Terminal Stress: An Analysis of Jewish and Common Law Doctrines Related to the Effects of Stress on Seriously Ill Patients

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TERMINAL STRESS: AN ANALYSIS OF JEWISH AND COMMON LAW DOCTRINES RELATED TO THE EFFECTS OF STRESS ON SERIOUSLY ILL PATIENTS

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ABSTRACT

This essay compares two American legal doctrines -- deathbed bequests and the therapeutic exception to informed consent -- with their Jewish law counterparts in order to contribute to the literature on these doctrines, evaluate recent empirical data and make suggestions concerning the current position of academics and practitioners. In this essay, I will explore the history and theory underlying the laws of delivery for deathbed bequests and the therapeutic exception to informed consent. In order to highlight the principles motivating the common law, I examine the Jewish law’s approach to these doctrines. I posit that Jewish law and common law doctrines reveal contrasting attitudes about the appropriate balance of autonomy and beneficence in law. The well-recognized effects of stress on the terminally ill raise serious bioethical questions, and recent empirical medical data suggest that the common law’s position should be reevaluated. In this essay I survey current law, physician practices and the relevant empirical medical data. I then challenge the prevailing American view, and recommend bolstering the therapeutic exception to informed consent; at the same time, I endorse the status quo of the laws of deathbed bequests.

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INTRODUCTION

This essay will examine two common law doctrines dealing with seriously ill persons: the doctrine of *donatio causa mortis*, the so-called “deathbed bequest,” and the doctrine of “therapeutic exception,” an exception to the requirement of informed consent in the delivery of health care. It will compare these doctrines in the common law and Jewish law to discern the normative values motivating each legal system. Then, using empirical medical data, it will recommend a reevaluation of some of the extant laws and procedures.

The common law makes it difficult amidst the stresses and strains of terminal illness for dying persons to dispose of their assets. To be valid, bequests must conform to rigid formal requirements.¹ The idea behind the requirement for formalities appears to be that the voluntary free will of the autonomous agent is easily overpowered in the circumstances of death.² To protect autonomy, the common law imposes rigid formalities.

In the law of health care, the principle of informed consent is sacrosanct.³ Patients have a right to understand and to choose. In the

³ See Helaine W. Heydman et al., Treatise on Health Care Law, Vol. 3 Ch. 12 §12.08 (Mathew Bender and Co. 2011); Bernadette M. Broccolo et al., Fundamentals of Health Law, Ch. 2 §2.2 (American Health Lawyers Assoc., 3rd ed. 2004); George D. Pozgar, Legal Aspects of Health Care Administration, Ch. 11
interest of beneficence, and mindful of the evidence that stress can worsen illness and speed death, the common law would permit physicians to withhold stress-inducing adverse medical information that might be otherwise due an autonomous adult agent. Yet the strict interpretation of informed consent implicit in recent common law does not sanction a therapeutic exception commended by some bioethicists and clinicians.

What is driving the autonomy-bias of common law apparent in estate law and health law? Should the law be changed to make room for other important values and policies?

In order to better understand the autonomy-bias of the common law and to elicit alternatives for public policy, I will make a comparison between Anglo-American common law and the Halacha, or Jewish Law. Through this contrast between legal systems, this essay will seek to expose what is motivating the common law and to assess whether the common law should be changed.

An examination of Jewish law compels us to confront how the law

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responds to a dilemma inherent in the care and treatment of the terminally ill. One way to frame the dilemma at hand is as a choice between providing for dying persons in the spirit of beneficence and providing for dying persons in the spirit of autonomy. Both beneficence and autonomy are ethical principles meant to enhance well-being; however, one commends ensuring that an individual has what he or she needs, the other ensures that the individual has what he or she wants. While in some circumstances there is no difference between what a person needs and wants, in certain circumstances need and want-- and hence respect for the principle of beneficence and respect for the principle of autonomy-- dictate disparate modes of behavior from others. One of the most difficult and subtle aspects pertaining to the care of the terminally ill is the need to act with sensitivity to their illness, to their pride, and to their quality of life. The complexity inherent within accomplishing this vital service to a patient lies in the often-contradictory behavior required in order to achieve this objective. Sensitivity to one’s illness calls for extreme delicacy when dealing with issues that may upset or emotionally disturb the patient. Sensitivity to their pride, however, requires giving a patient the frank and forthright information concerning his or her prognosis.

Parts I and II will lay out the autonomy bias of the common law. Part I will explore the history and theory underlying the donatio causa mortis. It will show how court decisions and many legal commentators choose to give normative weight to strict legal formalism in order to prevent fraud with regards to deathbed bequests. Part II will examine the doctrine of informed consent. After

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a quick summary of the historical and current bioethical principles surrounding the laws of informed consent, the therapeutic exception will be discussed. Then, an overview of the current law and physician practices concerning the utilization of the therapeutic exception will show how the common law disregards patient beneficence in favor of patient autonomy.\(^8\)

Parts III and IV introduce contrasting Jewish law approaches to deathbed wishes and deceiving dying patients. Part III will analyze how the Jewish code of law takes the exact opposite position regarding deathbed bequests and allows for a relaxation of formalist rules. The reason given for this informal attitude within Halacha is patient beneficence, or, more specifically, the fear of formalism-induced stress affecting the patient’s health.\(^9\) Part IV will look at what the Jewish Law holds about truth telling to terminally ill patients. Through an assessment of these laws the opposing values of patient autonomy and patient beneficence can be distinctly observed.

Part V will survey the most recent empirical medical data and approaches regarding the effects of stress on seriously ill and terminally ill patients in order to evaluate whether the common law’s disregard of these effects in favor of patient autonomy is in fact the optimal approach to embrace in shaping both legal and caregivers’ policy. Although it is difficult to measure or define stress, many

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studies have attempted to ascertain results concerning the causal or reactionary effects of stress. The findings reveal that for some patients there may be significant medical benefits if certain information regarding their condition is not revealed. However, effects will vary based on the type of information and the culture and expectations of the patient.

In Part VI, I posit that, as shown in Part V, although the data is not entirely convincing in any direction, there is clear suggestion that withholding information from some patients can be beneficial. Therefore, I recommend that the best way to optimize both patient autonomy and beneficence is to strengthen the use of the therapeutic exception and allow caregivers the ability to exercise this option. By acknowledging the beneficial aspects of withholding information from the patient, courts and commentators will be more accepting of the therapeutic exception. The Jewish law, through its strong advocacy of patient deception, suggests ways by which a system of law could be more responsive to modern medical understandings of the best interests of the ill and dying and that should be incorporated into the common law. I do not recommend a full rejection of patient autonomy in all cases but I believe in a measure of balance between the two competing values. However, with regards to the laws of donatio causa mortis I am reluctant to advocate a similar relaxation of the formalist doctrine that has developed within the common law.

Although comparable concerns regarding patient beneficence exist, I

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believe that in the context of deathbed bequests the value of uniformity and protection of patient autonomy from fraud are compelling reasons to disregard the chance that legal formalism will adversely affect the giver. Finally, I conclude by summarizing the lessons learned and the arguments made in the article.

A legal analyst’s toolbox of skills contains many different ways to analyze and shape legal practices, among which are the capacity to use empirical data, the ability to evaluate ideas using other disciplines and the use of varied legal regimes. I hope to make use of all of these tools to arrive at a novel perspective of the doctrines of the therapeutic exception and deathbed bequests.

I. DONATIO CAUSA MORTIS

The laws of the donatio causa mortis or deathbed bequest are widely discussed because they illustrate an interesting twist with reference to the laws of gift giving. As a rule, in order to effectuate any gift, a valid delivery of the gift is required. Scholars disagree about why there even is a requirement of delivery. The courts, in

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13 This requirement was judicially developed and was not enacted through legislation. See eg. Howell v. Herald, 197 S.W. 3d 505 (Kentucky 2006); Richard R. Powell, Powell on Real Property, Vol. 15, Ch. 85 § 85.21 (Patrick J. Rohan Ed., Matthew Bender 1998) (listing the three requirements of an inter vivos gift; intent to make a gift, delivery of the gift and acceptance by the donee.)

14 Id. at 85.21[2]. The two principal schools of thought on the matter are the “Historical School” and the “Functional School”. The Historical School explained delivery as a remnant of the concept of seisen, the fact that the law did not allow any gifts without a transfer of possession. Since this theory considers delivery to be a mere historical relic, it does not consider delivery to be indispensable to the transfer of gifts. The Functional School explained delivery as a method of accomplishing various functional elements within a transfer of a gift, namely, it
most cases of *inter vivos* or lifetime gifts, have relaxed the formal requirement of manually handing over the object and allowed other methods of delivery to be acceptable substitutes. However, for the *donatio causa mortis*, some courts adopt strict formalist tendencies and choose not to accept all substitutes. The case widely quoted to represent this trend is the case of *Foster v. Reiss*. This case makes concrete to the donor the significance of the act being done, it is unequivocal to the witnesses present and it gives the donee prima facie evidence of a transfer. The Functional School also agrees that, should there be other ways to provide these functions, a formal delivery would not be necessary. As a general rule both schools are in agreement that manual tradition and possession should not be made an ends in themselves. The only issue under discussion is whether the requirement of delivery currently serves any purpose. In a broader sense, Professor Lon Fuller argued that all legal formalities merely serve as expressions of intent. See Lon L. Fuller, *Consideration and Form*, 41 Colum. L. Rev. 799, 800-03 (1941). See also Philip Mechem, *The Requirement of Delivery in Gifts of Chattels and of Choses in Action Evidenced by Commercial Instruments*, 21 U. Ill. L. Rev. 341,354 (1926)(discussing reasons for delivery).

Although manual delivery has not been completely negated, the courts have accepted many substitutes such as constructive or even symbolic delivery. See, e.g., *In re Estate of Piper*, 676 S.W. 2d 897 (Mo. 1984) (while delivery may be actual, constructive or symbolic, there must be evidence to support the conclusion there was delivery); *Gruen v. Gruen*, 68 N.Y. 2d 48 (1986) (stressing that courts should apply delivery rules flexibly and in light of the policy behind the rule); *Speelman v. Pascal*, 10 N.Y. 2d 313 (1961) (upholding a delivery consisting of an informal letter); *Williams Hospital v. Nisbet*, 7 S.E. 2d 737 (Ga. 1940) (a gift evidenced by “ordinary writing” dispenses with the necessary delivery).

Additionally, the courts have not required delivery in certain cases such as when the donor and donee had joint possession; gifts of choses in action; gifts involving bulky objects and distant property; and transfer of a key to a receptacle. See A. C. H. Barlow, *Gifts Inter Vivos of Chose in Possession by Delivery of a Key*, 19 Mod. L. Rev. 394 (1956); W. Lewis Roberts, *The Necessity of Delivery in Making Gifts*, 32 W. Va. L. Rev. 313 (1926). See also Philip Mechem, *The Requirement of Delivery in Gifts of Chattels and of Choses in Action Evidenced by Commercial Instruments*, 21 U. Ill. L. Rev. 341,355 (1926)(stating that the existing case law supports the proposition that courts are accepting as substitutes for delivery, actions that satisfy the functional reasons behind delivery).

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concerned an elderly lady, who while on her deathbed, wrote an informal letter to her husband and instructed her caretaker that the note be delivered to him. The letter contained a list of various places where she had hidden money\textsuperscript{17} around her house and instructions of what to do with the money that was located in these places. It read as follows:

"My Dearest Papa:

In the kitchen, in the bottom of the cabinet, where the blue frying pan is, under the wine bottle, there is one hundred dollars. Alongside the bed in my bedroom, in the rear drawer of the small table in the corner of the drawer, where my stockings are, you will find about seventy-five dollars...The Building Loan book is yours, and the Bank book, and also the money that is here...God be with you. God shall watch your steps. Please look out for yourself that you do not go on the bad road. I cannot stay with you. My will is in the office of the former Lawyer Anekstein, and his successor has it. There you will find everything.

Your kissing, loving wife, Ethel Reiss"

Mrs. Reiss’ husband received the note and proceeded to take possession of the money. The donor never recovered from her illness and died shortly thereafter. The donor’s children from a previous marriage brought suit against the husband alleging that the money he had taken still belonged to their mother and consequently was theirs. One of the court’s main contentions was validating the gift due to the fact that it was never formally delivered from the woman’s possession to the defendant. Rather, the donee unilaterally took the gifts after receiving the instructions that the money belongs to him. The Majority opinion of the Court was that the gift was not valid, even though the donor had seemingly intended for the donee to receive the gift and had clearly instructed him to take possession of the money; the Court held that since he did not receive the money manually from the donor, the gifts were not valid. In this case, the Court adopted a strict formalist approach with regards to the act of delivery.

\textsuperscript{17} See John J. Sciullo, Case Note, 17 U. Pitt. L. Rev. 105 (1955) (arguing that the court should have validated the gift because revealing the hidden location of gifts should suffice as a replacement for manual delivery).
Not all courts have agreed with the ruling of the Majority in Foster. In fact many courts have explicitly held that even for deathbed bequests the donor’s intentions should be realized even without a formal delivery.  

Although the current state of the law is not entirely conclusive in any one direction, there have been cases in which other courts reached decisions similar to Foster. One such case is the decision reached by Superior Court in New Jersey in the case of In Re Estate of Link. That court held that merely stating an intention to transfer the property is sufficient to create a valid donation causa mortis.

18 See Begovich v. Kruljac, 38 Wyo. 365 (1928) (holding that “since the gift causa mortis does not come into the enjoyment of the donee till after the death of the donor... delivery can not be for the purpose of transferring possession and enjoyment.... Hence while in gifts inter vivos delivery is one of the constituent elements thereof. It subserves but the purpose of evidence in gifts causa mortis.” The Court therefore allowed the gift to transfer even without the formal delivery since there was evidence of the intention of the donor,) See also Pushcash v. Dry Dock Savings Institution, 251 N.Y.S. 184 (1931). These rulings stand in stark contrast to the ruling in Foster. There has been some strong criticism of the ruling in Foster, starting with the Dissent in Foster, written by Justice Jacobs and joined by two other Justices, including Justice Brennan, a future Supreme Court Justice. The Dissent argued that “here the donor’s wishes were freely and clearly expressed in a written instrument and the donee’s ensuing possession was admittedly bona fide; under these particular circumstances every consideration of public policy would seem to point towards upholding the gift.” The Dissent is quoted in the case of Whitney v. Canadian Bank of Commerce, 374 P.2d 441 (Ore. 1962) where the Court upheld a donation causa mortis that was not formally delivered. The Court in Whitney quotes many scholars who argue for a relaxing of formalist standards and some courts that had already begun to do so.

However, as recently as 2011 the decision in Foster was still quoted in court opinions. See Bhagat v. Bhagat, 2011 Westlaw 1529857 (N.J. Sup. Ct. 2011) (quoting the court in Foster and saying that “unless it is impossible or impractical, delivery of the object is required”) see also in Re Estate of Link, 746 A.2d 540 (N.J. Sup. Ct. 1999); Scherer v. Hyland, 75 N.J. 127 (1977).

19 See Schenker v. Moodhe, 175 Md 193, 200 (1938)(donor dying of contagious disease told donee to take donor’s keys, which were in the room; donee did not take physical possession and gift was invalidated) Keepers v. Fidelity Title and Deposit Co., 28 A. 585, (N.J. 1983) (delivery of a key was not considered enough of a delivery for a donation causa mortis). See also W.E. Shipley, Annotation, Delivery as Essential to Gift of Tangible Chattels or Securities by Written Instrument, 48 A.L.R. 2d 1405 § 9 (1956).

give over engagement and wedding rings does not satisfy the delivery requirement for a donatio causa mortis. Similarly, the Missouri Court of Appeals\textsuperscript{21} and the Supreme Court of Virginia\textsuperscript{22} have required strict formal delivery for deathbed bequests. All of these more recent decisions relied on some of the formulations and reasoning of the Foster court. However, there have been cases where the courts have been more willing to adopt a functionalist view of delivery and where they did not call for a strict fulfillment of this requirement.\textsuperscript{23} The Supreme Court of Virginia in the case of Brown v. Metz\textsuperscript{24} held that “while delivery and acceptance must be shown to establish a gift causa mortis, we have not retreated to such a formalist approach” and that “in determining whether a gift causa mortis has occurred we are guided by principles of reason and common sense as applied to the facts of the case.”\textsuperscript{25} Although the case law vacillates between formalist and functionalist approaches toward deathbed bequests, it seems that there is a clear reluctance to treat them as a regular type of gift. This attitude demands a look at the origins of the laws of deathbed bequests.

It is instructive to understand the origins and history of the donatio causa mortis in order to appreciate the more recent approach of the common law towards this type of gift. The modern laws of deathbed bequests originated in Greek and Roman law.\textsuperscript{26} It is interesting to note that the Roman law of the donatio causa mortis contained the possibility, in certain unique circumstances, of avoiding

\textsuperscript{21} Merchants Bank v. Donahue, 1992 Mo. App. LEXIS 571 (holding that an intention to give over a check without valid delivery does not constitute delivery for a donatio causa mortis).

\textsuperscript{22} Woo v. Smart, 442 S.E. 2d 690 (Va. 1994) (holding that a check does not constitute a valid delivery for a donatio causa mortis).

\textsuperscript{23} See eg. McCarton v. Estate of Watson, 693 P.2d 192 (Co. of App. Washington 1984) (holding that intention to deliver a gift coupled with constructive delivery should be enough to validate a donatio causa mortis).

\textsuperscript{24} 393 S.E. 2d 402 (Va. 1990) (whether a key to a deposit box constitutes valid delivery).

\textsuperscript{25} Id. at 404.

\textsuperscript{26} Blackstone believed that the Romans had taken it from the Greeks. William Blackstone, Commentaries *514 See also infra note 70 (possible Egyptian origins of the donatio causa mortis). See also Dig. 39.6 for a general discussion of this type of gift.
the formalistic requirements present in other dispositions of estates. In fact, William Buckland in his book, Elementary Principles of Roman Private Law, argues that the donatio causa mortis of Justinian did not require delivery at all. The donatio causa mortis served as an alternative opportunity for people to alter their will or in times when they did not have one, as a vehicle to bequeath their possessions. Although many doctrines within the Common Law have Greek and/or Roman origins, some modern day jurists only begrudgingly accepted the validity of the donatio causa mortis. The New Jersey Superior Court opinion in Foster quotes Lord Chancellor Hardwicke who said; “it was a pity that the Statute of Frauds did not set aside these kinds of gifts.” It also quotes New Jersey Vice-Chancellor Stevenson who said, “Such gifts are ‘dangerous things’.” In essence, modern day jurists were rebelling

27 See Dig. 29.1.1 (quoting Trajan who said that” following the openness of my heart towards my most faithful fellow soldiers…. that whichever way they make their will, their wishes should be confirmed. Therefore let them make their wills anyway they wish... and let the bare wishes of the testator suffice to settle the distribution of their property.”)
28 See W.W. Buckland, Elementary Roman Principles of the Roman Private Law, 103-105, (Cambridge University Press 1912)(“This rule requiring an overt act [of conveyance]… in strictness is applied only to transfers inter vivos: at death all sorts of interests are transferred by nothing but formal expression of intention.)
29 Foster at 558.
30 Ward v. Turner, 2 Ves. Sr. 431 (1752). See also, Duffield v. Elwes, 4 Eng.Rep. 959, 972 (1827)(quoting Lord Eldon, who expressed the opinion that it would be an improvement of the law to strike out altogether this peculiar form of gift, but since that had not been done, he felt obliged to "examine into the subject of it.").
31 Foster at 557.
32 Varick v. Hitt, 55 A. 139, 153 (N.J. Ch. 1903) (“These gifts causa mortis are dangerous things. The law requires, before Mr. Hitt can come into this court and claim $ 10,000 as an ordinary testamentary gift from Mrs. Thompson, that he should produce an instrument in writing signed by Mrs. Thompson, and also acknowledged with peculiar solemnity by her in the presence of two witnesses, who thereupon subscribed their names as witnesses. That is what Mr. Hitt would have to prove if he claimed a testamentary gift in the ordinary form of one-third of Mrs. Thompson's estate. And yet, in cases of these gifts causa mortis, it is possible that a fortune of a million dollars can be taken away from the heirs, the next of kin of a deceased person, by a stranger, who simply has possession of the fortune, claims that he received it by way of gift, and brings parol testimony to sustain that claim."). See also, Keepers v. Fidelity Title and Deposit Co., 28 A. 585, (N.J. 1983) (“When it is
against a perceived relaxation of the standard required in all gifts and testaments. The prevailing fear of those authorities was that deathbed bequests are ripe opportunities for fraud. Once the law allows such gifts, it opens the door for connivance, since the donor is now dead and not available to contradict any evidence the donee may bring to prove the existence of the gift. Because of this apprehension, although courts have allowed the gifts, they also insisted on strict formalism with regards to many of the aspects, delivery included, of the donatio causa mortis.

II. INFORMED CONSENT FOR THE TERMINALLY ILL

The doctrine of informed consent is well rooted in American jurisprudence. The doctrine emerged from cases involving rendition of treatment to which the patient had not consented, and its avowed purpose was to protect patients’ right to through-going self-determination. The oft-quoted case of Schloendorff v. Society of New York Hospital is viewed as one of the earliest cases implicating
the physician’s duty to disclose information to the patient in order to obtain the patient’s consent for a medical treatment. Justice Cardozo made the historical statement that “every human being of adult years and sound mind has a right to determine what shall be done with his own body.” This was later expounded on in Cobbs v. Grant where the Supreme Court of California held that a physician is required to impart information concerning the nature, risk, benefits and alternatives to a medical procedure. This was a significant recognition of the role patient autonomy has within medical treatment. The doctrine of informed consent is a natural outgrowth of the common law tort of battery that prohibits intentional unauthorized bodily contact. Over time the failure to obtain informed consent was treated as a negligence claim rather than as a battery cause of action.

Even after it was clearly held that physicians must disclose information to their patients, there was still much discussion in the courts concerning the standard used to determine the amount and type of disclosure. Courts originally used a “professional standard,”

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37 Id. at 94; See also Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093, rehearing denied, 187 Kan. 186, 354 P.2d 670 (1960)(Anglo-American law starts with the premise of thorough-going self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment. A doctor might well believe that an operation or form of treatment is desirable or necessary but the law does not permit him to substitute his own judgment for that of the patient by any form of artifice or deception.).


39 Among the advantages of allowing a patient to recover under a battery theory were a non-requirement of expert medical witness proving that the physician had violated the standard of care, recovery even if there was no resulting harm, and possible punitive damages.

40 “The reason perhaps being that medicine, being as much an art as a science, requires that physicians retain some judgment in determining the appropriate treatments. Failure to exercise proper judgment in treatment decisions is rarely done intentionally, therefore, medical malpractice claims due to lack of informed consent are based on negligence.” Barbra L. Atwella, The Modern Age of Informed Consent, 40 Rich. L. Rev. 591. See Encyclopedia of Bioethics 1298-99, for an alternative explanation of the change in jurisprudence posited by Yale Law School professor Jay Katz.
meaning what a reasonable medical practitioner would have disclosed under the same or similar circumstances. 41 This standard was a result of the court’s approach to the fiduciary duty of the physician. This view perceived the duty to disclose as subservient to the duty to do “what is best” for the patient. Therefore the duty to disclose was judged by what was accepted practice among physicians. However, over time some courts began to favor a different approach. 42 The court in the case of Canterbury v. Spence 43 held that the standard should be what a reasonable patient would consider important for their informational needs. 44 Proponents of the reasonable patient standard believed that the primary purpose of the informed consent doctrine was to allow the patient to decide whether to undergo a proposed therapy. 45 This approach favored the aspect of patient autonomy and within time became the accepted standard. 46 As the doctrine and laws of informed consent were being formed courts developed the doctrine of Therapeutic Privilege in order to balance practitioner’s autonomy with patients’ right to information. 47 This


43 See Canterbury at 786. The Court held that the information provided must be material to the specific patient before the physician. Other courts have held that the physician only need provide the information needed for a general “reasonable” patient. 45 Id.

44 In fact it was after Canterbury that legislation was enacted in many states which embodied the concept of informed consent. See Arthur B. LaFrance, Bioethics: Health Care, Human Rights and the Law, 569-573 (Mathew Bender 1999).

exception permitted doctors to withhold information that they believed might seriously depress or upset patients. However, ultimately courts have been reluctant to allow doctors the right to exercise this privilege. For example, in Canterbury the court recognized that the “physician’s privilege to withhold information for therapeutic reasons must be carefully circumscribed ... for otherwise it might devour the disclosure rule itself.”

Although there have not been many cases turning on the therapeutic exception, in 2002 the Supreme Court of Hawai‘i held that an appellate court was wrong in allowing a defendant to liberally exercise the therapeutic privilege. The case concerned Mr. Barcai who was admitted to the care of a psychiatrist, Dr. Betwee, after he exhibited symptoms of psychosis. After a few episodes of psychosis with deteriorating behavior, Dr. Betwee prescribed an antipsychotic medication. The administration of the medication allegedly caused Barcai’s death and was Dr. Betwee was sued on a number of grounds, one of which was failure to inform Barcai about certain potentially deadly effects of the medication. Dr. Betwee argued that he should be granted the therapeutic exception because he believed that acutely ill patients like Barcai often are unable to adequately understand detailed information and that the patient’s fear and paranoia support the assumption that it would have been harmful to the patient to reveal information about the potential side effects of the medication. The court held that Dr. Barcai did not properly establish the therapeutic exception defense. It used the Canterbury case to articulate the formula for the exception and then said although the cases suggest that expert testimony may be required


48 Id. at 789.
50 Id. at 963.
51 Id. at 959.
52 Id. at 961.
to rebut the physician’s claim of the therapeutic privilege that would allow to much leeway for a defendant physician. The court closed by insisting that the therapeutic privilege be once again carefully circumscribed.

Law review articles also called for the curtailment of this privilege. As recently as 1995, commentators have written articles

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53 Id.
54 Id. at 963. (“Plaintiffs also correctly point out that requiring expert testimony to rebut a generic assertion of therapeutic privilege would allow the "exception" to swallow the general rule that expert testimony is not necessary for a jury to decide whether a reasonable person would have wanted to be informed of a particular risk. If, for example, all a physician had to do to assert the privilege was to claim that he or she never told patients of a particular risk because the risk would "scare them," it would eviscerate the patient oriented disclosure standard because expert testimony would always be required to rebut such a general claim. Moreover, in discussing the therapeutic privilege exception, the court in Canterbury noted:

The physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs. That attitude presumes instability or perversity for even the normal patient, and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself.

Canterbury, 464 F.2d at 789. Thus, in order to assure that the use of the therapeutic privilege exception is "carefully circumscribed," the trial court should ensure that the defendant physician who claims the privilege expressly testifies that his or her decision to withhold information was based on specific considerations in the individual patient's case and identify those considerations.”).
55 Id. (“However,… given the need to "carefully circumscribe" the therapeutic privilege exception, we conclude that Dr. Betwee's testimony fell short of establishing the privilege in Barcai's case where Dr. Betwee did not expressly testify that his decision to withhold information was based on specific considerations in Barcai's case and did not identify those considerations.”)
expressing their amazement that courts did not strongly word their limitation on the exception’s use. 57 And the Canterbury courts’ ruling is still used to express the sentiment that the law of informed consent must do its utmost to protect patient autonomy. 58

Medical practice in recent years has changed as well, with practitioners almost uniformly reluctant to withhold any diagnostic information from patients. 59 Although the requirement to disclose

57 See William J. McNichols, Informed Consent Liability in a “Material Information” Jurisdiction: What Does the Future Portend?, 48 Okla. L. Rev. 711, 729 (1995). (“Courts and commentators have strongly cautioned that the exception must be kept within very narrow limits, else it will swallow the ‘material information’ doctrine under an avalanche of ‘doctor knows best’ scenarios. However, the Scott opinion endorses an extraordinary example. It states, “for example, [disclosure may be withheld where it] would alarm or emotionally upset an apprehensive patient.” Surely, the court is not to be taken literally, or perhaps even seriously, with this example. The example does not even say seriously upset! Almost any patient faced with any significantly risky therapeutic choice would be ‘apprehensive’ and ‘alarmed’ by the decision-making role in which she is placed. The case that Scott cites, however, is Nishi v. Hartwell, one of the more physician-protective of the “therapeutic privilege” cases. The exception would certainly swallow the patient oriented rhetoric of the Oklahoma prima facie case and will amount to a back door acceptance of the ‘doctor knows best’ tradition if courts subsequently interpret it, as the example in the Scott opinion suggests, to permit physicians to withhold material information which would cause a patient anxiety. One should note, however, that the Oklahoma Uniform Civil Jury Instructions have not taken Scott literally and have articulated the privilege in a way that limits the necessary emotional anxiety to situations where patients would not be able to weigh the risks rationally. The instructions state that the privilege exists when ‘disclosure would alarm an emotionally upset or apprehensive patient so that the patient would not be able to weigh rationally the risks of refusing to undergo the recommended treatment or operation. ’ Hopefully, in the future, the court will articulate the true scope of this exception, perhaps by endorsing the privilege-narrowing language of the Canterbury opinion, which it failed to mention in Scott.”)(emphasis added).
59 See Arthur B. LaFrance, Bioethics: Health Care, Human Rights and the Law, 569-573 (Mathew Bender 1999) (“In the 1960’s, 80% of physicians surveyed said they would not tell a patient of a cancer diagnosis; it would be too upsetting. In the 1990’s, 90% would tell.”); D. Palisano, J. Mang & J. Herbert, Informed Consent: A
prognosis information to terminally ill patients was once one of the most controversial topics within this area,\textsuperscript{60} it is now an almost uniform practice to have full and complete disclosure. This is the practice despite the negative consequences that may arise for patient health. Some legal scholars have even explicitly said that patient beneficence must be sacrificed for the sake of autonomy.\textsuperscript{61} One of the many legal ramifications of the change in medical policy would be the removal of liability from a physician, under the current state of the doctrine, when disclosing medical information that causes harm to the patient.\textsuperscript{62}

Courts and commentators arguing for stronger patient autonomy have invoked a variety of reasons such as the constitutional rights of privacy\textsuperscript{63} and freedom of religion,\textsuperscript{64} John Stuart Mill’s

It is not clear in which direction the influence flowed; did practice change the theory or vice-versa? However, many hold that the legal doctrines were the catalyst for physicians’ changed behavior. 3 Encyclopedia of Bioethics 1273 (3d ed. 2004).
\textsuperscript{60} 3 Encyclopedia of Bioethics 1273 (3d ed. 2004).

\textsuperscript{61} Elizabeth G. Patterson, The Therapeutic Justification for Withholding Medical Information: What you Don’t Know Cant Hurt You or Can It? 64 Neb. L. Rev. 721,738 (1985).

\textsuperscript{62} See Kraus v. Spielberg, 236 N.Y.S. 2d 143 (N.Y. Sup. Ct. 1962) (holding that where the doctor’s actions were medically warranted and constituted no deviation from medical practice, the doctor cannot be sued for psychic injury based on fright from medical advice given to the patient); Winik v. Jewish Hosp. of Brooklyn, 340 N.Y.S.2d 927 (1972) (no recovery where fear of cancer is unreasonable nor attributable to doctor’s negligence). See also the New Zealand case of Furniss v. Fitchett, 1958 N.Z.L.R. 396 (holding that doctors have a duty to ensure that no disclosure of diagnosis should be allowed in a non-tactful manner).


concept of freedom of choice,\textsuperscript{65} Kant’s belief that autonomy was essential to moral action\textsuperscript{66} and even tort doctrine.\textsuperscript{67} However, the strongest reason\textsuperscript{68} for the push towards patient autonomy may have been the rise of the field of bioethics. The study of bioethics has had a major impact on health care providers\textsuperscript{69} as well as the justice system.


\textsuperscript{65} Quoted in Elizabeth G. Patterson, \textit{The Therapeutic Justification for Withholding Medical Information: What you Don’t Know Cant Hurt You or Can It?} 64 Neb. L. Rev. 721 (1985) (“That the only purpose for which power can be rightfully exercised over any member of the civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear… Over himself, his own body and mind, the individual is sovereign.”).

\textsuperscript{66} Onora O'Neill, Autonomy and Trust in Bioethics 23 (Cambridge University Press 2002).


\textsuperscript{68} Two additional potential changes should be noted as well. The general rise of accommodations towards consumer informational needs, for example; in products liability, may have influenced the medical profession. Another factor may be the way that doctors are seen within the health care system. Whereas once a doctor may have a respected and unquestioned authority figure, recently he is seen as nothing more then a hired employee. See Stephen Metcalf, The Liberty Scam: Why Even Robert Nosick, The Father of Libertarianism Gave Up on the Movement He Inspired, Slate, http://www.slate.com, June 20, 2011 (“To take only the most pitiful example, medical doctors have evolved over this period from fee-for-service professionals totally in control of their own workplace to salaried body mechanics subject to the relentless cost-cutting mandate of a corporate employer. They've gone from being Marcus Welby—a living monument to public service through private practice—to being, as one comprehensive study put it, harried "middle management." Who can argue with a straight face that a doctor in 2011 has more liberty than his counterpart in 1970?”).

\textsuperscript{69} See generally Baruch A. Brody et al., \textit{Medical Ethics: Analysis of the Issues Raised by the Codes, Opinions and Statements} (The Bureau of National Affairs 2001).
One of the primary tenets of bioethics is patient autonomy. Self-determinism is the subset of autonomy most commonly associated with informed consent and health care, such that decisions originate freely from an autonomous agent who understands the facts and can engage in practical reasoning to come to a decision. Physicians have an obligation to respect the right of patients to have sufficient knowledge regarding their medical condition and treatment choices to make an autonomous medical decision. The normative weight placed by the study of bioethics on patient autonomy has had a profound impact on the formation and evolution of the doctrine of informed consent. In a research context, concern over informed consent, beginning from the Nuremberg Code through to reactions to the Tuskegee experiments, played a significant role within the discussion of mid 20th Century bioethics. By the 1980s, the AMA already recognized informed consent as a basic social policy and the U.S. President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral research placed informed consent as a main item on its agenda at their first conference. The commission argued that although informed consent emerged primarily through law its requirements are essentially moral and policy based.

72 Aside from the rise of bioethics, some other possibilities exist for the recent emphasis on patient autonomy. One of these may be the change in the way that health care is provided. Whereas once it was common to have a sole practitioner take patients cradle to grave, now impersonal teams of doctors provide medical care. Perhaps this has lead to a weakening in patient reliance on a physician’s decision and is now expected to take a much larger and commanding role. Additionally, the amount of viable medical treatments available to patients has sharply risen. This would be the cause for less reliance on the treating physician to be the sole arbiter of medical decision making as there may be many alternatives he or she are not familiar with.
74 Which stated that the primary consideration in research is patients’ consent. Germany 1947.
Since the primary tenet of bioethics is patient autonomy, the commission can be understood as endorsing a vigorous enforcing of the doctrine of informed consent and at best, a very minimal therapeutic exception. Over the last few decades, it has been widely acknowledged in the literature that autonomy has been given substantial priority over the other ethical principles, including beneficence.

Clearly when scholars and physicians call for patient autonomy in the face of potential negative health consequences for terminally ill patients, they are either rejecting the argument that the stress of knowing that one possesses a terminal illness can adversely affect a patient or they are implicitly giving stronger normative weight to other competing values.

III. JEWISH LAW OF DEATHBED BEQUESTS

In sharp contrast to the Common Law approach regarding the _donatio causa mortis_ stands the Halacha or Jewish legal code. An exploration of Halacha reveals an almost anti-formalist approach towards deathbed bequests. The Mishna in _Bava Basra_ discusses a _deyathiqi_, which is the Greek term for a Will and Testament. The

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75 It can be argued that there is a big difference between the informed consent of the bioethicists and the legal doctrine of informed consent. See 3 Encyclopedia of Bioethics 1279 (3d ed. 2004) which delineates two meanings of informed consent. The first is an autonomous authorization of medical intervention by a patient and derives it’s meaning from the philosophy that informed consent is principally a matter of protecting and enabling choice by patients. The second meaning is an analysis of informed consent in terms of institutional and policy rules of consent. It refers only to a legal or institutional effective approval by the patient. Conditions and requirements for consent are relative to the social and institutional context and need not be autonomous authorizations. One could make the argument that the differences between understanding the doctrine is what leads to these different meanings.

76 Beauchamp & Childress, _supra_ note 60, at 12; Kukla, _supra_ note 62, at 35; O’Neill, _supra_ note 55, at 34.

77 Compendium of Rabbinic Doctrines- Redacted 220 CE

78 8:6 Literally “the last gate.” (Tractate dealing with the laws of property disputes and contracts.)
Talmud\(^{79}\) in *Bava Metziah*\(^{80}\) explains that the *Deyathiqi* is a gift that is given from the donor’s deathbed and is only activated by the donor’s death.\(^{81}\) Later, in the Talmudic period, a gift in contemplation of death was referred to as *mtnas schiv mera*. The *donatio causa mortis* found in the Talmud shares many similarities with the Common Law version; principally, they are similar with regards to the law that should the donor recover from his or her illness, the gift is retroactively invalidated. Where they differ\(^{82}\) is that the *mtnas schiv mera* transfers the gift by mere words alone\(^{83}\) -- the act of oral communication effectuates the transaction,\(^{84}\) in stark contrast to the general insistence within Talmudic Law on strict formalism.

Generally, the transfer of possessions requires a *kinyan*, or an act of acquisition, in reference to which, the Talmud almost always insists on strict formalism.\(^{85}\)

The Talmud explores the history and legal reasoning behind the lack of formalism in deathbed bequests.\(^{86}\) It concludes that the

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\(^{79}\) Commentary on the Mishna- Published 500 CE  
\(^{80}\) 19a Literally “the middle gate.” (Tractate dealing with Property Law.)  
\(^{81}\) See Reuven Yaron, Gifts in Contemplation of Death in Jewish and Roman Law, 22-25(Oxford, Claredon Press 1960) (comparing the texts found in Ancient Greek Testaments to the texts of the ones mentioned in the Talmud).  
\(^{82}\) The Roman law also allowed the gift to be effectuated informally in certain circumstances, for example for soldiers, but the Talmudic version is always transferred through an informal delivery. See also *ibid*. n. 11. An additional difference is that the *mtnas schiv mera* must be a total disposition of the donor’s property. See *Bava Basra* 147b.  
\(^{83}\) Whether the oral delivery is in place of an actual delivery of the gift or merely an entirely different way to effectuate a transfer is an interesting question. Should the oral bequest not be considered a form of delivery, it would explain the opinion that holds that a *mtnas schiv mera* can be effectuated even on the Sabbath(a time when traditional transactions are prohibited), see *Bava Basra* 154b. However, the Talmud only allows a *mtnas schiv mera* to work for objects that can be transferred through a standard delivery see *Bava Basra* 147b. That would seem to indicate that the oral delivery of the mtnas schiv merah is in place of the standard delivery of all gifts. Also compare the language the Sheiltos uses (Sheiltos 33) with the language of the Talmud. The language used by the Sheiltos (*mtnas schiv mera* doesn’t require a *kinyan*) would indicate a total lack of delivery for the *mtnas schiv merah*.  
\(^{84}\) See *Bava Basra* 151a, 175a, *Gittin* 13a, and 15a.  
\(^{85}\) See Yaron, *supra* at 70.  
\(^{86}\) *Bava Basra* 147b. At the beginning of the discussion, the Talmud attempts to find a Biblical origin for the *mtnas schiv mera*, possibly as a reaction to the Greek
lack of a required formal delivery was a rabbinic enactment, created out of fear that the donor “will lose his mind.” As occurs often in Talmudic commentaries, this nebulous statement is interpreted in four ways. The accepted explanation is that the Rabbis were concerned about the potential health effects on the donor, who is in a perilous state of terminal illness, should his wishes not be carried out. The rabbis avoided the fear of fraud found in the Common Law by requiring two witnesses to observe and testify to the bequest.

and Roman law that were extant at the time of the Talmud and to prove that there was a Jewish origin. See Yaron, supra at 19 (discussing how the concept of the mtnas schiv merah was taken from the Greeks); Id. at 47 (discussing the Egyptian dispositions in contemplation of death).

Rashbam (Rabbi Shmuel ben Meir c. 1085-1158 France) at Bava Basra 147b notes one explanation (also found in the Ramah [Rabbi Meir Abulafia c. 1170-1244 Spain] id.) that the Talmud means that should we not allow the transfer to go through, there is a possibility that the donor may die or be incapacitated before he is able to complete a formal kinyan. The Rashbam was not satisfied with this explanation so he explains the Talmud to mean that the Rabbis were concerned of the potential health effects of stress on the donor should his wishes not be carried out. The Ramah also gives an alternative explanation and says that the labor of forcing the donor to complete a standard kinyan in addition to his oral command would be too oppressive and cause adverse health effects. Rabbeinu Gershom (Rabbi Gershom ben Yehuda c. 960-1040 Germany) id. posits a fourth possible interpretation and says that allowing the transfer through an oral command enables the donor to transfer his possession even on the Sabbath, a time when a kinyan is prohibited. See supra n. 23. This was done in order to ensure that a person would be able to transfer his possessions before he dies or is incapacitated. It is not clear whether the commentators understood the Talmud to give serious health concern to the stress involved with not having one’s desire accomplished or did they mean that this will exacerbate the current illness and therefore lead to ill effects on the donor’s health? Rashbam ibid. seems to indicate that the overarching concern is the illness that the terminal patient is currently afflicted with. However, Rabbeinu Gershom ibid. says we are concerned about the pain of the stress caused by the desire not being carried out. It is unclear whether this difference of opinions would lead to different Halachic rulings in other cases see the discussion further.


See Yaron, supra at 63.
Terminal Stress

Evidently, the normative values motivating each legal system, the fear of fraud on one hand and the concern for the donor’s health on the other, lead to very different conclusion of law.

IV. JEWISH LAW OF TRUTH TELLING TO TERMINALLY ILL PATIENTS

To understand the contours of the current debate in Jewish bioethics regarding truth telling to terminally ill patients, one must begin with the dismissive attitude concerning the doctrine of Informed Consent. The primary motivating factor behind the push for stronger patient rights through Informed Consent is the theory of patient

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For a compelling analysis in the contemporary Israeli context, see A. Edrei, Of What Purpose is Jewish Law? (Hebrew), 25 Iyunei Mishpat 467(2001).


autonomy. However, in Jewish bioethics the common consensus is that patient autonomy does not have primary or independent value. The reason for this is that patients are not considered free agents to determine ultimate values and cannot be considered fully in possession of their life and bodies. Rather, it is the Halacha that determines the value system and God that is in possession of one’s body. Nevertheless, there are circumstances where the patient is enjoined to make his own decision regarding medical treatment, but those circumstances only apply when there are various halachically acceptable treatment options with different sets of risks and benefits or where a risky therapy may reverse a condition. In such circumstances, the patient may choose the path of his therapy. However, where danger to life and limb is clear and immediate and a particular therapy is clearly indicated, appropriate and safe, Jewish bioethics holds that it should be administered even against the patient’s express wishes. Clearly, the Halacha does not fully accept the doctrine of Informed Consent.

When a patient has contracted a terminal illness, the Halacha advocates shielding the patient from any disturbing information. The

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93 Akiva Tatz, Dangerous Diseases and Dangerous Therapy In Jewish Medical Ethics, Targum Press 2010.
94 Igros Moshe Ch. M. 2:74 (therapy must have more then 50% likelihood of success).
95 See Tosefta Shkalim 1:2 (stating that a life saving amputation must be performed if necessary even if the patient must be constrained); Mogen Avraham O.C. 328:6; Sh. Aruch Ch. M. 420:3. A caveat to this rule is when the patient refuses treatment, even a clearly proven treatment suggested by an expert, because he does not regard the treatment as effective. Even if this is his own personal opinion (and especially if he has the support of a single other physician) the Halacha does not allow forcing therapy that the patient feels is harmful. See Mor u’Kziah O. Ch. 328; Igr. Moshe Ch. M. 2:74.
96 As a practical matter, one could argue that since the Halacha requires patient consent for any therapy that involves risks and since the level of risk considered significant by the Halacha is anything more then 1%, in almost all treatments of serious illness, patient consent will be required. This renders the Jewish bioethicists dismissal of the doctrine of Informed Consent basically moot aside from when the patient refuses all treatment.
Talmud states that one is not allowed to inform a seriously ill patient that a relative has died because “perhaps they may lose their mind.” This statement was codified in the Legal Codes and is the source of the modern day issue of how much information a physician is supposed to reveal to a patient. Most Jewish Bioethicists hold that the Law requires the physician to assume that as a general rule a patient should not be informed of any prognosis that contains the slightest possibility of upsetting the patient. They infer this from

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97 Babylonian Talmud, Moed Kattan 26b.
98 The Talmud uses the exact same language for the mtnas schiv merah See ibid. It is reasonable to assume that some of the same questions regarding this phrase apply here as well. See ibid. n. 26
99 Shulchan Aruch, Yoreh Deah 337, 338.
100 It is fascinating to explore the fact that an issue brought up by the Talmud has not been addressed in centuries of Jewish scholarship. From the … till the … there do not exist any Rabbinic Responsa concerning this subject matter. Perhaps the rise of the subject of Bioethics brought this law once again to the forefront of Rabbinic thought or perhaps the change in the way that health care is provided (less private and home bound, more public and institutionalized) has precipitated a new relevance to this doctrine.
101 See Abraham S, Abraham, Nishmat Avraham, Yoreh Deah 338:3 (holding that in the vast majority of terminal cases, the truth should be concealed from the patient): Abraham Steinberg, Disclosure of Illness to the Patient, Encyclopedia of Jewish Medical Ethics, Volume 1 pg. 317-28, Volume 2 Informed Consent, pg. 554-55 (Jerusalem Feldheim Publishers 2003).
See also, Gary J. Lavit, Truth Telling to Patients with a Terminal Diagnosis, Journal of Halacha and Contemporary Society XV, pg. 94-124, spring 1988 (saying that this is the majority opinion within Jewish Bioethics).
As is usually the case within Jewish legal issues there are many diverse opinions on the matter. More recently some scholars have questioned the accepted wisdom within Jewish Bioethics and now insist that the patient would receive more benefit should the physician inform them fully about their condition. To be clear, even many traditional scholars like Bleich, etc. agree that there are circumstances which call for more disclosure, yet they still hold that the standard approach a physician should take is to limit disclosure of any upsetting information to terminal patients. Some scholars like Jutkowitz and Glick advocate that the navigating the risk benefit disclosure should not be the province of the physician at all and rather patients should ultimately be in charge of their own medical care. They suggest that modern medical knowledge and a reshaping of the doctor-patient relationships have rendered past rabbinic statements functionally obsolete. See Alan B. Jotkowitz and Shimon Glick, The Physician Charter on Medical Professionalism: A Jewish Ethical Perspective, Journal of Medical Ethics 31, pg. 404-05 (2005);
the fact that the Talmud states that perhaps they may lose their mind.  

Even the slightest chance of an affect on a patient’s health is given serious weight. Rabbi Moshe Feinstein, one of the leading arbiters of Jewish law in the 20th century, argued that it is impermissible to move a terminal patient out of the intensive care unit (even if the move was made in order to give the bed to another patient with a better prognosis) for the move may induce anxiety and hasten death. He also ruled that treatment should never be discontinued, even if the physician feels it will not be beneficial, in order to prevent the patient from giving up hope. Given this attitude it is not surprising to find that Jewish bioethics end up promoting behaviors that stand in stark contrast to the bioethical values adopted by most scholars and practitioners.

V. OVERVIEW OF EMPERICAL MEDICAL DATA

The notion that psychological states can affect the outcome of human disease is an old one. As early as AD 200, Galen wrote that melancholic women were more susceptible to “swellings” of the breast than were sanguine women. More recently, Dr. Hans Selye


For an interesting analysis of the evolving views on Halacha and patient information and arguments about the incorporation within Halacha of evolving sociological and psychological assumptions of the medical community see Judah L. Goldberg, Towards a Jewish Bioethic: The Case for Truth Telling, 43:2 Tradition Magazine 9 September 2010.

See Joshua Kunin, Should Patients be told the Truth about their Illness: Jewish Perspectives, Israel Medical Association Journal 4 pg. 737-41, 2002; J. David Bleich, Bioethical Dilemmas: A Jewish Perspective, Disclosure of Information, Ch. 2. (holding that there is no prohibition of lying in such cases). This opinion differs from many philosophers who believe that falsehood is in itself mean and culpable (Aristotle) and Kant who wrote in a brief article that it would be wrong to lie even to a murderer seeking the hiding place of an intended victim. 3 Encyclopedia of Bioethics 1265.

Moshe Feinstein, Igrot Moshe, Choshen Mishpat Volume 2, no. 73 §2 (New York).

was one of the first reputable medical researchers to pioneer studies documenting the relationship between mind and body. Since his original work\textsuperscript{105} in the 1950s identifying the hypothalamus-pituitary-adrenal system and its effect on health,\textsuperscript{106} the field of psychosomatic medicine has mushroomed. Although it is now almost universally accepted that even purely psychological phenomenon can yield physical results, the degree to which one can influence the other is still not fully understood.\textsuperscript{107}

One of the mind body relationships that has been subject to much study is the effect of emotional/mental stress on disease. To illustrate, there are over 300 empirical articles alone on the association of psychological stress and the parameters of the immune system.\textsuperscript{108} Additionally, there is an ongoing and lively debate about whether stress, chronic depression and lack of social support serve as risk factors in cancer development.\textsuperscript{109} There are even studies

\textsuperscript{105}Hans Selye, The Stress of Life (1956).
\textsuperscript{106}This system, in short, governs the amount and kind of response the body produces to combat a stressing agent. Simplified, the hypothalamus (the bridge between the brain and endocrine system) sends a message to the pituitary gland (a hormone-producing gland embedded in bones at the base of the skull) to release ACTH (adrenocorticotropic hormone) into the blood stream. This signal prompts the adrenal cortex (located above the kidneys) to create corticoids, another hormone, from available raw material. These corticoids are then dispersed to the places in the body they are needed, where they are put to use in the various stages of defense against a stressing agent.
analyzing the effects of hope and hopelessness on sick patients.\footnote{See Garssen B. \textit{Psychological factors and cancer development: Evidence after 30 years of research}, Clinical Psychology Review 2004; 24(3): 321–330} Evidently, the question of how individual’s emotional state affects his/her physical one is of interest to researchers and practitioners.

Many studies on the effects of stress on disease are founded on evidence that shows that stress can alter endocrine, neurochemical and immune functions.\footnote{See Garssen B. \textit{Psychological factors and cancer development: Evidence after 30 years of research}, Clinical Psychology Review 2004; 24(3): 315; biology: \textit{Pathways and mechanisms}, Nature Reviews Cancer 2006; 6(3): 240–248; Thaker PH, Han LY, Kamat AA, et al. \textit{Chronic stress promotes tumor growth and angiogenesis in a mouse model of ovarian carcinoma}, Nature Medicine 2006; 12(8): 939–944; Reiche EM, Nunes SO, Morimoto HK. \textit{Stress, depression, the immune system, and cancer}, The Lancet Oncology 2004; 5(10): 617–625; Gina Kolata, \textit{Is There a Link Between Stress and Cancer}, New York Times, November 29, 2005.} Ironically, stress has the potential to compel the body to fight harder against a perceived threat, but it can also cause a weakening in the body’s ability to combat disease.\footnote{See Segerstrom S, Miller G. \textit{Psychological stress and the human immune system: A meta-analytic study of 30 years of inquiry}, Psychological Bulletin 2004; 130(4):601, 604; Reiche EM, Nunes SO, Morimoto HK. \textit{Stress, depression, the immune system, and cancer}, The Lancet Oncology 2004; 5(10): 621.} To resolve this paradox medical researchers posit different biochemical explanations\footnote{See Segerstrom S, Miller G. \textit{Psychological stress and the human immune system: A meta-analytic study of 30 years of inquiry}, Psychological Bulletin 2004; 130(4):601, 604} distinguishing between the body’s reactions to different types of stressors and between these reactions’ effects on different forms of disease.\footnote{Id.; Reiche EM, Nunes SO, Morimoto HK. \textit{Stress, depression, the immune system, and cancer}, The Lancet Oncology 2004; 5(10): 624; Gina Kolata, \textit{Is There a Link Between Stress and Cancer}, New York Times, November 29, 2005.} Through these findings studies have shown that the effects of stressful life events may cause cancer progression, however, this conclusion has not been wholly agreed upon.\footnote{Garssen B. \textit{Psychological factors and cancer development: Evidence after 30 years of research}, Clinical Psychology Review 2004; 24(3): 321 (arguing that} There have also been experimental animal studies that have

shown that stress may alter tumor growth, however, the biological mechanisms underlying these effects are not well understood, and, as such, their clinical significance remains controversial. One of the reasons that animal studies do not properly reflect effects on human subjects is because of the inherent difficulty in defining and conceptualizing stress. Most studies define stress as a circumstance that most people would find stressful—so called “stressors.”

There are five categories of stressors used in most studies: 1) Acute time limited stressors involve challenges such as public speaking or mental arithmetic, 2) brief naturalistic stressors involve real life short term challenges, 3) stressful events sequences refer to focal events, like the loss of a spouse, 4) chronic stressors pervade a person’s life, thus forcing him or her to restructure his/her identity or social roles and finally 5) distant stressors are traumatic experiences from the past that have potentially long term significance. However, the limitations of these studies are evident in that the effects of a given stressor vary widely based on the patient’s individual reaction to the stressor. Additionally, it is important to note the bidirectional stressful life events have not been found to influence disease progression; Reiche EM, Nunes SO, Morimoto HK. Stress, depression, the immune system, and cancer, The Lancet Oncology 2004; 5(10): 623 (arguing that stressful events may promote progression of some types of cancers); Antoni MH, Lutgendorf SK, Cole SW, et al. The influence of bio-behavioural factors on tumour biology: Pathways and mechanisms, Nature Reviews Cancer 2006; 6(3): 240–241 (arguing that stressful events may promote progression of some types of cancers); See also Thaker PH, Han LY, Kamat AA, et al. Chronic stress promotes tumor growth and angiogenesis in a mouse model of ovarian carcinoma, Nature Medicine 2006; 12(8): 939.
nature of the relationship between stress and disease, in that a disease can cause psychological reactions that can in turn affect the findings of an empirical medical study.\textsuperscript{121} As a result many researchers feel that there is a strong need for further and better studies examining the effects of stressors.\textsuperscript{122}

Some of the latest studies have shown that there is no correlation between patients’ awareness of impending death and shorter life spans.\textsuperscript{123} This would seem to indicate that the stress of receiving a terminal diagnosis does not affect one’s physical health. Additionally, studies have failed to demonstrate that any particular psychological factor contributes to cancer development.\textsuperscript{124} However, there is data that seems to indicate that depression and hopelessness can have strong negative effects on a patient’s immune system and can lead to unfavorable progression of an illness.\textsuperscript{125} This could be taken as a reason to proceed cautiously when divulging information to

\textsuperscript{123} Young Ho Yun et al., \textit{Impact of Awareness of Terminal Illness and Use of Palliative Care or Intensive Care Unit on the Survival of Terminally Ill Patients With Cancer: Prospective Cohort Study}, Journal of Clinical Oncology 29, 2011, 2474-2480.
a patient that may cause him/her to fall into a state of depression or hopelessness. Importantly, many studies have found that denial or minimization of the impact of cancer can lead to a more favorable prognosis.\textsuperscript{126} While the author of the review of the literature does not advocate deceiving a patient as to his/her condition, the evidence indicates that it may be advantageous to the patient’s health if he/she were to be kept somewhat unaware of the severity of his/her condition.

Another factor that merits consideration when deciding how much information to divulge is the cultural attitude of the patient. Studies have shown that while most cancer patients in Western cultures would prefer to be well informed of their diagnoses, prognosis and the probability of success of their treatment,\textsuperscript{127} some patients would prefer not to have all that information.\textsuperscript{128} Some physicians claim that many patients do not want to know all the risk information or contribute substantially in the decision-making.\textsuperscript{129} In fact, many seek medical care to relinquish some of the autonomy and responsibility to the experts.\textsuperscript{130}

\textsuperscript{126} Garssen B. Psychological factors and cancer development: Evidence after 30 years of research, Clinical Psychology Review 2004; 24(3): 327-328.
\textsuperscript{128} Steven H. Woolf, The Logic and Limits of Shared Decision Making, 166 J. Urology 244, 244 (2001).
\textsuperscript{130} Alfred I. Tauber, Sick Autonomy, 46 PERSP. BIOLOGY & MED. 484, 486 (2003).
In Japan,\textsuperscript{131} Egypt,\textsuperscript{132} Spain\textsuperscript{133} and Italy\textsuperscript{134} the disclosure rate is significantly lower than it is in most of the Western world. This preference appears to be cultural, members of these nationalities may either fear social isolation due to the stigma of having cancer\textsuperscript{135} or they simply may be kept in the dark due to familial protection of ill members of the family.\textsuperscript{136} Physicians in non-Western cultures were also more likely to withhold information at the family’s behest, to use euphemisms, and to engage in treatments that they knew were unlikely to work so as to maintain patients’ hopes.\textsuperscript{137} Patient’s expectations and physicians’ attitudes cannot be ignored when judging the potential effects of disclosure.

VI. RECOMMENDATION

After careful analysis of the above studies, and with detailed understanding of the issues of informed consent and the therapeutic exception, it seems only logical and prudent to conclude that the potential effects of awareness of a terminal diagnosis are highly individualized. Some patients would definitely be harmed by a very forthright and harsh prognosis, while others would perhaps benefit from an unvarnished, straightforward diagnosis. This makes it difficult to form a rule of behavior to be applied equally in all circumstances. The question therefore remains: what should the medical and legal policy be in such a situation? Some researchers

\textsuperscript{131} 30\%. \textit{Id.} at 2189. Eric Feldman has noted that many Japanese practitioners perceive disclosing terminal diagnosis as a “callous practice”. Eric Feldman, Medical Ethics the Japanese Way, 15 (5):21 Hastings Center Report.
\textsuperscript{132} 3\%. \textit{Id.}
\textsuperscript{133} 32\%. \textit{Id.}
\textsuperscript{134} 52\%. \textit{Id.}
\textsuperscript{136} Whereas in the United States physicians would hold back information at the families’ request only 17\% of the time. See Walter F. Baile et al., \textit{Oncologists’ Attitude Toward and Practices in Giving Bad News: An Exploratory Study}, Journal of Clinical Oncology, 20:8 2002 2194.
\textsuperscript{137} \textit{Id.} at 2193.
\textsuperscript{138} Possible benefits may be the ability to plan end-of-life strategies, avoid harmful effects of inappropriate therapies and make important personal decisions.
advocate a middle approach in order to respect both patient autonomy and to show beneficence towards the patient. This approach advocates enabling the patient to choose beforehand how much information he/she wishes to receive and how much family involvement there will be in the decision-making. The problem with such an approach is that, unfortunately, it is highly unrealistic to expect a patient to have decided on the level of information he/she wishes to receive before any occurrence.

I believe that the most efficient manner of balancing beneficence and autonomy is a process of strengthening the power of the therapeutic exception. By establishing a general rule of disclosure, patient autonomy is protected and physicians have an expected method of practice to follow. Then, under certain extenuating circumstances, such as a patient’s culture or condition, and whether he or she would be adversely affected by certain disclosures, a physician will be able to conceal aspects of diagnosis from his/her patients with his/her discretion. Although this position advocates a certain degree of patient deception, it appears that this is not an extreme or uncommon practice. In truth, even when patients are given full disclosure, a certain amount of patient deception is practiced, not in a malicious or paternalistic fashion but rather because by default, the manner in which procedures or diagnoses are explained allows for much nuance. This could occur through over or

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139 Some have advocated the use of decisional aids along with shared medical decision-making as an alternative to the current methods in order to better inform patients about treatment options, adopting this system has its own set of challenges and issues. See King and Moulton, Rethinking Informed Consent: The Case for Shared Decision-Making, 32 Am. J. L. and Med. 429 (2006).
140 Id. at 2194.
141 This would also place the burden of proof on the patient, thereby causing less medical malpractice suits and giving the physicians protection to act, as opposed to if the law would be that every case should be decided individually.
142 Similarly in the field of mental health counseling, HIPPAA authorizes that counselors are able to not disclose certain diagnosis and information to their patients if they believe that the disclosure could result in harm to the patient. See United States Department of Health & Human Services, Summary of the HIPPAA Privacy Rule, pg.12.
under simplification of medical procedures, through the use of carefully chosen descriptive terminology or even in how risk is presented. The reality of any medical diagnosis or procedure is multi-dimensional and complicated and therefore explanations and interpretations are necessary and usually welcomed. When the physician’s role is both explainer and administrator, the information can inevitably be packaged in a way that facilitates the physician’s purpose. Thus, there is strong reason to desire that in certain cases the therapeutic exception be invoked in order to enhance patient beneficence even if it comes at the cost of patient autonomy.

I find the Jewish law’s concern about a patient’s reaction to negative prognosis compelling in this respect. Although mores, attitudes, and scientific knowledge have changed since the times of the Talmud, natural human emotions and reactions, such as fear and anxiety, have not substantially differed over the course of the centuries. As such, the normative weight that the Talmud gives to the potential of stressful news affecting a terminally ill patient in a negative manner still holds true for many patients.

However, when it comes to the donatio causa mortis I am reluctant to endorse a similar “therapeutic exception” and relax the formalities the common law has instituted with reference to deathbed bequests. Although the Jewish law’s lack of formalist requirements is motivated by the effects of stress on a terminally ill person, and the empirical medical data supports such a position, the reasons offered by the common law for strict formalism remain compelling. Fear of fraud and uniformity in transfers of possessions are supremely important for any legal system adjudicating property law. Measures that are applied in the medical field, where physicians can be given license to exercise personal judgments, cannot be applied to make

143 See Peter H. Schwartz, Questioning the Quantitative Imperative, Hastings Center Reports March-April 2011 pg.31. (Arguing that different forms of disclosure may lead patients towards different decisions and that not everyone would benefit from quantitative or numbers based information.); See also, Alan Meisel, Exceptions to Informed Consent, 1979 Wisc. L. Rev. 413, 416; Beecher, Some Guiding Principles for Clinical Investigation, 195 J.A.M.A. 1135 (1966) (patients will, if they trust their doctor, accede to almost any request he cares to make).
general rules for financial transactions. Additionally, for deathbed bequests, alternative options can be put into place that will guard against the possibility of the burden of formalism in making a gift causing distress and aggravation of the donor’s health. Namely, the availability of the option of creating a will beforehand or in cases where that option is not feasible of using technology to alleviate donor concerns while at the same time conforming to formalist requirements.

CONCLUSION

The use of empirical data and comparisons to other legal systems are important tools for commentators to employ when analyzing the common law. After a review of the laws of the therapeutic exception to informed consent and deathbed bequests, it is illuminating to see how the Jewish law differs significantly in certain key aspects. Particularly, the normative value given to the effects of stress on terminally ill patients is marginalized in the common law and prioritized in Jewish law. Recent empirical medical data shows that full disclosure of the severity of a patient’s condition can have aggravating effects on the patient’s condition. Perhaps it may be time to rethink the balance between patient autonomy and beneficence that is manifest in legal doctrines, if it is, I believe that empirical data and other justice systems would have a vital contribution to make in that discussion.