

# A Halakhic Ethic of Care for the Terminally Ill

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פקוח נפש מצוה רבה היא. הזריז הרי זה משובח' הנשאל מגונה השואל שופך דמים, וכל שכן המתאש ואינו עושה.

*Saving life is a great mitzvah. Who approaches it with alacrity is praised, who hesitates is despicable, who questions it is guilty of murder, and certainly so, one who despairs and does not do it.*

*Nahmanides, Torat haAdam*

## שאלה

Increasingly, modern medical progress puts us face to face with a terrible dilemma – how do we treat a patient who is clearly beyond our powers of healing?

## תשובה

There was a time when the medical profession could do little in such a case beyond providing certain rudimentary comforts and companionship until the touch of the Angel of Death accomplished its mission. Today, however, medical technologies have progressed to the point where we can deflect and delay the Divine decree for a time, sometimes an extended time, though we do so without any hope of returning the patient to health. The results, it must be said, are often terrible to behold.

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*The Committee on Jewish Law and Standards of the Rabbinical Assembly provides guidance in matters of halakhah for the Conservative movement. The individual rabbi, however, is the authority for the interpretation and application of all matters of halakhah.*

An unresponsive patient, breathing with the aid of a respirator, fed through a naso-gastric feeding tube, periodically resuscitated from cardiac arrest crises, might be so maintained for months while the family tries to juggle the demands of their lives with the demands of hospital visits and a guilty grief that cannot be relieved through any proximate consolation. A patient in an advanced stage of cancer may suffer months of pain (and the stupor induced by the pain and by the drugs to fight the pain) while the family stands by helpless. Are we, in such cases, as patients, as relatives, as Jewish physicians, to hold on as long as we can, come what may, or is there a reprieve, a dispensation to do less than we can in order to find a quicker, more merciful death – that which has come to be known as “death with dignity”?

The answer to these questions must surely be placed at God’s doorstep, for the essential problem, the knot which we must untie, is the nature and value of life and death and the obligations that those most remarkable of God’s creations place upon us. The specifics are new, but the dilemma flows directly from mankind’s eating from the Tree of Knowledge, thereby gaining our awareness of mortality along with the ability – and the attendant responsibility – to heal. But we no longer have Abraham’s easy ability to converse with God nor Aaron’s access through the *Urim veTumim* nor even a prophet’s vision. How, then, do we determine God’s will? As always, we seek God’s direction through our understanding and through the medium of halakhah, through the unfolding texts and traditions which represent God’s Torah as placed before this generation.

To apply our understanding alone to the dilemma, to allow our untutored sensitivities to direct our thinking, is to put ourselves on an even footing with the secular ethicists who abound in our day. To do so is morally upright but alienates us from the Torah. But to apply our understanding only to the texts of our tradition, without striving to set them in the context of life as we feel and live it today, is to deny God the opportunity to address us directly through His Torah, insisting instead on distance and veils. So we choose to approach our texts through life and our life through texts in order to hear God’s instructions clearly so that we may carry them out.

What does our tradition teach?

## **The Value of Life**

We know, first, that we are obliged to heal, and that the saving of life is of such overriding importance that it takes precedence over virtually all of God’s other commands.<sup>1</sup> We recognize human lives as the infusion of God’s spirit by virtue of which we are considered made in His image, so

that death is a diminution of His image in the world.<sup>2</sup> We begin, in short, with a preeminent concern for life which we view as God's gift, one of the crowning achievements of creation, and with the understanding that the termination of life, like its inception, is God's domain.

How, then, can we approach the treatment of any patient, even one hopelessly ill, except with the determination to extend that life to the limits of our abilities? Indeed, until medical capabilities brought us up against the current dilemma, that was the position of secular medicine as well: that it is the physician's responsibility to do everything possible to preserve life.<sup>3</sup>

That orthodoxy has been ceded, by doctors and ethicists in light of the new technologies, to a new orthodoxy based on two fundamental and interdependent notions. The first of these notions is that of the absolute autonomy of the self. "The voluntary choice of a competent and informed patient should determine whether or not life-sustaining therapy will be undertaken," writes the Presidential Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.<sup>4</sup> The renowned Hastings Center frames the issue as follows:

Our ethical framework draws on the value of patient autonomy or self-determination, which establishes the right of the patient to determine the nature of his or her own medical care. This value reflects our society's long-standing tradition of recognizing the unique worth of the individual. We respect human dignity by granting individuals the freedom to make choices in accordance with their own values. The principle of autonomy is the moral basis for the legal doctrine of informed consent, which includes the right of informed refusal.<sup>5</sup>

The second notion, dependent on the first, is the notion often described as the "quality of life." If life should become so troubling to an individual as to be untenable – in the key terms of this analysis, should life's burdens outweigh its benefits – then it is reasonable and not contrary to any moral claims, to seek release from the burdens of that life which no longer offers rewards. Again the Hastings Center, which serves in many ways as the unofficial philosopher of the biomedical ethics community, best articulates the theory behind these ubiquitous terms.

Patient well-being – benefiting more than burdening the patient:

The obligation to promote the good of the patient is basic to the relationship between the health care professional and patient. A decision about whether to use life-sustaining treatment raises the question of whether it will promote the patient's good. Extending life is usually, but not always, a good-the patient's life, for example, may be full of pain or suffering and the patient may prefer to forgo the treatment even though

it means an earlier death. Individual patients evaluate the benefits and burdens of a treatment and the life it offers differently. Consequently, the obligation to promote the patient's good involves identifying the benefits and burdens of the treatment from the patient's perspective. Then the question becomes: do the burdens of the treatment outweigh its benefits from the patient's perspective? If they do, it is ethically acceptable to withhold or withdraw the treatment. When, however, the treatment provides more benefits than burdens from the patient's perspective, treatment should be provided. When it is unclear whether the burdens or benefits are greater, it is appropriate to err on the side of life...<sup>6</sup>

This latter notion of weighing benefits against burdens is not intended to override patient autonomy, but rather flows from it and serves as a means to approximate the decisions a patient who is incompetent might have made and to release any surrogate of the competing claims of external value systems. Clearly, if a competent patient determines to terminate treatment, that decision most closely corresponds to a decision from the patient's perspective that life's burdens outweigh its benefits. If a surrogate must make these decisions, however, that surrogate is advised to consider the patient's own value system and not to substitute his or her own nor any other received value system, neither religious nor traditional, for a judgment of the continuing value of life from the patient's perspective.<sup>7</sup>

From a Jewish religious perspective these two notions are fundamentally flawed, and all consequent deliberations of the secular literature on biomedical ethics must be read carefully in that light. Judaism, more than most of the world's major religions (certainly more so than Christianity in whose orbit we reside) has always respected individual autonomy. God is a creative and commanding presence in the universe, but mankind has perfect autonomous free will to live life as we choose. It is through our choices and our efforts that God is served. But ethics and morality are not conditioned by our choices. Their source and direction is eternal.<sup>8</sup> Indeed, we experience our subservience to God's command as liberating, giving us the opportunity, since the days of Sinai and yet today, to live our lives in God's image, not enslaved by idolatry. As we shall see in detail below, our autonomy in medical decision-making is not compromised by the halakhah but simply directed thereby. Ultimate choices rest squarely with us, under the mandate of God's command to choose life.

God's mandate to choose life follows from the very essence of His universe as we understand it. Life and the human soul are attributes of the divine essence; as such these are properly outside the domain of human choice even as we exercise effective control over them. The

martyr Rabbi Hanina ben Teradyon who urged that his own death in the flames not be hastened, provides the classic response, “It is well that He who gave it should take it. One should not injure himself.”<sup>9</sup> That is the basis of the Jewish and general prohibition of suicide, a prohibition the ethicists are loath to loose even as they function under the rubric of perfect autonomy.<sup>10</sup> Were this not the case, were life or death choices properly in the human domain, the halakhah should recognize a benefit calculation which would permit handing over one individual for execution to save many. It does not. Were this not the case, the basic ruling with regard to murder, יהרג ואל יעבר (be killed before transgressing) could not stand. Self-preservation would be a compelling argument, as it is in self-defense.<sup>11</sup> Refusing life-giving treatment with an eye to ending life, certainly active euthanasia, are tantamount to suicide if life is seen to be God’s alone to give and to take.<sup>12</sup>

Indeed, the Rabbis explicitly reflected on the matter of the benefits and burdens of life and their deliberations are instructive.

שתי שנים ומחצה נחלקו בית שמאי ובית הלל. הללו אומרים נוח לו לאדם שלא נברא יותר משנברא. והללו אומרים נוח לו לאדם שנברא יותר משלא נברא. נמנו וגמרו נוח לו לאדם שלא נברא יותר משנברא. עכשיו שנברא יפשפש במעשיו.

For two and one half years the schools of Hillel and Shammai differed, the one saying: “It is better for a person not to have been created than to have been created,” and the other saying: “It is better for a person to have been created than not to have been created.” They voted and determined: “It is better for a person not to have been created than to have been created, but now that he has been created, let him examine his deeds.”<sup>13</sup>

Life, it seemed to them, must be inherently burdensome to the divine soul, yet such is life – we are enjoined to carry on.

## **Concern for Suffering**

Is there, then, no compassion in Jewish tradition for the suffering, no recognition of the inevitable end as it comes? Certainly there is. Medicine, healing, is obligatory. Pain relief is considered without exception as a part of the healer’s brief.<sup>14</sup> But beyond these, the tradition early recognized that when the end comes, as it must, it is best to slip away easily. Several stories in the Talmud poignantly counsel us on the need to know and respond to that moment. In Rabbi Yoḥanan’s old age, grief over the death of his brother-in-law and closest colleague caused his “sense to slip away” (שף דעתיה מיניה). “The rabbis prayed for

mercy on him and he died.”<sup>15</sup> When Rabbi Yehudah haNasi was ill the Rabbis fasted and prayed for him. His maid prayed also, saying, “Rabbi is sought above and sought below; may the ones below prevail over those above.” But when she saw his great suffering she reversed her prayer. Seeing that the rabbis still prayed for his life, she cast a jug from the roof, disrupting the prayers being said on his behalf, whereupon he died.<sup>16</sup> It is clear that these stories are cited with approval. Rabbenu Nissim of Gerondi formulates a dictum thereby: “It seems to me . . . there are times when one must pray that the sick might die, as when he suffers greatly of his illness and he cannot live.”<sup>17</sup>

The Rabbis of the Talmud understood the need to respond mercifully in such situations. The response they proposed was prayer; the request that God offer a quick and merciful release to the sufferer. To be sure, prayer was considered efficacious, as the story of Rabbi’s maid clearly illustrates, but the final arbiter, the one who determines life and death in such a case, was God, not man.<sup>18</sup> No precedent for the withdrawal of medically effective treatment<sup>19</sup> can comfortably be derived from here.<sup>20</sup> No such remedy was proposed.

## **גוסס The Law of**

From medieval rabbinic sources we discover how feelings of compassion for a person’s final journey played themselves out in practice. Two texts preempt the field and serve, when merged in the codes, as the predominant rule and locus of comment. The first source is the minor tractate *Eivel Rabbati* or *Semaḥot*, ch. 1, which reads:

הגוסס הרי הוא כחי לכל דבר . . . אין קושרין את לחייו ואין פוקקין את נקביו . . . אין מזיזין אותו ואין מדיחין אותו . . . עד שעה שימות . . . הנוגע בו ומזיזו הרי הוא שופך דמים. ר' מאיר היה מושלו לנר שהוא מטפטף – כיון שנגע בו אדם מיד כיבהו.

A person on the deathbed (גוסס) is like the living in every regard . . . One does not bind his cheeks or stop his orifices . . . One does not move him or wash him . . . until the moment that he dies . . . Whoever touches and moves him, that one commits murder. Rabbi Meir would compare him to a candle which is flickering; should a person touch it, it immediately goes out.<sup>21</sup>

This source serves as the primary text codified in *Shulḥan Arukh, Yoreh Deah* 339:1. Its concern is primarily to prohibit beginning ministrations to the dead to a living person. Such ministrations, though an honor in death, are an affront to the life yet present in the dying patient. The *baraita* reflects on the ease with which our actions on behalf of the dying

may hasten death, if only by moments, and warns us that even an infinitesimally small precipitation of death is tantamount to murder – no uncertain term. Neither the quality of life nor its likely short duration are admitted as mitigating circumstances.<sup>22</sup>

The second source, united with the first in *Yoreh Deah* 339.1 through the agency of Moses Isserles' embedded commentary there, comes from *Sefer Ḥasidim* (723) via *Shiltei haGibborim* to Alfasi. *Sefer Ḥasidim* rules that where external impediments (such as the harsh noise of wood-chopping, or salt placed upon the patient's tongue) prevent the flight of the soul, it is permissible to remove those impediments, although to move the patient to a location where he might more easily die is prohibited. Here the countervailing concern for the merciful death of the lingering patient comes to the fore. Rabbi Joshua Boaz in *Shiltei haGibborim* formulates this principle as a command, not simply permission, as follows:

Certainly, to do anything which would cause a dying person not to die quickly is forbidden, for instance to chop wood in order to delay the soul's departure or to put salt on his tongue so that he not die quickly...In all such matters it is permissible to remove the causative factor.<sup>23</sup>

We have, then, two competing demands codified as one-to maintain life to its utmost while not hindering death at all.<sup>24</sup> It is not surprising that we suffer some perplexity in walking that very delicate and cosmically important line.

Some would claim that the category of גוסס (the patient on the deathbed) is severely limited and diagnostically unclear, not to be applied to most of today's hospitalized patients; a גוסס is one who cannot live three days, and given today's technology, that cannot be assumed of any patient. Since the call not to hinder death is made only in the context of such a גוסס the rule is moot.<sup>25</sup> This is, however, a classic case of overreaching. That a person reported to be a גוסס may be assumed to have died after three days is the codified ruling in *Shulḥan Arukh*, *Yoreh Deah* 339.2, because, in the words of the gloss there “ודאי כבר מת”, he has surely died. The ruling has its provenance in a case that came before Rabbi Meir of Rothenberg and is reported in Tur here, and in the Rosh to *Moed Katan*, ch. 3, #97. It is the case of a woman who had received a report that her husband was seen on his deathbed four days before. Rabbi Meir permits her to mourn, reasoning that the Talmud indicates (*Gittin* 28a) that most persons who lie deathly ill do not recover (רוב גוססין למיתה), and those generally pass away within three or four days. A גוסס might indeed live longer. We are nonetheless instructed to remove impediments to his death. We are also instructed to do nothing to hasten that death and do everything to prolong life.

Sharp as this conundrum appears, we firmly believe that it can be construed and resolved in a way which responds to our moral and psychological needs and remains true to the intent of the sources before us, while addressing as well the medical knowledge and technologies of our day. The first key to this resolution is to recognize that whatever *חיים* may have meant specifically to our rabbinic sources, it refers in our day to all those who have been diagnosed as imminently dying. The halakhic sources ask us to define the distinction between extending life – any life, not just “quality life,” for even the smallest duration – and prolonging the process of dying. That, and not the right to die, is what we seek as a Jewish response, as a God-fearing response, to these dilemmas.<sup>26</sup>

## **Natural Death**

How are we to define, then, the natural process of life and the natural process of dying, given that we are mortal and our lives can be said, in a sense, to be a terminal disease? Earthly life, biological life, is that ordering of cells and systems such that they maintain animate life, such that they take nourishment and excrete waste, grow and multiply.<sup>27</sup> Should these processes cease, life is no more.

Now, God did not create (or leave) our human bodies immortal. Death, every bit as much as life, is a natural part of the biological system. Biological systems are designed to change and ultimately to deteriorate, with reproduction an essential part of God’s creation, to replace the lives thus decommissioned.

What constitutes natural death? The cessation of the integrated biological functioning of an organism due to natural causes. Perhaps surprisingly, all deaths have one proximate cause – the deprivation of oxygen to the cells. The mechanisms that lead to a shortage of oxygen and the death of a cell may differ considerably, but whether the heart ceases to circulate the blood due to mechanical failure or whether the lungs cease to maintain the oxygen levels in the blood or whether either of these follow upon a breakdown of instructions from the brain stem (brain death as it must be defined by the halakhah), the proximate cause remains the same.<sup>28</sup> Yet not all deaths are the same in our moral accounting. We recognize some deaths as untimely, and others as natural.

Death by violence is culpable not because the death is intrinsically different from a natural death but because of the agent and the untimeliness. Death by famine and disease (not caused by specific human design) is intolerable but not culpable because the agent is “an act of God” but the death remains, in our minds, untimely. Death of old age is neither intolerable nor culpable since it is timely and attributable to the



nature of our creation. The permission granted in the Torah for a physician to heal, according to the primary midrash of *רפא ירפא*, is, in the first instance, granted with regard to injuries in the first category. Of healing in the second category there existed some debate; perhaps these afflictions should be taken to be God's will, but Jewish law and tradition ruled firmly that here, too, we are required to act to the extent of our ability.<sup>29</sup> The third category was never before susceptible to our ministrations. Nor is it evident that it should be or ever will be meaningfully within our ken. This, ultimately, is God's calculation. This, it seems to me, is the theological rationale behind removing impediments to death – and not primarily the relief from pain (which is the rationale behind praying for death). We try in all our dealings, including healing and including death, to act in that way which corresponds to God's will.

The diagnostic problem remains. How do we determine that a particular death is “natural” and timely, according to God's will and plan? The answer must reside within medicine. If timely, death – the ultimate death of God's choice – will not be meaningfully affected by our ministrations. We need only see if our medicine is able or futile. Here is the law of treatment of the dying rephrased. By doing everything possible medically, biologically, to treat the life systems of the critical patient, while removing impediments to death, items or procedures that interfere with the natural shut-down of the body's major systems in death, we allow ourselves to see if, indeed, God has ordained the closure of this life, while we do not cede at all our roles as healers and nurturants.

This corresponds, in many ways, to what was possible before the new technologies, but it is not simple nostalgic thinking. Medical treatment has always been a biological endeavor. Medicine aimed to heal and strengthen the body by providing chemicals needed by the cells, to attack invader organisms biochemically, enhancing the body's own biological defense mechanism. Many of our most promising medical advances today are on the level of genetic manipulation to heal through the internal mechanisms of life. This, as Maimonides notes, is perfectly analogous to the elemental natural process of nutrition which is necessary for the life and well being of any living organism.<sup>30</sup> Some of our more recent technologies are mechanical rather than biological, however, and do not parallel life functions. Thus, for instance, a heart-lung machine, while it has the effect of continuing to circulate and oxygenate the blood, thus providing the needs of life to the cells, does not operate as a biological system but rather circumvents one. Its function is mechanical, a holding mechanism maintaining the status quo against the deterioration and death which would follow on cessation of

heart and lung function. It has a major medical function in enabling open-heart surgery and may carry a patient over a crisis. Taken alone, however, it offers no curative potential. It is not and does not promise the return to a living, organic system. It is thus a candidate for the category “impediments to death.” In this category we might put respirators, dialysis machines, and perhaps certain transfusions.<sup>31</sup>

We need to be very cautious before agreeing that a life saving procedure should be classified as a dispensable impediment to death. We need to weigh not just the mechanics, but the medical utility of any procedure and the medical situation in which it is applied. We need to weigh carefully the medical uncertainties that come with any medical diagnosis or prognosis. Nevertheless, certain clear lines derive from this analysis which are, first, traditional; second, God-and life-affirming; and third, powerful aids in making the decisions that we face in treatment of the critically ill. They are traditional in that they follow from a crisp reading of the regnant distinction in the codes. Furthermore, despite whatever claims for flexibility might be made, halakhah has not been a fluid, relativistic system (איש הישר בעיניו יעשה – Every man did as he saw fit-is the Book of Judges’ formula for godlessness, not autonomy). It has always sought specific directives which might then be tailored to the specific situation under the trained eyes of the consulting authority. This runs counter to the relativistic norms of most secular ethicists today, and is, in that sense, traditional. They are God-and life-affirming because they insist that we must maintain our treatment of life at all times, and leave it to God alone to determine journey’s end. They are powerful because they establish fairly clear directives and directions in the treatment of the terminally ill which it should be possible to apply even in the tension of a hospital room or intensive care unit.

## **Patient Autonomy**

We shall proceed to break these principles down into specific guidance, but first a few more words on the matter of patient autonomy and the role of surrogates in end stage treatment of patients unable to express their will. On its face, the line of halakhic reasoning developed here seems to be leading to a rather mechanical solution of a human problem. Whereas the secular ethicists speak continually of patient autonomy and the patient’s perspective and choices, there appears, so far, to be no such concern in Jewish law. Indeed, as we said, Jewish law is not generally relativist, but there are two major areas where human autonomy can dramatically color the final result. These are the patient’s autonomy under Jewish law to choose between competing physicians and treatments, and the fundamental element of human free will which

leaves the ultimate choice to act upon or disregard halakhic counsel in the hands of individuals and their personal reckoning with their Maker.

A physician is enjoined in Jewish law to use his/her skill to heal. Although piety would like to claim that a person should seek to be healed by God, not man, the definitive ruling has been that when ill one is required to seek medical attention without delay.<sup>32</sup> It follows, therefore, that a patient must also heed medical directives. Yet, if the doctor rules that a patient may fast on Yom Kippur and the patient claims he cannot – even should a hundred physicians concur, we listen to the patient. The Talmud claims scriptural precedent for this counter-intuitive autonomy against the judgment of the experts, citing Proverbs 14:10, “The heart knows its own bitterness.” Yet even without a scriptural basis, this follows from the ruling *ספק נפשות להקל*, where there is any uncertainty we are required “to err on the side of life.”<sup>33</sup> Unlike the absolute autonomy recommended by secular ethicists, this autonomy inheres in the patient choosing life-giving treatment. It cannot reach to the autonomous choice to seek death. But it is a powerful autonomy nonetheless.

Medical science is, by its very nature, a science full of uncertainties. The myriad variations in the constitutional makeup of individuals, in the virulence and etiology of disease, in the effectiveness of various medications together leave the art of medical prognosis just that, an art, and not a matter of scientific precision.<sup>34</sup> This uncertainty opens the very question of the nature of treatment, and not simply the question of whether treatment is indicated, to the autonomous determination of the patient. Thus the Talmud reports of Rabbi who suffered from an eye disease. His physician, Samuel Yarhina’a, prescribed an injection into the eye but Rabbi waved him off saying, “I cannot endure it.” Samuel’s second suggestion, a salve, was similarly rejected and only his third proposed treatment was applied.<sup>35</sup> While many treatments entail some risk to the patient, and the requirement to seek healing includes the permission to undertake reasonable and commensurate risk to effect a cure, no patient is required to undergo significant risk or endure abnormal pain if an alternative treatment exists or if the efficacy of the proposed treatment is in doubt. Some rabbinic authorities have been of the opinion that all medical treatment is of such character. But without recourse to such radical distrust of medicine it remains clear that the patient’s own judgment whether to undergo risk is determinative unless medical certainty in the efficacy and low risk of a treatment is exceedingly high and the patient’s objection is clearly irrational or suicidal.<sup>36</sup>

This realm of patient autonomy, then, does not reach quite as far as proposed by the secular ethicists. But it effectively controls most of the

significant decisions to be made in treating the critically ill. Those who are imminently threatened with death, those of whom the question of the nature of treatment comes up, are almost without exception in need of treatment which carries with it real risk, or whose efficacy is uncertain at best. Were this not the case, we could all agree that treatment is required by the accepted prohibition on suicide. The one area of exception is the quality-of-life judgment wherein secular ethicists have accepted the patient's autonomous right to seek release from a burdensome existence, though stopping short, as a rule, from condoning euthanasia or suicide. Thus, save the decision to seek death, we function, here, almost exclusively within the realm of patient autonomy.

This fact is the source of Jewish legal and moral support for hospice care. Hospice care is an attempt to ease the burdens of terminal illness, that is, to address the question of the quality of life of a terminally ill patient through support of their lives, not the pursuit of their deaths. As such, it meets the aims of secular ethics while preserving the value of life, as Jewish law requires. Critics object that hospice care cannot provide the same level of critical intervention as a hospital setting, and that, therefore, it should be forbidden for a Jewish patient to forgo hospitalization in favor of hospice care. Here the uncertainty of medical effectiveness and the high risk of treatment enters. Candidates for hospice care have all been through the medical mill and have concluded that since there is no treatment available to them, even in a hospital's intensive care unit, they would choose the palliative and reassuring care the hospice offers. They have exercised their autonomy in the realm of medical uncertainty, albeit rather broadly, to seek the treatment they deem tolerable.<sup>37</sup> Again, it must be emphasized that the permission to seek hospice care is a life-affirming permission. One may not choose hospice so as to die more quickly, but, rather, only in order to live one's remaining days in the best way possible. As such, instructions to the hospice should clearly state that while only palliation is in order for the immediate incurable condition, other unrelated and curable conditions that may arise, such as infections, should be treated in line with standard medical care.<sup>38</sup> Jewish hospice must be an attempt to live one's best with dignity, not an attempt to speed an escape into death.

This leads us to consider the other, ultimate autonomy. No one can know, for certain, why a patient chooses one treatment over another, nor why they reject hazardous treatment, whether out of fear of the risk or out of a will to die. As rabbis, it is our duty to present the case of Jewish law and ethics to those who face these situations, but it is not ours to judge whether a given decision was made well or not. That is ultimately a matter for God's reckoning, as is the evaluation of all our doings, for good or for ill. Ultimately, then, the patient has the autonomy of

individual free will, including the autonomy to reject God's commands and seek death. The propriety of such a deed is exclusively subject to the individual dialogue between the affected soul and its Maker; a dialogue soon to be continued in person. This is not to say that we may sit back and counsel the moral neutrality of this decision. We must counsel the choice of life. It is to say that as we counsel that choice we need to acknowledge our own humanity, to realize that we cannot judge others until we have ourselves been in their place, that God may apply a different calculus in His compassion for us than He allows us to apply for ourselves.<sup>39</sup>

It is precisely when faced with this autonomy over the advice of our physician that we need the direction of our faith and law. Far from the halakhah being a constraint, it serves as an anchor at a time of bewildering choices. In this context, our tradition counsels an uncompromising regard for and pursuit of life. It asks that as patients, or as counselors to patients, or as surrogates for patients, we seek to maximize life by choosing the best endurable treatment we can find. We may choose to avoid fear, risk and pain, when we do so in the interests of the remaining moments of life. We may not do so in an attempt to attain release, to annul our final moments and travel a short route to oblivion. Withal, we are not to stand in the breach to ward off death in its time. Thus where medicine yields to technology we may assume the law of the **טוגט**, one whose death process has begun, and withhold or withdraw such procedures in the interests of God's natural order.

## **Treatment Guidelines**

How do we apply this in practice?

A) *Nutrition, Hydration, Medication*: All nutrition and medication against illness – antibiotics, insulin, intravenous fluids, etc. – organic treatments whose effectiveness is well established and which have no significant attendant risk cannot be classified as impediments to death. These should generally be continued as long as they are effective, notwithstanding a patient's requests to discontinue, when those requests are indicative of the patient's desire to die.<sup>40</sup> Where that is not the case, however, that is, where those procedures or treatments entail recognized risks beyond the most minimal, or where the option of another line of treatment exists, the patient should exercise choice, and Jewish law recognizes the patient's choice as the final word even against the doctor's advice, even should this ultimately hasten death. The patient must be encouraged not to choose based on a desire to die, but to live. Still, choice of treatment rests with the patient. In terminal illness, the patient is perforce in some form of very personal dialogue with God and we are

not appointed – nor are we able – to judge the resolution of a soul’s accounts with God.

The area of greatest debate in this regard is the initiation (and in some cases the continuation) of “artificial nutrition and hydration,” via intravenous fluid and feeding tube. There can be no question that intravenous fluids are medically indicated and do not entail measurable risk or unbearable discomfort, at least until veins collapse, requiring an incision to insert the IV. These must be continued. To withhold them is effectively a decision to hasten the death of the patient affected since death by dehydration is likely to precede death from the underlying disease. Even when surgical techniques are necessary to emplace the IV, the difficulties would have to be large and the patient quite deteriorated before such basic care could be considered futile and therefore dispensable, or of significant risk, and therefore subject to the patient’s choice.<sup>41</sup>

The same is not the case with tube feeding. Lack of interest in food to the point of substantial anorexia is normal in late stage terminal illness. This is simply symptomatic of the decreased needs of a system engaged in shutting down, and death by starvation is a far less proximate outcome than by dehydration where fluids are not supplied. Most important, there does exist significant risk of aspiration surrounding tube feeding, a risk which requires consistent, careful attention. Furthermore, significant discomfort, often reported as unendurable, accompanies the naso-gastric tube, while surgery with anesthetic, albeit simple surgery, accompanies the placing of a gastrostomy tube, unlike IV fluids which require no surgery and can go unattended for long periods of time with only topical discomfort.<sup>42</sup>

Once risk and prognostic uncertainty is present the patient retains the right to choose to accept such risk or reject it. Thus, for instance, elderly patients who eat fitfully, but do not refuse all nutrition, can be presumed to best know the needs of their own bodies. We may cajole, but should not resort to forcible tube feeding.<sup>43</sup> Again, the patient’s right to subjectively choose between risks is substantially less for physician and surrogate. Their determination must be made more objectively in terms of their understanding of the best course of treatment.

The other side of the equation needs to be stated boldly as well. There is no obligation nor any merit on the part of the patient or physician to continue a treatment of any sort, even nutrition and hydration, where it is clearly futile. “Futility” must be defined closely, however, in order to protect life to its last. A course of treatment which is organic and expected to extend life, and which is not rejected as untenable by the patient, cannot be considered futile solely because the prolongation of life will be minimal. However, where death is imminent, that is,

anticipated from the underlying condition before the effects of the withheld treatment would threaten the patient, the treatment need not be applied (save that palliative effects must also be considered). This holds true for nutrition and hydration as for medication where imminent death is anticipated from the underlying disease and not from the withholding of the treatment. In such a case the cessation of futile ministrations, which pretend to ward off death where it cannot be fought, is an act of *hesed* (an act of love) and an acknowledgement of God's domain. This is the classic *גוסס* for whom no ministration is the order of the day.

B) *Life support systems*: Mechanical procedures undertaken to immunize the body from the failures of the major organs and bodily systems should be done only where there is a medical reason to hope that they will contribute to a healing, curative process or to the return of the body's systems to unaided function. Thus, heart-lung machines during bypass surgery, respirators during breathing crises which are understood to be reversible, indeed, transplants – all gross attempts to circumvent the deterioration of major bodily organs – all these are proper and required (insofar as the patient does not opt for alternative treatment to avoid risk, as mentioned above). These same procedures undertaken without hope of any curative process, simply to prolong the beating of the heart or expansion of the lungs mechanically, are unnecessary, and it would be proper to disconnect them from a patient who had initially been connected in hopes of some success in treatment when those hopes have been abandoned completely by qualified medical personnel.<sup>44</sup>

Where intubation alone, without attachment to a respirator, is recommended in order to assist a weak respiratory system to gain access to oxygen, it is the natural biological system which continues functioning. As such this should be seen as extending life, not delaying death. However, intubation is a procedure which is invasive, debilitating, and can be very disturbing to the patient. Patients may refuse intubation as unendurable, choosing instead an oxygen tent or other less invasive means to support their normal respiratory reserve.

C) *CPR*: Cardiopulmonary resuscitation poses an unusual legal situation. The patient is in cardiac arrest, a condition that surely qualifies the patient as a *גוסס*, for the dying process has begun. The laws of *גוסס* limit our manipulation of the patient's body in the interests of allowing the patient to die. Yet we know that such patients can often be saved, not only momentarily, but for years of subsequent health. The patient may have begun to die, but we know that God's last word is not necessarily in. In seeking to determine the capacity of the natural biological system of the patient to function again, it should be obvious that, for an otherwise healthy individual, a first attempt at resuscitation must be attempted if any chance of recovery to unsupported function

exists, notwithstanding specific instructions to the contrary by the patient. Here, no analysis of the risk inherent in chest compression and shocks applied to the heart muscle can activate patients' rights to direct their treatment, since any other treatment is a choice not of treatment but of death. However, subsequent attempts at resuscitation, after it has been determined that no unsupported life is possible, are clearly unnecessary. (Here we refer to a patient who is maintained on a respirator after cardiac arrest and resuscitation, for whom the determination is made that no treatment is possible and the respirator is removed as an impediment to imminent death. When cardiac arrest ensues it is part of the dying process. CPR intervention will simply prolong that death.)<sup>45</sup>

For most patients the real situation is in an intermediate category: Cardio-pulmonary resuscitation may restore them to unaided function for a short period, but their general condition leaves it highly unlikely that they will continue in life for an extended period. Indeed, the success rate of cardio-pulmonary resuscitation is directly correlated to certain measures of frailty through age or disease.<sup>46</sup> Normally we would require saving the individual even if only for *חיי שעה*, life of short duration. In this case, however, a loophole of a sort provides the patient with an additional moment of autonomy. The patient in cardiac arrest presents a figure that is dead by standard legal criteria.<sup>47</sup> Our obligation to heal extends to the ill, but does not extend to reviving those of whom it may definitely be said that dying has set in. Our interest in life leads us to override that technicality when we are hopeful of our ability to restore a full measure of life. Where we are not so hopeful it is proper to respond to a Do Not Resuscitate request wherein patients assert that if death overtakes them, they would have us let it be. It should be noted, however, that nothing in the permission granted for removal of impediments to death mandates that removal if the patient expresses the wish to be saved with all available measures. Miraculous cure is unlikely, but the patient is allowed to hold out such hopes until the patient's unreasonable hopes interfere with the realistic treatment of another patient.<sup>48</sup>

D) *Transfusions*: Transfusions for loss of fluid during surgery or accident or to relieve any acute but temporary condition are akin to medicine and nutrition in that they provide necessary biological material. Transfusions undertaken to remove toxins accumulating due to renal failure resemble more closely mechanical circumvention of system failure. In the context of awaiting transplant or of radiation or bone marrow treatment these procedures are clearly medical/curative and are therefore required. Taken alone in the absence of any hope of restored function they are impediments to death which may be foregone.<sup>49</sup>



E) *Pain relief*: Treatment of pain is considered medical treatment, even though it is not undertaken for curative purposes. It is required because of our concern for suffering and because great pain is debilitating and assumed to be antithetical to healing (unless we specifically know otherwise). As such, all agree that this is an elemental requirement until the very last.<sup>50</sup> The question arises, however, of a dying patient in great pain whose dosage of pain killing medication no longer suffices, while any greater amount might hasten death. Here, Catholic medical ethical thinking took the lead in the general biomedical ethics literature, defining a “doctrine of double effect” that permits medicating for the virtuous intention of achieving pain relief even though death is a foreseeable consequence of that action. This has been interpreted by many to allow “double effect euthanasia,” that is the administering of large doses of pain-killing medication with the expectation that death will follow.<sup>51</sup>

In Jewish precedent, such a choice would not be allowed even the competent patient since the expectation of death overrides any apparent benefit. In this case the physician cannot be excused from the analysis which is his/her profession and the competence of the patient is suspect in the face of great pain. For the physician this is essentially a dilemma of medical judgment. As long as the physician can honestly say that the hastening of death is not probable, the uncertainty is sufficient to prescribe medication to relieve suffering, despite its inherent risks. When the probability turns, so must the physician’s behavior, for our concern for pain must be second to the claim of life, and the physician cannot escape his medical judgment.<sup>52</sup>

To a large extent, however, we can hope, and demand of our physicians, that the number of cases that require this judgment may be reduced to a null set. There is growing literature in the medical community arguing that the old dilemma of narcotic-induced respiratory failure can even now be successfully circumvented with the proper palliative regimen. Speaking before our subcommittee in February of 1989, Dr. Pat Hartwell, an anesthesiologist at Einstein Medical Center, former director of its critical care unit and past president of the New York State Society of Critical Care Medicine, insisted that with the newest narcotics and anesthetic techniques, the control of pain is always possible before depressing respiration and that “the fear of overdose is not real.” She railed against physicians who have not kept up with the state of the art and leave their patients to suffer pain for fear of applying inappropriate doses of pain-killing medication at inappropriate intervals.<sup>53</sup>

## **Advance Directives**

We believe that this biological versus mechanical criterion for distinguishing the extension of life from the prolongation of death, if applied assiduously in line with the clinical discussion above and in light of patients' autonomy to direct their own treatment, can serve to direct patients, surrogates and physicians aright in affirming life yet recognizing death in its time. It does not differ much from the conclusion reached by Rabbi David M. Feldman in his recent book, *Health and Medicine in the Jewish Tradition*:

A clear distinction is thus implied between deliberate termination of life and the removal of means that artificially prolong the process of death. Jewish law codes subsequently make the teaching explicit: To "remove hindrances to the soul's departure is permitted and even mandated." While physicians, then, may not disconnect life-support systems where they shorten life thereby, they may do so to shorten the death process. . . . At the outset, the physician should connect the support systems of respiration or circulation; he should not decline to do so on the grounds that this may be prolonging death. He must give the patient every chance for life. Having connected the systems conditionally, however, he may remove them if he then determines that their function was not prolongation of life but of death.<sup>54</sup>

This paper has sought to determine the parameters of the halakhah with regard to treatment of the terminally ill. Since so much of this treatment comes under the sway of our ultimate right to direct our own treatment, it follows that this paper becomes primarily an instrument to advise Jewish individuals concerning the decisions that they may have to make about their own care. Unfortunately, all too often our frailty at the latter stages of terminal illness gets in the way of a conscientious personal application of the halakhah and it is the family or the physician who will seek this guidance.

It is immensely important, halakhically and morally, that all concerned with the treatment of an end stage patient remember that the ultimate autonomy which undergirds patient decision-making rests with the patient alone. Competent individuals can assert the interests of their souls, plausibly claiming to know God's will for themselves, or to be willing to face His judgment. No one else can fully project themselves into another's soul and another's place. When patients are unable to express their wishes, however, surrogates<sup>55</sup> and physicians must take over. Lacking direct access to the mind and feelings of the patient, these surrogates need be even more careful to affirm life in their judgment of the best course of treatment than patients themselves, for to fail would be, in the Baraita's words, akin to murder.<sup>56</sup>

Here is the area where there is a great usefulness for the living wills or durable powers of attorney that have come into use. Surrogates or physicians armed with written indication of patients' wishes may rely on those instruments to permit that which would be permitted the patients under their right of directing their treatment. Even when designated as surrogate by a patient without specific instructions, the surrogate may make necessary decisions that are normally within the realm of the individual since *שליח אדם כמוהו* (a man's messenger is like him). As surrogate, one functions as an extension of the patient. Nevertheless, as a *שליח*, a surrogate must proceed with extreme caution and humility not to presume of the patient what cannot be assumed. The surrogate can never be privy to the personal dialogue between the patient and God, the ultimate source of autonomy. Patients themselves cannot know, when they draft a living will, the precise nature of their encounter with God in their final illness. Changes of heart are not uncommon.<sup>57</sup> Thus even living wills are suspect. Yet treatment decisions must be made. In the face of an incompetent patient, those who knew best the soul of the patient need to stand ready to shoulder the burden of surrogacy with a commitment to furthering the interests of the patient's life in accordance with his or her desires.

### **Additional Guidelines**

Some cases involving surrogates pose additional problems because the very meaning of the patients' lives and desires comes into question.

F) *PVS: Persistent Vegetative State*: A special complication is posed by cases of extended, irreversible coma and PVS, persistent vegetative state. Such unconsciousness follows upon destruction of the higher brain while the brain stem remains largely intact. Patients in this condition may maintain spontaneous reflexes, including heartbeat and respiration, circadian wake/sleep rhythms, eye-movements and gestures, but are altogether without consciousness and must be nourished artificially. Physicians feel confident of their ability to diagnose this state, given a flat EEG and lack of responsiveness or of any purposive action with no change over a period of one month. Certain other confirmatory tests, such as CAT scan, MRI (Magnetic Resonance Imaging), blood flow studies and carbon dioxide levels would be used to support such a diagnosis. If maintained, such patients can live for years (the longest recorded case being 37 years).<sup>58</sup> Increasingly, the courts in this country, on the basis of the literature of biomedical ethics, have considered these cases under the rubric of benefits and burdens as cases of no conceivable life benefit to the patient, and therefore, cases in which life-sustaining treatment (including nutrition and hydration) may be withheld or

withdrawn. Recently, that question centered around the removal of a feeding tube from PVS patient Nancy Cruzan.<sup>59</sup> We do not accept that burdensome life is dispensable, and such a patient is manifestly not in the process of dying.<sup>60</sup> Does that mean that we must maintain patients in such condition until their natural deaths?

If vegetative life is life, the answer would appear to be that we must. We have expressly rejected quality of life calculations, nor are such patients able to appreciate the quality of their lives. Here, it appears that we have been cast by God in the role of custodians of a life that He has harshly reined in but allowed to continue. We do not maintain the patient in hopes of some future cure, which would be too slight a hope to maintain, nor against the possibility of error in the diagnosis of irreversibility, though any remediable uncertainty in the diagnosis must be pursued.<sup>61</sup> We maintain the patient because it is not within our domain to choose to terminate life.

But these cases remain deeply troubling. Is such a life really life? Has not the soul departed while the body, in some aberrant glitch, refuses to shut down? If so, what courtesy do we owe such a soulless body – surely not all the reverence we accord human life? Yet when we see the body of a patient breathing and moving before us, though unconscious, and, to the best of our medical and scientific knowledge, destined never to be conscious again – can we be certain that this patient’s soul (a soul we cannot quantify in scientific terms) has departed? When the family of Nancy Cruzan, the principal in the case argued before the Supreme Court, spoke to her at her bedside, they said things to the effect of, “We do not know if you are there, if you can hear us . . .” The relief they sought for their daughter was not predicated on her being dead, but on the undesirability, even horror, of living with no interaction with the human world. Their question to her was to the point, and as for the answer—we have no way of knowing. Facing an evidently living being, not knowing the state of its soul, we are left with the *ḥazakah* (the legal presumption) of life, and the requirement to treat that life as we would any other life.<sup>62</sup>

G) Neonates: Another area requiring special consideration is that of neonates. These fragile creatures are increasingly being rescued from the grave by extraordinary medical and technological means. They clearly have no personal opinions about their care. To what extent may they be considered sentient creatures at 23 weeks and at 500 grams? Their prognosis for healthy life is often very poor; and for them, as well as for full-term but grossly abnormal babies, what is required of us in terms of treatment?

The principles may be set out in brief: On the one side, our reverence for life, our opposition to determinations based on quality of life; on the

other, our awareness of the non-viability of many of these infants (a non-viability recognized by the halakhah in the area of bereavement), and our questions about the limits of medicine and God's intentions. To deal with these issues exhaustively would require a thorough classification of the genetic and medical problems being faced by neonatologists every day. We reserve that discussion for a later paper.

## CONCLUSION

Judaism holds clearly and unequivocally that human life, that special presence we know as the human soul, is a divine gift. It comes from God and returns to Him. We seek to do, in our allotted stay on this earth, that which He has commanded us to do, as we best understand it, through the tools offered us by revelation, tradition and reason. We embrace medicine and science as advancing the cause of humankind without any theological hesitation. We demur, however, at that point where our earthly sojourn meets divine destiny. There we continue to apply our best science and our best sense and sensitivity, all the while looking over our shoulders so as not to miss the divine whisper. We must undertake to treat people, even in extremis, even to the very last, in a humane and life affirming way. That means that we must accord the patient's wishes great respect, and our concern for the patient's total well-being must be seamless. Yet above the patient is the presence of the Almighty, closer, it would seem, than at almost any other time. His is the final medical judgment, the final intervention. We seek His guidance and test His instructions by doing all we can to heal and treat the ill, to the last; we recognize His hand by staying ours where it seeks to overrule the very nature of His creation in favor of a new one we have devised.

אלהים יחננו ויציא כאור משטינו, איום קדוש.

May God favor us and broadcast our judgment like radiant light,  
for He is awesome and holy.

## NOTES

1. *Bava Kamma* 85a, *Shulhan Arukh Yoreh Deah* 336.1. And see *Turei Zahav* 1 and *Beur haGra* 1 there. Sh.A. *Orah Hayyim* 329, *Yoma* 85a ff. For a full discussion see Rabbi Immanuel Jakobovits, *Jewish Medical Ethics*, chapters 1 and 3.
2. *Genesis* 1 and 2. *Mishnah Sanhedrin* 4.5.
3. In the Hippocratic Oath every physician vowed, "I will use treatment to help the sick according to my ability and judgment, but

never with a view to injury . . .” (*Bartlett’s Familiar Quotations*, p. 88). It was understood that physicians could take life as well as protect it, so the oath took care to proscribe the use of medicine against life. “I will give no deadly drug, though it be asked of me, nor will I counsel such” (Cited in *Journal of the American Medical Association* 259.14, 4/8/88, p. 2143). This commitment was translated by the American Medical Association in 1982: “The social commitment of the physician is to prolong life and relieve suffering” (*President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment*, p. 16, n.2).

Some cite Hippocrates, from another treatise entitled *The Art*, as one who did not recognize a duty to prolong life. They refer to a passage which advises the physician to refrain from treating “those who are overmastered by their diseases, realizing that in such cases medicine is powerless.” (*Pres. Comm., ibid.*, and see below, note 23). This recognition of the limits of his medicine, however, should not distract from the primary message received in the Hippocratic tradition, that the physician was to use his art in the interests of life and the relief of suffering. The President’s Commission offers its own formulation of this common understanding: “The individual health care provider is likely to help dying patients most by maintaining a predisposition for sustaining life . . . Indeed, this favoring of life is part of society’s expectation regarding health care professionals” (p. 48).

4. *President’s Commission*, p. 3. This Presidential Commission was made up of eleven members and an extensive staff. Among its members were Rabbi Seymour Siegel, ל”ט, and its chairman at the time of this report in March 1983, Morris Abram, former President of the National Conference on Soviet Jewry.

5. The Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying*, p. 7.

6. Hastings Center, *Guidelines*, p. 19. Even the Vatican has invoked this concept of burdens, stating, “When inevitable death is imminent in spite of the means used, it is permitted in conscience to make the decision to refuse forms of treatment that would secure a precarious and burdensome prolongation of life” (*Critical Care Medicine*, Jan. 1984, p. 61, and see *New England Journal of Medicine* 4/14/88, p. 986 and n. 3).

7. This is intended expressly to overrule the old medical orthodoxy wherein the doctors must exert their life-saving abilities and did regularly do so in a paternalistic and dogmatic way, overriding patient choices in the name of their own professional obligations.

8. Mishnah *Avot* 2:7 cites Rabbi Yehudah haNasi offering advice concerning “the right course that a person should choose for himself.” The commentary Midrash Shmuel by Samuel diOzeida objects: “The

right course that a person should choose for himself?" As if it is in man's hands to choose a path according to his will! Not so. The Torah directed us on the right path, and none is straighter, as is written: 'and you shall show them the path they should follow and the deed they should do.'"

9. *Avodah Zarah* 19a.

10. Using a strict benefit/burden analysis, from the patient's perspective one could easily argue the case for suicide if one's despair so elevated the burdens of life as to offer no release. That conclusion is unacceptable to everyone.

Seeking a non-religious, theoretical justification for the prohibition of suicide and euthanasia, the Hastings Center concludes:

Finally, under the rubric of "termination of treatment," we do not include active euthanasia or assisted suicide. These Guidelines have been formulated in the belief that a reasonable, if not unambiguous, line can be drawn between forgoing life-sustaining treatment on the one hand, and active euthanasia or assisted suicide on the other.

Our society forbids assisting suicide or active euthanasia, even if the motive is compassion. This prohibition serves to sustain the societal value of respect for life and to provide some safeguards against abuse of the authority to take actions that shorten life. (Guidelines, p. 6)

11. Maimonides, MT, *Hilkhot Yesodei haTorah*, ch. 5; Mishnah *Terumot* 8:12 and *Yerushalmi* thereon; *Bavli Sanhedrin* 74a, 72a.

12. Thus *Arukh Hashulhan*, *Yoreh Deah* 339:1, simply:

ראע"פ שאנו רואים שמצטער הרבה בגסיסתו וטוב לו המות מ"מ אסור לנו לעשות דבר לקרב מיתתו והעולם ומלואו של הקב"ה וכך רצונו יתברך.

Even though we see that he suffers greatly in dying and death would be better for him, nevertheless we are forbidden to do anything to hasten his death, for the world and all it contains is God's, and such is His will, may He be praised.

13. *Eruvin* 13b.

14. Eliezer Waldenberg, *Tzitz Eliezer* XIII, 87.

15. *Bava Metzia* 84a.

16. *Ketubot* 104a.

17. *Nedarim* 40a, s.v. אין מבקש עליו רחמים

The last phrase, שמצטער החולה הרבה ואי אפשר לו שיחיה (since the patient suffers greatly and cannot live) has some ambiguity. Does it refer to the nature of the illness, which is terminal so that the patient "cannot live," or is the reference subjective, that the patient suffers such that he

cannot stand it (אי אפשר לו)? Either is linguistically defensible. Is suffering a sufficient condition to warrant death, or is the objective medical prognosis material? The subject, however, is prayer, so that even the more liberal interpretation offers no dramatic turn.

R. Nissim's dictum is cited by Rabbi Y. M. Epstein in his *Arukh Hashulhan, Yoreh Deah* 335:3 and by many modern Jewish writers on biomedical ethics. However, Rabbi J. David Bleich (in F. Rosner and J. D. Bleich, *Jewish Bioethics*, p. 35) points out that Rabbi Waldenberg rejects the dictum as a point of law (*Tzitz Eliezer*, IX, 47).

18. To attempt to blur the distinction between God's role in answering prayer and His role in our direct actions by contending that even where we act, it is God who ultimately determines whether our act will succeed or fail, is unacceptable. Such a claim reduces our free will, making God ultimately responsible for our actions, and could be used to justify any sinful conduct.

19. It goes without saying that a course of treatment which is medically worthless, lacking even a placebo effect, is not medical treatment at all. It should never knowingly have been begun and may be withdrawn at any time. The question of how to gauge medical futility is itself subject to the ethical analysis of this paper.

20. Attempts to do so (see Rabbi Moses Feinstein, *Iggrot Mosheh, Hoshen Misphat II* 73:1; Rabbi Morris Shapiro, "To What Extent Should Life Prolonging Means Be Extended to a Dying Person," presented to CJLS, Nov. 1987, not accepted) notwithstanding, the inference is not valid.

21. M. Higger, *Treatise Semahot*, pp. 97ff.

22. The halakhah is clear that life should be saved even on Shabbat even if it is for a very limited duration (חיי שעה), *Shulhan Arukh, Oraḥ Hayyim* 329.4, *Yoma* 85a. In Responsa *Beit Yaakov* (#59) the author argues that a גוסס need not be saved for a limited duration, since the death process has begun and we are not to intervene to thwart it. He argues that for a גוסס, since we are required to remove impediments to death, any treatment undertaken solely for a temporary lengthening of life is inappropriate. This ruling is contrary to the ruling of Tosafot. *Niddah* 44a-b, s.v. איהו; and many others, as cited in Waldenberg, *Ramat Rahel* 28, following *Tzitz Eliezer V*. Even *Beit Yaakov* limits said ruling to a classic end-stage גוסס, specifically exempting a longer term טריפה, who must be saved in accordance with the ruling in *Yoma* above.

The question of the definition or duration of חיי שעה (life of short duration) is moot as long as there is no functional legal difference between treatment לחיי שעה (for the short term) and that חיי שעה (for the long term). Those who would so distinguish define חיי שעה (the short term) as less than one year, based on the definition of טריפה, collapsing



categories and muddying *Beit Yaakov's* own distinction. See sources cited, note 19.

The other major source cited to release us of concern for *חיי שעה* is a gemara on *Avodah Zarah* 27b with its related Tosafot, s.v. *לחיי שעה לא חיישינן*. Faced with conflicting *gemarot* on whether we take *חיי שעה* into account, Tosafot concludes *עבדינן לטובתו* in each case we do what is best. This source is cited by Rabbi G. A. Rabinowitz in *Halakhah uRefuah*, vol. 3, p. 113ff, to suggest that we might disregard any temporary life-extending treatment for a patient in pain, where death is preferable to such a life. Thus do some propose putting the quality of life, benefits and burdens analysis into the mouth of Tosafot.

An analysis of the text source, however, does not admit of this reading of *לטובתו*. The mishnah and gemara there deal with the following scenario: Gentile physicians are suspected of murdering their Jewish patients. The mishnah therefore rules that it is forbidden to accept treatment by a Gentile physician. But what, asks the Talmud, if one is deathly ill? Comes the response: If it is unclear if the patient will live or die, we do not resort to the Gentile physician – perhaps the patient will live, and the “treatment” is too dangerous. If, however, the patient will surely die then he may try the Gentile physician, for there is nothing to lose. But, objects the gemara, there is something to lose – *חיי שעה*! Should his physician kill him, his life will have been shortened thereby. The Talmud waves off this concern, saying, *לחיי שעה לא חיישינן*, we do not take into account life of a short duration. Now note, this is no different than a standard calculation on whether to undertake risky treatment. If the risk of treatment is greater than the risk of the illness (the first case of uncertainty) – do not undertake treatment. If the risk of the illness is greater, you may risk treatment even though it may fail and be fatal.

Tosafot question the dismissal of *חיי שעה* in the case of the Gentile physician, since in the case of a building collapse we *are* concerned about it. Tosafot's resolution: “in both cases we do what is best for him.” Note that in both cases “what is best” is to live longer. In the one case we override Sabbath restrictions so that perhaps he can live longer; in this case we do or do not accept treatment from a Gentile based on our analysis of what is likeliest to prolong life. Thus Tosafot in detail:

הכא והתם עבדינן לטובתו. דהתם אם לא תחוש ימות הכא אם תחוש ולא תרפא  
מן נכרי ודאי ימות וכאן שבקינן הודאי (שימות!) ועבדינן הספק (שמא יחיה!)

In both cases we do what is best for him. In the one case [building collapse], if you are not concerned [about life of short duration; therefore, do not clear the debris on Shabbat] he will die, whereas here if you are concerned [about the possibility of his remaining life of short duration] and [if, therefore,] he does not seek medication from the

Gentile, he will surely die. Therefore, here we eschew the certain result and act on a possibility.

There is no precedent here for acting on the “benefit” of an earlier death, and the phrase *לא חיישינן שעה לא חיי* does not mean that we may dispense with a life of short duration, but, rather, that we always trade up with regard to life. In life a little is very much, a little more is very much better.

23. *Shiltei haGibborim* to Alfasi, *Moed Katan*, ch. 3, #1237.

24. It must be said that the impediments to death outlined by Isserles and *Shiltei haGibborim* are not medical but rather folkloristic. One might conclude that we may do only non-physical things (like prayer) in hopes that they affect, inexplicably, the death of the patient. But whatever we think about the efficacy of the actions mentioned, prayer was addressed to God who properly determines life and death whereas these folkloristic acts are intended to affect the patient directly. Thus the principle that is being pointed to is very much as expressed, to set aside anything that is preventing the soul’s departure.

25. Rabbi J. David Bleich, “The Moribund Patient,” in Bleich and Rosner, *Jewish Bioethics*, pp. 33-35 and Fred Rosner, *ibid.*, p. 263, who characterizes Rabbi Immanuel Jakobovits as “quick to point out” this three-day limit. In fact, in Jakobovits, *Jewish Medical Ethics*, this goes unmentioned in the text, but appears in a footnote, #18 to chapter 11, as the opinion of Rabbi Joshua Falk, author of the *Perishah* commentary to the *Tur*.

Rabbi Moses Feinstein defends the three day notion more plausibly as not being a physical fact, but rather a strong probability (רוב). It is that probability that allows the legal presumption of death after three days. It is safe to say that this is the classical notion of *גרוסס* codified in the literature, whereas this discussion presumes a major expansion of this category to medicine’s category of the terminally ill who have not days but months to live, in all probability. See next note.

26. Some general writers on medical ethics have adopted a similar stance, placing themselves at some distance from the “benefits and burdens” view, but with results distinctly different from those we propose here. Thus Kenneth L. Vaux, a professor of Ethics in Medicine at the University of Illinois, cites approvingly the “classical clinical wisdom”:

In this tradition the physician was discouraged from invading the atrium of death therapeutically or technologically. Attempts to cure were now to yield to attempts to comfort. In the Hippocratic treatise, the *Art*, the *techne iatrike* is defined as follows: “In general terms it is (1) to do away with the sufferings of the sick, (2) to lessen

the violence of their diseases, and (3) to refuse to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless.” This reflects the fundamental religious and ethical genius of classical ethics: In the atrium of death, one’s life is given over to the transcending spirit who gave it. (*Hastings Center Report*, Jan./Feb. 1989, pp. 20-21).

He would, on that basis, permit some cases of euthanasia. Drs. Kenneth Micetich, Patricia Steinecker and David Thomasma (*Archives of Internal Medicine*, 143, May 1983, p. 977) write:

We agree that respect for the living, regardless of their status or function, is an important value for medicine and for society. However, if no intervention we can conceive of will stave off death, then our obligations toward living beings are altered. Thus, just prior to the discussion of faithfulness toward the dying, Ramsey (Paul Ramsey, *The Patient as a Person*, Yale University Press 1970, pp. 113ff.) points out that the morally significant point is that one is not obliged to prolong dying *in any way*. Once a judgment can be made that death is irreversibly imminent, the medical obligation to prolong life drastically changes. It is not now a question of prolonging life, but of postponing death (emphasis in original).

They then define their terms as follows (p. 978):

Our suggestion about drawing the line between prolonging life and prolonging death is the criterion that death will be imminent (within two weeks) no matter what intervention we may take.

They would withhold even nutrition and hydration once the criterion of imminence is fulfilled, as represented by their arbitrary choice of a two-week limit. Thus they take a technical position that the imminence of death releases altogether any obligation to medicate or treat other than that which relieves suffering. This is akin to the objective position of *Beit Yaakov*, who finds that the state of גסיסה (imminent death) requires cessation of life-giving care, so that it would be inappropriate to desecrate the Sabbath to save the life of a גוסס, even though the Talmud specifically requires doing so to save a life even temporarily and a גוסס is emphatically protected as a living person. Teamed with a mechanical time limit of three days under the guidance of halakhic precedent (see previous note), this is a narrow approach to the rule of גסיסה which yields an expansive result in terms of withholding treatment. But life and time are innately valuable in our tradition, even in their smallest denominations, and prevailing opinion runs counter to the position of *Beit Yaakov* and, it follows, of Micetich, Steinecker and Thomasma. (See note 22).

Rather, we need to adopt a more expansive theoretical reading of the principles espoused in the halakhot of גוסס and follow those principles to a life-affirming, compassionate stance that recognizes the twin provinces of life and death. I believe this expansion of the law, creating a second category of גוסס, is warranted by the facts. In antiquity, diagnostic tools were insufficient to diagnose consumptive illnesses and to predict long term prognoses. (See note 33 on the extent of our weakness in this regard yet today.) Only the טריפה, suffering from a visible puncture wound to a vital organ, could be so diagnosed, and the one who was but moments away from death – the classical גוסס. Anyone dying of illness but not falling in these two categories would have been classed a שכיב מרע – deathly ill, but who is to say what miracles God has in store in His treasury? Today, with our expanded medical knowledge, we can identify the inexorable march toward death much earlier. In that situation, it is precisely the logic of the rule of גוסס that applies. The patient is dying by God's decree. Yet we are enjoined to treat and save even לז"י שעה for a short duration. We can only walk that line by applying these rules of גוסס and leaving the final judgment in the hands of the Ultimate Judge.

27. *Encyclopedia Britannica* (1901), Vol. III, 684-5; (1982), Vol. 2, 1015-16.

28. A. M. Capron and L. R. Kass, "A Statutory Definition of the Standards of Determining Human Death," *Law Review* 87 (1972), pp. 87-89, 100-118, n. 89:

Life is supported by the smooth and integrated function of three principal systems: circulatory, respiratory and nervous . . . So long as the integrated function of these three systems continues, the individual lives. If any one of them ceases to function, failure of the other two will shortly follow, and the organism dies. In any case it is anoxia, or deprivation of oxygen, that is the ultimate cause of death of cells: in central nervous system failure, because the impulses which maintain respiration cease; in cardiac failure, because oxygenated blood is not moved to the cells; and in respiratory failure, because the blood, although circulating, is not releasing carbon dioxide nor replenishing oxygen in the lungs. Although other organs, such as the liver and kidneys, perform functions essential to life, their failure does not *per se* result in immediate death; it results, rather, in the eventual failure of one of the three systems described, and is thus only an indirect cause of death. (M. Houts and I. H. Haut, *Courtroom Medicine*, 1.01(2)(a)).

It has long been known that, even when a patient loses consciousness and becomes areflexive, he may recover if heartbeat and breathing continue, but if they do not there is no hope of

recovery. Thus, death came to be equated with the absence of these two “vital signs,” although what was being detected was really the permanent cessation of the integrated functioning of the circulatory, respiratory and nervous systems. In recent years, the traditional concept of death has been departed from, or at least severely strained, in the case of persons who were dead according to the rationale underlying the traditional standards in that they had experienced a period of anoxia long enough to destroy their brain functions, but in whom respiration and circulation were artificially recreated. By recognizing that such artificial means of support may preclude reliance on the traditional standards of circulation and respiration, the statute proposed here merely permits the logic behind the long-existing understanding (i.e., integrated trisystemic functioning) to be served... Dr. Jean Hamburger has observed, “After the guillotine has cut off a criminal’s head, it is possible now to keep the heart and lungs going on for days. Do you think such a person is dead or alive?”. . . The purpose of the “new” standard is to make clear that the answer to Hamburger’s question is unequivocally that the person is dead. Cf. *Gray vs. Sawyer*, 247 S.W.2d 496 (Ky. 1952) “newly discovered evidence that blood was gushing from decedent’s decapitated body is significant proof that she was still alive . . .”

Brain death may be formally new to the halakhah, but the premises required are old and were always self-evident. Cf. *Mishnah Oholot* 1.6 and Rambam’s commentary thereon, and the famed dictum פסיק רישיה ולא ימות “Should you cut off its head, will it not die?” (*Shabbat* 75a, 103a, et al.). See ahead, note 43.

29. See Jakobovits, *Jewish Medical Ethics*, chapter 1, particularly pp. 3-5.

30. Maimonides, Commentary to the Mishnah, *Pesahim* 4.9. This reference was uncovered by Rabbi Bleich, *Jewish Bioethics*, p. 270. Maimonides draws the analogy that these are both God-given for one’s satisfaction and health. Bleich concludes that the analogy applies as well to life-saving medical technology. We agree, but sense in the texture of Maimonides’ passage the physical image of ingestion.

31. We are not alone in championing this distinction as the proper implication of the precedent before us in the codes. One of the stellar thinkers of this generation in matters of halakhah, science and society, Dr. Yeshayahu Leibovitz, in a 1977 lecture at Tel Aviv University published in a collection of his essays titled, “אמונה, הסטוריה וערכים” (Akademon, Hebrew University, 1982), p. 249, states simply:

מסתבר שהרמ"א מבחין בין שני סוגים של מעכבי המיתה במקרים של גסיסה זו. א. של מיתה בלתי – נמנעת: עיכוב מחמת גורם חיוני שעדיין מוסיף לפעול באורגניזם של הגוסס עצמו, ובמקרה זה אסור להפסיק את פעולת הגורם הזה, ועיכוב מחמת גורם חיצוני, שאלמלא הפעלתו על הגוסס בדרך מלאכותית כבר היו החיים נפסקים מעצמם, ובמקרה זה אין חיוב להאריך את הגסיסה. והרי לפנינו המקרה של קארן קוילנן ממש. יש פוסקים החולקים על הרמ"א בנידון. אבל יתכן שהמקרה שלנו ייאמר – בנוסח הפסיקה במקרים קשים – "כדאי הוא הרמ"א לסמוך עליו בשעת הדחק אנחנו נמצאים בדחק אינטלקטואלי ורגשי כאחד. נמצא, שאילו עמד המקרה ואין ספק שהמקרה האיוש הזה." האיום הזה הוא מקרה של שעת הדחק: של קארן להכרעה לא בבית-משפט באמריקה, אלא להכרעה עפ"י ההלכה, רשאים היינו לעשות את רצון ההורים ולהפסיק את הטיפול שאיו בו תוחלת ושיש בו לפי הרגשתנו משום ניוול הגוסס ועינוי נפשי של בני-אדם חיים.

It appears that Rabbi Moses Isserles distinguishes between two impediments to death in cases of imminent death, that is to say inexorable death: an impediment due to a necessary factor which continues to function in the dying organism itself, in which case it is forbidden to stop the functioning of this factor; and an impediment due to an external factor, such that were it not applied artificially to the dying patient, his life would have already ended on its own. In this case there is no requirement to prolong his life. We have before us the very case of Karen Quinlan. There are *poskim* who disagree with Isserles in this regard. But it is likely that in a case such as this it would be said—as is the norm in difficult cases – “Isserles may be relied upon when in dire straits,” and there is no doubt that this is a case of dire straits: we are in both intellectual and emotional straits. It turns out, then, that were the Karen Quinlan case to be decided not in an American court, but according to Jewish law, we would be permitted to do the parents’ bidding and stop treatment that has no hope and which we feel has an element of desecration of the dying patient and torture of living people.

Dr. Leibovitz goes on to hesitate at the boldness of his own understanding. He worries of the slippery slope and concludes הלכה כן ואין מורין כן This is the law but we do not so instruct.” Withal, he proposes that doctors should function by the הלכה and not seek the judgment of the court, which, should it need to rule, would perforce need to speak the הוראה (instruction) publicly and not the proper הלכה (law).

Nor is Leibovitz alone in proposing this distinction. Its earliest clear proponent, to my knowledge, was Rabbi Moshe Munk in an article in *Shearim* 24 in 1968. (This understanding is referred to in passing even earlier, in 1957, in a long but opaque article by Rabbi M. D. Wollner in *HaTorah vemaMedinah* Vols. 7-8 (5716-17), p. 318ff). It is supported by

Rabbi Y. Rabinowitz in *Assia*, no. 3 (1971) and reported as normative by Dr. Abraham Steinberg in an excellent review of the halakhic literature pertaining to euthanasia, “רצח מתוך רחמים” in *Assia*, Vol. 5, no. 19, pp. 5-38. He cites Rabbi Eliezer Waldenberg, *Tzitz Eliezer* 13.89, as arguing this case at length—and, indeed, he seems to do so. However, in the following number of *Assia* (5.20), p. 17ff. Rabbi Waldenberg insists in two letters that his permission to remove life-support is only for one who is effectively brain dead, and that that was the only גוסס to which Isserles ever referred. Save, then, for that rather surprising limitation of Isserles, the case for extending Isserles’ ruling to mechanical life support is made by Rabbi Waldenberg quite effectively.

Similarly, Rabbi G. Rabinowitz and Dr. M. Koenigsberg (*HaDarom*, Tishri 5731) also state that mechanical life support is clearly not a vital sign, but they do so in the context of brain death. Whether they would extend that notion to the matter of גוסס remains open to speculation.

Against this understanding, see the demurral by Dr. Yaakov Levy in *Noam* 16 (1973), p. 61.

32. *Berakhot* 60a with Rashi and Nahmanides’ commentary to Lev. 26.11 are two loci of the pietistic approach. But even Ramban did not so rule at law, as R. Eliezer Waldenberg shows definitively, *Tzitz Eliezer* XI, 41. He cites Nahmanides’ *Torat haAdam* in the chapter on danger, addressing the very heart of the issue before us, as follows:

שופך דמים וכל שכן המתאש ואינו עושה. פקוח נפש מצוה גדולה היא, הזריז  
הרי זה משובח, הנשאל מגונה, השואל

Saving life is a great mitzvah. Who approaches it with alacrity is praised, who hesitates is despicable, who questions it is guilty of murder, and certainly so, one who despairs and does not do it.

And see Fred Rosner’s article, “The Physician and the Patient in Jewish Law,” *Jewish Bioethics*, pp. 45ff.

33. *Yoma* 83a, codified at *Shulhan Arukh, Oraḥ Ḥayyim* 618.1. The same ruling applies to transgressing Shabbat for treatment, O. H. 328.10.

The phrase “to err on the side of life” appears often in the literature of biomedical ethics, and is used in the report of Hastings Center (see note 4). I am unable to verify its original source.

34. *President’s Commission*, p. 176:

...uncertainty affects any scientific proposition about as-yet-unobserved cases. No matter how extensive the past evidence is for an empirical generalization, it may yet be falsified by future experience. Certainty in prognosis is always a matter of degree, typically based upon the quantity of the evidence from which a prediction is made.

p. 23, n. 37:

When 205 physicians in one study were presented with a hypothetical case, the range of assessments was striking, with those who favored and those against aggressive treatment offering the same reasons but projecting very different views of the patient's future.

p. 25, n. 44:

Physicians' predictions of prognosis were relatively inaccurate, with actual survival plus or minus one month coinciding with that predicted in only 16% of patients. Except in patients who were very ill and had short prognosis (*sic*) of three to four months, survival was consistently underestimated.

The subjective nature of prognoses affects the types of treatment that are encouraged, which in turn affects patients' outcome. In one study, physicians who preferred to intubate and artificially ventilate a patient with severe chronic lung disease projected that the patient would survive about 15 months; other physicians who decided against artificial ventilation when presented with the same case predicted that, even with artificial life support, the patient had only 6 months to live.

*Archives of Internal Medicine*, 145, June 1985, p. 1117, Lo et al.:

In six cases a DNR (Do not resuscitate) order was made without the agreement of the patient or family . . . The physicians in these cases believed that the futility of further treatment justified overriding the families' wishes. The judgement that patients 2, 3, and 4 would die despite treatment seemed incontrovertible (N. B.: But went untested given the DNR order). However, for patients 5 and 6, the physicians' assessment of futility were incorrect, perhaps influenced by their judgement of the patient's quality of life; *patients in these cases survived to discharge* (emphasis added).

35. *Bava Metzia* 85b.

36. On this matter of hazardous and uncertain treatment, see the discussion by Rabbi Bleich, *Jewish Bioethics*, Ch. 1, pp. 29-33, "Experimental Therapy and Hazardous Procedures." He reviews the literature, citing various rabbinic positions. Within these shades of opinion, however, two statements are unequivocal. "A patient may be compelled to submit to medically indicated therapy" (p. 28). But "procedures which involve any significant risk factors are always discretionary rather than mandatory." Determining which of these



formulations applies to any given situation is, in the nature of things, subject to medical opinion and patient discretion.

Here, medical and rabbinic humility before the autonomous choice of the patient is crucial. We may advise, but the patient alone chooses. The Sephardic Chief Rabbi of Israel was recently taught a poignant lesson in this regard. Early in 1990, 84 year old Ruth Trabelsi lay in a hospital in Israel refusing amputation of a gangrenous leg. Rabbi Mordecai Eliyahu, the Sephardic Chief Rabbi of Israel, intervened to convince her, despite her resolve to meet her Maker whole, to accede to the surgery, because ostensibly halakhah demanded that she act to prolong her life. But life confounded his good counsel. Having acceded to the rabbi's intercession, Ruth Trabelsi died of respiratory complications following upon surgical anesthesia.

And see Rabbi M. Feinstein, *Iggrot Moshe*, H. M. II, 73.5.

37. On the uncertainty inherent in the prognosis of terminality, see note 33.

Given the great uncertainty affecting prognosis and treatment, there can be no assurance that a particular patient will not live longer under the care of a hospice program than in the hospital. The only possible advantage is the availability of cardio-pulmonary resuscitation. This procedure, if successful, restores life immediately where it would otherwise be lost. May one forego that possibility by placing oneself beyond the reach of critical care equipment?

It is plain that we are not required to live our lives in intensive care units. Being beyond the reach of critical care equipment is within the purview of normal risk, a permission assumed in all our behavior, e.g. automobile or air travel. Only where cardiac arrest is specifically and imminently anticipated might this question arise as a serious consideration. (See ahead on DNR orders).

38. See ahead, Treatment Guidelines A.

39. Kenneth Vaux labels a certain subset of euthanasia cases as "exceptional case euthanasia." He writes (JAMA 259.14 4/8/88, p. 2141 in a response to the article "It's Over, Debbie" JAMA 259.2, 1/8/88):

I argue that while positive euthanasia must be proscribed in principle, in exceptional cases it may be abided in deed. There has always been a place, albeit carefully restricted to a limited range of cases, for voluntary euthanasia. From classical times throughout the Christian centuries and into modern secular society, this allowance has always existed alongside the dominant ethic of prolonging and sustaining life. . . . In his classic of medical ethics, *The Patient as a Person*, Paul Ramsey, PhD, a spokesman for traditional ethics, makes unrelenting cancer pain an exception to the dominant ethic of

“doing nothing to place the dying more quickly beyond our love and care.” Here, “one can hardly be held morally blameworthy if in these instances dying is directly accomplished or hastened (p. 163).”

Philosophical ethics aside, the most moving evidence I have witnessed for this viewpoint . . . is the testimony of highly ethical and humane physicians . . . Although impeded by law and custom from giving a lethal dose to their patient, these physicians would, in fact, do so . . . for their wife or father or child . . . Such loving acts illustrate a kind of “exception” ethic that has a place in the tradition of alleviating suffering.

This sense of the exceptional case is probably quite as Vaux has described it. Except that it was never concretized as permission for euthanasia; rather, it allowed courts and juries to mercifully acquit where the crime of euthanasia seemed humanly justified, if not legally so. This refers, then, to a special form of the ultimate autonomy of our individual accounts with God. Who knows if what was done contrary to law and custom, but out of love, finds favor or disapproval before the Lord? Who would want to ascribe guilt in such a case?

The case of Rudy Linares, the father of a two year old child in a technologically assisted vegetative state, who forcibly detached his child’s life support system, then held the hospital guards at bay with a gun while holding his son until he died (Chicago, April 26, 1989) strikes one as such a case. The Talmud’s case of the martyr, Rabbi Hanina ben Teradyon (*Avodah Zarah* 19a), is oft cited as an example of Judaism’s aversion to suicide (“One should not injure himself”), but halakhah’s permission to remove impediments to death from the dying (the centurion removes the protective damp tufts). Neglected in this analysis is the fact that the centurion also stokes the flames. The approval merited by the centurion is almost certainly based on such an exceptional case understanding, and does not imply any standing permission for euthanasia.

The case of Saul’s apparent suicide, much debated in the codes (*Tur* and *Shulhan Arukh*, *Yoreh Deah* 345) and considered by some as a warrant for suicide in some circumstances, is also best viewed as an exceptional case (like a חידוש) from which no warrant to follow suit can be derived. See Fred Rosner, “Suicide in Jewish Law,” *Jewish Bioethics*, ch. 20 for more on this debate. The halakhic distinctions ultimately made between a culpable suicide, for whom we do not mourn, and an excused suicide for whom we may, revolve around this problem of exceptional cases and our right to judge them. In a moment of humility before the depth of human emotion, on the one hand, and divine compassion on the other, we leave judgment in these cases to God’s infinite wisdom.

40. This follows from the value placed upon חיי שעה (life of short duration) see note 21. It is expressed clearly by Rabbi Eliezer Waldenberg in his conclusion to *Tzitz Eliezer* 5.28. The same is stated by Rabbi Moshe Feinstein in *Iggrot Moshe*, H. M. 2, 74.2, as long as excessive suffering is not present.

This raises the nub of the issue. As long as we are required to respect unconditionally the importance of God-given life, even חיי שעה, then the position espoused in this paper follows. Some respected authorities, however, have sought to resolve our dilemma by manipulating that principle in search of exemptions.

Secular ethicists, of course, are not committed to the absolute value of life. Thus “many medical and legal scholars hold that medical benefits should not be understood only in a narrow physiologic sense (after all, there always are some potentially achievable goals) but, instead, within a broader context that is relevant to the patient’s own values and proportional to their general condition and prognosis” (Dr. Michael Nevins, unpublished draft, “The Legacy of Karen Quinlan”). Colloquially, they speak of curing the person and not the individual diseases. Thus, where a patient is terminal, these voices would allow death by a subsidiary, treatable ailment, since a full cure of the primary disease is unavailable.

Something akin to this position is argued by Rabbi Immanuel Jakobovits in *HaPardes* 31.1 and 3. He returns to the basic question of the source of the requirement to medicate (See note 1). He concludes, with Rambam, that the Talmud’s provision permitting medication is based in the verse ורפא ירפא (he shall surely heal) as elucidated in *Bava Kamma* 85, but that the requirement to heal follows from the rules of return of a lost object, in this case, health. But where a cure cannot be effected, health cannot be restored; therefore all obligation to treat is removed. My discomfort with this position stems, in the first instance, from my unwillingness to grant that the requirement to heal is simply a version of returning lost objects. Healing clearly flows from the grand premise of life, not the minor premise of property. Furthermore, this position is weaker in that it can permit only inaction (no obligation) but not withdrawal of treatments. Though there is ample halakhic warrant for the distinction in liability between active and passive involvement, where the issue is life or death, this is a very thin reed indeed. Moreover, this perception will often lead to pernicious results, for if we cannot withdraw a treatment once begun, but only withhold it *ab initio*, the pressure rapidly grows against initiating any treatment that might later prove hopeless, but would nonetheless cause the patient to linger. Yet we often do not know which treatment will succeed, which patients will respond, and the pressure not to initiate treatment will certainly cause

unnecessary deaths before long. Last, and quite basically, this position opens the door too wide. What is left of the clear prescription that we transgress the Sabbath to save a life even for the shortest duration? If healing, in such a case, is impossible, the treatment, it follows, is optional – yet it overrides the Sabbath? I do not believe this to be the intent of the tradition.

A second approach, that taken by Rabbi Moshe Feinstein, was proposed before the CJLS by Rabbi Morris Shapiro (see note 19). Rabbis Feinstein and Shapiro propose to utilize the Talmudic precedents concerning prayer for the release of a suffering soul to argue that excessive pain may make life undesirable, therefore not to be maintained. At the extreme, this argument could admit quality of life considerations and even legitimize euthanasia. Feinstein and Shapiro do not go that route, being constrained by the taboo on murder to limit this policy to inaction *שב ואל תעשה*. As with Jakobovits, this argument only extends to withholding treatment, not withdrawal. It also applies only in cases of excessive pain, offering no leniency where pain is controlled or the patient is insensitive thereto. Indeed, Rabbi Feinstein expressly reviews the rulings concerning impediments to death, asserting that they only apply in the case of extreme pain, that being the key to releasing our concern for *חיי שעה*. But no such proviso appears in those rulings, nor does that appear to be the focus of their concern. But more fundamentally, I argued above that the Talmudic passages on prayer cannot serve as a precedent for effective medical steps to shorten life. Rather, the limitation of our examples to prayer and later to extraneous impediments to death argues the opposite, that effective life-shortening action (including intentional inaction) must be forbidden, therefore the resort to prayer.

The third approach that appears in some writers, including Rabbi Shapiro, Rabbi M. D. Wollner (see note 27b, p. 315ff.), and Rabbi G. A. Rabinowicz and Dr. M. Koenigsberg (*HaDarom*, Tishri 5731, p. 75), attempts to mitigate the demands of protecting life by questioning the status of the life of the terminally ill patient. Utilizing sources concerning a *טריפה* – that is, a person so wounded in a major organ that he or she cannot live – which sources rule that the murder of such a person is not punishable (Maimonides, *Mishneh Torah, Hilkhot Rotzeah* 2.8 et al.); or sources that rule that certain catastrophically broken accident victims are considered “as dead” for purposes of imparting impurity (Maimonides, M. T., *Hilkhot Tum’at Met* 1.15), these authors argue that given the virtual death of terminally ill patients, they lose their claim to maintenance *חיי שעה* (for the short term). Technically these arguments open themselves to great problems in determining which of our patients, diagnosed as terminally ill, fit the much more restrictive criteria of *טריפה*

(fatally wounded) or נקרא כרג (mangled). Thus Wollner, for instance, using the more stringent purity source, sets criteria that might apply to accident victims but not to end-stage cancer patients.

But much more important is my fundamental objection to taking this tack—that to do so is to permit hastening the death of patients, albeit based on a humanitarian impulse, because we vacate their lives in theory in advance. This is (a) pernicious, (b) unseemly, (c) wrong. Yes, such precedent exists in the literature, but always about incidental results. If you kill a טריפה can you be found guilty, given the stringency applied to capital punishment? No. But there is no implication that such murder is permissible. Do badly injured accident victims defile? Perhaps so, but this does not override the requirement to transgress the Sabbath for an accident victim. Should it?

Rabbi Elliot Dorff (in his article which appears in this issue), basing himself on the work of Dr. Daniel B. Sinclair (*Tradition and the Biological Revolution: The Application of Jewish Law to the Treatment of the Critically Ill*, Edinburgh University Press, 1989), has argued this case elegantly. Notwithstanding the persuasiveness of his prose, the fundamental flaw remains. It devalues life in order to attain its end. The approach taken herein to the contrary, I believe, is consistent, precedented, Godly and life-affirming. The other attempts, though all well-intentioned, it seems to me, are deeply flawed.

41. Many secular ethicists have drawn the line at artificial nutrition and hydration, seeing these as normal care and, therefore, not dispensable. But increasingly, the secular ethical consensus in favor of the “right to die” has affected this area, too. Thus, for instance, in an article on hydration (*Archives of Internal Medicine* 143, May 1985, p. 977, Micetich et al.), the authors argue that in comatose patients, who will not suffer from thirst, and whose death is imminent (less than two weeks), it is permissible to withdraw IV fluids, though not a respirator. They argue:

We are aware of the irony of withdrawing IV fluids but maintaining the respirator. While there is no normal obligation to continue to use the respirator after the patient’s condition is stabilized, nevertheless its withdrawal would precipitate immediate death. Withdrawal of the respirator, while normally possible, creates an immediate consequence of death for which we must take responsibility. It represents an extreme form of abandonment. Letting the patient die of later dehydration or other complications permits the family time to reconcile themselves to death.

Death, to these thinkers, once imminent, may be morally effected by any means, so long as they are not too sudden or jarring.

42. *President's Commission*, p. 288. Hastings Center, *Guidelines*, p. 60.

In a presentation to the Subcommittee on Biomedical Ethics of CJLS on 3/30/89 and in a subsequent phone conversation, Dr. Michael Nevins, a cardiologist at Pascack Valley Hospital in Westwood, New Jersey and member of the New Jersey Bioethics Commission, emphatically made the point that artificial feeding is not benign, and carries significant risk of its own, due to aspiration, whether by naso-gastric tube or gastrostomy (direct to intestine). He reports that according to a soon-to-be-published study of twenty nine patients with gastrostomy tubes, within days 50% suffered episodes of aspiration pneumonia and half of those died of pneumonia rather than of their underlying conditions.

43. That oral feeding is preferable to any artificial feeding procedures is obvious. Yet both the President's Commission (p. 288) and the Hastings Center (*Guidelines*, p. 62) felt the need to say so, so powerfully are we drawn to our technological toys (and see comments by Rabbi Moshe Feinstein, *Iggrot Moshe*, H. M. II, 74.3).

The problem of patient choice with regard to feeding tubes is exacerbated by problems of patient competence that often accompany conditions requiring feeding tubes. Surrogates and physicians need to maintain life wherever possible when the patient's choice is unknown. However, they may choose to see the recurrent removal of a naso-gastric tube by a patient who is not otherwise violent as indication of a desire not to suffer the tube.

Dr. Nevins suggests that in line with the distinction we have established between medicine (which is the support and enhancement of the body's systems) and the circumvention of major organs and bodily systems, it follows that in advanced Alzheimer's disease and similar degenerative neurological disorders, the failure of the swallowing reflex should be seen as a system failure which the feeding tube seeks to circumvent. This is less obvious a proposition than that concerning mechanical life support. While we do not endorse this view, it appears cogent and one could be justified in applying the method of this paper in that way. If so, feeding tubes would be dispensable even without patient approval, in such cases where no hope of a return to unaided function is possible. These cases would not include PVS where no dying process is in evidence and where the swallowing reflex may be in place, but the lack of patient consciousness makes oral feeding virtually impossible.

44. This is an area where the question of the status of brain death under Jewish law becomes highly relevant. The question is often raised whether patients who are being maintained on respirators may be removed from the respirator, and whether other treatment may be discontinued when they show signs of brain death. This differs somewhat from the termination of treatment questions addressed here, since a

finding of brain death, should it be acceptable to halakhah, would show the patient to be already dead, and therefore not a candidate for further treatment. To continue the trappings of treatment in such a case by mechanically maintaining the operation of the lifeless body, must surely be forbidden as a particularly morbid form of גיבול המת.

Two types of brain death have been proposed; the cessation of function of the cerebral brain which controls thought and language, an effective definition of a vegetative state or irreversible coma (see ahead, on PVS), or the cessation of function of the whole brain inclusive of the brain stem which controls reflex functions, including breathing and heartbeat. The courts and medical community have, to date, taken the more conservative measure of brain death. The Uniform Determination of Death Act proposed jointly by the American Medical Association and American Bar Association states:

An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. (Pres. Comm., p. 9, n. 7)

Halakhah has as its established criterion of death: the cessation of breathing and heartbeat, viz. respiration and circulation (*Yoma* 85a). This is the age-old form of recognizing death codified as the first criterion in the UDDA. It may be noted that this criterion has often proven problematic. Thus, Isserles required a waiting period after apparent cessation of respiration for fear that we are insufficiently expert at recognizing the true moment that breathing finally stops (Shulḥan Arukh, Oraḥ Hayyim 330:5). Against this stricture it has been congenitally argued that medical technology has progressed to a point where even the most minimal respiratory and circulatory activity can be measured, such that, in their absence no further waiting period need apply. (J. Levy, *HaMaayan*, Tammuz 5731. On all this, see chapters 17-19, by Rabbis Bleich and Aaron Soloveitchik in Bleich and Rosner, *Jewish Bioethics*, pp. 277-316.) On the other hand, modern advances in resuscitation techniques have rendered the cessation of respiration and heartbeat no longer the final word. This does not affect the definition of death – thus, for instance, a patient in whom resuscitation efforts fail is considered to have died at the original cessation of heartbeat even though some sporadic activity may have been elicited in the attempt. It does, however, require efforts at resuscitation unless such efforts are known to be futile (Jakobovits, *Jewish Medical Ethics*, p. 278. And see ahead re CPR).

Using a respirator or heart-lung machine, it may be impossible to tell if circulation and respiration are naturally continuing. Here, the second criterion of the UDDA comes into play: the brain is no longer able to

support independent respiration and circulation, so that it may be said that the ongoing processes are purely mechanical, but that the organism is no longer functioning. As noted previously (note 28), Mishnah *Oholot* 1.6 and Maimonides' commentary thereon, along with the principle of פסיק רישיה (a legal doctrine concerning effects which follow inexorably upon their cause), establish clearly that when the integrated function of mind and body is irreversibly destroyed, death is established. It is but a small and necessary step from there to the comparable ruling that where we are able to determine that there is no brain activity, even of the brain stem, with elevated carbon dioxide levels and no perfusion of blood into the tissue of the brain, no communication of brain to body is possible and the irreversible atrophy of the body known as death has begun. This determination must be made with adequate and redundant testing to guard against human and equipment failure, and accounting for factors such as trauma, hypothermia or drugs which might have a temporary effect on the adequacy of such tests, since the determination is of such moment, but whole brain death, as opposed to higher brain criteria, is acceptable according to halakhah.

Rabbi Bleich, in particular, has argued vehemently against this possibility, basing himself on the decapitation model of Mishnah *Oholot*. He writes (p. 308):

The currently proposed criteria differ significantly from decapitation as described in the Mishnah. Decapitation involves destruction of the entire brain. It might be argued cogently that total cessation of circulation of blood to the brain will result in destruction of brain tissue. Total destruction of the brain might then be equated with decapitation and the patient pronounced dead after total destruction has occurred.

He renews that thesis in *Tradition* 24:3, Spring 1989, pp. 44-66, writing:

Decapitation . . . involves physical severance of the entire brain from the body. Physiological decapitation, then, must also be defined as physiological destruction of the entire brain. That phenomenon has simply never been observed. To be sure, autopsies performed on patients pronounced dead on the basis of neurological criteria reveal that the brain has become a spongy, liquidy mass. In colloquial medical parlance this phenomenon is categorized as "respirator brain" because the condition is found in patients sustained on a respirator for a lengthy period of time and is the result of lysis or liquefaction of the brain. However, total lysis apparently does not occur . . .



This analysis is untenable. Decapitation does not signal total destruction of the tissue of the brain, but only its loss of contact with the organism. Destruction of the brain tissue will surely follow, but only at some unspecified later time. It is precisely the irreversible cessation of the integrated function of brain and body that is modeled by decapitation. Indeed, Bleich's rather lurid description of the deterioration of the brain of respirator patients may be the most eloquent testimony that death has indeed set in, despite the apparent maintenance of life signs through mechanical means. Furthermore, in footnotes 4, 5 and 6, Bleich admits that death follows rapidly upon total brain disfunction even where mechanical life-support is continued. He expresses puzzlement as to why this should be so, but ignores the obvious message that life is not meant to be prolonged in such cases. He seeks refuge in medieval halakhic argumentation concerning incomplete decapitation, arguments which are not compelling given the different physiological problem and the difference in medical knowledge.

Bleich does cast some doubt on the efficacy of presently available tests of total cessation of brain stem activity. However, he defends the right of experts to make final determinations about the cessation of respiration despite the potential for error, yet will not apply similar standards to a determination of brain death. For our purposes these fine points are close to irrelevant, since even where brain stem death cannot be conclusively shown, the use of mechanical life support is dispensable as an impediment to impending death.

Standing against Rabbi Bleich has been Rabbi Moshe Tendler who in July of 1986 supported the halakhic acceptability of brain-stem death and reported the same in the name of his father-in-law, Rabbi Moshe Feinstein (Teḥumin 7, 5746, pp. 187ff; *Tradition* 24:4, Summer 1989, p. 9, n. 9; and see back and forth by Rabbi Aaron Soloveitchik and Rabbi Tendler on this in *JAMA* 240 (7/14/78):109). This position effectively became the norm when the Chief Rabbinat Council in Israel cautiously endorsed brain death criteria for the purposes of transplants in Israel in 1987. These criteria are laid out in detail in the Chief Rabbinat Council's report which appeared in *Assia* 42-43, Nisan 5747, pp. 70-81 (*Sefer Assia*, Vol. 6, pp. 27-40) and in English with notes by Dr. Yoel Jakobovits in *Tradition* 24:4, Summer 1989, pp. 1-14. These operating instructions are essential for any medical team evaluating a patient for a diagnosis of brain death, but they are not carved in stone. They will certainly change over time.

Bleich, who strongly endorses the views of Israeli authorities who oppose the new criteria, attempts to cast even those criteria as not truly related to brain death, but to the proven expectation that independent respiration can never be restored. There is a tautology here. The total

brain death criteria were never intended to do other than establish a neurological analog to the traditional definitions of death.

Thus, the UDDA definition of death is acceptable under halakhah. When these criteria are present, no further treatment of any kind is necessary or indeed permitted, and organ donation is then possible. Even without the fulfillment of these criteria, a patient exclusively and irreversibly reliant on life-support equipment, though yet alive, has begun the dying process and it is appropriate to remove all impediments to death, though patients may continue them if they wish.

45. See prior note.

46. JAMA 260.14, 10/4/88, p. 2069f., Taffet *et al*, “In-Hospital Cardiopulmonary Resuscitation.”

Of the 77 CPR efforts in patients 70 years of age or older (N.B.: males) who had arrests, 24 (31%) were successful, and in 22 (92%) patients were alive after 24 hours. None lived to discharge. There were 322 CPR efforts in the younger cohort: 137 (43%) were successful, in 124 (91%) of these 137 efforts patients were alive after 24 hours and in 22 (16%) patients were discharged alive . . . When a multivariate analysis was used, the presence of sepsis, cancer, increased age, increased number of medication doses administered and absence of witness were all “predictive” of poor outcome.

47. While it is true that Isserles rejects this conclusion until an hour has passed without heartbeat or respiration lest it be a faint with heartbeat and respiration imperceptibly maintained, our diagnostic and monitoring abilities are significantly improved and may be relied upon. See note 38 and see Rabbi I. Untermann’s classification, *obiter dictum*, in Noam 13.1, pp. 3-4.

48. The question of triage, which goes beyond the scope of this paper, deserves separate treatment. The general principles with regard to life-saving treatment would appear to be the well known dictum *אין דוחין נפש נפש* – “one life does not take precedence over another” (Mishnah *Oholot* 7.6, the famed abortion text) and the rules of personal priority derived from the desert stories in *Bava Metzia* 62a. But the level of danger and prognosis, as well as certain broad enactments for the sake of society, should all enter into the picture. Some attention is given these problems by Dr. Fred Rosner in *Modern Medicine and Jewish Ethics*, chapter 23. And see Dr. Elliot Dorff’s suggestive arguments in his paper which appears in this issue, and Dr. Moshe Sokol, “The Allocation of Scarce Medical Resources,” in *AJS Review* v. XV, no. 1, Spring 1990, pp. 63ff.

49. This implies that patients on dialysis could choose to cease treatment without incurring the full severity of the sin of suicide. This

may indeed be a necessary corollary of the analysis herein. Where an active life is possible, however, the patient must certainly be advised to choose life, much as any patient facing a choice of treatments is advised to maximize life. In the event of willful death, however, this would be a mitigating circumstance which would allow us to treat the deceased with full honor.

This provision will effectively apply, as well, to any new mechanical devices which may be devised, such as artificial hearts and lungs. These are clearly mechanical means circumventing system failure. However, their efficacy at restoring meaningful life argues powerfully for their use, even though rejecting them would not constitute suicide. The provisions here permitting the removal of impediments to death do not mandate doing so, nor do they even establish permission to do so when restoration to an active life can be effected by their use.

50. R. Immanuel Jakobovits, *Jewish Medical Ethics*, ch. 8; Rabbi Moshe Feinstein, *Iggrot Moshe*, H. M. 73.9. As Feinstein suggests, pain treatment can have some effect on longevity. "The relief and comfort given an aged patient often affects the prolongation of life if only by restoring the willingness to live." (Pres. Comm., p. 77, n.100) Similarly, Dr. Pat Hartwell reported before the subcommittee (2/2/89) that pain can interfere with a patient's sleep and ability to heal, as well as lead to depression which can further aggravate many conditions. Such pain relief is, in almost all cases, organic and could not be considered an impediment to death. Moreover, it is undertaken to relieve suffering, not to extend life, a separate justification which stands on its own.

51. *President's Commission*, p. 80, n. 110. Kenneth Vaux in the Hastings Center Report, Jan./Feb. 1989, p. 20.

52. Rabbi Immanuel Jakobovits refers both to intent and probability of effect in his description of the situation in which pain-killing medication is permitted. He writes (*Jewish Medical Ethics*, p. 276):

Analgesics may be administered, even at the risk of possibly shortening the patient's life, so long as they are given solely for the purpose of rendering him insensitive to acute pain.

Clearly, proper intent is necessary, but it is unclear how great a risk Rabbi Jakobovits had in mind. He does not use words such as "likelihood" or "expectation" of death, as do the representatives of the doctrine of "double-effect," but rather refers to "risk" and "possibly." I am not convinced that proper intent can be claimed when flying in the face of legitimate expectations. Therefore the criterion proposed here.

The role of legitimate expectations is highlighted in a ruling by Radbaz, as cited in *Magen Avraham, Oraḥ Ḥayyim* 328.8 who states clearly:

חולה אומר צריך אני לתרופה פלונית ורופא אומר א"צ שומעין לחולה האם הרופא אומר שאותו תרופה יזיקהו, שומעין לרופא.

The patient says, "I need a certain medication," and the physician says, "He doesn't need[it];" one listens to the patient. But if the physician says the medication will harm him, one listens to the physician.

Even the patient is limited by the physician's knowledge.

(Oddly, Radbaz is cited in the Magen Avraham elsewhere in a seemingly contradictory ruling that "אפ' הרופאים אמרים שהמאכל יזיקהו" "אפ' הרופאים אמרים שהמאכל יזיקהו" (Magen Avraham, Oraḥ Ḥayyim 618:3) Even where the physician says the food will harm him, one listens to the patient. See *Levushei Srad* there, that the distinction has to do with the relative competences of doctor and patient. With regard to medication, as against food, a patient may exercise autonomy only within accepted medical wisdom. (But see Wollner, n. 27b, who tries to derive a further leniency based on the contradiction. His argument fails to convince.)

Essentially, this becomes a problem of פסיק רישיה wherein the high probability or expected after effect cannot be divorced from the action, and intent is no defense, wherefore the ruling אסור ליה ניהא דלא פסיק רישיה דלא ניהא דלא פסיק רישיה דלא ניהא דלא פסיק רישיה. Where the effect is certain, even though it is not pleasing to him, it [the causative action] is forbidden. Where ill-effect is less certain there is no פסיק רישיה and intent governs.

Interestingly, the President's Commission, though it proposes to permit use of potentially lethal pain-killers when the benefit/burden ratio so indicates, nevertheless criticizes the use of intent to immunize physicians from the foreseeable consequences of their treatment. They write (p. 77-82 and n. 101):

The question arises as to whether physicians should be able to administer a symptom-relieving drug such as a pain-killer knowing that the drug may cause or accelerate the patient's death, even though death is not an outcome the physician seeks. The usual answer to this question... is often said to rest on a distinction between the goals physicians seek to achieve or the means they use, on the one hand, and the unintended but foreseeable consequences of their actions on the other. (Note: The customary use of "foreseeable" is for those things that would be predicted as possible outcomes by a person exercising reasonable foresight; it is not limited to consequences that are certain or nearly certain to occur.) ... however, health care professionals cannot use it to justify a failure to consider all the consequences of their choices. By choosing a course of action a person knowingly brings about certain

effects . . . The law . . . holds people to be equally responsible for all the reasonably foreseeable results of their actions and not just for the results that they acknowledge having intended to achieve.

For the use of morphine, or other pain-relieving medication that can lead to death, to be socially and legally acceptable, physicians must act . . . in a professionally skillful fashion (for example, by not taking a step that is riskier than necessary), (and) that there are sufficiently weighty reasons to run the risk of the patient dying.

Of course, the commission's judgment regarding "sufficiently weighty reasons" and our own differ.

In an interesting turn, Rabbi Moses Feinstein, writing in *BiShvilei haRefuah*, a journal published by the Kiryat Sanz/Laniado Hospital, no. 6, Sivan 5744 (June 1984), p. 35, permits withholding medicines that would extend the life of a patient in severe pain even before that patient is classified as ג'ויטס, but does not permit pain-relief medication that would shorten life even for a moment, relying on the difference between action (עשה) and inaction (שב ואל תעשה). He does not address uncertain effect, but clearly holds any life threatening action as precluded even to release a patient from a pain which he considers sufficiently important to allow the remedy of conscious and intentional passive hastening of death. His ruling, like this whole discussion, is born of a pessimism and frustration concerning the possibility of continuing life and controlling pain. On this, see directly ahead.

53. Dr. Pat Hartwell, at a meeting of the Subcommittee on Biomedical Ethics of the CJLS of the RA, 2/8/89.

In the aftermath of the controversy in the Journal of the American Medical Association in 1988 over a physician's confession to administering pain-killing medication with the intent of putting an end-stage patient permanently beyond the reach of suffering, known by the name of the original article (volume 259.2, 1/8/88, "It's Over, Debbie"), Dr. Porter Storey reports of his hospice training:

During the past five years I have treated some 2000 terminally ill patients to the times of their deaths, mostly in their own homes . . . I have learned that patients like Debbie do not need to be killed by their physicians to be relieved of their shortness of breath . . . Shortness of breath, like pain, can be effectively palliated by administering narcotic analgesics . . . (which) can be used safely in people who have very poor respiratory function if the dose is carefully titrated against the symptom. (JAMA 259.14, 4/8/88, p. 2095)

Even the President's Commission, which exerts much effort articulating their position in the event of conflict between pain-killing and maintenance of life (see previous note), expends greater efforts directing

physicians as to the proper treatment of pain, a discussion which virtually precludes the problem at the heart of the prior discussion. One gets the impression that the classical dilemma need no longer exist if physicians only performed up to the best standards of medical science. They write (pp. 278ff.):

Only a minority of dying patients . . . have substantial problems with pain . . . Fortunately, the chronic pain of dying patients is almost always fairly easy to control. First, the care givers should seek a remediable cause . . . Second, anxiety and fear must be mitigated . . . A nurse or physician who can say with assurance that a patient need never (or never again) feel overwhelmed by pain, and who proceeds to demonstrate the truth of the assertion, greatly eases the patient's mind and reduces his or her attentiveness to pain. Conversely, the most potent stimulus to fear of pain, and thus to increased pain, is inadequately treated pain. Patients who obtain short periods of relief with a narcotic followed by periods of pain while waiting for a next dose become trained to fear the expected onset of pain while pain-free . . . Adequate treatment for the pain can break this cycle . . .

Control of pain with narcotics involves continual experimentation to keep the dose in the zone between oversedation on the one hand and recurrence of pain on the other, so that the patient stays fairly alert but pain-free. Most patients have a substantial "therapeutic window," though what doses achieve it and at what frequency do change over time. For a few patients, especially when death is close, there is no such zone and the physician, with the patient's or family's concurrence, must be willing to accept sedation if pain is to be avoided.

As described by the President's Commission, the dilemma may only exist with regard to "agonal respiratory insufficiency" in "the last few hours and minutes." (See their description, pp. 294-5.) Is this the classical symptom of גסיסה (imminent death), the noise or liquid in the throat that is referred to by Maimonides in the commentary to Mishnah Arakhin 1.3 and codified in a gloss to *Shulhan Arukh, Even HaEzer* 121.7 and *Hoshen Mishpat* 211:27? But Dr. Storey expressly refers to this situation as did Dr. Hartwell, and both insist that the dilemma is moot with proper care.

54. Rabbi David M. Feldman, *Health and Medicine in the Jewish Tradition*, p. 95.

Closest to our approach, across the board, among the writers and speakers on biomedical ethics, appears to be Dr. C. Everett Koop, former Surgeon General of the United States. He writes "The Challenge of Definition," *Hastings Center Report*, Jan./Feb. 1989, pp. 2-3):

Tradition... places a consistent and primary emphasis on the supreme value of human life... Each one of us must choose for himself or herself. And we're enjoined to choose life...

I've been in medicine for a half century, and... I have no idea what anyone else's "quality of life" was, is or will be... If "Granny Doe" appears on my watch, I will want her to receive whatever medical treatment is indicated... I will pay special attention to her receiving the best possible regimen for the management of pain... That does not mean prolonging the act of dying. But it does at least mean providing her with the nutrition and fluids needed to sustain life at most basic levels. And if indeed she were in the final stages of a terminal illness... I would prescribe basic nutrition and fluids and then stand back to let nature take its course.

On a public television broadcast on 12/13/89, part of the "Frontline" series, Dr. Koop, sitting in a panel discussing the Cruzan case, repeatedly distinguished between nutrition and hydration, on the one hand, and respirators on the other, based on the fact that "they (respirators) are machines."

55. The qualifications for serving as a surrogate are not subject to halakhic review, being determined by the courts, and are properly subsumed, as a matter of Jewish law, under the principle of *דינא דמלכותא דינא*, that the law of the land controls. The natural surrogate empowered by courts and legislatures in this country, through whatever mechanism, will tend to be a family member, though not necessarily the closest member, due to problems of emotional involvement. Jewish law is aware of reasons to suspect the emotional motivations of close relatives and would tend, rather, toward rabbinic decisors. This is impractical, in many cases, and will certainly run counter to the law of the land. Rabbinic advisors should make themselves available to the family, however, in an advisory capacity.

56. This means, in effect, that a surrogate must be cautious never to assume the autonomy of the patient and make treatment decisions according to his or her own predilections. Wherever possible the surrogate must decide based on the known predilections of the incompetent patient. Indeed, it is for possessing that knowledge that a given surrogate is usually designated. Absent that knowledge, the surrogate or physician should presume the preference for life which our tradition assumes and not substitute any personally held preferences.

57. An eloquent testimony to the fact of a patient's changing perceptions and to the pitfalls often encountered in family surrogate situations appeared in JAMA 251.24, June 22/29, 1984, entitled "Three Worlds," by Dr. Carl Kjellstrand.

Her husband left her with us. He refused to dialyze her at home; lately she saw things that weren't there, was up all night and slept at odd hours. They quarreled, and he wanted her treatment discontinued... A family conference was called... A daughter was there, too, and she agreed with her father. "No, I can't do it anymore. She is no longer what I was married to. She is crazy... Quarrels, accusations, wandering around at night. Insanity! Better off dead!"...

I left them and went in to see my patient... "Ann, do you know you are on dialysis, on the artificial kidney?" "Yeah, I've been on for four years." "What would happen if we stopped treatment?" "I would croak." "Some time ago you said you would rather be dead than to go to a nursing home. Lars cannot care for you at home any longer..."

"Doc, death is scary. I'll make friends in the nursing home, we'll play cards and talk... Lars and I used to love each other so... maybe we still do. Something has come up and it pushes us around..."

We, of course, continued the treatment. She lived on in her three worlds, the grim real one that we shared, her world of memories, softened by time, and a world of frightening hallucinations. Lars never returned to see her...

58. *President's Commission*, chap. 5, p. 170ff; Dr. Pat Hartwell, presentation to the subcommittee, 12/12/88.

59. Quinlan, N. J. 1976; Leach, Ohio 1980; Severn, Del. 1980; Jobes, N. J. 1987. However, in the state of Missouri case before the Supreme Court the lower court held that the state has an absolute interest in protecting life and refused to permit withdrawal of her feeding tube.

Interestingly, Missouri State Attorney General Webster, whose office argued the case, when pressed during a televised symposium on the Cruzan case aired 12/13/89 as part of public television's Frontline series, admitted that had the patient's family objected to the insertion of a feeding tube initially, when her condition had not yet stabilized into long term PVS, that request would in all probability have been honored. His answer was not perfectly clear, but he appeared to justify this with the standard distinction between withholding treatment and withdrawing it. It was noted, however, that in the early context when the patient's prognosis was not yet known, it would be medically most unusual not to emplace any mechanism that might aid in producing a cure. Only later, when PVS is finally diagnosed confidently, is the question of sustaining the patient indefinitely in a vegetative state likely to surface. So, if the



family could reject the feeding tube earlier, it was asked again, why can they not now? No answer was forthcoming.

It should be noted that the halakhic criteria established in this paper produce a similar split, but offer a rationale that was not available to the attorney general of Missouri. If a patient, through a living will or other manner, had made known an objection to being sustained on a feeding tube, said patient's right to direct treatment would permit a surrogate to refuse the feeding tube. This refusal, however, must be predicated on the patient's concern about the method of treatment. Without direction from the patient, the surrogate alone would not inherit the patient's autonomy, and must offer the medically indicated treatment. Furthermore, were the patient's living will so worded as to indicate, for instance, "I do not wish to be maintained in a persistent vegetative state. Should it be determined, after a reasonable period of observation, that my consciousness is irreversibly impaired, I would wish all treatment discontinued, including provision of nutrition and hydration," it would be null, for the message contained in that statement of the patient's will is not a legitimate choice between different modalities of treatment, but rather the illegitimate choice of death over life. (Save any contrary considerations raised in the body of this paper directly ahead.) This distinction would quite obviously apply in the matter of the Cruzans. In its ruling on the Cruzan case in the summer of 1990, the U.S. Supreme Court allowed that a state may demand great certainty of the patient's specific wishes, as Missouri did, and therefore found for the state which had prohibited the removal of nutrition and hydration. This left open the possibility of state review of the instant case and the likelihood that permission to withdraw these treatments would eventually pass muster in some state, if not, ultimately, in Missouri itself. Indeed, in December of 1990, the court in Missouri approved and Nancy Cruzan's feeding tubes were removed, and she died several weeks later.

60. Former surgeon general C. Everett Koop, PBS, "Frontline," aired 12/13/89, characterized Nancy Cruzan's condition as follows: "This young lady is severely impaired. She is not terminally ill." Koop opposed removal of the feeding tube and took a position strikingly similar to that of this paper. Another physician, Dr. Joanne Lynn of George Washington University Medical Center, herself favoring removal of the feeding tubes, when asked if Cruzan was dying, answered, "Yes. She's dying like you or I are dying." (N.B.: Gist of remarks, not a true transcript.)

61. Although physicians insist on the high level of certainty that can be obtained with proper testing and observation over time, the possibility of error always remains (see note 33) due to the inherent uncertainties of medicine and due to human errors and inattention that

lead, from time to time, to half-baked determinations. Halakhah recognizes the real, but expects maximum attention to detail in arriving at the judgment upon which actions are based.

The following frightening scenario was recently played out in New York State, as reported in the *Hastings Center Report*, 19.4, July/Aug. 1989, pp. 14-5, Bonnie Steinbock, "Recovery from Persistent Vegetative State?: The Case of Carrie Coons."

Carrie Coons, age 86, had a massive stroke in late October 1988 and entered a vegetative state in November of that year. She was unresponsive, and CAT scan and EEG (electro-encephalogram) supported the diagnosis of PVS. In late January her sister, with whom she lived, asked that the feeding tube be removed, since her sister would not want to be maintained in that condition. A specialist was consulted and recommended a second CAT scan, but the family refused since the diagnosis appeared settled. On April 4, 1989 a state Supreme Court judge granted the petition for removal of the feeding tube, "the first New Yorker for whom a right-to-die petition was approved since the state's highest court, the Court of Appeals, authorized in 1988 the removal of feeding tubes in cases in which the prior wishes of an incompetent patient could be proved."

On April 9 she regained consciousness, took food by mouth, and on April 10 engaged in conversation. On April 11 the judge vacated his order. She remained alive and alert as of the published report, and her court-appointed lawyer found her "lucid and able to speak," though she is still classed incompetent since, among other things, the neurologist does not find her lucid, but rather "more or less communicative" though "inconsistent." Asked about removal of the feeding tube, she has been ambivalent.

In a similar vein, *Time* magazine, 3/19/90 reports the case of Rev. Harry Cole whose comatose wife he sought to detach from a respirator, only to have her regain consciousness and return to a full, active life. "I thought my decision was well planned," said Cole.

Although halakhah allows action on the basis of our best knowledge, cases such as that of Carrie Coons and Jackie Cole must give pause to those who would push for a standard that allows the removal of feeding tubes from PVS patients, given our present state of knowledge (see ahead). As Professor Steinbock (philosophy and public policy, SUNY Albany) observes, the court in the Quinlan case argued that there was no doubt that Karen Quinlan would seek to have her respirator removed were she to become "miraculously lucid" yet know that she would soon return to a permanent vegetative state. There is, in fact, no way to project what a "miraculously lucid" PVS patient might choose, given

their new and radically altered perception of life during and after an episode of PVS. *Caveat decisor*.

62. Some voices in the medical ethics community would define brain death as the irreversible cessation of the function of the cerebral brain, rather than of the whole brain, so as to declare such permanently unconscious patients for whom there appears to be no hope of ever regaining sentient function as, in fact, dead. This position was taken, during the PBS “Frontline” broadcast of 12/13/89, by Dr. Fred Plum, a neurologist at Cornell University Medical College. It is argued forcefully by Drs. Stuart J. Youngner and Edward T. Bartlett in “Human Death and High Technology: The Failure of the Whole-Brain Formulations,” *Annals of Internal Medicine* No. 99, 1983, pp. 252-8.

Our halakhic descriptions of death clearly preclude such a definition. The President’s Commission likewise found that “permanently unconscious patients are not dead” (p. 173). However, there may be room to consider a more lenient ruling in this regard based on Maimonides’ description of ensoulment, for he claims to know what we do not otherwise know of the soul. Maimonides writes:

נפש כל בשר היא צורתו שנתן לו האל, והדעת היתרה המצויה בנפשו של אדם היא צורת האדם השלם בדעתו. ועל צורה זו נאמר בתורה נעחה אדם כדמותנו, כלומר שתהיה לו צורה היודעת... ואינה הנפש המצויה לכל נפש בצלמנו חיה שבה אוכל ושותה ומוליד ומרגיש ומהרהר, אלא הדעה שהיא צורת הנפש ובצורת הנפש הכתוב מדבר בצלמנו כדמותנו...

The vital principle of all flesh is the form which God has given it. The superior intelligence in the human soul is the specific form of the mentally normal human being. To this form the Torah refers in the text, “Let us make man in our image, after our likeness” (Gen. 1.26). That means that man should have a form that knows... Nor does (this) refer to the vital principle in every animal by which it eats, drinks, reproduces, feels and broods. It is the intellect which is the human soul’s specific form. And to this specific form of the soul, the Scriptural phrase “in our image, after our likeness” alludes. (Maimonides, *Yad haHazzakah*, Hilkhoh *Yesodei haTorah* 4:8 (English, Moses Hyamson, *The Book of Knowledge*, p. 39b).

A similar bifurcation of the brain into the sub-cortical brain, the equivalent in humans of the brain of animals, and the neo-cortex, the seat of humanness, is described in evolutionary terms by Dr. Carl Sagan in his book, *Dragons of Eden*.

If we were to seek to elevate this description to practical halakhah, it would seem possible to conclude that patients with irreversible loss of consciousness have already lost their human life, having been reduced to

their former state of animal life. As such our obligations to such life might be adjudicated under the rules of *צער בעלי חיים* (concern for the pain of living creatures), and generally under a lower level of sanctity. We are loath to consider this option. We do not share Maimonides' certainty about the life of the soul. Furthermore, while this may help solve the particular moral dilemma described here, it does so by demeaning the sanctity of a vessel that carried God's image. To do so carries grave risk of opening the door to the warehousing of cadavers for research and a continuous supply of biological products, and the risk, as well, of extension to the mentally ill. Thus an anonymous marginal commentary to Maimonides. Nor is it clear that this rethinking would resolve the dilemma, since the patient is not in any recognizable pain. The cost of maintaining such creatures might then prove to be the decisive halakhic factor in a decision to discontinue care. I believe this would be repugnant. Rather, as in antiquity, this is a case that allows us no recourse but to pray for God's compassion, upon the patient and upon us.