The Installation of Timers on Ventilating Machines: A Closer Look

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Abstract

The health care profession often uses the moral distinction between an act and an omission to justify moral decisions that they make. Health carers in Israel are no exception to this. Generally omissions that result in the death of a patient are permitted by Israeli religious law, where any direct action taken to hasten the death of a patient is forbidden. In 2005, the Israeli Parliament enacted the Patient Nearing Death Act which proposes that timers should be installed in mechanical ventilators to give patients the option of being disconnected from mechanical ventilators. If the dying patient is determined not to have his or her life extended, the timers will not be reset by the health care team and will automatically turn the ventilator off. Thus patients can be disconnected from mechanical ventilators without the health care team having to perform any action per se. It is proposed that the timers will convert an act of commission into an omission. Hence, by Israeli religious law, the health care team will not be held morally responsible for the deaths of patients that result from the timers switching off the mechanical ventilators. This thesis aims to explore whether the timers actually convert an act into an omission and furthermore, whether health care professionals only bear moral responsibility for the deaths of their patients that result from their (health professionals) actions and not their omissions. I argue that there are plausible reasons to suggest that these two claims are, at least, problematic.

Acknowledgements

“A journey is best measured in friends rather than miles”

Tim Cahill

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Introduction

Overview

Can it be justified that we are only morally responsible for our actions and not our omissions? Health care professionals frequently use the moral distinction between an act and an omission to justify moral decisions that they make.\(^1\) An act is viewed as ‘killing’ and an omission as ‘letting die’, where the latter is sometimes permissible, the former is always forbidden.\(^2\) However, in an era where there is simultaneous resurgence of religious trends with existing counter-trends of secularization,\(^3\) the ethical significance of this distinction remains inconclusive. While some argue that there is a moral difference between an act and an omission, others disagree.

An example of a country that supports the moral distinction between an act and an omission is Israel.\(^4\) In 2005, after five years of deliberations, the Patient Nearing Death Act was enacted in Israel. A novel aspect of this law was that it proposed that timers be installed in ventilating machines so that patients could be disconnected from mechanical ventilators without anyone having to act.\(^5\) Previously patients, once connected to the respirator, could not ask to be disconnected as Israel forbade any action taken to hasten the life of a being as this was viewed as killing.\(^6\) The timers, at the end of a set time and if not reset by the health care team, automatically switch off the

ventilating machines. By using these timers, two assumptions are made; first, it is proposed that an act of commission will be transformed into an omission and second, that the health care team will not bear any moral responsibility for the death of the patient that results, since their death results from an omission.

In this thesis, I argue that there are plausible reasons to suggest that these two claims are, at least, problematic. In Chapter 1, I outline the main aspects of Jewish religious law that underpin Israeli’s proposal for timers to be installed in ventilating machines used by terminally ill patients. I go on, in Chapter 2, to describe how the proposal for the timers was initiated and how these timers work, the future developments made regarding the installation of these timers and issues that are raised by these timers. Then in the following chapters, I consider the two claims that the use of the timers seem to rest on. In Chapter 3, I consider whether the timers are successful in converting an act into an omission. Finally, in Chapter 4, I argue that to claim that health care professionals are morally responsible for the deaths of their patients that result from their actions and not their omissions is problematic.

Methodology

This thesis is a conceptual analysis of a scenario in which timers are installed in ventilating machines and used to convert an act of withdrawing mechanical ventilation into an omission. The two questions that this thesis explores are:

(i) Does the use of the timers convert an act into an omission?

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(ii) Do health care professionals only bear moral responsibility for the deaths of their patients that result from their (health professionals) actions and not their omissions?

Therefore, for the purpose of my research, qualitative methodology was selected as it is best suited to a phenomenon as complex as the moral distinction between an act and an omission in euthanasia, which cannot be accessed through quantitative or statistical designs.

My approach to answering my research question is non empirical. Hence, my thesis does not report any primary data gathered with a view to answering my question. Instead, I have used the tools of analytic philosophical bioethics to ethically evaluate the use of these timers in ventilating machines with regards to the act-omission debate. The major modes of analysis used in my research are conceptual analysis (philosophical enquiry) and critical evaluation of argument. For the type and size of my project, there is a sufficient body of literature related to my topic. Therefore, the data collected was ‘retrieved data’ in the form of academic literature such as journals and books. Relevant academic literature was identified using philosophical encyclopaedias and via relevant search engines such as Medline, Expanded Academic ASAP, Philosophers Index and Proquest, for example. Search items included, but were not limited to, ‘acts’, ‘omissions’, ‘doctrine of acts and omissions’ and ‘letting die’. In addition, relevant ethics theory texts were investigated to help me gain a deeper understanding of the content in my research question.

The main aim of this thesis is to explore the theoretical issues raised by the use of the timers attached to ventilating machines; rather than to make any proposal for policy or medical practice. Furthermore, although there is a large body of existing literature on the doctrine of acts and omissions, a detailed discussion of the proposed timers in regard to this doctrine is, to my knowledge, novel in the literature. Therefore, I hope to add to the existing body of literature
regarding the moral validity of this doctrine in practical situations, such as the use of timers in ventilating machines in this instance.
Chapter 1

Background

In this chapter, I outline the main aspects of Jewish religious law that underpin Israeli’s proposal for timers to be installed in ventilating machines used by terminally ill patients. I will first give a summary of the religious demographics of Israel. I will then go on to outline the place of Jewish bioethics in relation to the other main ethical theories; the main sources of the key theological principles that dominate Israeli bioethical discourse concerned with the termination of life and Jewish bioethics as it relates to the withholding and withdrawing of life sustaining treatment. In the final sections of this chapter, I will mention exceptions to the stance taken by Jewish religious law in regards to withholding and withdrawal of life-sustaining treatment. I will also briefly mention patient suffering and how it relates to decisions made at the end of life.

For the most part, the contents in this chapter have been informed by literature written by Barilan. Barilan participated in the parliamentary deliberations dealing with the new law (in which the timers were proposed) as a representative of the Israeli Medical Association. I have drawn on literatures written by other authors, such as, Melltorp, Nilstun and Ravitsky, to supplement Barilan’s work.

Israel’s Religious Demographics

Barilan has described Israel as a largely heterogeneous population with a highly ‘Westernised’ social strata, with eighty percent of its population made up of Jews from all over the world and in different stages of assimilation. He points out that there are two main groups of Jews; the Oriental

Jews and the Ashkenazi (European) Jews. Contrary to the rest of the world, where the majority of
the Jews are secular, in Israel the vast majority of Jews practice Orthodox Judaism, often within a
strong communitarian framework. This, as Gross suggests, means that an individual is expected to
alter their preferences to better correspond with the collective voice. This collective voice is
shaped by Jewish religious law. In Israel, only the posqim have direct impact on Jewish religious
law (which extends to cover orthodox ethics) compared to the West where ethical issues are usually
dealt with among theologians and philosophers. The posqim are the rabbis, chosen in every
generation, who specialise in answering Halakhaic questions.

Furthermore, Israel also differs from most Western nations in the fact that it does not recognise full
separation of the state and the church. Rather, it seeks to fuse together its democratic and Jewish values.

10 Barilan, Y.M (2004). Is the clock ticking for terminally ill patients in Israel? Preliminary comment on a proposal for a
12 Barilan, Y.M (2004). Is the clock ticking for terminally ill patients in Israel? Preliminary comment on a proposal for a
Report 29: p.13-20
16 Ibid.
Withdrawing and Withholding Treatment: Jewish Bioethics in relation to Other Ethical Theories

Melltorp and Nilstum identify four main bodies of ethical theories, namely deontological ethics, consequential ethics, virtue ethics and situation ethics.\(^{18}\) They go on to suggest that “all ethical positions can be expressed as one or a combination of these four theories.”\(^{19}\) The relevance of these to the issues raised by the development and introduction of timers on ventilators is explored in the following sections.

**Deontological ethics**

According to Sprung et al., Jewish bioethics follows deontological ethics.\(^ {20}\) Deontological ethics suggests that the moral difference between X and Y depends on the act involved. That is, regardless of their consequences, some acts are deemed right or obligatory.\(^ {21}\) Melltorp and Nilstum state that some deontologists argue that there is a moral distinction between an act and an omission.\(^ {22}\) Therefore in relation to withholding and withdrawal of life-sustaining treatment, it is argued that the former is regarded as an omission and therefore ‘letting the patient die’, whereas the latter is considered an act and therefore ‘killing’ the patient.\(^ {23}\) Thus, killing, which is causing a death, is, as a rule, ethically worse than letting die, which is not preventing a death.\(^ {24}\) In Jewish religious law, this distinction stems from the religious literature which I will expand on in the following section of this chapter.

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\(^{19}\) Ibid.


\(^{22}\) Ibid. p1266

\(^{23}\) Ibid.

However, the moral relevance of the distinction between an act and an omission is problematic. In Chapter Four, page 42, I will revisit this distinction and analyse it further in relation to its use in the moral justification for the use of timers on ventilating machines.

The next three ethical theories all differ from Jewish ethics in regards to how they judge the moral distinction between withholding and withdrawing treatment.

**Consequential ethics**
According to this second theory of ethics, the morality of an act is determined by its consequences.\(^{25}\) Therefore, if it can be assumed that all the consequences of withholding treatment and withdrawing from treatment are the same, then there is no moral distinction between an act and an omission and thus between withdrawing and withholding treatment.\(^{26}\)

**Virtue ethics**
Virtue Ethics states that what matters morally is the intent or motive that underlies an act or an omission. Therefore, withholding and withdrawing treatment are morally indistinguishable, if their motives are the same, regardless of the morality of the act and the consequence.\(^{27}\)

**Situation ethics**
The Encyclopedia of Ethics states that according to situation ethics, actions are judged morally depending on their context or circumstances.\(^{28}\) Thus, in determining the moral significance between withdrawing and withholding treatment; the act, the motive and the consequences of the two cannot

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\(^{27}\) Ibid.

be the only determining factors. Rather it is the situation, taken in its entire context, that determine whether there is any relevant distinction between the two. Other factors are, for example, the difference in the prognosis of the patient (usually there is more uncertainty in the prognosis when decisions to withhold treatment are made compared to decisions to withdraw treatment) and the time available to reflect on decisions relating to treatment.29

In summary, deontological ethics, which Jewish religious law follows, states that there is a moral distinction between an act and omission and therefore between withdrawing and withholding treatment. In contrast, consequential and virtue ethics state that if the consequences and the motives, respectively, are the same, then there is no moral difference between withdrawal and withholding of treatment. Finally, situation ethics holds that there is more to determining the morality of something, other than the type of act, the consequence and the motive. Thus, other factors such as those mentioned above, are also important in judging the morality of withholding and withdrawing treatment.

Jewish Bioethics and End-of-Life Decisions

Steinberg suggests that the Jewish bioethical system takes on a duty-based approach which differs in comparison to contemporary secular bioethics which is based on rights.30 Lord Immanuel Jakobovits, the late chief Rabbi of the British Commonwealth of Nations, articulates this Jewish view in the following way:

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In the moral vocabulary of the Jewish discipline of life we speak of human duties, not of human rights, of obligations, not entitlement. The Decalogue is a list of the Ten Commandments, not a Bill of Human Rights.31

By choosing to follow God’s law, with the assistance of their rabbis, orthodox Jews are thereby perceived to limit their autonomy.32 God’s law is defined by the Bible and post biblical sources such as the Talmud and Halakhaic responsa.33 The importance of Judaic texts to end-of-life ethical issues is described in the following section.

Main sources relevant to Jewish bioethical discourse
The Torah, also referenced by Christians as the Old Testament, is the bedrock source of Jewish Law.34 That is, the Torah is the root of all other Jewish religious literature. According to Werber, there was an attempt, by an earlier group of rabbis, to give interpretations and applications of the Torah. This body of literature is known as the Mishnah.35 As time progressed, another group of rabbis attempted to more fully explain the Mishnah. The body of literature that emerged from this is called the Talmud. However, these collected works of law and interpretation mentioned above, are more than one thousand five hundred years old. Therefore, in order for their literature to be applied to modern problems, their literature would require further explication. This body of literature that explains the earlier works of law and interpretation as they relate to modern day problems is called Halakhaic responsa.36

33 Ibid.
35 Ibid.
36 Ibid.
These main sources all espouse the infinite value of human life and conclude that a human being’s life belongs to God and that decisions regarding life and death should be left to Him. Therefore, life should not be ended before its time and nothing should be done to hinder the death process once it has begun. Jewish law defines death as the cessation of breathing and heartbeat.

The main sources that dominate Jewish discourse regarding end-of-life ethical issues are;

(i) Two Talmudic stories (‘the death of rabbi Judah Ha-Nasi’ and ‘the Martyrdom of Rabbi Hanina Ben Teradion’),
(ii) The Shulhan Arukh (early modern code of law), and
(iii) Contemporary Halakhaic (religious law) responsa.

Withholding and Withdrawing treatment
A distinction that stems in part from the above statement, that humans should not play an active role in the dying process, is as Ravitsky writes, that between withdrawing and withholding treatment.

According to the Encyclopedia of Jewish Medical Ethics, written by Steinberg, while withholding of treatment is considered a permitted non-interference in the natural process of dying, the

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38 Ibid. p.149.
43 Professor Abraham Steinberg is an orthodox rabbi, a professor of medical ethics and a paediatric neurologist. He headed the Steinberg Committee that was designated with the task of drafting a law devoted to end-of-life issues in Israel. It was in the report submitted by this committee that the installation of timers on ventilating machines was proposed. Barilan, Y.M (2004). Is the clock ticking for terminally ill patients in Israel? Preliminary comment on a proposal for a bill of rights for the terminally ill. British Medical Journal 30: p.353.
withdrawal of treatment is considered an act to hasten death and is therefore forbidden by Jewish law.\textsuperscript{44}

According to Jewish law, a person, in the eyes of God, has responsibility for an action he commits but not for something that merely happens.\textsuperscript{45} Barilan suggests that this may be because inaction leaves “responsibility in the hands of God, which humans might usurp by active intervention.”\textsuperscript{46}

As Ravitsky writes, in Jewish law, the procedure leading to the outcome has independent moral value from the outcome itself.\textsuperscript{47} Barilan adds that, “it is neither the context nor the consequences that matter in this regard but the ways in which human agency is involved.”\textsuperscript{48} This differs from a consequentialist approach where the moral value inheres only in the final outcome\textsuperscript{49} (as outlined in a preceding section, ‘Withdrawing and Withholding Treatment: Jewish Bioethics in relation to Other Ethical Theories’, page 7). Therefore, while in certain cases it is agreed by rabbis to be a moral good for the patient to die, an act such as the withdrawal of mechanical ventilation is forbidden.\textsuperscript{50} However, when it comes to switching off mechanical ventilation, the rabbis seem to have differing views. These differences will be outlined in a later section of this chapter, ‘Exceptions to the Prohibition on Withdrawing Treatment’, page 13.

Furthermore, the rabbis see nothing wrong with acting with the intention of death as long as the process to bring about the death is an omission and not an act. Therefore, as Barilan writes, the

\textsuperscript{46} Ibid.
\textsuperscript{50} Ibid.
rabbis seem to reject the common claim that life has an inherent value and that any decision to terminate life is therefore irrational.  

An exception to Jewish religious law on withholding treatment

In an earlier section of this chapter where I discussed Jewish religious law and the withholding of treatment, it was stated that withholding treatment is acceptable as this is viewed as an omission. The fundamental Halakhaic distinction between an act and an omission is not taken in the literal sense but rather given naturalistic interpretations. For example, Rabbi Feinstein argues that “abstaining from food and oxygen is like an act of commission because it goes against human nature.” Jewish religious law does not recognise the right to withhold basic life-sustaining care such as nutrition, hydration, and oxygen. Discontinuation of these kinds of treatment if they are not futile, even by acts of omission, may be tantamount to the commission of homicide. Therefore it appears that even in Jewish law; there are instances where an omission cannot be morally justifiable. However, abstaining from medical care is regarded as a genuine omission because medical care is not ‘natural’.

Exceptions to the Jewish religious law’s prohibition on withdrawing treatment

Jewish religious law forbids any action taken to hasten the death of a person. However, in relation to the withdrawal of mechanical ventilation, rabbis seem to have differing views. While some rabbis, such as Rabbi Elyashiv, hold that an act should never be taken to hasten a person’s life, there

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52 Ibid.
53 Ibid.
appears to be two arguments given by other rabbis, for example Rabbi Waldenberg and Rabbi Halevi, to support the active withdrawal of mechanical ventilation. These are arguments from viewing mechanical ventilation as a ‘hindrance to the process of death’ and from the ‘religious duty of neighbourly love’.

**I. Hindrance to the Process of Death**

Because Jewish law defines death as a loss of respiration, this sets issues that arise from the use of mechanical ventilation apart from all other forms of medical care.\(^{58}\) Dependency on respiratory support is viewed by some rabbis as a hindrance to death rather than a life-sustaining measure.\(^{59}\)

Rabbi Waldenberg and Rabbi Halevi rule that turning off a respirator used by a terminally ill patient is allowed since this is equivalent to removing a hindrance to death.\(^{60}\) In an enquiry about mechanical ventilation, Rabbi Waldenberg explains that it is forbidden to artificially prolong the lives of patients who cannot survive independently as this is going against God’s will.\(^{61}\) He goes on to state that a patient’s inability to maintain independent circulation and respiration is a sign that the soul wishes to leave the body. Hence delaying the process of death makes the soul suffer.\(^{62}\) In addition, the Shulhan Arukh “permits and even requires active action that removes hindrances to death.”\(^{63}\) It goes on to state that the removal of a hindrance to death does not count as active killing.\(^{64}\) However, there are rabbis such as Rabbi Elyashiv, who insist on full life support even for patients who are in a persistent vegetative state. He argues further to oppose Do Not Resuscitate

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\(^{59}\) Ibid.


\(^{63}\) Ibid.

\(^{64}\) Ibid.
orders for patients who are not suffering physically as he believes that unless a person is suffering physically, no act should be taken to hasten the death of a human being.\(^{65}\)

**II. Duty of Neighbourly Love**

Rabbi Israeli tackles the problem of withdrawing life support differently and goes on to suggest that there is a religious duty of neighbourly love to shorten the life, as much as legally permitted, of a terminally ill patient who is suffering immensely.\(^{66}\) His suggestion stems from the Talmudic decree to “help one’s neighbour have a ‘beautiful death'”\(^ {67}\) which has been interpreted as a death in the absence of suffering and disfigurement.\(^ {68}\) However, this duty is in conflict with the “divine decree against bloodshed.”\(^ {69}\) Therefore, Rabbi Israeli supports “legal and technical tricks”,\(^ {70}\) as Barilan puts it, such as the installation of timers on ventilating machines, which allow for patients’ lives to be ended without anyone having to commit murder.\(^ {71}\) Another reason for these ‘tricks’, as Barilan suggests, might be the need to prevent suffering as rabbinic sources regard overwhelming suffering as worse than death.\(^ {72}\)

**Practical implications of the prohibition on withdrawal of mechanical ventilation by Jewish bioethics**

The prohibition on the withdrawal of treatment by Jewish religious law, poses some practical problems for patients in Israel who require artificial ventilation. Patients, once connected to a respirator cannot opt to be disconnected from the machine. They may, however, refuse to be

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66 Ibid.

67 Ibid. p.288.

68 Ibid.

69 Ibid.

70 Ibid.

71 Ibid.

connected to the respirator in the first place. Ravitsky outlines three problems that this situation might create. These are:

i. Patients who dread being trapped in a cycle of suffering against their will might refuse the intervention and thus unnecessarily shorten their lives.

ii. There are some urgent and unexpected situations where patients need to be connected to a respirator. The decision to do this would be made in haste and without proper consultation among family members.

iii. Health care providers may also be hesitant to initiate ventilation knowing that it cannot be withdrawn once initiated.

These problems may have played a role in causing the need for the Israeli government to revisit the withdrawal of mechanical ventilation and try and draft a law that would overcome such problems. The name given to the committee assigned to this task of looking at end-of-life issues was the Steinberg Committee. The Steinberg Committee and the timers will be elaborated on in the next chapter.

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74 Ibid.
Suffering
Rabbinic law operates on the assumption that personal suffering shortens the lives of the dying\textsuperscript{76} and that overwhelming personal suffering is worse than death.\textsuperscript{77} Rabbi Waldenberg suggests that human anguish is a sign that the soul wants to fulfil God’s will and leave the body. He adds that this is the reason why a being who is suffering is better off dead rather than merely because of the presence of suffering.\textsuperscript{78} According to Orthodox Halakha:

\begin{quote}
(It is) permissible to shorten the life of patients undergoing such suffering as long as the actions taken do not fall within the Halakhaic definition of “murder”, namely, an act of commission that directly kills the patient by an assault on the organism of the patient and on the natural life processes.\textsuperscript{79}
\end{quote}

An example of this would be the infusion of a poison.\textsuperscript{80} However, with regard to mechanical ventilation, differing views amongst rabbis exist. While some rabbis hold that it is forbidden to withdraw mechanical ventilation, other rabbis do not consider the withdrawal of ventilation to be morally problematic.\textsuperscript{81} Reasons for this discrepancy in views amongst the rabbis were discussed earlier in this chapter.

Chapter Summary
In this chapter, I have outlined the main aspects of Jewish religious law that underpin Israel’s views on the termination of life and exceptions that the law makes. It has been said that Jewish religious law forbids any act taken to hasten the death of a human being. The withdrawal of mechanical

\textsuperscript{78} Ibid. p.149.
\textsuperscript{79} Ibid. p.160.
\textsuperscript{80} Ibid.
ventilation is regarded as an act taken to hasten a patient’s death and is therefore forbidden by Jewish law. I have shown that this poses practical problems for patients that are currently on mechanical ventilators or that require artificial ventilation as well as for health care professionals. A recent Israeli proposal attempts to provide a solution to this problem by proposing the installation of timers on ventilating machines. These timers are the focus of the next chapter.
Chapter 2

The Proposal for Timers on Ventilating Machines

In the previous chapter I outlined the main theological aspects that form the basis of the proposal for the installation of timers on ventilating machines in Israel. In this chapter, I will give a brief description of how the proposal for the timers was initiated and how these timers work. I will then outline expected future developments regarding the installation of these timers and finally, I outline some of the issues that are raised by the use of these timers.

A large amount of my knowledge on these timers is informed by articles written by Barilan and Ravitsky. Apart from the works of these two authors, there is very limited additional information on these timers available to the public.

The Proposal for the Timers

The 1996 Patient’s Rights Act was enacted, in Israel, with the aims of establishing the rights of every person who requests medical care and to protect his or her dignity and privacy. Before the enactment of the 1996 Patient’s Rights Act health care in Israel, with abortion as an exception, was subjected to the ‘reasonable physician standard’, with an absence of laws that directly governed medical practice. Yet, even after this law was enacted, end-of-life care in Israel was still not regulated by legislation. This is because a section in the proposal for the Patient’s Rights Act, “the

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right to death with dignity” caused dispute between religious and secular representatives in the Israeli Parliament (the Knesset). The religious representatives objected to any kind of passive euthanasia, while the secular representatives insisted that forcing patients to live against their will violates the very notion of human rights. This subsequently resulted in the complete omission of end-of-life issues from the law.

However, a lack of coherent policy and continuous petitions to the courts, from patients, for permission to refuse and even halt “life-saving” medical care resulted in the necessity of the Knesset to revisit end-of-life issues. In 2000, in order to develop a coherent policy and create guidelines for end-of-life issues, the Minister of Health, Rabbi Shlomo Benizri, designated a special public committee (this is the Steinberg committee referred to earlier in Chapter One, page 16) to draft a law devoted to end-of-life issues which had to be supported by the broadest possible consensus. This law was intended to complement the 1994 Bill of National Health Insurance and the 1996 Patient’s Rights Act.

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The committee, headed by Rabbi Dr. Avraham Steinberg, was broken down into four sub-committees and comprised of fifty-nine people in total. The four sub-committees were a legislative group that contained judges and lawyers, a religious group made up of rabbis and other religious leaders, an ethical and moral sub-committee with philosophers, and a medical/scientific sub-committee that included doctors, nurses and social workers. This was done to ensure that the complex issues were examined from different angles.

In 2002, a report was published by the Steinberg Committee, which served as the foundation for the final law. The report, known as the Steinberg report, was eventually passed for its final reading by the labour, social affairs and health committee of the Israeli Parliament.

The report discusses several end-of-life issues that clinicians are commonly faced with and offers guidelines on how to deal with these situations. Examples of such issues are the refusal of therapy, nutrition, hydration, and oxygen, living wills and proxy decision making, and withdrawing life support, to name a few. For the purpose of my thesis, I will be focusing on the proposal for the installation of timers on ventilation machines which, as the report suggests, will...

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97 Ibid.
allow patients to choose to discontinue mechanical ventilation without the need for anyone to take action. Thereby, it is claimed, an act of commission will be transformed into an act of omission.\textsuperscript{104}

Israel considers “itself as a “Jewish and democratic state” and attempts to integrate a liberal democracy with a Jewish communitarian approach.”\textsuperscript{105} Therefore, the timers\textsuperscript{106} (a technical solution) were proposed in order to bridge the gap between the two opposing parties, the conservative orthodox rabbis and the liberal members of the committee.\textsuperscript{107} As discussed in Chapter One, Orthodox rabbis, who follow Jewish religious law, forbid any action taken to directly hasten death, for example, the withdrawal of active treatment that has already been initiated.\textsuperscript{108} As stated in the literature, the liberal members (unnamed) of the Steinberg committee strongly uphold the concept of patient autonomy and believe that patients should be able to make decisions in regard to their own life.\textsuperscript{109}

The timers are expected to respect the Jewish religious law by attempting to transform an act into an omission\textsuperscript{110} so that no action, \textit{per se}, will be taken by the health care team to end the life of a patient who does not wish to go on living. Because of this conversion of an act into an omission, health care professionals are now permitted, by Jewish religious law, to disconnect patients from mechanical ventilators. Therefore, patients can now be given the option of choosing whether or not

\begin{thebibliography}{99}
\bibitem{106} These clocks were initially proposed in 1978, in a letter written by Dr Meir, the director general of a religious hospital in Jerusalem, to Rabbi Waldenberg. The use of clocks to disconnect an ‘unpromising’ patient from a respirator to be used by a new patient who might be saved was proposed by another prominent rabbi in 1990. These two men are not credited in the Steinberg report and to my knowledge, reasons why these clock ventilators never materialised has not been publicised.
\end{thebibliography}
they want to be disconnected from mechanical ventilators once artificial ventilation has already commenced. This option was not available before the installation of the timers and in this sense; the timers seem to have enabled patients to make autonomous decisions in regards to receiving artificial ventilation.

In December 2005, the Knesset, after five years of public and parliamentary deliberations, enacted the Patient Nearing Death Act. Barilan feels that this new law is noteworthy for at least two reasons. First, it has been approved by both the religiously conservative and the liberal politicians; groups that in other parts of the world have not yet reached agreement on the regulation of end of life. Second, the law contains novel concepts, for example the installation of timers on ventilating machines, and methods for the care of the terminally ill. It is beyond the scope of my essay to mention and discuss all these novel concepts and methods. However, an article by Barilan, “The New Israeli law on the care of the terminally ill: conceptual innovations waiting for implementation”, provides a detailed report of these novel innovations.

Scope of the Steinberg Report

The scope of the Steinberg committee was limited to terminally ill patients, defined as those patients with a life expectancy of less than six months, who are aged seventeen or over. The placing of a restriction on the definition of terminal illness to a life expectancy of no more than six months puts the special arrangements that accommodate patients who make the decision to die on

112 Ibid.
113 Ibid.
115 Ibid. p.4.
116 This definition was used because the majority of the bioethical and clinical references use this time period as their chosen time span. Ibid.
the “safe side” of human error in prognosis and of Jewish law.\textsuperscript{118} This is because, in strict legal terms, the homicide of a \textit{terefa}\textsuperscript{119} is considered a lesser offence than the homicide of, as Barilan puts it, an ‘ordinary’ person.\textsuperscript{120} Whether this concept holds any moral or ethical weight remains questionable and is beyond the scope of my thesis. In addition an adult who has power of attorney can also make the decision, on the patient’s behalf, not to extend life by artificial means.\textsuperscript{121}

How the Timers are proposed to Work

As mentioned earlier, pages 11-13, withholding treatment (with the exception of basic life-sustaining care such as food and water) is permitted in the clinical setting as Jewish religious law views this as an omission.\textsuperscript{122} However, in practical settings, such as hospitals, the distinction between procedures that are viewed as ‘withdrawing treatment’ and procedures that are viewed as ‘withholding treatment’ are not so clear cut. Therefore, in an effort to make a clear distinction between procedures that are considered ‘withdrawing treatment’ and procedures that are considered ‘withholding treatment’, the philosophical subcommittee proposed that a distinction should be made between ‘continuous’ and ‘discrete’ treatments.\textsuperscript{123}

\textit{Continuous} treatment is defined as uninterrupted treatment that has no clear distinction between the termination of one cycle and the initiation of another cycle, for example mechanical ventilation. According to Wagner and Goldschmidt (two of the three nurses present on the committee), the

\begin{footnotes}
\item[119] \textit{Terefa} is a Hebrew term for a person whose life expectancy is less than a year. Ibid.
\item[123] Ibid.
\end{footnotes}
Steinberg committee agreed to view mechanical ventilation as a continuous form of treatment.\textsuperscript{124} Discrete treatment is defined as treatment that occurs in well defined cycles,\textsuperscript{125} for example, blood transfusion, drug treatment and dialysis.\textsuperscript{126} Hemodialysis is the typical example used to describe discrete treatment. It is usually carried out in sessions of a few hours, a couple of times a week, with the sessions starting and ending at specific times.\textsuperscript{127} Interestingly, some rabbis, such as Rabbi Feinstein and Goldberg, do not view mechanical ventilation as a continuous form of care, as every so often the patient is disconnected from the ventilator in order to suction mucus.\textsuperscript{128}

According to the proposal “not continuing discrete treatment” is viewed as withholding treatment, which is permitted.\textsuperscript{129} This is because every cycle of discrete treatment is considered as an initiation of a new treatment and therefore refraining from additional cycles is viewed as an omission and not as an active act that hastens death.\textsuperscript{130} In contrast, “not continuing continuous treatment” is viewed as a withdrawal of treatment. This is forbidden, according to the new law, when the termination may result in the death of a patient, regardless of their competency.\textsuperscript{131}

The timers will be attached to mechanical ventilators and will operate in twenty-four hour periods, setting off a red light or alarm after twelve of these hours. As long as the timer is ‘ticking’ the

patient can change their decision\textsuperscript{132} and an extension can be requested at any time by the patient or their proxy. Thus, resetting of the clock will be included in routine care unless the patient requests this not be done.\textsuperscript{133} If the dying patient is determined not to have his or her life extended, the timers will not be reset by the health care team and will automatically turn the ventilator off at the end of the cycle.\textsuperscript{134} Shortly before the timer is about to turn off the ventilator, the health care team will commence care as if the “patient had never been on a ventilator and had chosen not to be ventilated in the first place”.\textsuperscript{135} Whether this procedure would involve sedation or the removal of an endotracheal tube from the patient before the ventilation machine stops has not been mentioned and remains to be questioned.

Therefore, in order to solve the problem of switching off ventilating machines, the installation of timers in these ventilating machines were proposed in order to convert continuous mechanical ventilation into a repetitively discrete mode of treatment\textsuperscript{136} which could be terminated.

Of interest to note is that prior to the proposal for the use of timers in a medical setting, timers have been employed by observant Jews for many years in Israel\textsuperscript{137} as a technical solution to “render an action legally inactive.”\textsuperscript{138} This however, has been used in solely religious frameworks, such as the observance of Jewish Sabbath.\textsuperscript{139} For example, according to orthodox Halakha,\textsuperscript{140} active and direct

\textsuperscript{133} Ibid.
\textsuperscript{136} Ibid.
\textsuperscript{139} Ibid.
use of electrical appliances is forbidden on the Sabbath\textsuperscript{141} (Saturday). Religious homes of orthodox Jews use timers to switch the electrical devices on and off on the Sabbath,\textsuperscript{142} thus preventing the need for active intervention on that day.\textsuperscript{143} It appears that finding an alternative pathway to a desired outcome is an integral part of devout religious life\textsuperscript{144} and a classic Halakhic approach.\textsuperscript{145}

Steinberg expects that most elderly and chronically ill people will want to prepare a living will for any possible event that might occur, such as a situation where the patient will need mechanical ventilation. Living wills will be stored on a national database on the internet by patients. These living wills will be accessible at all hospitals and will be renewable every five years.\textsuperscript{146} The wills will provide the care team with information regarding, for example, whether or not a patient wishes for their life to be extended by ventilators or other artificial means.\textsuperscript{147} Therefore, in relation to the three problems mentioned earlier, page 16, with current ventilating machines, these living wills will enable health care professionals to have prior knowledge of whether or not to connect patients to ventilating machines. Furthermore, as mentioned previously in this chapter on page 22, the use of timers give patients the option of being disconnected from mechanical ventilators even after they have been connected to these mechanical ventilators and artificial ventilation has commenced. In the absence of a living will and when no proxy, evidence, or testimony is available the patient will


\textsuperscript{147} Ibid.
be given, according to Barilan, “full, ordinary life prolonging treatment even in the face of extreme agony.”

In relation to the proposal for timers on ventilating machines, Barilan makes the point that, in order to transform mechanical ventilation from ‘continuous’ to ‘cyclical’, no novel invention is needed as a similar set up already exists. Portable respirators (paraPac machines), used by hospitals to transfer patients from one place to another, derive their mechanical energy from the pressure within the oxygen tank. When a patient uses the ventilating machine, the oxygen runs out. This results in a pressure reduction within the oxygen tank and the ventilating machine eventually ceases to function. An alarm is usually set off as the oxygen is about to run out, however, this alarm can be disconnected so that it does not make any noise as the patient is dying. Therefore, Barilan suggests that for patients who wish to end their lives, all that needs to be done is to switch them from a regular ventilator to a paraPac machine. A patient connected to a portable respirator could be helped to die without any act being performed by the care team as the oxygen will eventually run out and the ventilator will stop working.

An Alternative Suggestion: A Modification of the Use of the Timers

Barilan uses the initial concept of the timers and goes on to make another possible suggestion for patients who wish to end their life, taking in to account that Jewish religious law prohibits any action that hastens death. Barilan proposes that a special switch connected to the timer should be added to the ventilating machines and that control of this switch should be strictly given to the

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150 Ibid.
151 Ibid.
152 Ibid.
patient or their proxy. If the patient does not wish to go on living, he or she can turn the switch on which will turn the timer on. The timer will then disconnect the ventilator in a given period of time. During this time the health care team will be alerted in order to verify the decision made by the patient and institute other forms of appropriate support and sedation. Thus the choice to terminate one’s life will be completely in the patient’s hands and would not require any action taken by the care team.

A discussion of this alternative solution is beyond the scope of my thesis as my thesis is limited to the current proposal for the installation of timers.

Future Developments of the Timers

A special subcommittee, headed by Rabbi Dr. Halperin, has been nominated to implement these timers. At present, preliminary sketches of the timers have been made based on an apparatus that supplied gas for stoves in tenement apartments in Britain after World War II. A tender has been issued for the design and construction of pilot machines for preliminary testing. The intent is to eventually make all ventilating machines in Israel timer-dependent.

Issues Raised by the Timers

There are a number of moral and practical issues (regarding the use of the timers) which are raised in the literature written by the public in response to Ravitsky’s article “Timers on ventilators” and

154 Ibid.
156 Ibid.
by Barilan in one of his articles “Is the clock ticking for terminally ill patients in Israel? Preliminary comment on a proposal for a bill of rights for the terminally ill”.  

Ravitsky’s article gives information regarding the installation of timers on ventilating machines. His article appears to have been written with the intent of seeking public submissions as it was written under the ‘Education and Debate’ section in its corresponding journal. The following objections were made by the public to the use of the timers:

i. Ventilating machines are essential to preserving life. There is a possibility that these ventilating machines will stop when they are not supposed to, resulting in a disastrous situation. Hence a proposal of adding an “auto-cut off” function to these machines seems to go against existing efforts to improve the safety of mechanical ventilators.

ii. The intent and outcome still exist irrespective of the time delay. Therefore, deliberate setting up of the timers is a more complex way of withdrawing artificial ventilation.

iii. Irregardless of the distinction between an act and an omission, if switching off the ventilators is perceived as an act; then does that not mean that setting up the timers ought to also be classified as an act? As Papanikitas says, “The initial lethal intervention is clearly

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160 Ibid.
161 Ibid.
an ‘act’. I take Papanikitas’ statement to mean that the actual installation of timers in ventilating machines can be considered the act.

The last two points that I have mentioned are relevant for my paper and will be looked at, in greater depth, in the following chapters of my thesis.

In addition to the public responses to Ravitsky’s article, Barilan outlines what he thinks are six “demerits of the clock ventilator concept”. These are listed below:

i. There may be a negative psychological impact posed on a patient and their family when the patient is assigned to treatment that is made with the clear aim of allowing for passive euthanasia. Additionally, they may find ‘counting’ the minutes till their death and the endless burden of thinking about whether to go on living or not unbearable.

ii. Patients might fear stigmatisation as ‘clock patients’ and consequent reduction in their standard of care.

iii. That the possible problems associated with being on a machine with a timer as opposed to a regular machine have not yet been tested or discussed anywhere.

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iv. The scope of the Steinberg committee was limited only to terminally ill patients. Therefore, non-terminal but severely disabled patients might feel discriminated against if their request to have access to a ventilating machine with a timer is denied.

v. It has been proposed that all the ventilating machines in Israel will be fitted with timers. This might help solve the issue raised above but it creates a new problem. The intention to transform all ventilating machines into ventilating machines with timers might disrespect the autonomy and safety of the large number of patients who are dependent on mechanical ventilation and who are unlikely to stop it.

vi. Patients and medical professionals will have to deal with these timers that have “no technical, legal or moral precedent.” Additionally, their use may be unsafe as continuous monitoring of the timers to ensure that the ventilators are not switched off accidentally might be impractical.\(^\text{164}\)

Although these problems listed by Barilan are beyond the scope of my thesis, further investigation into these areas may prove to be useful when assessing the overall validity of the proposal for these timers. In addition, another possible area for further research would be to examine whether the alternative suggestion to the timers, discussed previously on page 28, solves the moral problems that the current timers pose.

Chapter Summary

In an effort to solve some of the practical and moral problems currently associated with withdrawing mechanical ventilation, the Steinberg report proposed the installation of timers on ventilating machines so that the machines could be disconnected without anyone having to take any action. This is because, according to Jewish religious law, it is forbidden to take an action to hasten death. The Steinberg committee argues that the timers enable an act of commission, which is the active withdrawal of mechanical ventilation, to be converted into an omission.

The proposal for the timers appears to rest on two points. First, that the timers convert an act into an omission and second, that because of this conversion of an act into an omission, health care professionals are not morally responsible for the deaths of their patients that result from them (health care professionals) not resetting the timers. But do the timers really convert an act into an omission? This question will be considered in the next chapter.
Chapter 3

Timers and Acts

So far, I have outlined the Jewish theological aspects that underlie the views of Jewish religious law in regards to the termination of life of a competent, terminally ill patient. I outlined the moral problems that Jewish religious law has with the withdrawal of mechanical ventilation and the practical problems this, therefore, poses. In the previous chapter, I discussed the recent Israeli proposal for the installation of timers on ventilating machines which attempts to solve the moral and practical problems of withdrawing mechanical ventilation in Israel by converting an ‘act’ into an ‘omission’.

Chappell states that there appears to be three known tests that can be used to determine whether a performance is an action. These are causation, intention, and the ability to do otherwise. Depending on the degree of each of these three tests in every performance, it follows that each performance has a different degree of ‘actionhood’ assigned to it. Chappell adds that there may be even more possible degrees of actionhood if there are more than these three tests available to determine an action.165

In this chapter, I suggest that there are plausible reasons to be cautious about making the assumption that the timers convert an act into an omission when tests such as causation, intention, and ability to do otherwise, used to define an act, are applied to the use of the timers.

Timers and the Definition of an Act

Causation

Gruzalski states that:

According to recent accounts of how to distinguish between causes and background conditions, a causal factor is regarded correctly as the cause of an event only if it differentiates between the actual situation in which the event occurs (the effect-situation) and certain actual or hypothetical situations with which the effect-situation is being compared.166

These certain or hypothetical situations, called comparison-situations, that the effect-situation is compared to contain all the causally relevant background features which are found in the effect-situation.167

As mentioned in the previous chapter, the timers attached to ventilating machines, if not reset, automatically turn off the ventilating machines at the end of their cycle. In this case, the timers appear to convert an act, which is regarded as killing, into an omission, which is regarded as letting die. However, even in the latter case of letting die, the agent still has the alternative of preventing the death in question by resetting the timers. Gruzalski suggests that in order for us to be able to apply the above analysis (in order to distinguish the differentiating causal factor) to cases such as the one above, a comparison would need to be made between situations in which the deaths occur, or would have occurred, and other similar situations in which the death does not or would not have occurred.168

167 Ibid.
168 Ibid. p.95.
Therefore in order to identify the cause of death in the case where the timers are employed and the health care team appears to let the patient die, the effect-situation in which the patient connected to the mechanical ventilator (with a timer) dies, needs to be compared with other similar situations in which the patients connected to ventilating machines (with timers) do not die. When the two situations are compared, it appears that the failure to reset the timers by the health care team is what differentiates between the situations in which the patients do not die and those in which they do.

Thus, it can be concluded that letting die or the failure to reset the timers is the cause of death. As Lewis states, “it is not to be denied that there is causation by omission”.\textsuperscript{169} In addition, if causation is regarded to be a test for an act then it appears that in this case, letting die is in fact an act of killing.

However, it is argued that omitting to provide treatment to a patient is not the cause of the patient’s death. An argument that is usually given to support this notion is that omitting to provide treatment is simply ‘letting nature take it course’.\textsuperscript{170} As Hart and Honore point out, human omission is often regarded as the cause of something, which from a different point of view, may appear very much an act of nature.\textsuperscript{171} Yet, by using the above analysis of comparing the effect-situation and the comparison-situation to identify the cause of the patient’s death, Kuhse and Singer show that the doctors failure to treat the patient is a cause of the patient’s death and hence it cannot be concluded that the patient’s death is caused by ‘nature’ rather than by the physician.\textsuperscript{172} Therefore, when applied to the use of the timers, it can be argued that the conversion of an act into an omission


(withholding mechanical ventilation) and thereby not causing the patient’s death but rather allowing nature to take its course cannot be justified, as Kuhse and Singer have shown.

However, Chappell argues that omissions are not causes.\textsuperscript{173} He states that in order for something to be a real cause, its results have to be additive. That is if X causes E1 and X causes E2, then X causes (E1 and E2).\textsuperscript{174} He uses cases such as the one below to illustrate his point.

A nefarious machine has trapped Alan and Bill. It will either kill Alan and release Bill, or kill Bill and release Alan, depending on whether Conor presses button A or button B. If Conor does not press either button, the machine will randomly kill one and release the other. If Conor presses button A and not B then Conor rescues Bill and omits to prevent Alan’s death. If Conor presses button B and not A then Conor rescues Alan and omits to prevent Bill’s death. What if Conor omits to press either button? Then Conor omits to prevent Bill’s death, and Conor omits to prevent Alan’s death. It does not follow that Conor omits to prevent (Bill’s death and Alan’s death); for Conor is not in a position to save them both. A \textit{a fortiori} it doesn’t follow that Conor \textit{causes} (Bill’s and Alan’s death), because that result doesn’t even happen… Rather Conor \textit{causes} (Bill’s death or Alan’s death).\textsuperscript{175}

Chappell argues that cases such as these show that the results of omissions are not additive and goes on to make the conclusion that, as a result, omissions cannot be causes.\textsuperscript{176} He suggests that a possible reason why the general public might feel that an omission is causal is because they think that agents must be morally responsible for their omissions. And in order to be morally responsible

\textsuperscript{174} Ibid. p.217.
\textsuperscript{175} Ibid. p.217-218.
\textsuperscript{176} Ibid. p.219.
for an omission, the public feel that an agent should be causally responsible for their omissions. To this point Chappell argues that this is not the case and that agents are morally responsible for their omissions precisely because they are not causally responsible for them. 177

I suggest that although such cases, used by Chappell, might be successful in showing that the causes of omissions are not additive, this conclusion cannot be applied to all omissions. The cases that Chappell uses, I argue, make the assumption that omissions always have more than one ‘result’, that is, E1 and E2. I propose that in some situations there might only be one result of an omission. For example, in the case of the health care team omitting to reset the timers, the only result that can occur is the ventilating machines being switched off and the patient dying.

Furthermore, Kuhse goes on to make the distinction between “causing death by omission and refraining from preventing death.”178 These voluntary omissions, that is, refraining from preventing death, are referred to as ‘allowings’ by Chandler.179 Kuhse argues that if we are in a position to prevent death (that is we have the ability, the opportunity and the awareness necessary to prevent a being’s death) and do not prevent their death, then we are refraining from preventing death. Refraining from preventing death, she argues, can be considered as a cause of death.180 Kuhse’s argument, when applied to the mechanical ventilating machines using the timers shows that the agents in this situation can be considered to be refraining from preventing death and hence causing the patient’s death because they:

(i) Have the ability to prevent the death by resetting the timers,

Have the opportunity to prevent death because they are alerted before the timer reaches the end of its cycle, and

Are aware that the timers will switch the ventilators off automatically and that they can prevent this from happening by resetting the timers.

Additionally Davis argues that the distinction between doing something and allowing it to happen is not an exclusive one because there are instances where, first, allowing someone to die is actually doing or causing something and second, where allowing someone to die is killing.¹⁸¹ She argues her case using an example of a man who allows his children to starve to death. In this instance, Davis argues, the man does something by allowing and therefore, acts by omitting.¹⁸²

**Intention and the Ability to do otherwise**

In this section I argue that the health care team refraining from resetting the timers and therefore allowing the patient to die can be considered an act when we consider the intention and the ability to do otherwise in this case.

The timers are installed on ventilating machines with the intent of allowing a patient to die. A patient who requires artificial ventilation is then connected to this ventilating machine and it is switched on. The ventilating machine is switched on with knowledge that if the timer is not reset the machine will be turned off and the patient will die. If a patient requests to be disconnected from the ventilating machine because they want to die, the health care team allows this to happen by not resetting the timer when the timer sets off an alarm to alert the health care team that it is about to turn off the respirator. This case can be compared to the case given by Thomson. Thomson


¹⁸² Ibid. p.192.
describes a person P who puts chocolate on a heater and turns on the switch. Now, at time T, Person P stands by and watches the chocolate, waiting for it to melt. To this, Thomson states that it seems right to say of Person P that now, at time T, she is melting the chocolate and this is the case even though she is not doing anything now to melt it because she has already done all she needed to do before for the chocolate to melt.\(^{183}\) In this case, I have taken person P to refer to the health care team, the heater to be the ventilating machine, the term ‘melt’ to refer to ‘ending the life of the patient’ and the chocolate to be analogous to the patient.

In cases like the one given by Thomson, Mackie suggests that even though the agent is no longer actively carrying out her intention, she has the ability to control the realisation of her intention by changing the process initiated by her activity.\(^{184}\) Thus she has the ability to do different. Therefore, I argue that even though the health care team is no longer actively\(^{185}\) doing anything to bring about the patient’s death, they still have the ability to change the outcome of their initial intention (allowing the patient to die) by resetting the timers.

Furthermore, Mossel adds that in cases such as the one above, the agent *acts* by supervising the process and that even though this is a negative action, it is an action all the same.\(^{186}\) To illustrate his point, Mossel gives the example that swimming supervisors get paid for their supervision.\(^{187}\) I assume that by this example Mossel wants to illustrate that to supervise something must be an act as people do not get paid for not doing anything. I suggest that Mossel’s statement that supervising a process can be considered an act can be extended to the situation of the patient and the ventilating machine given above. Moreover, if switching off the ventilating machine by the health care


\(^{185}\) Here I use the term ‘actively’ to refer to the ‘physical’ act of killing a being.


\(^{187}\) Ibid. p.260.
professionals is considered an act, then I argue that the initial installation of timers on the ventilating machines is also an act. However, this argument is weakened by an argument of *reductio ad absurdum*. This is because, if the initial installation of timers is considered the act, then it seems plausible to also consider the makers of the timers, the people who provide the makers with the materials (assuming they have knowledge of what the materials are being used for) and so on, as acting to bring about the death of the patient.

**Chapter Summary**

Causation, intention, and the ability to do otherwise are suggested to be the three tests used to define an act. In this chapter I have shown that the first claim that the use of timers to prevent health care professionals from ‘acting’ appears problematic. This is because when we consider these tests used to define an act, the use of timers does not seem to convert an act into an omission.

However, if something has the same consequences, then why does it matter morally whether something is an act or not? The second claim made is that, irrespective of the end result, we are only morally responsible for our actions and since the timers enable health care professionals to refrain from disconnecting the ventilating machines, they are not morally responsible for the deaths of the patients that result from the disconnection of the ventilating machines by the timers. This claim derives its support from the doctrine of acts and omissions. But just how valid is this doctrine? This will be the focus of the final chapter.
Chapter 4

Timers on Ventilating Machines and the Doctrine of Acts and Omissions

In the previous chapter, I argued that when the three tests, causation, intention, and the ability to do otherwise, are used to determine an act it becomes problematic to claim that the timers convert an act into an omission.

In this chapter, I argue that to claim that we are morally less reprehensible for our omissions than we are for our acts is not convincing because the distinction between an act and an omission and hence between killing and letting die is morally problematic. In the first section of this chapter, I will discuss arguments given for and against the distinction between an act and an omission. I will then go on to suggest reasons why it might appear that, in the context of killing and letting die, an act is morally more reprehensible than an omission. Finally I will briefly comment on another body of thought where, contrary to the majority of the literature written, philosophers such as Foot, Locke and Chandler argue that the moral distinction between killing and letting die is not an instance of that between an act and omission.

In this chapter I will examine secular arguments surrounding the distinction between an act and an omission. I do this while acknowledging that many people’s attitudes to the distinction between an act and omission and that of killing and letting die are inextricable from their religious views.

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188 In this thesis I use the term secular to refer to non religious arguments
The Doctrine of Acts and Omissions

Health care professionals frequently justify moral decisions, such as those concerning life and death situations, for example euthanasia, by appealing to the distinction between an act and an omission. The moral significance of this distinction is referred to as the doctrine of acts and omissions and is often quoted in arguments dealing with ‘killing’ versus ‘letting die’,\(^ {189}\) where the central issue appears to pivot upon the moral evaluation of acts and omissions.\(^ {190}\) In these instances of killing and letting die, killing is thought to be an act and letting die an omission. The most widely accepted and commonly used definition of the doctrine of acts and omissions is that given by Jonathan Glover. It states:

> In certain contexts, failure to perform an act, with certain foreseen bad consequences of that failure, is morally less bad than to perform a different act which has the identical foreseen bad consequences. It is worse to kill someone than to let them die.\(^ {191}\)

However, the moral significance of the distinction between killing and letting die\(^ {192}\) is debatable and continues with very little hope of consensus emerging.\(^ {193}\) While some, for example Nesbitt,\(^ {194}\) hold that there is a moral distinction between an act and an omission and therefore between killing and letting die, others, such as Rachels, Glover and Tooley,\(^ {195}\) do not.

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Arguments in Support of the Doctrine of Acts and Omissions

**A case to show that an action is morally worse than an omission**

Scenarios such as the one given below are commonly used to show that, where consequences are both equal, an action is always morally worse than an omission.

If I do not send a cheque to Oxfam someone will probably die who otherwise would not have died. Suppose I discover who that person is and send him (in addition to my cheque to Oxfam) a small personal food parcel containing a Danish pastry that I have carefully flavoured with the appropriate almond flavoured poison. Would I then have the moral defence that as there is no morally relevant difference between acts and omissions I was doing nothing worse in sending the poisoned cake than if I had not sent the cheque to Oxfam?\(^{196}\)

As Gillon states, it can be concluded that in this case it is worse to kill the person and that any other moral theory that was not able to justify this conclusion would be condemned “by that fact alone by an argument of reductio ad absurdum.”\(^{197}\) In addition, Gillon adds, it is not the acts and omissions doctrine that explains the moral distinction in scenarios such as the one above.\(^{198}\)

Rachels, one of the most widely known and cited opposers of the moral distinction between killing and letting die, believes that the doctrine rests on a distinction between an act and an omission that itself has no moral significance. To explore this idea, Rachels gives two identical cases, that of

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198 Ibid.
Smith and Jones, with the only exception being that first case involves killing and the second involves letting die. In the first case, Smith will gain a large inheritance if his six-year-old nephew were to die. With this motive, one evening when his nephew is taking a bath, Smith sneaks into the bathroom and drowns him. The second case of Jones is identical to that of Smiths, except that as Jones sneaks into the bathroom to drown his nephew, the child slips, hits his head and falls unconscious into the bath-water. Jones watches as his nephew drowns ready to push the child’s head back into the water in order to ensure that the child dies.  

Rachels proposes that in both these cases, the men acted from the same motive, personal gain and the same end result in mind and that, morally, a distinction could not be made between the two cases.  

I suggest that the motive, personal gain and the end result remain the same whether timers are used to disconnect the patient from mechanical ventilators or patients are actively withdrawn from these machines. In both cases, the health care professionals would be seeking to respect the wishes of the patient and in both cases the end result would be the death of the patient. Therefore, I argue that whether we use the timers to convert an act into an omission or not appears to be morally irrelevant.

Nesbitt agrees that in the examples provided by Rachels there is no moral distinction between killing and letting die, but he objects to these cases provided by Rachels because, as Nesbitt suggests, “the examples produced typically possess a feature which makes their use in the context illegitimate, and that when modified to remove this feature, they provide support for the view which they were designed to undermine.”

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200 Ibid.
201 For the purpose of my thesis, I have considered only competent patients that have the ability to make informed decisions and express their wishes.
Nesbitt supports the idea that in Rachels’ cases, common intuition will suggest that both Smith and Jones are equally reprehensible and that there is no moral difference between the two acts.203 However, the fact that Jones was prepared to kill his nephew is a crucial fact that, Nesbitt feels, has been neglected.204 With a modification of Rachels’ case of Jones to add in this feature, Nesbitt intends to show that even if the event of the nephew drowning had not occurred; we would still have judged Jones as harshly as Smith because of his intent.205 Nesbitt holds that “what determines whether someone is reprehensible is not what he in fact does but what he is prepared to do, perhaps as revealed by what he in fact does.”206 Therefore, he argues, Rachels cannot use these examples to show that the difference thesis is false as in both cases Smith and Jones were prepared to kill. He follows on by saying that the problem with Rachels’ examples are that he makes the cases too identical so that in the end, Smith and Jones “are guilty of the same moral offence”207 because in both cases the agents are prepared to kill. Nesbitt goes on to say that for Rachels to disprove the difference thesis, this feature should be changed. That is, we must assume that Jones would not be prepared to kill his nephew because he believes that there is a strong moral difference between killing and letting die.

In his argument against Rachels’ position, Nesbitt concludes that if a person is not ready to kill another but willing to let them die then “such a person will not save me if my life should be in danger, but in this he is no more dangerous than an incapacitated person, or for that matter a rock or

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203 Ibid. p.232.
204 Ibid.
205 Ibid. p.233.
206 Ibid.
207 Ibid.
A person, however, that is willing to kill for personal gain is a threat. Killing is therefore morally worse than letting die.\footnote{Ibid. p.234}

In a response to Nesbitt’s article, Kuhse proposes that Nesbitt’s arguments rest on a number of contestable assumptions but that even if we acknowledge Nesbitt’s arguments as sound, the conclusion that killing is worse than letting die does not follow.\footnote{Ibid.} Kuhse suggests that there is an unwarranted conflation in Nesbitt’s argument “between the rightness and wrongness of actions, and the goodness and badness of agents”,\footnote{Ibid. p.237.} and goes on to propose that killing is not always morally wrong and in some cases morally better than letting die.\footnote{Ibid. p.238.} It appears, from Kuhse’s argument that Nesbitt seems to draw the conclusion that killing is morally worse than letting die by assuming that in cases of killing, the agent always acts from a bad motive.

To defend this claim, that killing is not always morally wrong and in some cases morally better than letting die, she gives examples of situations where the agent who kills is not driven by personal gain\footnote{Ibid. p.237.} or a bad motive, as in the case of the Oxfam scenario, but rather by compassion.\footnote{Ibid. p.237.} Therefore, it seems that there is no intrinsic moral distinction between killing and letting die and instead, what appears to matter morally is the intent of the agent. Hence, if the health care professional’s intent is to respect the wishes of the patient who requests to die, as I have suggested earlier on in page 45, then it does not seem to matter morally whether this death is brought about by an act or by an omission.

\textsuperscript{208} Ibid. p.234
\textsuperscript{209} Ibid.
\textsuperscript{211} Ibid. p.237.
\textsuperscript{212} Ibid. p.238.
\textsuperscript{213} Ibid. p.237.
\textsuperscript{214} Ibid. p.237.
Letting nature take its course
Another argument that is given in support of the distinction between acts and omissions is that omitting from treating a patient is merely ‘letting nature take its course’. Kuhse and Singer look at the two possible interpretations of this claim. First, when death results from an omission we are not causally responsible and second, we are not morally responsible. Kuhse and Singer give arguments to refute both these claims. The first interpretation of omissions and causality was discussed in the last chapter, pages 35-39. In this chapter, I will focus on omissions and moral responsibility.

Kuhse and Singer argue that to claim that we are not morally responsible for our omissions is even less plausible than the claim that we are not causally responsible. They go on to suggest that this is especially true in a medical setting where the doctor has an obvious moral responsibility to care for their patient. As they write, “moral responsibility…is strengthened when we have a specific duty that is relevant to what is happening.” To argue their case, they suggest that a doctor who deliberately leaves a baby to die when they have all the means necessary to save its life is just as morally responsible for the baby’s death as the doctor would be if he had brought about the death of the baby by a positive action. I argue then that the health care professionals are just as morally responsible for actively withdrawing the ventilating machine as they are for refraining from resetting the timers. Considering the duty of care that the doctor has for the patient, it can be argued that switching off the ventilating machines and allowing them to be switched off are both ‘morally good’, but this still does not show that there is a distinction between the two.

216 Ibid. p.81.
217 Ibid. p.84.
218 Ibid.
219 Ibid. p.84-85.
In summary, I have shown that the arguments given to support the distinction between an act and an omission are not conclusive. In the next section, I will give additional arguments that suggest that there is moral difference between an act and an omission.

Arguments Against the Doctrine of Acts and Omissions

Behaviour of the Agent
Von Wright defines an act as a transformation of states and adds that in order to define an action as a transformation of states, we require the following three items:

i. Knowledge of the *initial stage* – von Wright defines this as the state at which the world is in at the moment the action is initiated. This for the purpose my thesis will be that the patient to be connected to the mechanical ventilator is terminally ill.

ii. Knowledge of the *end stage* – the state of the world at the completion of the action. Von Wright adds that the end result may be brought about not only by an action but also as a result of an omission. The end state results from the ‘action’ of the agent, which von Wright refers to as the ‘behaviour’ of the agent. In this case, the end state, resulting from the health care team not resetting the timer, is that the patient connected to the respirator is dead.

iii. Finally, we require knowledge of the state that the world would be in had the agent remained passive and there had been no interference from the agent. If the health care team had not behaved in the way that they did, the patient connected to the respirator would still be alive.

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Begley makes the point that because von Wright qualifies the term ‘action’ by referring to it as the ‘behaviour’ of the agent, it would suggest that the agent’s behaviour is of significance and that the nature of the behaviour itself is irrelevant. Hence, “if we consider that our behaviour brings about change rather than focus on the nature of that behaviour, that is, whether it is an act or an omission, then it becomes more clear that the acts and omissions distinction is not so important” as compared to the behaviour of the agent and the final outcome.\textsuperscript{221} That is, whether or not the health care team acted or omitted to bring about the death of the patient is not relevant if in the end stage the patient is dead.

**Omissions - More than not doing**

Walton points out that “the language of action is linked to the language of control”.\textsuperscript{222} Something can only be considered an omission if “an agent could have brought about a state of affairs, or could have been expected to do so.”\textsuperscript{223} The Linacre Centre gives three conditions which need to be satisfied to qualify as an agent omitting to do something. The person omitting to do something must:

i. Have the ability to do what they are omitting,

ii. Have the opportunity to do it, and

iii. Be expected to do it and this expectation must be reasonable.\textsuperscript{224}

Begley adds that an omission then appears to be more than “simply ‘not doing’”\textsuperscript{225} when looked at in the context of the doctrine of acts and omissions.\textsuperscript{226} Dines also seems to share Begley’s view. She


argues that, assuming Glover’s definition of the doctrine is correct, the bad consequences are foreseen and thus to be inactive is not a neutral stance, as assumed in the distinction, but rather it is “to make a choice, not to act, which affects the outcome.”227 I agree with Dines but feel that her argument needs some modification as she assumes that death is always a bad consequence, which I suggest is debatable for various reasons. However, discussion of these reasons is not needed for the purpose of this thesis. I propose that the argument against the distinction between an act and an omission should instead be that where the consequences (good or bad) are foreseen, to be inactive is not a neutral stance, but rather it is “to make a choice, not to act, which affects the outcome.”228

In regard to the three conditions, stated above, that need to be satisfied to qualify as an agent omitting to do something, the health care team appear to satisfy all the three conditions and in addition, are aware of the consequences of their inaction. Thus, to use the doctrine of acts and omissions to morally justify a health care practitioner who allows a patient to die by omitting to reset the timers appears problematic.

If the behaviour of the agent is what needs to be morally evaluated and as Begley suggests, an omission is more than simply not doing,229 why do some people still feel that an omission carries less moral weight than an act? Opponents of the distinction have given at least four possible explanation to suggest why this may be the case.

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226 Ibid.
228 Ibid.
Why We Regard Acts to Bear More Moral Weight than Omissions

First, Begley suggests that the distinction between an act and omission seem obvious because the practical differences between an act and an omission are straightforward. Walton’s explanation of this is that:

Positive action normally implies a deliberate interruption of the course of nature, whereas allowing nature to take its course, although a certain sanction or approval is implied – remember the connection with control – does not carry with it such a strong imputation of intention and deliberate agency.

Begley thinks this suggests that “the more ‘active’ the agent is in bringing about death, the more morally responsible he is.” However, Walton acknowledges that the more active agent is not necessarily the more morally responsible agent and that we have to look elsewhere for a moral distinction between an act and omission because it is not enough to make moral distinctions based on physical differences between the two. Furthermore, unless we can identify the moral difference between an act and an omission, we can not use the doctrine of acts and omissions to justify that an omission is morally less reprehensible than an act. If two people both have good motives but one person commits an act and the other omits from an act that both result in the same outcome, we can not say that the omission was more morally acceptable than the act because it was an omission rather than an act.

234 Ibid.
Second, Glover proposes that a reason why people may be prone to believe that an act is worse than an omission is because an uncertain or probable death resulting from an omission is preferable to a definite death produced from an act.\textsuperscript{236} Dines refers to this as the ‘probability of outcome’. She states that “actions usually do have a positive effect, whereas in the case of some inactions a third party may intervene and alter the outcome”,\textsuperscript{237} leading to the misguided, as Dines puts it, view of a moral distinction between killing and letting die.\textsuperscript{238} But in this case I argue that it is almost definite that when the health care team does not reset the timers, the timers will turn off the ventilating machine and the patient will die.

Third, Gruzalski believes that a possible reason that may account for the widespread belief that killing is worse than letting die is that as children we are first told that killing is wrong and only late in life learn that acts of letting die, here he gives the example of starving a pet to death, are also acts of killing.\textsuperscript{239}

Fourth, Rachels believes that the media portrayal of killing and letting die may be a reason why people find the notion that there is no moral distinction between the two (killing and letting die) difficult to accept. The media commonly shows murders as examples of acts and doctors withholding treatment because they are driven by humanitarian reasons, as examples of omissions. Thus the public are more inclined to believe that \textit{all} acts are morally reprehensible and \textit{all} omissions are not, which Rachels believes is not the case.\textsuperscript{240}

\textsuperscript{238} Ibid.
Gruzalski’s and Rachels’ arguments seem plausible, but whether they can be applied to the Jewish community in Israel, remains to be questioned.

Singer identifies several significant differences between killing and letting die which he suggests should not be used to argue that there is an intrinsic difference between the two.241 These differences, which Singer refers to as *extrinsic* differences, are prior intentions, subjective certainty of death, risks to the agent, the identification of victims, and responsibility.242 Tooley adds that when these differences and other background factors are held constant, no moral difference exists between an act and an omission.243

An Exception to the Doctrine of Acts & Omissions and Killing & Letting Die
Interestingly, there is another body of thought that exists where theorists such as Foot, Locke, Chandler and Malm argue, contrary to the majority of the literature written, that the moral distinction between killing and letting die is not an instance of that between an act and an omission.

Foot and Malm defend the view that killing is not necessarily worse than letting die.244 Foot goes on to argue that it is the fact that killing and letting die are contrary to separate virtues, namely, justice and charity, “which gives the possibility that in some circumstances one is impermissible and the other permissible”.245 Locke, on the other hand, argues that the distinction between killing and

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242 Ibid.
letting die ought to be that between producing (causing) and allowing because, as Locke and Chandler argue, it is possible to kill a being by not doing something.246

Further discussion of these alternative arguments is beyond the scope of this thesis. However, further work done on these arguments may prove to be useful in trying to find a moral theory that better articulates the moral distinction between killing and letting die. As this chapter has shown, resting the distinction between killing and letting on the doctrine of acts and omissions is problematic.

Chapter Summary

The function of the timers on ventilating machines is to convert an act into an omission as, according to the doctrine of acts and omissions (on which the function of the timers are based), we are morally less responsible for our omissions. In this final chapter, I have argued that this distinction is morally problematic. I have shown that the arguments in favour of the distinction hold less weight when compared to arguments against the distinction. Therefore, to claim that a being is not morally responsible for his or her omissions (in this case, omitting to reset the timers and hence allowing them to turn off the ventilating machines which results in the death of the patient) appears to be morally problematic. Furthermore, there is a body of thought that goes a step further to argue that the distinction between killing and letting die does not even rest on the distinction between an act and an omission.

Conclusion

This thesis began by stating that Jewish religious law makes a distinction between an act and omission. Any action taken that will hasten the death of a being is considered ‘killing’ and is forbidden by Jewish religious law. An omission is viewed as letting the patient die because Jewish religious law holds that it is merely letting nature take its course and not interfering with the will of God.

Therefore in order to allow health care practitioners to disconnect patients, who wish to be disconnected from mechanical ventilators, the use of timers was proposed by the Steinberg Committee. The timers are to be installed in ventilating machines and are proposed to convert an act into an omission. Thus, health care professionals will now be able to disconnect a patient from a ventilating machine by omitting to reset the timers. The timers, if not reset, will automatically switch off the mechanical ventilators at the end of their cycles. Hence, the health care professionals are not held morally responsible for the death of their patients that result from the timers disconnecting the ventilating machines as they have not performed any action per se. In this scenario, the use of the timers rest on two moral claims. First, that the timers convert an act into an omission, and second, that health care professionals are not morally accountable for the deaths of their patients which result from their (health care professionals) omissions.

However, in this thesis I have argued that these two moral claims are problematic.

First, I have argued that a closer examination of the use of the timers with the three tests used to define an act shows that the assumption that the timers convert an act into an omission is
problematic. That is, on the grounds of causation, intention and the ability to do otherwise, the use of the timers can still be considered an act.

Second, I have also argued that even if the timers convert an act into an omission, this is not enough to hold (when secular arguments are drawn upon) that the health care professionals are no longer morally responsible for the death of a patient because they omit to do something rather than act. This conclusion is questionable because as I have argued, it rests on the moral distinction between an act and an omission which itself is difficult to prove. Furthermore, there are philosophers who argue that the moral distinction between instances of killing and letting die cannot be based on the distinction between an act and omission respectively.

It should be noted however, that my primary aim in this thesis is not to argue for or against the implementation of the timers in Israel. Rather it has been to identify and show that the above assumptions and claims made by the Steinberg Committee surrounding the use of these timers are problematic and need more defence. While the timers may provide a solution to the problems that Israel faces, with trying to combine secular views on autonomy and Jewish religious views on actions taken to hasten death, the use of these timers may not provide a universal solution and may well be a continued debate in Israel. Furthermore, any other country wishing to install these timers might need to pause and consider the deeper moral implications of these machines. Things are often more complex than they first appear.
References


