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Patient Autonomy in Talmudic Context: The Patient's "I Must Eat" on Yom Kippur in the Light of Contemporary Bioethics

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Abstract In contemporary bioethics, the autonomy of the patient has assumed considerable importance. Progressing from a more limited notion of informed consent, shared decision making calls upon patients to voice the desires and preferences of their authentic self, engaging in choice among alternatives as a way to exercise deeply held values. One influential opinion in Jewish bioethics holds that Jewish law, in contradistinction to secular bioethics, limits the patient's exercise of autonomy only in those instances in which treatment choices are sensitive to preferences. Here, we analyze a discussion in the Mishna, a foundational text of rabbinic Judaism, regarding patient autonomy in the setting of religiously mandated fasting, and commentaries in the Babylonian and Palestinian Talmuds, finding both a more expansive notion of such autonomy and a potential metaphysical grounding for it in the importance of patient self-knowledge.

Keywords Jewish bioethics · Talmud · Shared decision making · Religion · Autonomy

Recent years have seen a prioritization of patient autonomy in medical decision-making, individual self-governance, especially in regard to a treatment plan (Fox 1990; Wolpe 1998; Quill and Brody 1996). This focus has its historical roots in notions of informed consent—the idea that the patient must understand the risks and benefits of a treatment plan as a bulwark against exploitation of patients in medical experimentation.

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The move to autonomy was then extended to situations in which multiple treatment options exist and the risk/benefit ratios of the different options are similar. In such cases, the physician might previously have weighed the options, made a choice, and then presented that plan to the patient as a settled matter. The proponents of patient autonomy argued that in such cases where the choice is not about expertise, the patient should be given the necessary information and allowed to determine the treatment that will ultimately determine her own well-being.

Even this latter notion of autonomy, though, grants the patient decision-making power in only a limited range of situations, those in which there are several equally plausible treatment options. It assumes that the primary factor in medical decisions is the expert judgment of the physician, and only when that expertise is unable to render a verdict, do the feelings or preferences of the patient take priority.

In recent discussions, according to a more robust concept of autonomy, the patient is called upon to voice their authentic desires and preferences, engaging in choice as a way to exercise deeply held values (Barry and Edgman-Levitan 2012). This approach differs significantly from the others in both conceptual and practical ways. Conceptually, it makes patient input a desired goal based on the belief that the patient has a unique and relevant perspective which is as valuable as the physician's expertise. Practically, it asks treatment providers to actively seek out opportunities to solicit and enable meaningful patient input, rather than consulting her on an occasional, as-needed basis. Enabling this input means educating her in a clear and non-prejudicial way in order to enable her to make choices based on an accurate understanding of the risks and benefits of each option.

In a recent article, David Shatz attempts to distinguish the Jewish legal discourse on this question from secular bioethics in a somewhat confusing way. On the one hand, he says that Jewish texts have only the notion of practical autonomy—involving the patient when it is not clear what the correct treatment option is—but have no notion of attempting to explore the patient's subjective values. He suggests that Jewish law grants patient autonomy mainly for practical reasons—"there is no unique rational decision in cases of uncertainty," and if there is no "correct" answer, no one can justify making such decisions on the patient's behalf (Shatz 1997). It does not consider the patient's values because, he asserts, "the values are set more or less objectively" by the legal system, and those values, understood as expressions of the Divine Will, are assumed to be absolute.

Yet he also suggests that Jewish law may in some cases grant more power to a patient's choices than secular bioethics. He claims that whereas bioethicists only mandate following patient choices that are fully autonomous expressions of their values, but not those based on limited understanding, "Jewish bioethicists, in contrast, leave the matter entirely in patient hands … *without setting down further conditions that assure that the patient's decision in (descriptively) autonomous*" (Shatz 1997). He sees the notion of "descriptive autonomy" (making sure that patient decisions are a true reflection of their values) as enabling physicians to override patient choices in some situations where Jewish law would honor them.

This latter point seems to misunderstand the goal of enabling values-based autonomy in two key senses. First, the goal of prioritizing this level of autonomy is to significantly expand the range of decisions into which the patient has input. Thus, the situations where a physician is deciding whether or not a patient's input is "descriptively autonomous" are precisely those cases where Jewish law would not allow any patient input at all. It argues that even in situations where the physician *does* have an opinion about the correct course of treatment, the patient may nonetheless, if given full information, have preferences that should be considered. Second, the main implication of the demand for fully informed

decisions is to raise the expectations on physicians to convey the necessary information. It turns communicating both diagnoses and expert knowledge to the patient into a role as vital for the physician as prescribing treatments.

On Shatz's first point, the evidence is clearer. Jewish texts generally presume that in most cases there is a right answer as to what treatments are called for, and it is assumed that patients resist those treatments for non-medical reasons. Thus, A. Steinberg, under the entry "Patient" in his Encyclopedia of Jewish Medical Ethics (Steinberg 2003), says that "he who refrains from consulting a physician when ill is doubly wrong: First, it is prohibited to rely on a miracle because the person may not be worthy that a miracle be wrought on his behalf. Second, it constitutes arrogant behavior" (pp. 789–90). He then elaborates at length, drawing on multiple Talmudic sources, telling us that one may not ignore medical advice in order to fast on the Day of Atonement, observe the Sabbath, or fulfill the rituals associated with any of the Jewish holidays. In all of these cases, the question is whether a patient is permitted to refuse a medically indicated procedure and the answer is that the law requires us to do what is necessary to protect life, even over the patient's objections. Crucially, the (improper) motive for refusing treatment in all of these cases would be the desire to avoid a violation of Jewish law. In no instance does Steinberg consider a case where the patient's concern stems from her feelings about the treatment itself.

In cases of uncertainty, a similarly simple outlook applies. If we are unsure whether a certain treatment is needed, or following a certain ritual practice would endanger the patient, the principle of *safek nefashot lehakel,* "we are lenient regarding doubt involving life and death," is invoked. It is only in cases of real uncertainty as to what is the best course that the rabbis cede decision-making authority to the patient.

In the remainder of this article, we present a passage from the Babylonian Talmud that seems to suggest an approach in keeping with above-mentioned notions of shared decision making; i.e., the patient should have the power to decide about his own treatment even when her choices contradict the advice of experts. It further offers language for why this should be so, language that may help to expand how we understand the importance of enabling patient autonomy. *Such considerations allow us a broader consideration of the ways in which patient autonomy might be exercised, in dialog with and apart from the physician, potentially shedding new light on the place of autonomy within Jewish law.*

To understand the passage, we must step back and begin with a scenario presented by the Mishna, the third-century text upon which the Talmud is based. The Mishna, in the context of the obligation to fast on the Day of Atonement (*Yom Kippur*), discusses how we should handle those who for health reasons may have trouble fasting. Here is the text, from Mishna Yoma 8:5:

חולה מאכילין אותו על פי בקיאין, ואם אין שם בקיאין מאכילין אותו על פי עצמו עד שיאמר די׃

One who is ill, we feed him under the guidance of experts, and if there are no experts present,

we feed him until he says "enough".

The Mishna says that we make choices about feeding the patient based solely on the opinions of experts if they are available, and we consult the patient's wishes only in the absence of experts. There is no question that on the one hand, if fasting will harm his health he should eat; but on the other hand, given the importance of the prohibition, he should not eat more than necessary. The Mishna here is asking how we determine *how much* to feed

him. If there are experts, we feed him the minimum they say will be enough, but if not we feed him as much as he says he needs. The presumption is that the patient will overestimate how much he needs while the experts will give a more accurate estimate, and we should prefer the latter estimate if it is available. This parallels the previous statement in the Mishna, which explains that a pregnant woman who feels faint due to fasting must be revived, but should be revived with the minimum amount of food possible, first just sauce, then small amounts of food, until she is calmed.

Discussing this Mishna, the Palestinian Talmud (PT) considers a related but, for our purposes, crucially distinct case.

1. חולה אומר יכול אני ורופא אומר אינו יכול שומעין לרופא. רופא אומר יכול הוא וחולה אומר אינו יכול שומעין לחולה.
2. לא צורכא אלא חולה אומר יכול אני ורופא אומר איני יודע.
3. רבי אבהו בשם רבי יוחנן נעשה כספק נפשות, וכל ספק נפשות דוחה את השבת.

1. If the sick person says I can [fast] but the physician says he cannot, we follow the physician. If the physician says he can [fast] but the sick person says he cannot, we follow the sick person.
2. We have a question only [in a case where] the sick person says I can and the physician says "I do not know."
3. R. Abbahu said in the name of R. Yohanan: It becomes a case of doubt regarding life and death (*safek nefashot*), and all cases of doubt regarding life and death override the Sabbath.

Line 1 addresses the case in which the disagreement between patient and doctor is about whether he needs to eat at all, not about how much he needs to eat (it is not clear whether the PT reads the Mishna this way, as the BT does). It also presents a scenario in which we hear both patient and doctor speaking, though not in dialog, and saying different things. The principle is clear and simple: A disagreement about whether the patient needs food or treatment is classified as a case of doubt and therefore falls under the general rule, presented in Mishna 8:6, that in *any* doubt regarding matters of life we err on the side of caution and give the food or treatment. The patient is here given a limited measure of autonomy in that his view is deemed sufficient, even in the face of expert opinions, at least to create doubt about what is needed and thus to invoke the doubt rule.

Line 3 takes this even further, saying that even a case where the patient does not want to eat and the physician expresses uncertainty creates sufficient doubt to invoke the rule. Normally, when choosing between one who is uncertain and one who is certain, we would follow the certain person. By telling us that *even this* counts as *safek nefashot*, R. Yohanan illustrates the strength of this rule. Unlike other types of doubt, *safek nefashot* overrides ritual laws even when the doubt is quite minor. This concords with R. Yohanan's statement on the next Mishna, regarding a case where a building collapses and it is unknown whether anyone is trapped underneath, and digging to search would entail violating the Sabbath. The Mishna says that if there is doubt whether anyone is buried there, or whether the buried person is a Jew or a non-Jew, one digs to free them. R. Yohanan comments that this

is true even if there is a 90 % chance that the person is a non-Jew; that is, while *safek* may normally apply only to a case where either of two alternatives is equally likely, that is not true of *safek nefashot*, in which we accept the doubtful position even when it is far less than half likely.

In sum, the Mishna and the PT consider two cases—one in which the patient and doctors have different estimates of how much food the patient needs to eat to avoid harm and the other in which they disagree as to whether or not the patient needs to eat at all. In the former case, we follow the opinion that minimizes the amount eaten, but we classify the latter case as *safek nefashot* and thus prioritize the choice that will safeguard health over adherence to ritual laws, *regardless of who takes which position*. Thus, the PT discussion gives the patient some measure of agency, but only as a corollary to its main interest, which is to illustrate that *safek nefashot* is applied even to the most minimal forms of doubt.

The parallel passage in the Babylonian Talmud (BT) seems to simply pick up the PT's idea and elaborate it further. In doing so, however, it introduces a major shift in its understanding of how and why we defer to the patient or physician in each case. It is this shift that generates a rationale for granting patient autonomy that has potentially wide-ranging significance for how we understand the relevance of a patient's wishes to treatment decisions. Here is the text, from BT Yoma 83b:

אמר רבי ינאי: חולה אומר צריך, ורופא אומר אינו צריך - שומעין לחולה.

מאי טעמא? לב יודע מרת נפשו.

פשיטא! מהו דתימא: רופא קים ליה טפי, קא משמע לן.

רופא אומר צריך וחולה אומר אינו צריך - שומעין לרופא.

מאי טעמא? תונבא הוא דנקיט ליה.

R. Yanai said: If the sick person says I need [to eat] but the physician says he does not, we follow the sick person.

Why? "The heart knows its own bitterness." (Proverbs 14:10)

This is obvious! What might you have said? The physician knows better [and so we should always follow his view], this teaches [that we do follow the patient].

If the physician says he needs [to eat] but the sick person says he does not, we follow the physician.

Why? Confusion must have seized the patient.

The statement of R. Yanai, underlined, is the statement from the PT, reversed but with no difference in meaning. The BT's explanation, however, changes the picture considerably. In the PT, both parts of the statement had the same reason—a disagreement in either direction qualifies as a case of doubt, thus triggering the rule about *safek nefashot*. The BT treats them as two separate cases each with its own rationale, neither of which relies on the concept of doubt. In one case, the BT claims that we listen to the patient because the

patient knows something about herself that no one else, no matter how skilled in the medical arts, can know. In the other, the Talmud assumes that the patient wishes to be stricter than the doctor only because he is confused. This may be meant as definitional—any patient who wishes to be stricter with herself than necessary must not be thinking straight. But it opens the possibility that if we can determine that the patient is in fact not in a confused state and wishes to refuse food, we should listen to him. Such a reading would open up a greater range of decisions that the patient would be empowered to make, reinforcing the statement that we honor the patient's self-knowledge.

The BT then examines the seeming contradiction between the statement of R. Yanai and the Mishna, assuming that the Mishna prioritizes the opinion of experts regarding whether or not to feed the patient rather than how much food he might need. It dwells on the Mishna's use of the plural "experts," reading it as meaning two *and not one*, which suggests that we need two experts in order to feed him. This turns the decision into a question of numbers. If two experts say he should eat, he should do so regardless of how many others (including the patient) say he need not eat. If two experts say NOT to eat, however, the patient may not eat—his view by itself overrides the opinion of a single expert but not of two or more. By reading into the Mishna an intentional distinction between one expert and two experts, this explanation turns the patient's view into a vote of equal but not greater standing to that of a doctor.

But the final word in the passage is given to Mar Bar Rav Ashi, who rejects the head-counting approach and once again emphasizes the uniqueness of the patient's self-knowledge.

מר בר רב אשי אמר: כל היכא דאמר צריך אני אפילו איכא מאה דאמרי לא צריך - לדידיה שמעינן, שנאמר לב יודע מרת נפשו.

תנן: אם אין שם בקיאין - מאכילין אותו על פי עצמו. טעמא - דליכא בקיאין, הא איכא בקיאין - לא!

הכי קאמר: במה דברים אמורים - דאמר לא צריך אני, אבל אמר צריך אני - אין שם בקיאין כלל מאכילין אותו על פי עצמו, שנאמר לב יודע מרת נפשו.

> Mar bar Rav Ashi said: Any time the patient says "I need", even if 100 doctors say he does not, we listen to him, as it says, "The heart knows its own bitterness."
>
> But the Mishna says: if there are no experts present, we feed him until he says "enough". Only if there are no experts present, but if there are, we do not [listen to the patient]!
>
> Read it this way: When is this so [that we follow the experts]? When the patient says "I don't need." But if he says "I need", the experts are irrelevant and we feed him based on his wishes, as it says, "The heart knows its own bitterness."

Mar bar Rav Ashi dismisses the relevance of numbers and in doing so returns to the idea behind R. Yanai's original *memra* as understood above. The use of neither the plural in the Mishna nor the singular by R. Yanai carries particular significance—if the patient says he needs to eat, the number of experts who disagree is irrelevant. It is here that the full meaning of "The heart knows its own bitterness" becomes clear. This quote is not meant merely to put the patient on par with the experts, to suggest that she has relevant

knowledge and should be able to participate in the decision. It conveys that the patient possesses knowledge about his own condition that is of a totally different nature than any expert's knowledge about it. We should thus speak of the patient's view as distinct and essential to full consideration of a treatment decision, weighted equally with the "expert view" regardless of how many experts are involved. It potentially also becomes a vital perspective that should be actively elicited when possible rather than a piece of input to be considered only when necessary.

What is important here is not the ruling but the reasoning. We could easily permit the patient to eat in this scenario simply based on the fact that "we are lenient for *safek nefashot*" includes not only true, 50–50 uncertainty but even a slight chance that life is endangered. The patient's own statement of need certainly passes that minimal threshold, as does even ambivalence on the part of the doctor, as we see in the PT. Instead, the BT argues that the patient is followed regardless of the number of doctors because he possesses this self-knowledge that they, regardless of their expertise, cannot grasp. This self-knowledge gives him the right, at least within certain parameters, to determine what is best for himself regardless of "doctors' orders."

Jewish tradition has long recognized that some medical decisions are far more complex than whether to eat on a fast day: prolongation of life versus continued pain; risks versus benefits of intervention; and others. Modern medicine has deepened our awareness of this complexity, in terms of both the range of available treatment options and a recognition of the costs and benefits of the many possible outcomes. The expert must know more, and the number and type of choices have multiplied. Many of these choices are essentially judgments which, this passage suggests, should reflect the subjective experience and values of the patient who will live with their consequences. We are thus left with the challenge that in the modern context more technical knowledge is required in order to make informed decisions; yet we are asking physicians whenever possible to give patients sufficient information to make "autonomous" decisions in light of their own values.

In keeping with this modern dilemma, we find that patient self-knowledge, as a counterweight to physician expertise, has played a not insignificant role in at least one corner of Jewish law. At least from this Talmudic discussion, the understanding of autonomy in the Jewish legal tradition should be regarded as nuanced; perhaps the principle of patient self-knowledge can be considered and put into practice by contemporary jurists. Second, contemporary understandings of shared decision making (and halachic approaches to medicine) might include in their philosophical justifications an appreciation of life with disease—the patient as person, not merely decision maker.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Human and Animal Rights This article does not contain any studies with human participants or animals performed by any of the authors.

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