A Proposal to Improve Rabbinic Decision-Making for Serious Medical Problems

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Abstract:

A rabbi is often consulted for advice by Jewish patients faced with a decision regarding medical treatments or operations that may pose serious health risks. Providing such advice carries a serious responsibility, and in order to optimize the likelihood of making the most appropriate decision possible, rabbis frequently consult with physicians to provide them with critical medical information. This paper discusses the potential role that an epidemiologist (a scientist and/or physician who studies the incidence, prevalence, spread, causes, prevention, and control of diseases in specified populations) might serve in addition to the rabbi's medical consultant panel.

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A rabbinic decisor (*posek, poskim* (pl.)) is often consulted to help a patient decide whether or not it is *halakhically* permissible to undertake a medical procedure. Some consult *poskim* who have a special reputation within the Orthodox Jewish community of being experienced in such consultations, and are widely sought out for their rabbinic knowledge. Frequently, the local synagogue rav / *posek* is consulted, who is more familiar with the patient and family situation. However, in both scenarios, the *posek* may not have the experience and or expertise to deal with a complex medical issue. This can present a significant dilemma for him, especially for unusual questions where appropriate medical consultation is not readily available.

The objective of this paper is to suggest an additional resource for this problem. Even in the best of circumstances, there is a critical need for improvement of the process of making the most complete, relevant medical information available to the *posek*, so that he can provide appropriate advice that is consistent with Jewish law (*halakhah).* The road toward an acceptable, easily available and logistically feasible methodology may be a long one, and perhaps it may be too complicated to actually develop and maintain a fully acceptable process. However, it behooves us to address the issue responsibly.

Some medical *halakhic* decisions are relatively simple (if there is even the need to ask a *shailah*), such as removal of a cataract that significantly affects a person's vision, or repair of a torn rotator cuff (shoulder injury) to relieve pain and restore mobility. The *halakhic* risk/benefit consideration is readily apparent and easy for the *posek* to decide with minimal if any medical consultation. However, decisions about other procedures, such as cardiac surgery, salvage cancer chemotherapy, or surgical treatment of back pain, may be more complicated *halakhically.* To provide the best *halakhic* advice, a *posek* should consult with expert, experienced physicians. While most procedures and operations have usually been thoroughly vetted and evaluated before they become common practice, and medical specialists can provide the *posek* with reliable opinions, there are cases that are not as clear, e.g., for recently introduced medical / surgical therapies and for controversial or less well-proven regimens. The fact that procedures or operations are widely accepted does not nec-

essarily guarantee their effectiveness. The paper *When professional opinion is not enough*[1] discusses precisely that problem, as does the book *How doctors think*,[2] by Jerome Groopman, past Chairman of Medicine at Harvard Medical School.

Many *rabbonim* frequently rely upon clinicians in their community for practical medical advice regarding questions they receive, but a physician may be too busy or inadequately trained to comprehensively explore and critically evaluate a given treatment in areas that they do not regularly practice. Most medical schools require a course in research design, and throughout medical training physicians attend journal clubs where they are required to analyze medical papers and assess the validity of a study's conclusions in light of its research methods. Nevertheless, decades of working with physicians in the capacity of consultants for their research designs or as participants in their journal clubs have shown us that physicians often do not have the time or skills to critically evaluate medical research in areas outside their expertise. In contrast, epidemiologists (scientists and / or physicians who study the incidence, prevalence, spread, causes, prevention, and control of diseases in populations, and take courses in biostatistics and research methodology) are trained to critically evaluate literature reports about treatment and often themselves contribute to such literature. Therefore, a *posek* should be aware that expert epidemiologists can provide an important element of critical evaluation of the treatment literature.

We would like to clarify that *poskim* and their consulting physicians currently are committed to helping patients choose the best medical options in the most responsible way they know. The objective of this paper is a constructive one; i.e., to improve the quality of a *posek*'s options for the less common conditions where a clinical expert is not readily available or where there is a difference of opinion amongst the clinical experts. Further, the applicability of the points made in this paper may vary from *posek* to *posek*. For example, it may be less applicable to *poskim* who live in large metropolitan areas and consult with practicing physicians of high-caliber academic institutions, as compared to those who do not have access to these professionals. Nevertheless, this paper can be helpful to all *poskim*.

Let us present a hypothetical issue that might require a *posek*'s opinion, and then follow it with several actual problem issues in the areas of cancer and heart disease.

Suppose a *posek* is asked whether a patient should undergo a certain serious cardiac operation that is purported to extend life, and let us suppose that the operation has become accepted because investigators found that patients who underwent the operation lived longer than those who had only medical treatment. A clinician or epidemiologist trained to critically evaluate such reports would pose several questions about how study patients were chosen to undergo the operation: Did the surgeons choose the healthiest patients? Were patients who were especially frail and not expected to live much longer, no matter what, excluded from the study? If so, the observed beneficial effect of the operation might be an artifact, with the longer survival due to the better pre-op health of these patients, and not to the operation itself. More definitive and reliable evidence for the benefit of the operation could be demonstrated if the study patients were properly controlled and randomized *a priori* to undergo surgery or to be non-operated, medication-treated "controls," with the two groups having similar pre-operative health status and life expectancy assessments. Having a clinician or epidemiologist available to critically analyze a study to see whether or not it met those standards would enable a *posek* to get the best advice from physicians he may consult.

Could the need for obtaining the advice of an epidemiologist be obviated by consulting comprehensive review articles about outcomes, such as those in the Cochrane Database of Systematic Reviews, an electronic library that is available to the public and physicians, dedicated to providing accurate, up-to-date information about the effects of various aspects of healthcare? Such reviews can be very helpful, but one must recognize that the state of medical knowledge is dynamic—the best practice changes as a result of newer critical studies and evaluations. A review article, be it ever so comprehensive, is fixed at a point in time, whereas a living, critically trained advisor, such as an epidemiologist, is continuously current with the best available practices.

An example of this issue is provided by the history of surgical removal of pulmonary metastases from colon cancer. Over the past

10–15 years, numerous papers have addressed the advisability of this procedure.[3–15] While the results have been somewhat inconsistent, on balance the evidence, till very recently, indicated that the procedure could extend survival, and was so stated in a review in 2007.[3] However, a more recent study, in 2009,[16] reports that surgery was usually unsuccessful in female patients under 65, with less than one year between the diagnosis of colon cancer and the appearance of lung metastases, and/or with more than two metastases. No such patient was cured by the surgery. The investigators concluded that indeed routine surgery for these patients was not indicated, and that medical management should be the standard treatment for patients who have more than two metastases and less than one year between the diagnosis of the primary cancer and the lung metastases.

In order to further clarify which patients can benefit from surgical removal of lung tumors that have metastasized from a colon malignancy, a funded randomized clinical trial was launched in the United Kingdom in March 2010.[17] This example underscores the dynamic nature of medicine and that a physician who advises a patient or a *posek* must be completely *au courant* with the latest research studies of a procedure and capable of evaluating them critically.

Another example of the importance of keeping up with the latest developments in a critical area of medical or surgical treatment is provided by the history of the evolution of knowledge about hormone replacement therapy (HRT) for postmenopausal women. The earliest clinical observation in this area was that women in every country, whether the prevalence of coronary artery disease (CAD) was high or low, have much lower rates of fatal CAD than men.[18] This prompted "observational" (i.e., non-randomized and usually non-prospective) studies that compared the incidence of CAD in women who received HRT and those who did not. Many such investigations concluded that HRT provided cardiac protection. Here too, however, the issue was clouded by the non-comparability of women who did or did not take HRT. Women who take HRT are more likely to be white, educated, upper middle class, and lean, and often have a generally healthy lifestyle; *thus one could not separate the effects of HRT itself from effects of the low-risk profile of women who take it*. Nevertheless, it became conventional wisdom that

HRT greatly lowered the risk of CAD. The ongoing concern about the validity of this conclusion prompted several randomized, placebo-controlled, double-blind studies of the effects of HRT on CAD. One such study, the Women's Health Initiative (WHI), was supposed to last 8.5 years but was terminated prematurely when it became evident that women taking HRT had significantly poorer health outcomes than those who were not. They had higher rates of CAD and also higher rates of breast cancer, stroke, pulmonary emboli, and dementia. Another trial, the Heart and Estrogen/Progestin Replacement Study (HERS), demonstrated similar results. These findings are highly instructive: it is just not possible to substitute non-randomized "observational" studies for the gold-standard randomized, double-blind, placebo-controlled studies—the results may be completely wrong, as they were in this case.

We now describe a patient in whom clinical and epidemiological information interacted with a *posek*'s decision about heart surgery.

Judy (not her real name) had had a mitral-valve defect since childhood. When she came into menopause, her physician prescribed HRT to control her hot flashes. Judy was pleased to read that HRT was also cardio-protective. When the results of the WHI and HERS trials were reported, Judy was horrified and immediately stopped taking HRT. Thereafter, her cardiac function deteriorated severely, and her physicians recommended that she undergo surgical repair of her mitral valve. The thought of open-heart surgery was, if anything, not taken lightly. As Judy was smart and an Orthodox Jew, she tried to cover all her bases. Her research revealed that a surgeon from a heart clinic that is well recognized for its expertise in cardiac surgery was moving to a hospital very close to where she lived. This, she thought, was indeed welcome news (although she did not know the reasons for his leaving the clinic). She would not need to burden herself or her family by being treated in a clinic accessible only by an airplane trip. Since Judy was an Orthodox Jew, her family asked their *posek* whether she should undergo the surgery. He advised that she should. Judy had the surgery and at first seemed to have come through it well. However, it soon became apparent that her liver and kidneys were failing; after 11 weeks in the hospital's intensive-care unit, Judy succumbed to an infection.

It should be pointed out, that the quality of a surgeon explains only a small part of the better surgical outcomes of a highly regarded heart clinic. Such clinics have systems in place and multidisciplinary teams that play critical roles in preventing and rapidly addressing complications after surgery. It is this team's interventions that can reduce morbidity and mortality. The decision as to whether to choose the best physician or the best medical center varies from case to case, and is recognized as being both critically important and complex (19). In retrospect, an expert physician could have made this clear to the *posek* who advised Judy.

As an aside, we now have information that can be relevant for future cases that could be similar to that of Judy's. In 2008,[20] after reviewing the medical charts of 24,977 patients (49% women) who had undergone mitral valve surgery, investigators concluded that estrogen withdrawal during the perimenopausal period is associated with a substantially higher mortality after mitral-valve surgery. Once again the dynamism of medicine, and thus the need to have up-to-date information, is apparent.

Summary and Conclusions

When a *posek* gives advice to a patient about undergoing an operation or dangerous medical procedure, he bases that advice on the information that he received from his panel of medical advisors. In seeking the best possible advice, as demonstrated from the examples presented in this article, such a panel should include experienced clinicians and /or epidemiologists who, when deemed necessary, can critically assess the total medical evidence and provide a report that is custom-tailored for a specific patient and their unique set of risk characteristics. A recent article in the New England Journal of Medicine holds that such personalized assessments are at times essential.[21] Further, in *Dangerous disease & dangerous therapy in Jewish medical ethics*,[22] Rabbi Dr. Akiva Tatz expounds, and argues that in order to act appropriately according to *halakhah*, it is frequently critically important to undertake the complex endeavor of accounting for both personalized medical and *halakhic* factors simultaneously.

There may be potential gaps that need to be filled when arriving at the correct *halakhic* answer for selected complicated medical con-

ditions, and we hope that this article will serve as motivation to seek appropriate advice from experts. First, a *posek* needs to obtain appropriate information from his consulting physicians to make the best *halakhic* decision. The physicians should feel confident that they have provided all the necessary accurate information. If they feel any uncertainty, they should recommend that another specialist be consulted in order to get the most updated and complete relevant information. Second, for *rabbonim* without easy access to qualified experts, we need to develop and adopt an appropriate method for identifying the most competent physicians to serve as consultants for these *rabbonim*. Perhaps we should have a "bank" of physician consultants and epidemiologists who can competently access, assess, and review the literature for various medical conditions. Along with the creation of this "bank" one would need to design a mechanism for its funding.

Our proposal has advantages over other systems, such as ECCO, that primarily recommend physicians. 1) Our proposal involves a team that is dedicated to getting the most current, in-depth, accurate information that is applicable to a particular individual patient; 2) We propose to form a team that includes physicians who are recognized by their peers for their competence, as well as scientists who are capable of compiling a custom-tailored report based on a critical evaluation of the available medical literature. 3) As there are clinical situations for which Orthodox Jews would not deem such reports to be sufficient for arriving at a final decision, our team is led by *rabbonim*, who can integrate all relevant information in an Orthodox Jewish context. This could be critical when, for example, final *halakhic* decisions might require risk/benefit considerations—what the individual considers to be a worthwhile risk might not be *halakhically* justified. Working through *rabbonim* ensures that *halakhic* factors, even when not apparent, are considered. Working through respected *rabbonim* who are objective and compassionate provides a humane setting that facilitates the processing of information by the patient.

As no other existing system incorporates all these essential components—i.e., clinical advice from recognized physicians, a further custom-tailored report based on a critical assessment of the current state of knowledge, and the assimilation of this information by

a Rav into a decision that is optimal medically and *halakhically*—it is likely that our proposal would consistently provide better results than other existing systems. We would, however, explore the possibility of forming a consortium with other systems in order to produce an organized, non-fragmented service, whose parts are not wastefully replicated.

Thus, improving the process of making *halakhic* medical decisions may be complicated and take a long time. However, it is our obligation to start.

*VeCHAI BaHEM (*AND LIVE BY THEM*)*[23]

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References

(1) Treasure T, Utley M, Hunt I. *When professional opinion is not enough.* BMJ 2007; 334(7598):831-832.

(2) Groopman J. *How doctors think.* New York: Houghton Mifflin Company, 2007.

(3) Pfannschmidt J, Dienemann H, Hoffmann H. *Surgical resection of pulmonary metastases from colorectal cancer: a systematic review of published series.* Ann Thorac Surg 2007; 84(1):324–338.

(4) Pfannschmidt J, Muley T, Hoffmann H, Dienemann H. *Prognostic factors and survival after complete resection of pulmonary metastases from colorectal carcinoma: experiences in 167 patients.* J Thorac Cardiovasc Surg 2003; 126(3):732–739.

(5) Shah SA, Haddad R, Al Sukhni W, Kim RD, Greig PD, Grant DR et al. *Surgical resection of hepatic and pulmonary metastases from colorectal carcinoma.* J Am Coll Surg 2006; 202(3):468–475.

(6) Miller G, Biernacki P, Kemeny NE, Gonen M, Downey R, Jarnagin WR et al. *Outcomes after resection of synchronous or metachronous hepatic and pulmonary colorectal metastases.* J Am Coll Surg 2007; 205(2):231–238.

(7) Okumura S, Kondo H, Tsuboi M, Nakayama H, Asamura H, Tsuchiya R et al. *Pulmonary resection for metastatic colorectal cancer: experiences with 159 patients.* J Thorac Cardiovasc Surg 1996; 112(4):867–874.

(8) Iizasa T, Suzuki M, Yoshida S, Motohashi S, Yasufuku K, Iyoda A et al. *Prediction of prognosis and surgical indications for pulmonary metastasectomy from colorectal cancer.* Ann Thorac Surg 2006; 82(1):254–260.

(9) Zink S, Kayser G, Gabius HJ, Kayser K. *Survival, disease-free interval, and associated tumor features in patients with co-*

lon/rectal carcinomas and their resected intra-pulmonary metastases. Eur J Cardiothorac Surg 2001; 19(6):908–913.

(10) Inoue M, Kotake Y, Nakagawa K, Fujiwara K, Fukuhara K, Yasumitsu T. *Surgery for pulmonary metastases from colorectal carcinoma.* Ann Thorac Surg 2000; 70(2):380–383.

(11) Saito Y, Omiya H, Kohno K, Kobayashi T, Itoi K, Teramachi M et al. *Pulmonary metastasectomy for 165 patients with colorectal carcinoma: A prognostic assessment.* J Thorac Cardiovasc Surg 2002; 124(5):1007–1013.

(12) Koga R, Yamamoto J, Saiura A, Yamaguchi T, Hata E, Sakamoto M. *Surgical resection of pulmonary metastases from colorectal cancer: Four favourable prognostic factors.* Jpn J Clin Oncol 2006; 36(10):643–648.

(13) Sakamoto T, Tsubota N, Iwanaga K, Yuki T, Matsuoka H, Yoshimura M. *Pulmonary resection for metastases from colorectal cancer.* Chest 2001; 119(4):1069–1072.

(14) Yedibela S, Klein P, Feuchter K, Hoffmann M, Meyer T, Papadopoulos T et al. *Surgical management of pulmonary metastases from colorectal cancer in 153 patients.* Ann Surg Oncol 2006; 13(11):1538–1544.

(15) Watanabe I, Arai T, Ono M, Sugito M, Kawashima K, Ito M et al. *Prognostic factors in resection of pulmonary metastasis from colorectal cancer.* Br J Surg 2003; 90(11):1436–1440.

(16) Onaitis MW, Petersen RP, Haney JC, Saltz L, Park B, Flores R et al. *Prognostic factors for recurrence after pulmonary resection of colorectal cancer metastases.* Ann Thorac Surg 2009; 87(6):1684–1688.

(17) Treasure T, Fallowfield L, Lees B. *Pulmonary metastasectomy in colorectal cancer: the PulMiCC trial.* Journal of Thoracic Oncology: Official Publication of the International Association for the Study of Lung Cancer 2010; 5(6 Suppl 2):S203–S206.

(18) Barrett-Connor E. *Clinical review 162: cardiovascular endocrinology 3: an epidemiologist looks at hormones and heart disease in women.* J Clin Endocrinol Metab 2003; 88(9):4031–4042.

(19) Reynolds E. *A 37-Year-Old Man Trying to Choose a High-Quality Hospital.* JAMA 2009;2009.

(20) Song HK, Grab JD, O'Brien SM, Welke KF, Edwards F, Ungerleider RM. *Gender differences in mortality after mitral valve operation: evidence for higher mortality in perimenopausal women.* Ann Thorac Surg 2008; 85(6):2040–2044.

(21) Swensen SJ, Meyer GS, Nelson EC, Hunt GC, Jr., Pryor DB, Weissberg JI et al. *Cottage industry to postindustrial care—the revolution in health care delivery.* N Engl J Med 2010; 362(5):e12(1)–e12(4).

(22) Tatz A. *Dangerous disease & dangerous therapy in Jewish medical ethics.* Israel: Targum Press, Inc., 2010.

(23) Leviticus chapter 18, verse 5 (see Nachmanides [Ramban]).