists of different schools ruled that once invasive treatment has been intensified to save the life of a patient, life-saving equipment cannot be turned off unless the physicians are certain about the inevitability of death. Terminally ill Muslim patients are permitted to have life-sustaining treatments withheld or withdrawn if the physician judges the treatment to be futile, not improve the patient's condition or quality of life, involve great complications, delay the dying process, or involve suffering. ***(Sachedina, 2005)***

However, it should be a collective decision acquired on the basis of informed consent after consultation with the patient's family and all individuals involved in providing care. ***(Daar and Al Khitamy, 2001)*** In these situations, death is allowed to take its natural course. Basic nutrition should not be discontinued because such an action would starve a patient to death—a crime in the Islamic faith. ***(Ghazal et al., 2002)***

The withdrawal of support in the setting of a persistent vegetative state is less clear, as Islam requires that no life be taken and does not formally recognize brain death as death. ***(Naughton and Davis, 2003)***

Understanding Christian interests in decisions regarding the end of life is complicated by the dominance of Christian culture, which has framed much of the law and public policy governing end of life decisions in many countries.

Traditional Christians recognize that there is no obligation always to postpone death, but there could be a duty to use high technology medicine to gain a last opportunity for repentance. ***(Engelhardt and Iltis, 2005)***
Patients are permitted to withhold and withdraw life-sustaining treatments if the methods are judged to be extraordinary by the patient and family. ***(Markwell, 2005)*** These life-sustaining treatments include CPR, mechanical ventilation, pacemakers, and VADs. Hydration and nutrition, including by medically assisted means, are considered ordinary means to preserve life and must be provided to patients, including those with apparently chronic irreversible conditions who are expected to live indefinitely. ***(United States Conference of Catholic Bishops, 2009)***

The administration of nutrition and hydration by natural or medically assisted means is not morally obligated when food and water cannot be processed by the patient's body, causes significant physical discomfort, or becomes a burden to the patient. In regard to oxygen therapy, if intubation is chosen to be withheld, a means of oxygen therapy should be administered to decrease patient discomfort. ***(William, 2007)***

According to the Jewish religion and law, patients who are terminally ill, treatments that are not potentially curative may be refused, especially when harm may result. Under certain circumstances, treatments may be withheld, but active treatment already started may not usually be withdrawn. While patients should generally not be laid to regarding their conditions, withholding information or even providing false information may be appropriate when it is felt that the truth will cause significant harm. ***(Barry, 2004)***

Nevertheless, hydration and nutrition (by the oral route, feeding tubes, or intravenous lines) are not considered medical interventions but are considered supportive, basic care and must be provided to the patient. However, if a competent, adult Jewish patient refuses hydration or nutritional support after attempts have been made to convince the patient to agree to the care, one must respect the patient's wishes. In regard to oxygen therapy, if intubation is chosen to be withheld, a means of oxygen therapy should be administered to decrease patient discomfort. ***(Loike et al., 2010)***

Mechanical ventilation may be withheld; however, once mechanical ventilation has begun, it may not actively be withdrawn. Some Halachic authorities allow the patient to be placed on a ventilator with a timer so that care is not actively withdrawn. ***(Ravitsky, 2005)***

AIM OF THE STUDY

To illustrate the perspectives of different major religions for management of critically ill patients and to what extent religious beliefs would influence decision making in respiratory intensive care practice.

RELIGIOUS METHEDOLOGIES

The primary goals of intensive care medicine are to help patients survive acute threats to their lives while preserving and restoring the quality of those lives. These goals are frequently achieved, with approximately 75% to 90% of patients admitted to an intensive care unit (ICU) surviving to discharge ***(Luce and Prendergast, 2001).***

Technological advances in modern medicine have had a great impact on the care of critically ill patients, saving many children's lives, but also leaving others with chronic diseases and disabilities. The increased ability to sustain life with intensive care may lead, unfortunately, sometimes only to prolonging suffering when treatment is unsuccessful, and prolonging the dying process, attached to technology, instead of dying with dignity in the company of loved ones. (***Wong et al., 2005***)

Twenty percent of deaths in the United States follow admission to an ICU **(*Angus et al., 2004*)** often in association with decisions to forego life support **(*Truog et al., 2008*).**

End-of-life treatment choices are increasing in intensive care units (ICUs) around the world (***McLean et al., 2000***) with 16–90% of all deaths preceded by some kind of limitation of life-sustaining therapy (***Kapadia et al., 2005***), and patients and physicians with different religious, cultural and ethical backgrounds adopt different approaches, even within the same religion (***Sprung et al., 2003***).

Recent research has shown that the religious affiliation of both physicians and patients markedly influences end of-life decisions in the intensive care unit in the Western world. The world's major religions' standings on withholding and withdrawing of therapy, on hastening of the death process when providing pain relief (double effect) and on euthanasia are described. (***Hans et al., 2008***)

Judaism, Christianity, and Islam share a host of theological commonalities, yet religious ethicists from each of these three traditions utilize distinct religious methodologies when attempting to resolve ethical quandaries. In attempting to elucidate the religions' perspectives on issues of medical ethics, Jewish, Christian, and Muslim ethicists regularly turn to scripture, religious doctrine, and tradition.

Religious ethicists also utilize independent reasoning and analysis when rendering ethical decisions. Not surprisingly, interpretive disagreements frequently emerge,

even among religious ethicists who are staunchly committed to orthodox readings of their tradition's texts.
As Jewish ethicist Louise Newman acknowledges, Jewish sources (like Christian and Muslim sources) are not exactly "pre-labeled" to indicate which sources are applicable to particular ethical dilemmas، especially dilemmas concerning strictly contemporary issues such as those related to modern medical technologies. Consequently, Newman concludes, "there is considerable room for contemporary authorities to differ in their choices of precedents for modem cases involving euthanasia." ***(Newman and Louis, 1995)***

Muslim ethicist Ebrahim Moosa suggests that intra-religious ethical disputes emerge in response to two critical challenges. The first challenge is to foster a system of laws and ethics that continuously responds to a dynamic and changing universe. The second challenge is to enable theories and practices to retain their sacrosanct character and serve as salvific practices and performances. ***(Moosa Ebrahim, 2005)***
Ethicist James F. Childress notes that "recent studies suggest that liberals (or conservatives) in Protestantism, Roman Catholicism, and Judaism may share more with liberals (or conservatives) in the other traditions than with their own religious colleagues who do not share that liberal (or conservative) orientation." ***(Childress and James, 1998)***

Consequently, any attempt to distinguish Jewish, Christian, and Muslim viewpoints when examining ethical issues should take into account the spectrum of viewpoints represented within each religion. The following section contains
a brief overview of how scholars within each of these three monotheistic traditions employ religious methodologies to approach and resolve modern ethical controversies.

Judaism

Traditional Judaism is a highly legalistic religion that places a great deal of emphasis on meticulous textual study and legal precedent. For observant Jews, Halakhah, which is the Jewish code of law and jurisprudence, serves as the ultimate code of conduct. Halakhah comprises far more than a set of laws and observances; it is an all-encompassing way of life, literally translated as "the path that one walk" ***(Rich and Tracey, "Judaism 101 ")***

Halakhah is based on several sources, including:1) the 613 *mitzvot* (i.e. commandments) present in the Torah; 2) the prescriptions found in the *Mishnah* (known in English as the Oral Torah, which was set down following the Woman

destruction of the Second Temple in 70 C.E.); 3) the teachings articulated in the *Talmud*, which consists of extensive rabbinic commentaries on the Mishnah. Additionally, two particularly significant codes of *Jewish law*, the twelfth-century *Mishneh Torah* of Moses Maimonides and the sixteenth-century *Shulchan Aruch* of Joseph Caro, as well as many other rabbinic writings and religious traditions, have contributed to the contemporary legal and moral interpretations of Jewish texts embodied in Halakhah.

As adherents of a text-based religion with a defined set of authoritative religious texts (albeit a voluminous set), observant Jewish thinkers are unified in that they are committed to the same canon. ***(Newman, k., 152)*** Yet despite certain underlying commonalities disagreement and argument are not unusual (and are often a source of pride) among Jewish scholars. Judaism notably "does not have one central authority which ultimately establishes a universal answer as the necessary or definitive view of a specific question."***(Grodin and Michael, 1992)***

Christianity

Given the vast array of Christian traditions that exist and the impossibility of addressing the methodological approaches of each within the confines of this paper, I chose to focus on the Catholic tradition and on Protestant traditions that maintain dissenting viewpoints on the practice of euthanasia. Christianity, like Judaism and Islam، is a text-based religion, and whereas orthodox adherents regularly interpret scripture as the direct word of God, liberal Christians tend to interpret scripture metaphorically.

The Christian scriptures include the Hebrew Bible and the New Testament, which is comprised of the Gospels, the Epistles (i.e. Letters) and the books of Acts and Revelation. Christian theology is additionally based on the concept of "natural law", which is defined as a doctrine that "holds that God made the world with a specific purpose in mind, and that everything in this world, both living and non-living, conforms to this natural order." ***(Brockoff and Jonathan, 2002)***

Roman Catholicism, the largest and most centralized of the Christian denominations, upholds the religious primacy of the Pope and the hierarchical clerical organization of the Roman Catholic Church. Magisterial teachings are considered to be authoritative and binding upon all observant Roman Catholics, although considerable epistemological diversity exists among the Catholic laity.

Theologian Vigen Guroian explains that "from early on, Roman Catholic moral theology was closely allied with canon law ***(Catholic Encyclopedia)***….Catholic moral theology assumed a distinctly juridical character tied closely to church order and penitential practices."***(Guroian and Vigen, 2005)***

Beginning in the sixteenth-century with the Protestant Reformation, numerous Protestant denominations evolved first in Western Europe and then throughout the United States. The largest of these Protestant groups are the Lutheran, Reformed, and Anglican denominations. Protestants do not recognize the ecclesiastical supremacy of the Pope, and while some Protestant churches are more conservative than their Catholic counterparts, other Protestant churches are considerably more liberal in their religious and social ideologies. Evangelicalism, a growing movement that predominates among some American Protestant groups in the South and Midwest, maintains that the Bible must be understood in an "immediate, literal sense" and should be considered "the final authority in all questions of faith and ethic."***(Schinmacher and Thomas, 2003)***

Islam

Islam was founded in the seventh century C.E. and is the youngest of the three monotheistic religions. Muslims believe that the Prophet Muhammad (c. 570 -632) was the last messenger sent by Allah before the Day of Judgment. Through his holy actions and divine revelations, the Prophet serves as a guiding model for Muslims. Islamic scholars traditionally seek answers to ethical quandaries by searching "not for the relevant principle, but rather for an analogous case, preferably involving someone worthy of emulation such as the Prophet."
Despite his centrality to Islam, Muhammad is not considered a divine being and is not worshipped as such. According to traditional Islamic theology, Allah is "the absolute and only source of volition. Simply put, nothing can occur, no bird can fly and no human decision can be made, without direct dependence on God's well" ***(Brockopp, 2003)***

The Quran, which is believed to be the direct word of God, was revealed to Muhammad during his lifetime and was transcribed by his followers after his death. The Quran is Islam's holiest text, and it serves as the primary basis for *Shariah*, or Islamic law, (which in many respects is analogous to Halakhah in Judaism). Shariah literally means "the path". In addition to being based on the Koran, Shariah is derived from the *Sunna* and *Hadith* (traditions concerning the life and sayings of Muhammad), the opinions (*fatwas*) of Islamic scholars (known as *muftis*), relevant previous decisions, and local customs. Partially because Islam has no centralized magisterial institution, Shariah is not uniform throughout the Islamic world. Despite the credence bestowed on respected jurists, Moosa contends that "individual responsibility is at the center of Muslim ethics. Even if a jurist issues an informed opinion, the lay person is compelled to subject any ruling to the scrutiny of the inner forum of the conscience." ***(Mossa, 2004)***

Two major schools of Sunni Muslim dialectical theology emerged among medieval Muslim scholars: The Mutazilite School, which shared its ethical epistemology with Shiite Muslim theology, and the Asharite School. Author Abdulaziz Sachedina explains that today the Mutazilites, along with Shiite Muslims, are commonly categorized as "rationalists". The predominantly-Sunni Asharites are correspondingly grouped as traditionalist". ***(Abdulaziz Sachedina, 2005)***

> Sachedina writes:The basic Mutazilite thesis is that human beings, having been endowed with an innate capability to know right and wrong, and having been endowed with free will, are responsible for their actions before a just God. Furthermore, good and evil are rational categories that can be known by intuitive reason, independent of revelation. The Mutazilite standpoint was challenged by Asharites who rejected the idea of natural reason as an autonomous source of religious-moral guidance. They maintain that good and evil are as God commanded them in the scripture. ***(Sachedina, 255)***

According to Moosa, the predominant contemporary approach to Islamic ethics can be described as *doctrinaire traditionalism.* In this approach, "the formalized legal and ethical opinions of past jurists form the canon of normative teachings. This normativity, rooted in the past, is regarded as universally value and perfect as inherited from the ancients. To depart from the views of past authorities is only permitted in very limited instance." Moosa also notes that *critical traditionalism* is a developing trend in Muslim ethics: "Intellectuals who lean towards this ethical orientation view the juridical tradition as a work-in- progress. They invoke the critical thinkers of the past, historicize the tradition, and adopt contemporary knowledge and experience as part of tradition."***(Moosa, 2004)***

Religious doctrine gives a framework for understanding the human experience of death and dying for patients, family members, and health care professionals. Spirituality and religion should be associated with a decreased fear of death and greater acceptance of it ***(Neimeyer 1994)***. The objective of quality comfortable death is achieved by meeting a patient’s needs and by paying attention to the social, psychological, and the spiritual and religious dimensions of care (**Table 1**) ***(Byock, 1997; Emanuel and Emanuel, 1998)***

Ethical decision must balance the rights of the individual, views of the society as a whole and the desires and wishes of the family or those close to him. An individual's freedom of choice is constrained by the harm it causes others. ***(The British Medical Association, 1999)***

Decision making in terminal care is a demanding and stressful duty for all involved that can take place in any setting in which patients die in hospitals, nursing homes, hospices, and at home. End of life care is an emerging field in all countries, irrespective of their economical, cultural, or religious backgrounds. ***(van der Heide et al., 2003 and Dickenson, 2000)***

TABLE 1. THE FOUR ETHICAL PRINCIPLES DEALING WITH TERMINALLY-ILL PATIENTS

Principle	Approach
Beneficence	The determination to give benefits and equilibrate benefits against right
Non-maleficence	The determination to eliminate the causation of Injury
Autonomy	Respect the decision-making capacity of people
Justice	Determination of fairness in the impartation of benefits and risks

Courtesy of Ana L. Huerta-Alardín, Agustín Cruz-Amador, George Sternbach, Joseph Varon, Withholding and withdrawing life-support, Crit Care & Shock (2004) 7: 64 – 68.

DEATH

Human death definition was much easier in past eras than now. When our heart or lungs stopped working, we died. Sometimes our brain stopped before our heart and lungs did, sometimes after. But the cessation of these vital organs occurred close together in time. ***(Center for Bioethics University of Minnesota, 2005)***With advances in life support, the line between who is alive and who is dead has become blurred. ***(Capron, 1995)***
In the United States of America, the Uniform Determination of Death Act (UDDA), written in 1981, confronts the complexities concerning the declaration of death. The UDDA states that a person can be declared dead when either the heart and lungs or the brain and brain stem stop functioning permanently. *(**The National Conference of Commissioners on Uniform State Laws, 2006**)*

Disparate scientific and theological conceptions of death contribute to the complexity of the matter, especially in situations where cognitive and physiological functions do not cease simultaneously.
In recognition of the inadequate definitions of death that prevailed at the time, the Ad Hoc Committee of the Harvard Medical School published a highly influential report in 1968, the primary purpose of which was "to define irreversible coma as a new criterion for death." As the report acknowledges: "Improvements in resuscitative and supportive measures have led to increased efforts to save those who are desperately injured. Sometimes these efforts have only partial success so that the result is an individual whose heart continues to beat but whose brain is irreversibly damaged." The resulting burden is great for all people and institutions involved. Additionally, the report points out, "obsolete criteria for the definition of death can lead to controversy in obtaining organs for transplantation. ***(Report of the Ad Hoc Committee of the Harvard Medical School, 1968)***

Clearly the debate over the definition of death is as pragmatic as it is theoretical. The way that death is defined in a medical setting can have a serious impact on the viability of organs for transplant. A person must be certifiably dead in order for his or her organs and/or tissues to be donated in an ethical manner. Yet certain physiological conditions may need to be maintained in order for the person's organs to be harvested optimally for transplantation. The critical question is at what stage along the continuum of cognitive and physiological dysfunction should a person be considered spiritually, as well as scientifically, dead? In situations of

this nature, clashes between religious and scientific conceptions of death can have profound consequences if they are not addressed in a sensitive manner. ***(Ashley, 1997)***

Because every person's body belongs to God, a patient does not have the right either to commit suicide or to enlist the aid of others in the act, and anybody who does aid in this plan commits murder. The patient does have the right, however, to pray to God to permit death to come (RaN, B *Nedarim* 40a; the *Talmud* records such prayers: B *Ketubbot* 104a, B *Bava Mezia* 84a, and B *Ta'anit* 23a). ***(Lancet, 2005)***

Most contemporary Jewish ethicists also recognize total brain death as conclusive, despite the fact that "the classical sources in Jewish law all seem to concur that the definition of death is the total and irreversible cessation of respiration. ***(Grodian, 364)*** *Author Naama Wietchner* highlights the position of the Chief Rabbinate of Israel, which ruled that "death occurs when the brain stem which activates the respiratory system, irreversibly ceases to function.***(Wietchner, 1998)*** However, not all Jewish ethicists - especially Orthodox ethicists – accept the validity of this ruling. According to Immanuel Jakobovits, former Chief Rabbi of Great Britain, "Jewish law cannot accept [irreversible brain damage] as absolute in defining death, and we would certainly regard any spontaneous life function still being maintained.. .as indicating that a patient is still alive, whatever the condition of the brain. ***(Jakobovit, 1986)***

Writing from a Catholic clerical perspective, theologians Benedict Ashley and Kevin Rourke state that "although we accept total brain death as a sufficient criterion for human death, we do not believe that partial brain death is sufficient." ***(Ashley, 1997)***

To recognize a diagnosis of brain death as conclusive death would deny the possibility of miraculous, divine intervention on behalf of the patient. Some non-orthodox ethicists maintain that in certain situations, partial brain death, as opposed to total brain death, is for all intents and purposes equivalent to death. As Episcopalian ethicist Joseph Fletcher contends, "It is personal function that counts‹ not biological function."***(Fletcher, 1998)*** Fletcher's contention is particularly relevant when considering the situation of patients in a Permanently Vegetative State (PVS). As Thomas Shannon and James Walter explain, "a PVS patient is not dying. In these patients the brain stem is intact, with the major damage to the brain occurring in the neo-cortex and cortex. Thus these patients breathe spontaneously, have their eyes open, have a sleep-wake cycle, their pupils respond to light, and they typically have normal gag and cough reflexes."***(Shannon et al., 1992)***