RECENT MEDICAL ADVANCES IN THE LIGHT OF THE JEWISH RELIGIOUS TRADITION

Recent advances in medical techniques, especially heart transplants, have aroused considerable controversy. Some of the basic moral and religious issues involved are discussed from a Jewish point of view in the following three articles. Dr. Tendler, Chairman of the Biology Department of Yeshiva University, is a renowned Talmudic scholar and Rabbi of the Community Synagogue of Monsey, New York. Dr. Elihu Schimmel is Assistant Professor of Medicine of Boston University School of Medicine and Chief of the Gastroenterology Section, Veterans Administration Hospital in Boston. Rabbi Rabinovitch of the Clanton Park Synagogue in Downsview, Ontario, is Associate Editor of *Hadarom* and lecturer in mathematics at the University of Toronto.

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MEDICAL ETHICS AND TORAH MORALITY

And heal he shall heal (Exodus 21:19). From this verse we deduce the license (permission) granted the physician to heal (*Bava Kama 85a*).

The physician should not refrain from offering his medical services because he fears he may kill the patient, since he is a competent, well-trained physician. Nor should he abstain because *Hashem* alone is Healer of All Flesh — for such is already the natural order . . . the Torah does not have supernatural basis for its instructions to mankind. . . . But indeed when man's ways are pleasing to God he will not have need of human physicians . . . (for I, God, am your physician) (Nachmanides [Lev. 26:11]).

Science has made us gods before we are even worthy of being men.[1]

Morality is of limited help in the moral problems of the doctor. . . . Problems involving medical conscience are nearly always of such a nature that moral principles are not sufficient to indicate the course of action; in one sense it could be said that medicine is amoral.[2]

Throughout the history of civilization, the universally binding Divine command, "I am the Lord thy God," was opposed by many aberrant theological systems. The only significant challenge to monotheism, however, arose from a man-God theology. The second commandment of the Decalogue, *Lo yiheye lecha elohim acharim,* assumes new significance, when heard through the cadence of Asaph's plea (Psalms 81-9-10): "Hear O my people, and I will testify against thee . . . there shall be no strange God *in thee.*"

The godliness that is in man poses the only serious challenge to God the Creator. As man's mastery over nature increases, so does the tendency to boast, "My power, the strength of my hand has wrought all this."

The Sabbath day testimony, negating man the creator, has special import in an age when work is no longer measured in foot-pounds, in ounces of sweat. The push of a button creating fire and flame, death and destruction thousands of miles away, is a challenge hurled at the heavens. Who, indeed, is master of this physical universe? Is it still the God of Genesis, the Creator and Sustainer of heaven and earth, of man and nations?

When the physician was a practicioner of the art of medicine, he could not delude himself into a man-God complex. Now that medicine has become a science, and the physician has assumed significant control of biological phenomena, he has within his heart and hand the ability to benefit or harm his patient. The danger that he will be tempted to "play God" is real. The facts are that he has been doing so for the last decade.

It is my thesis that, by default, society has assigned to the physician the role of theologian and moralist — a role for which he has no competence. The fear of sickness and death, aided by the intentionally cultivated aura of mystery and the deep respect of the laity for scientific achievement, has resulted in this unwitting election of the medical community as arbiter of the most fundamental truths of Torah morality and of Western civilization.

Just as there are certain *mitzvot* that cannot be delegated to others, so in a society founded on democratic principles that take their origin from Torah axioms, there are fundamental truths

that require the personal supervision of each member of society. The inviolate integrity of the human being, as distinguished from infra-human species, is the personal responsibility of every citizen. Delegation of this responsibility to others presages the degradation and destruction of a democratic society. With respect to medical ethics, we committed this error, with the resulting impairment of the integrity of man. The physician now experiments on his patient for the benefit of other patients. Another safeguard has been violated and an escalation of the dehumanizing influences in our society has occurred. Man has been pressed into the service of man without his conscious acquiescence. The healing art is the goal, not the means. A moral means towards a noble goal is anti-Torah whose boast is, "Our ways are ways of pleasantness and all our *paths* are peaceful." I contend that it is also abhorrent to our society and in violation of the ethical foundations of Western civilization.

Several well-documented texts have appeared,[3] listing hundreds of incidents of patients serving the medical profession as experimental animals without any benefit to the patient. I will not elaborate on what is already published, except to ask: Why are we silent? These revelations by leading medical men are really a call for help in controlling the new powers concentrated in the hands of the physician. The challenge to our fundamental constitutional rights is far more direct than eavesdropping, loyalty oaths, or military draft. Why the deafening silence?

As I write these lines, the *New York Times* (March 3, 1968) carries for the *fourth* time in a fortnight the unbelieveable report that a "wonder drug," Chloramphenicol, implicated as the cause of fatal blood dyscrasias as long as 15 years ago, is still being used by licensed physicians for the treatment of the common cold. Government action has been promised by the Food and Drug Administration to revise the drug label "to make the warning stronger." This may be some comfort to the three-and-a-half million Americans who were treated with this drug last year. It is of paramount concern to me that not once has the issue of medical ethics been raised. Not once has there been an attempt to discipline the amoral, conscienceless physicians whose names appeared on those millions of prescriptions.

Torah ethics emphasize that medical intervention occurs under Divine license. The obligations and responsibilities far exceed the privileges (*Yoreh Deah,* 336:1) — "If the physician who is competent errs, he is not subject to court action but is *guilty* in the eyes of God. If his error causes the death of his patient, he must go into exile (as any other person who commits manslaughter)".

I am a knowledgeable layman in the field of medical science. I fail to see this sense of personal responsibility portrayed in medical literature or at convention addresses. The medical community coined a new word, IATROGENESIS, to encompass "the diseases of medical progress." They compartmentalized their ethical concern in a new medical specialty so that it will not interfere with their practice of the healing arts.

The full magnitude of the chasm that has formed between current medical practice and accepted mores of our society is best appreciated if one analyzes the status of renal transplants in relation to hemodialysis (kidney machine). Let me enumerate the areas of ethical concern:

(a) In the United States of America and England, there are more than 5,000 fellow humans who will die this year because hemodialysis equipment and personnel are unavailable to them. The *only* reason this life-saving treatment is unavailable is the decision of the medical profession to remain silent because of the high cost of treatment.[4] The total cost of treating these patients for one year is not equal to the cost of one day's warfare in Vietnam. It is a fraction of the one billion dollars spent by Americans annually on cosmetics. Who decided that it was not moral judgment that 5,000 (and many more) lives are not importantly, why were we not asked? The physician made the moral judgment 5,000 (and not only many more) lives are not worth the cost. The medical community is not competent to make such decisions for society. They have neither the religious training, nor the broad humanistic experience or erudition to serve as guidelines for so momentous a decision.

(b) It is axiomatic that the act of surgery is legal assault unless the consent of the patient or his legal representative is obtained. Consent has been defined as, "informed consent ob-

tained without duress." How voluntary a contribution does a brother make when he is informed that unless he offers his kidney, his twin brother will die? Can there be greater coercion than the sanction of family and friends in such a situation where the probability of successful transplantation is indeed very good? Yet what value judgment would society place on the rich industrialist who buys a kidney for his dying son for $100,000 from a poor employee in one of his factories? What about prisoners who volunteer?

In this month's *New England Journal of Medicine,*[5] it is reported that four patients who were recipients of kidney transplants developed cancer from the donor kidney taken from a cancer patient. Was there "informed consent" in these cases? Were the recipients told the following:

(1) The kidney is from a cancer patient.

(2) Our present state of knowledge concerning circulating cancer cells indicates some risk that cancer may replace kidney failure as the cause of death, as indeed it did for three of these patients.

(3) Hemodialysis is physiologically as good as, and most likely to be preferred to transplantation surgery. In fact, renal transplantation is at times inferior to hemodialysis except for the increased geographic mobility provided by the grafted kidney over the kidney machine.

(c) Under the existing condition of inadequate supply of hemodialysis equipment, who decides which patient shall be given machine time and will live, and which patient will be refused and will die? Is it the London hospital director who issued the infamous regulation that no man over 65 shall be resuscitated? On what social scale is a 21-year-old "acid head" to be given preference over a 70-year-old teacher of truth and beauty?

(d) If the donor be not a volunteer but a comatose patient, additional problems come to the fore. Who may authorize use of the kidney? When is he legally dead? When the heart stops or when there is a cessation of brain-wave activity? In the absence of any clear decision, the kidney of a dying woman was transplanted to a recipient in Sweden.[6] The donor had suffered a cerebral hemorrhage, and her condition was pronounced hope-

less. She died two days after surgery. Was her husband's permission adequate safeguard of her rights and privileges as a human created in God's image? Compare this medical decision with the halakhic safeguards as outlined. "The dying patient is in all respects a living human being . . . he who touches him is a murderer. It is to be likened to a flickering candle, when touched by man it is snuffed out." (*Maimonides Hilkhot Avel,* 4:5; 1.)

There are many more ethical considerations that must be evaluated, such as the right of the patient to die with dignity, the responsibility of society to the volunteer donor if his one remaining kidney should fail sometime in the future, and many more. But of greatest import to the survival of our society is the realization that all these great moral issues are being decided without our participation. By default of society, the physician has become theologian, moralist, and ethical essayist. His acceptance of this role has cast doubt on his integrity as a man and as a physician.

Heart transplant surgery is but an acute and dramatic example of an area of medical progress in need of moral directives. The public acclaim, the favorable press that followed the first heart transplant virtually stifled all attempt at analysis of the great moral decisions that were made. Despite the inexplicable refusal of the press to publish negative opinions (except my own), negative opinions there are, indeed. The snub of Dr. Barnard by the medical community of England reached its climax when Dr. Barnard appeared on television before a studio audience and was asked by the irascible Malcolm Muggeridge (nearly exact quote), "Why was South Africa the first to undertake a heart transplant? Is is because your surgeons are the finest, your hospitals the best, or because your policy of apartheid has lowered your evaluation of human life?" This whole incident remained unreported in any American newspaper despite the obvious "fitness" of this newsworthy item. Dr. Werner Forssmann, 1956 winner of the Nobel prize in medicine, compared the heart transplant to "some of the Nazi experiments on humans."[7] Dr. C. A. Hofnagel, Professor of Surgery at Georgetown University Medical School, the first to devise and use a plastic heart valve, says bluntly, "Human application is premature."

After a pregnant silence of several months, the National Academy of Science's Board on Medicine urged caution and proposed a set of guidelines. "Heart transplants should not yet be considered a form of therapy. They are still in the stage of *scientific experimentation,* with the long range outcome of such experiments uncertain." The Board urged three guidelines:

a) The transplant teams should be highly skilled with extensive laboratory experience.

b) The work should be carefully planned and the results rapidly communicated to others in the field.

c) Both the surgical team and the patient should be "protected by rigid safeguards. An independent group of expert, mature physicians, none of whom is directly involved in the transplantation effort should examine the prospective heart donor and another similar group examine the prospective recipient."

In summation, the Board strongly urged that "institutions even though well equipped from the standpoint of surgical expertise and facilities but without specific capabilities to conduct the whole range of scientific observations involved in the total study, resist the temptation to approve the performance of the surgical procedure until there has been an opportunity for the total situation to be clarified by intensive and closely integrated study."[8]

These guidelines, in turn, require clarification on two major points. If, as quoted, heart transplant is in the area of experimentation, not therapy, how does heart transplantation conform to the Nuremberg Code[9] which demands that proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability or death? Secondly, is not the proposal for an independent group of physicians a self-indictment of the medical community? Since they do not trust each other, why should we put our trust in them?

Torah morality demands that one "be innocent in the eyes of God and the eyes of man." The scientific reports of the transplant procedures that have appeared supply little information to establish "innocence in the eyes of man" or to provide any answers to the moral questions raised:

— Did Dr. Barnard expect to treat his patient or just to experiment on him?
— Did he have laboratory evidence of potentially successful therapy? Why did he answer on his television interview that his dog experiments had no long-term survival since they were designed only to "perfect surgical technique"?
— Why did the surgery come as a surprise to the world? Was Dr. Barnard in consultation with the great surgeons and immunologists of the world who would undoubtedly have been willing to be at his service?
— Why did he (by his own admission) "overtreat" his patient with immuno-suppressive therapy when evidence, available as long ago as 1961, showed that the heart was less antigenic than the kidney? Why did the next patient, only a few weeks later, receive little or no anti-rejection therapy? Did Dr. Barnard finally read the literature in the field or obtain proper consultantship services?
— Why did he not use anti-lymphocytic gamma globulin (ALGG), believed to be a major breakthrough in transplant surgery and credited with the success attained in several liver transplants by Dr. Starzl at the University of Colorado?

The right to know extends past the patient's bedside to all of society. Here was an erosion of another ethical principle of our society. Besides the decision — much of which is still shrouded in mystery — as to when the donor is truly dead, the decision to cut out the weakened but functioning heart of the recipient was a decision to condone an act of killing. Our society so defines the physical removal of the heart — an act of killing. We are not involved in surgical risk, but rather in active destruction of a human organism with only an unproven hope of undoing, even for a short time, the damage wrought by the surgeon's scalpel. Dr. Barnard owes it to me to explain his entire thought process, his preparations and lack thereof. No man can claim right of independent action based on his own conscience if this act involves boring a hole under his boat seat. Not unless he is alone in the boat. But we are all in the same boat. Any erosion of the safeguards to man's right and privileges in South Africa

affect my family here in New York.

Medical practice is in need of moral and ethical guidelines. The ethical foundations that support our social order are biblical in origin. It is the great privilege and obligation of those whose lives are devoted to the study and teaching of these Biblical truths to join in formulating such guidelines.

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