

A Jewish Approach to End-Stage Medical Care

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This paper was adopted by the CJLS on December 12, 1990 by a vote of eleven in favor, two opposed, and five abstaining (11-2-5). Members voting in favor: Rabbis Kassel Abelson, Ben Zion Bergman, Elliot N. Dorff, Amy Eilberg, Dov Peretz Elkins, Howard Handler, Reuven Kimelman, Lionel E. Moses, Mayer E. Rabinowitz, Joel Rembaum, Morris M. Shapiro. Members voting against: Rabbis Avram I. Reisner and Joel Roth. Members abstaining: Rabbis Stanley Bramnick, Jerome Epstein, David Feldman, Sam Frint, and Herbert Mandl.

At the same meeting, the CJLS adopted a separate paper by Rabbi Avram Reisner entitled "A Halakhic Ethic of Care for the Terminally Ill."

שאלה

In view of modern medicine's technological ability to sustain biological life, how should we treat the terminally ill?

תשובה

The ability of medicine to sustain people in conditions which would have been unquestionably fatal just a decade or two ago is, in some cases, a clear blessing and, in others, the source of physical pain for the patient and of agonizing decisions for all concerned. As I try to address the latter situations here, it is with full appreciation of their inherent moral ambiguity and a renewed sense of my own limitations as a human being and as a Jew in being able to discern the right and the good. Not to face these situations, however, is to make Conservative Jewish law irrelevant to some of the most crucial cases confronting us today, and so one must try.

Rabbi Morris Shapiro first presented a responsum on many of these issues in May, 1988. After a full session of discussion, the Committee on Jewish Law and Standards decided to ask the Chair to appoint a

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.

Subcommittee on Bioethics to discuss these complex matters at greater length before the full Committee took action on them. After the Subcommittee had the benefit of hearing from a number of physicians on the relevant medical data, Rabbi Avram Reisner, Chair of the Subcommittee, wrote a responsum. In further discussion and correspondence, it became clear that the Subcommittee was evenly divided on how to conceive of these issues, and so I wrote this responsum to articulate the alternative position of the Subcommittee. In doing so, I have found myself largely agreeing with one of the suggestions in Rabbi Shapiro's original responsum. In this responsum, then, I have proved that proposal, providing the relevant argumentation and spelling out its implications.

To make sure that the reader can distinguish the forest from the trees in the rather lengthy essays which Rabbi Reisner and I have produced, let me briefly state at the outset the similarities and differences in our approaches. Rabbi Reisner and I share a common Conservative methodology, and we share the strong reverence for life at the heart of the Jewish tradition. This leads us to agree on most of the practical questions. We have, however, chosen different legal categories in which to construe many of the issues at the end of life. He prefers to treat most of them as instances of ג'ויטס, a person in the very last stages of life, while I think that the category of ט'רייפה (a terminally ill person) better describes the medical realities and the legal status of the people about whom we are most troubled, the ones whose cases raise difficult ethical questions. This leads us to disagree on some matters now, and our disparate approaches will undoubtedly mean that there will be some differences in future issues as well. From beginning to end, though, this is definitely א'שם שמים, a dispute in the name of Heaven.

A. Some Important Methodological Points

Several methodological convictions define my approach to matters in medical ethics – and, indeed, to Jewish law generally. In a recent, insightful article, Professor Louis Newman has pointed out how crucial matters of method are in deciding contemporary issues on the basis of Jewish sources.¹ With that as an admonition, and since those who part company with me on points of method may well take another tack on the practical matters as well, simply to understand my current decisions it is important to spell out the principles of my methodology at the outset. Moreover, since the medical technology at our disposal and the questions which accompany it change almost daily, only if the parameters of a general approach are delineated clearly can one hope to have the tools to make sound, reasoned judgments on future issues.

1. A Legal, Rather than a Non-legal, Approach. The Jewish tradition has had a long love affair with medicine. It has not flinched from exploring and applying whatever could help people overcome illness, seeing this process not as an infringement upon God's prerogatives, but as aiding God in the process of creation. In doing this, it has been remarkably open to seeking and using new discoveries. Indeed, medieval rabbis/physicians largely ignored express talmudic passages detailing specific cures which they found to be ineffective.² They saw their overarching duty in this area to be the healing of the sick, even when that required deviating from precedents encased in legal sources.

I mention this because when we turn to the difficult issues we are now considering, we are confronted with the fact that precedents within the tradition dealing with extending the life of the dying are very few and, more significantly, are not to the point. Some commonly used sources are not even properly medical; one, for example, recounts Rabbi Hananya ben Tradayon's responses to his students while being burned at the stake, and another describes Rabbi Yehudah Hanasi's handmaiden interrupting the prayers of her master's students to permit the rabbi to die. Others, while medical, assume far less human ability than we now have to affect the condition of the dying. They speak, for example, of the efficacy of salt on the tongue or a knocking noise coming through an open window to extend life. This is hardly the world of respirators and gastro-intestinal tubes.

Rabbi David Ellenson, an important Reform ideologue at Hebrew Union College in Los Angeles, has pointed out that, largely because of the wide disparity between contemporary medical conditions and those of times past, but also for some other reasons, some rabbis in all three of the major movements have suggested abandoning legal methodology altogether. They claim that applying legal methods to earlier sources is playing fast and loose with the sources and is simultaneously not doing justice to current issues. Instead, these writers are individually developing an alternative, non-legal approach which Ellenson, following Rabbi Irving Greenberg, calls "covenantal."

This approach is marked by the dialectical, personal model of relationship between God and humanity found in the Bible. It affirms the belief that "humankind is created so as to be God's partner in completing creation." This means that God's covenant with Israel does not restrict human freedom, but presupposes it. . . . This means that one must search out the tradition for those precedents relevant to the making of an ethical decision. Not to do so would provide an unwarranted break with a huge dimension of the tradition and would deny Jews the wisdom such precedents have to offer. However, this theory also affirms that since

human beings are created in the image of God, they share in God's power . . . In short, human autonomy-the ability of individual persons to make and to act upon their own ethical decisions-derives from the freedom that God has given persons. The affirmation of human autonomy is not the product of Enlightenment thought. Rather, it receives a divine, religious warrant.³

In this approach, the rabbi, while certainly a resource for the patient, family, and health care personnel, is not the ultimate arbiter of what is moral in any given case; the individual patient is. As a result, if the patient so chooses, quality of life considerations can enter directly into medical decisions, contrary to the bulk of rabbinic opinion to date.

I understand the allure of this approach; as Ellenson says, it "empowers" individuals to make their own decisions, and who does not want to do that? Moreover, the realities of contemporary medicine are indeed very different from those of our ancestors – so much so that one (sometimes) wonders whether *any* reading of the sources can properly give guidance to our decisions. Greenberg also claims that the Holocaust has shown us what terrible things can happen when individuals do *not* take responsibility for their own decisions.

Nevertheless, I think that this approach is wrong-headed. My view ultimately rests upon three factors: (a) my appreciation of the *strengths* of a legal approach to the moral issues in life, and the corresponding weaknesses of the suggested alternative; (b) my conviction that personal responsibility *can* be retained in a properly understood halakhic system; and (c) my confidence that, *when properly understood and applied*, legal methods can enable Jewish law to treat realities as new as contemporary medical phenomena. I shall explain the first two assertions in this section, and the third in the next.

Over the course of history, human beings have decided moral issues in a variety of ways, each with its strengths and weaknesses. Some religions and secular systems depend upon the decision of a specific person, chosen for any of a variety of reasons (e.g., Catholicism). Others ask the individual to exercise his or her own conscience to resolve moral dilemmas (e.g., Protestantism). Some secular systems decide these matters by majority vote, at least in theory. Judaism, however, has historically depended upon a judicial mode, blending exegeses of the Torah and later rabbinic literature, precedents, and customs to arrive at a decision. No method is a fool-proof path to moral sensitivity and wisdom, and each one can be abused. Nevertheless, the features inherent in these various procedures give us grounds for analyzing and predicting their respective strengths and weaknesses.

In contrast to the other methods mentioned, the judicial way of deciding moral issues, used by Judaism, has the distinct advantage of

continuity, for the determinative parties in the other procedures – a specific person, each individual, or a majority of a society – can switch gears at any moment. A judge may innovate as well, but he or she must justify the innovation in terms of the past tradition. This does not assure a good decision, and it does not even guarantee that the present decision will be a clear-cut copy of past policies; but it does insure that the tradition will be taken seriously into account and that a thoughtful rationale may be demanded of a judge who deviates from it. Jews have historically adopted this method because they believed that this was the only way to preserve the divine authority of the tradition, but such continuity is also crucial to preserve the identity of a people as widely scattered as Jews are. Moreover, the inherent conservatism of the judicial mode enables it to bring to bear the wisdom of the past without being enslaved to it – at least if judges are adept at judicial methods of stretching the law when necessary. Judgment calls are clearly central to this method, and not everyone will agree with any given decision; but the continuity, authority, and coherence that this method produces, together with its ability to balance the past with the needs of the present, are clear advantages which should not be lightly discarded.

In contrast, a method which seeks to determine morality on the basis of each individual's interaction with God poses a severe danger of anarchy. One wonders how community is supposed to be maintained under such a system. Reform thinkers like Rabbi Eugene Borowitz have claimed that Jews are identified by their common commitment to the Covenant, but I, for one, doubt whether that has any meaning in practice without specification of authoritative norms under that Covenant. Moreover, this method ironically robs individuals of precisely what they seek when they turn to religion for guidance in these matters, for it tells them to seek God and decide for themselves! The Reform movement, committed to this kind of autonomy, has even produced a body of responsa in an attempt to inform people of how some rabbis, at least, understand the tradition, but ultimately these responsa cannot relieve individuals of any of the responsibility of such decisions, for on this model, everyone bears the full weight of moral culpability for the decisions they make.

In one sense, of course, this is right and proper, and this brings me to my second point. For Rabbi Irving Greenberg, one lesson of the Holocaust is that people should not depend upon the law to tell them what is right and proper, for the legal mode carries with it the ultimate danger of legitimizing morally atrocious acts. He is clearly right in his warning, but certainly even he must admit that the Nazis' use of law constituted an *abuse* of it. The correct lesson to learn from that event is not that, because of this danger, the law should be abandoned as a way

of determining moral decisions, but rather that individuals retain the obligation to examine any law for its morality and to disobey any ruling which is immoral on its face. Once again, this is not an easy criterion to use, especially in morally complex matters such as those posed by contemporary medicine, for one person's judgment about these issues may well differ from another's. If a legal system is working properly, however, those *adhering* to it should be able to depend on it to guide them through morally murky waters, and they would need to disobey the law only in cases of obvious and gross moral perversion. Jewish law clearly assumes both elements of this methodology: it asserts that God's law is just and good, and it bids us obey the rabbis' interpretation of that law in each generation; but it also requires that we go beyond the letter of the law and even disobey it when it – or a given interpretation of it – is mean-spirited or downright immoral.⁴ Thus personal responsibility *can* and *would* be retained in a properly understood halakhic system, but the burden of moral responsibility would not fully and exclusively devolve upon the individual.

2. *Weighing the Applicability of Precedents.* How, though, should we apply Jewish law to contemporary medical questions? Orthodox rabbis have generally taken their customary literalist approach. Some have indeed been ingenious in making the few precedents available seem to determine the outcome of contemporary questions; Basil Herring's *Jewish Ethics and Halakhah for Our Time* is an especially thorough and fair presentation of their various attempts to do this on many issues. This procedure, however, ignores the historical context of past medical decisions and the crucial differences between medical conditions then and now. In Arthur Danto's felicitous phrase, such responses to the issues are paradigm examples of "misplaced slyness." The sources simply did not contemplate the realities of modern medicine; neither for that matter, do American legal sources from as recently as the 1940's. Consequently, reading such laws and precedents closely to arrive at decisions about contemporary medical therapies all too often amounts to sheer sophistry. The texts themselves, in such attempts, are not providing clear guidance but are rather being twisted to mean whatever a particular rabbi or judge wants them to mean.

In a different form, in truth, this is simply legal method. To bring new situations under the umbrella of the law, judges in any legal system must often stretch precedents to make them relevant to new circumstances. Indeed, for a legal system to retain continuity and authority in current decisions, this *must* be done. Thus, if a decision is going to be *Jewish* in some recognizable way, it *must* invoke the tradition in a serious, and not a perfunctory, way. One can do this without being devious or

anachronistic if one does not pretend that one's own interpretation is its originally intended meaning (*its peshat*) or its only possible reading. The Conservative objection to many Orthodox readings of texts is thus both to tone and method: not only do many Orthodox responsa make such pretenses (often with an air of dogmatic certainty), but they do so with blatant disregard for the effects of historical and literary context on the meaning of texts and for the multitude of meanings that writings can often legitimately have.

Even if we set aside such matters of intellectual honesty, on a purely practical basis literalist efforts to arrive at contemporary medical decisions seem to me to be misguided. Even if we presume that our ancestors were consummately wise and perhaps even divinely inspired in making the decisions they did, there is no reason to suppose that their decisions would bear those qualities in our own setting. On the contrary, I am sure that they themselves would have insisted, as the Talmud did, that each rabbi now take a good look at "what his eyes see"⁵ to be sure that his or her application of the tradition is deserving of the godly qualities of wisdom and kindness which we ascribe to Jewish law.

In our topic, "what his eyes see" means, in my view, just what it meant for medieval Jewish physicians and rabbis. Specifically, we should apply the general theological and legal concepts which emerge out of our heritage to the conditions at hand, even if this means deviating from the specific directions given in a specific precedent. We want to root our decisions as strongly as possible in the tradition, but not at the cost of ignoring the significant differences between the medical circumstances of our own time and those of the past. To carry out this program, we must first determine whether or not medical practice has changed significantly in the area of medicine we are considering. This is in itself a judgment which depends on a substantial understanding of the history of medicine, among other factors. If medicine in this area is more or less the same as it was in times past, we can proceed in a fairly straightforward, legal manner. If, on the other hand, we find that innovations in medical practice have made conditions relevantly different from what they had previously been, we will have to stretch some halakhic and aggadic sources beyond their original meanings. We *should* do this in order to retain clear connections to the tradition – not only in spirit and concept, but even in expression. At the same time, we should openly state what we are doing: namely, that we are choosing both the texts to apply and the interpretations of those texts in order to develop a Jewish medical ethic which carries traditional, Jewish concerns effectively into the contemporary setting.

In insisting that we retain the legal form and substance of past Jewish law, I am disagreeing with Reform positions such as that articulated by

Matthew Maibaum. He claims that the radical individualism and secularism of contemporary American Jews mean that “to an increasing degree, trying to talk about Jewish medical ethics from a traditionalist point of view will impress no one.”⁶ He objects not only to using the precedents of the past, but even to many of the concepts which underlie those precedents – concepts such as God’s ownership of our bodies.

It seems to me that this makes one’s claim to articulate a *Jewish* position all too tenuous. With such an approach, for example, how does one rule out anything as being contrary to Judaism? Why, indeed, would one be interested in developing a specifically Jewish approach to medical matters in the first place?

From one perspective, then, there is a methodological spectrum, in which positions are differentiated according to the *degree* to which individual Jewish sources are held to be determinative of specific, contemporary medical practices. For most Orthodox rabbis, who read the classical texts of the Jewish tradition in a literalist way, such texts are totally determinative, and so the only substantive question is how you are going to read your decision out of, or into, those sources. For at least a segment of the Reform movement, the goal, as Maibaum says, is to show secular Jews that a given Jewish position “also happens to be immediately and centrally good for them.” If this cannot be shown, then the whole tradition is “like a fine fossil or an elegant piece of cracked statuary; it is venerable, but is not relevant today.”⁷ I am taking a methodological position between these two poles, affirming the necessity to root a contemporary Jewish medical ethic in the Jewish conceptual and legal structure of the past, but recognizing that to do so honestly and wisely we will have to make difficult judgments as to when and how to apply that material to substantially new settings.

The Conservative position, however – in these matters, as in all others – is not defined solely by what it denies or by its comparison to others; on the contrary, central to its identity is its positive position on the proper way to understand and apply Jewish sources. In brief, it affirms that an accurate assessment of Jewish conceptual and legal sources – both early texts and their later interpolations throughout history – requires studying them in their historical contexts. Once one has done that, one can identify the relevant similarities and differences between previous settings and our own. Only then can one hope to apply traditional sources authentically and perhaps even wisely to contemporary conditions.

3. *Rules vs. Principles and Policies* Ronald Dworkin, an eminent legal philosopher of our time, has made a distinction which is important for our purposes. He points out that some standards which judges invoke

are rules which “are applicable in an all-or-nothing fashion.” If the rule describes facts which exist, then the rule is either “valid” or not. The rule is “valid” if we agree that it governs the situation we are considering, in which case the answer the rule supplies must be accepted. If the rule is not valid – that is, we decide that it does not govern the situation – it contributes nothing to the decision. Rules play a central role in domains like games, military procedure, and diplomatic protocol much more than they do in legal decisions, and so the use of rules is probably best illustrated in one of the former settings. To use Dworkin’s example, in baseball an umpire cannot consistently acknowledge that a batter who has had three strikes is nevertheless not out. There may be exceptions to the rule (e.g., if the catcher drops the third strike), but then an accurate statement of the rule would stipulate that exception. Once the conditions of the rule have been met, however – in this case, three strikes which the catcher has caught – the result that the batter is out follows inexorably.

In contrast, principles and policies do not automatically determine consequences when the conditions stipulated are met. Dworkin defines principles and policies as follows:

Most often I shall use the term ‘principle’ generically, to refer to the whole set of . . . standards other than rules; occasionally, however, I shall be more precise, and distinguish between principles and policies. . . . I call a ‘policy’ that kind of standard that sets out a goal to be reached, generally an improvement in some economic, political, or social feature of the community (though some goals are negative, in that they stipulate that some present feature is to be protected from adverse change). I call a ‘principle’ a standard that is to be observed, not because it will advance or secure an economic, political, or social situation deemed desirable, but because it is a requirement of justice or fairness or some other dimension of morality.⁸

Legal decisions use principles and policies extensively, but the latter never totally determine the outcome of a case. One principle of American law, for example, is that people should not profit from their legal wrongs, but there are clear cases in which the law allows them to do just that. For example, the law recognizes that adverse possession (that is, when I trespass on your land unchallenged long enough) ultimately establishes my right to cross whenever I please, and, while it may punish my breach of contract with civil damages, I can still break my contract to take one which is much more lucrative. In these instances, we do not say that the principle needs to be amended to stipulate exceptions to it because we cannot hope to capture all of the situations in which we would want judges to decide contrary to the principle. They are not

treated, as rules are, in an “all or nothing” fashion. Instead, we ask judges to weigh principles and policies against each other in every case to which they reasonably apply. In that way principles and policies establish important considerations which courts must address in cases to which they are relevant, but they do not determine outcomes without exception. (There is no weighing of one rule against another; when rules conflict, some second-order rule must stipulate which takes precedence – e.g., a second-order rule which prefers a rule enacted by a higher authority, or a rule enacted later, or the more specific rule).

In law, though, it is not always clear whether a standard is to function as a rule or a principle (or policy). Does the first amendment to the United States Constitution ban Congress from *any* impediment to freedom of speech (that is, is it a rule), or does it establish a policy that Congress may not ban freedom of speech *unless* there is some important social reason to do so? The amendment is not clear on its face as to that issue; only later court decisions determine how the law is going to be construed and used.⁹

It is precisely this issue which applies to much of what we will have to say about end-of-life issues. Orthodox responsa generally treat the sanctity of human life and the consequent need to preserve even small moments of it (חיי שעה), whatever its quality, as an overarching axiom – a rule, in Dworkin’s terminology. In an immensely insightful, newly published doctoral thesis at the Hebrew University, however, Daniel Sinclair has pointed out that, while Judaism certainly cherishes human life, it does *not* include a duty to preserve all human life under all circumstances at whatever cost. On the contrary, in some situations we are actually commanded to *take* a human life (e.g., when execution is mandated by law, or when killing another in self-defense). In others, we are obligated to give up our own lives (specifically, when the alternative is that we ourselves must commit murder, idolatry, or incest).¹⁰ Although Sinclair does not mention this, it is important to point out, along these lines, that the biblical phrase, “and you shall live by them” (Leviticus 18:5) is a divine *promise* in the Torah, not a command, and in Jewish law it functions as the ground to justify overriding other commandments in order to save a life; it is not meant, either in the Bible or in later rabbinic literature, as a general command to save all human life in all cases. Instead, Jewish law, based upon that verse and others, establishes a general *policy* to preserve life, but, like all other policies, this one is open to being supplanted in given circumstances by specific considerations.

It was Maimonides, Sinclair suggests, who was the quintessential exemplar, in the Jewish tradition, of the method of creating rules to derive specific laws deductively from them. This followed from Maimonides’ general distrust of analogical, legal reasoning. One of the

principle criticisms leveled against his code, in fact, was that if Jewish law amounted to a series of unexceptional rules, there was no need for rabbinic adjudication. The overwhelming preponderance of rabbis, however, did *not* follow Maimonides in articulating general rules and deducing specific rulings from them; most rabbis instead reasoned analogically from individual precedents. The latter method might admit of generalizing commonly held *policies* with regard to a given matter, but *not* of creating inviolable rules.¹¹

Whether one agrees with Sinclair's ascription of this method to Maimonides or not, it can certainly be said that historically some rabbis have tried to establish rules and to deduce their rulings in specific cases from them, while others – the vast majority – have understood generalizations in the law as summaries of some decisions but not as determinative instructions for others. The former, deductive approach was undoubtedly influenced by the medieval penchant for systematics in both thought and law, and it produced the genre of codes; the latter, casuistic method has its roots in the Bible and the Babylonian Talmud, and it has led to the genre of responsa.¹² While many rabbis in the last millennium have used both methods at various times, some have tried as much as possible to fit their decisions under the rubric of a well-defined rule, while most have preferred to reason analogically from a variety of precedents.

In any case, this distinction in method is crucial in cases such as those treated in this responsum for two reasons. First, a rule that seems unexceptional in one era may be subject to serious criticism in another when circumstances have changed. The use of rules to determine law would then require the wrenching task of either discarding the long-standing rule, radically reconceptualizing its meaning and application, or bearing the guilt of making exceptions to it. Any of those alternatives would amount to a disorienting departure in what one had assumed to be a fixed rule. Normal legal reasoning, however, simply sets one on a search for other precedents within the law that seem to be more appropriate to the case at hand. One may not always find such precedents – and then some serious revision of the law may be necessary even when using this approach – but the chances of extending the law aptly by using this method are considerably greater than when invoking hard and fast rules. Moreover, arguing analogically from precedents is the *standard* method in Jewish law, and so following it is actually adhering to the more traditional approach!¹³

4. Balancing General Rules and Individual Cases. One other methodological point. Through the good efforts of our chair, Rabbi Avram Reisner, the Subcommittee on Bioethics of the Committee on Jewish

Law and Standards has had the immense benefit of talking with a number of physicians who deal with various aspects of end-stage care on a regular basis. One of our consultants was Dr. Michael Nevins, who, in addition to his medical expertise, is an observant and active Conservative Jew. In a written response to an earlier draft of Rabbi Reisner's responsum, Dr. Nevins pointed out how important the *context* of a specific medical decision is. He urged us to use not only what Harvard psychologist Carol Gilligan has called the "masculine voice" in ethics – that voice concerned primarily with abstract principles – but also what she calls the "feminine voice," which pays more attention to the specific human situation in which the decision is made, the relationships of the people involved, and the question of how a course of action will help or hurt.¹⁴ Dr. Nevins also invokes another model to make the same point:

In these cases, perhaps we do best when we emulate the Hasidim who followed their emotions rather than the *Mitnagdim* who relied excessively on their intellect. Yes, we must be cognizant of standards, both secular and religious, but we should not lose sight of the human tragedies of patient and family, and our first responsibility is to them.

I agree with his concern, as the sections below will demonstrate. I must say though, that this approach is neither distinctly feminine nor distinctly hasidic. The first story I heard about Jewish law, in fact, came from my father. My grandparents and their children lived across the street from a large Orthodox synagogue, of which they were members. Because of the proximity, my grandparents often hosted guests of the congregation for Shabbat. One Friday afternoon my grandmother sent my father, then a lad of fifteen or so, to ask Rabbi Solomon Scheinfeld when the guests for that week were expected. Rabbi Scheinfeld served that congregation from 1902 to 1943, and, according to the *Encyclopedia Judaica*, he "was the recognized head of the city's Orthodox congregations during his tenure."¹⁵ The *Encyclopedia* clearly refers to the camp of the *Mitnagdim*, for the Twersky family was firmly in charge of Milwaukee's Hasidim. When my father entered the rabbi's office, he was literally in the process of deciding whether a chicken was kosher. As Rabbi Scheinfeld turned the chicken over in his hands, he asked the woman who had brought it many questions about the physical and economic health of her husband and family. After he pronounced the chicken kosher and the woman left the room, my father asked him why he had asked so many questions about her family. The rabbi turned to my father and said, "If you think that the kosher status of chickens depends only on their physical state, you understand nothing about Jewish law!"

This, of course, attests only to the attitude of one rabbi in one instance, but it does bespeak the Jewish tradition's insistence that law and morality are, and must be, intertwined.¹⁶ In any case, I cannot help but think that Rabbi Scheinfeld was right about how Jewish law should be applied to chickens and, all the more so, to human beings.

Even Drs. Nevins and Gilligan, though, acknowledge the importance of articulating general standards – that is, commonly used policies; one must just know when and how to use them. In the technical terms of contemporary ethicists, I am arguing neither for an exclusively situational ethic nor for a solely rule-based one (regardless of whether the rules are seen as deontological or consequentialist); I am suggesting instead a character-based ethic, in which both rules and contexts play a part, along with moral moorings in philosophical/religious perspectives and narratives, and moral education to produce moral sensitivity in the first place.¹⁷ This is a much richer – and, I think, a much more realistic – view of how moral norms evolve and operate than is the traditional attention exclusively to rules and specific decisions taken under them.

This approach does include principles and policies, though, as important components of how we make moral decisions. Let us turn, then, to some basic policies which, I think, come out of the Jewish tradition and which, at least in many cases, can and should inform our decisions on medical matters at the end of life.

B. Some Basic Concepts And Policies

What are the relevant Jewish concepts and rules in our cases? I think they can be summarized as follows:

1. The Duty to Maintain our Life and Health. Our bodies are not our own to do with as we will; they are rather God's property, on loan to us throughout our lives. We therefore bear a responsibility to God to take reasonable care of them through proper diet, exercise, sleep, and hygiene, and we have a clear-cut duty to avoid endangering them. Although the Talmud does not explicitly establish a duty for each Jew, when ill, to seek medical care, it does permit physicians to heal (despite God's role in inflicting sickness and healing it), and it does require that Jews live only in a community which has a physician. These and other provisions of talmudic law – as, for example, the mandate to violate the Sabbath to save a life – were seen in later Jewish legal literature as the basis for a positive duty on the part of each Jew to seek professional medical help in regaining health. It is important to note that, for the tradition, this is not simply good advice, as it is for adults in American law, but a legal duty, which we *must* do. Even though it took some time

for the tradition to articulate this as such, it follows naturally from the theological presupposition underlying all of Jewish medical ethics, that our bodies belong to God.¹⁸

2. The Role of the Patient in Determining Therapy. What constitutes appropriate care depends, of course, upon objective medical data concerning the status of the patient and the outcome of possible therapies, but it also depends upon the patient's will. Individual Jews do not, under Jewish law, have the same degree of autonomy they increasingly enjoy under American law. They do not, for example, have the right to refuse medical care altogether, and under Jewish law women do not have nearly the scope of discretion to abort a fetus as they currently do under American law.

Nevertheless, as Rabbi Avram Reisner has aptly demonstrated, individual Jews do determine considerable elements of their health care. Specifically, if individuals feel they cannot bear the treatment that the physician prescribes, they may refuse such treatment. Indeed, the Talmud specifies that patients may choose both their physician, when there is more than one available (the basis for the penchant of Jews, more than others, to seek a second opinion?) and their therapy, when several courses of action are medically justifiable. Ultimately, people have the freedom of will and the physical ability – although not the sanction – to disregard Jewish law entirely, and this includes the directives of the physician to carry out the halakhic mandate to preserve one's health.¹⁹

In practice, this means that a dramatic confrontation between physician and patient should be avoided in the first place. Instead, in prescribing a therapy, the physician should explain to the patient the facts and the alternative modes of treatment, each with its benefits and drawbacks, and then the physician and patient should together decide what to do. As contemporary ethicists have pointed out, this process is immensely complex, for patients and physicians may not share the same values, goals, sensitivities, or life styles, and physicians may be so unaware of these differences in perspective that they never even bother to explore or explain alternative approaches to treating a disease. They simply assume that what they think is right is what the patient wants. This, however, is futile, for the best of prescribed treatments, if not endorsed and followed by the patient, is useless. Thus while classical Jewish sources put the decision as to the course of therapy in the hands of the physician, every sensible doctor will discuss the proposed form of therapy with the patient and will ultimately decide on one which will enlist the patient's agreement and cooperation.

3. *The Distinction Between Sustaining Life and Prolonging Dying.* For the last eight hundred years or so, traditional Jewish sources have drawn a line between sustaining a person's life, on the one hand, and prolonging his or her process of dying, on the other. The former we are obliged to do, the latter we are not.²⁰ In many contemporary instances medical technology has made this distinction harder to draw. Nevertheless, we must try to preserve the tradition's intent in differentiating these activities – namely, that we do nothing to hasten death and thereby co-opt the prerogative of God to determine such matters, and, along the same lines, that we openly recognize that physicians are not, and should not be expected to be, omnipotent in effecting cure. In the words of *Kohelet* (Ecclesiastes) 3:1-2, “A season is set for everything, a time for every experience under heaven; A time for being born and a time for dying . . .”

4. *Effective vs. Beneficial Therapies.* The line which the tradition draws between sustaining a person's life and prolonging his or her death also bespeaks another of its concerns. In times past, choosing an appropriate course of care with this distinction in mind was relatively straightforward since nothing much could be done to keep the patient alive anyway. In our time, though, this is no longer true. We can now keep people alive long past what would have been their natural life spans. In some cases – as, for example, the prescription of antibiotics to cure pneumonia in an otherwise healthy patient – there is no question that we should use the medical means available to use in an attempt to restore a person's health. We have, however, *effective* means to prolong the functioning of vital organs, even when most other functions of the body have shut down. This, then, leads to the independent issue of whether a given therapy is not only effective, but *beneficial* to the patient.

This question demands a difficult judgment call on the part of the patient (or, when the patient cannot make a decision, the surrogate) and the physician. Orthodox responsa have closed off all discussion of these issues on the grounds that, according to their interpretation, Jewish law establishes an inviolate *rule* that all life is sacred and must be preserved under all circumstances. As I have indicated above, that is a mistaken reading of the tradition, for there are cases in which Jewish law expressly requires that we take a life or give up our own. Jewish law *does* embody a strong push for life as a consistent *policy* (or, perhaps, *principle*), but *not* an unexceptional rule. In my view, the later tradition's distinction between sustaining life and prolonging dying establishes the minimization of pain, for example, as one factor which, under specific circumstances, can be used to set aside the tradition's general policy to preserve life with all possible effort.

Other sources in the tradition argue that we should use the benefit to the patient as the primary criterion in determining a course of action rather than our ability to accomplish a limited, medical goal (like keeping one or more organs functioning). *B. Avodah Zarah 27b* specifically states that one need not be concerned for “the life of the hour” (היי שעה). ;The context is a discussion of an opinion by Rabbi Yohanan that “Where it is doubtful whether [a patient] will live or die, we must not allow them [Gentiles] to heal, but if he will certainly die, we may allow them to heal.” It is clear, then, that the *Gemara* defines “the life of the hour” as the time a person lives after having being diagnosed as having a terminal illness. After that time, we need not try to cure a person who, as far as we know, cannot be cured. (An objection to this is raised in the name of Rabbi Ishmael, but it is deflected.) In our setting, this means that we may relinquish aggressive medical treatment, even if it is effective in prolonging vital organs, if the patient is dying of a terminal disease. We then may, and probably should, concentrate instead on relieving pain.

In commenting on this talmudic passage, *Tosafot* ask how the *Gemara* can say here that we need not be concerned about “the life of the hour” and yet state in *Yoma* that we should violate the Sabbath to remove debris from a person buried under it in an attempt to try to save the person, presumably even when we have little hope that he or she is alive (for otherwise there would be no question). This latter precedent assumes that we do indeed care about “the life of the hour.” *Tosafot* reconcile these sources as follows:

There are grounds to say that in both sources we should act *for his benefit*, for there [in *Yoma*] if you do not care [about “the life of the hour”], he will die, and here, if you do care [about “the life of the hour” and therefore prohibit the Gentile physician from treating him], he will not be healed by the Gentile and will certainly die. So here and there we abandon the certain [course of action] to do that which is doubt [fully appropriate].²¹

Jewish vitalists – if I may call them that – seize upon the specific therapy which *Tosafot* prescribe here and claim that they always want us to act to sustain life, that they always think that that is “for his good.” Such an interpretation, however, confuses examples with rules. It is, in fact, to use the examples to create a rule in direct contradiction to the principle for which the examples were adduced in the first place. *In these two cases*, acting for the victims’ good amounts to trying to preserve their lives, despite the grounds in each instance for thinking that we should not do so; that, however, does not mean that in *every* case such a goal would be appropriate. On the contrary, *Tosafot* articulated a *general*

principle on the basis of this case – namely, that the proper objective of the medical care of a patient is to act *for his or her benefit*. The very fact that they generalized in this way indicates that the patient’s benefit be the relevant criterion. When we apply that standard to some contemporary cases, we may have to abandon the attempt to save a life – that certain course of action which presents us with least moral risk – and adopt the therapy fraught with moral doubt – just as Tosafot describe the situation here.²²

The Subcommittee on Bioethics was, in part, launched by a responsum by Rabbi Morris Shapiro to these issues. In that responsum, he listed a number of other sources which support his contention, and mine, that it is the patient’s belief which should be our paramount concern in determining a course of therapy, and that the pain of the patient can, in some circumstances, be sufficient warrant to decide that it is not in his or her best interests to continue aggressive treatment.²³ This would definitely *not* justify active euthanasia, even in cases where the homicide would clearly be a “mercy killing”; absent the excuse of self-defense or a court order, we never, in Jewish law, have the right actively to hasten our own death or that of another person. Moreover, when there is a reasonable chance that medical intervention can redeem the person from a terminal illness (that is, from being a טריפה) or a state of morbidity (גסיסה), we must do everything in our power to do so, even if it means that the patient must suffer pain. When there is little or no chance of doing that, however, and when aggressive treatment will involve considerable pain to the patient (as it usually does), we need not follow that course of therapy.

It is legally and morally much easier, of course, to ignore all such considerations. One can then take what appears to be the moral high ground by insisting that we expend every effort to save any human life, no matter how tenuous or painful. With the ongoing development of more and more means to sustain vital organs, however, what may once have been the high moral position has ceased to be that. Aggressive medical treatment comes at considerable cost in pain to the patient (let alone the monetary cost to both the patient and the society) and, as discussed below, other considerations also may mitigate against such therapy. Like it or not, we can no longer rely alone on what we *can do* to sustain a patient but must rather face the difficult decisions which must be made concerning what *benefits* him or her. This will inevitably involve decisions about quality of life issues, and there is always the danger of a slippery slope in that. The danger should not be exaggerated, however, for we certainly can discern at least some cases in which treatment is clearly in the patient’s interest and some cases in which it is not.

Moreover, the essence of moral sensitivity is *not* the evasion of life's complexities, but rather the ability to make distinctions within them.

5. Hazardous Therapies. In making their joint decisions, physicians and patients *may*, according to Jewish law, try a risky therapy if it has a chance of curing the disease. (It is *not*, however, a sin of omission to choose not to employ such therapies.) The decision to employ high-risk procedures, however, must be justified in terms of the benefit which the patient may be expected to gain if it works. A physician may not suggest them on the grounds of "one chance in a million," and a patient may not use them on the grounds of "what do I have to lose?" for, when the chances really are one in a million, one does not honestly expect that the therapy will work, and one is, in the meantime, hastening the person's death.

In general, minimum risk may be assumed for minimum benefits, maximum risk only for maximum benefits. Thus, if a therapy presents a reasonable chance of actually curing a patient's life-threatening disease, it may be employed even if it simultaneously poses the risk, if it fails, of actually hastening the patient's death. The patient and physician may decide to engage in such treatment as long as the motive is to try to cure the patient.

On the other hand, if a disease is incurable and the only hope is to reduce pain, only the risks which need to be assumed to accomplish that may be undertaken. One may take those risks, however. This applies even in cases in which a person is suffering from a non-terminal disease and, all the more so, when such a disease is present.²⁴ Thus, for example, in an attempt to alleviate the severe pain of a person in the last stages of dying, morphine and other pain medications may be administered in doses sufficient to dull the pain, even if this simultaneously hastens the person's death. The intent to treat is the crucial factor.

In applying this principle, we must recognize three important variables. First, people have differing thresholds of pain and differing tolerances of risk. Consequently, in judging what is a "reasonable" risk to take to cure a disease or to dull pain, the patient, if possible, must make the decision on the basis of the information the physician supplies. Patients (and, if they are incapable of making the decision, the family and physician) should not be second-guessed in this; the variation in people's assessment of pain and risk is real, and the relevant factor in deciding whether or not to use hazardous therapies is the depth of this particular patient's experience of pain and hope for recovery.

Moreover, medical science is excruciatingly uncertain in predictions of death, and so there will always be a small number of unexpected results – e.g., recoveries from apparently permanent comas and longer survival

than anticipated in specific patients with a given disease. Jewish law cannot be properly interpreted, however, to oblige us to be omniscient, and so what counts in a decision to use dangerous drugs or surgeries (or not to use them) is the judgment of the attending physicians.

And finally, in these areas, as in many others, human motivations are often multiple and, indeed, conflicting. What is required, then, is simply that the intent to help the patient live as comfortably as possible is the predominant motive in administering a treatment.²⁵

As we learn more about pain management (hospital teams focused exclusively on pain management have come into existence only in the last decade or so), we may no longer need this “double-effect” argument, for it appears that new techniques of pain control actually lengthen life.²⁶ This is understandable, for people can be expected to fight for their lives harder and longer if they are not wracked with pain. As our abilities to manage pain improve, we certainly are under a Jewish mandate to mitigate it as much as possible; pain is not seen as an independent good in the Jewish tradition, as it is in some others.²⁷

6. Ineffective Therapies. On the other hand, patients and physicians need not engage in a therapy which lacks a reasonable chance of effecting a cure. We have previously asserted that even if a mode of treatment is effective, we may not use it if it is judged not to be beneficial to the patient; we certainly do not need to employ medical means which are not even expected to be effective. Moreover, if a mode of therapy is tried and it proves to be ineffective, it may, and probably should, be removed.²⁸ These principles may seem obvious – Jewish law, no matter how interpreted on specific issues, surely could not require us to do that which in all probability will not work – but they must be reiterated in the context of modern medicine, for they hold the key to restraining us from well-intentioned, but overzealous and ultimately misguided treatment.

C. טריפה, Rather than גוסס, as the Operative Category

Before we proceed to some applications of the above policies, we must consider one conceptual matter. Almost all discussions in Jewish circles of the terminally ill have relied on what Jewish law does with the category of גוסס, a moribund person. As indicated above, during the last eight hundred years, Jewish law has continued to prohibit hastening a person’s death but has permitted (or, in some versions, required) removal of anything which impedes the death of a moribund person. This distinction originates in the thirteenth-century work, *Sefer Ḥasidim*, and in the sixteenth century it is incorporated, with some modification, in Isserles’ authoritative comments on the *Shulḥan Arukh*.²⁹

The case in both sources is one of a person literally on his deathbed. In our time, however, people can be “on their deathbeds,” as it were, almost indefinitely, sustained by heart and lung machines as well as by other medical paraphernalia. Thus definitions of “mortally ill” (גוסס) in terms of a specific number of hours (commonly held to be within 72 hours of death³⁰) are inappropriate to today’s medical realities, such as our ability to maintain artificial respiration. Even if one restricts the use of such a definition to the expectation of one’s remaining life unaided by medicine, one still must face the problem which this definition has always entailed, namely, how can one know ahead of time the moment of a patient’s impending death with such certainty? Moreover, the distinction between direct and indirect means of letting people die has become increasingly difficult to recognize and maintain and, according to some contemporary ethicists, it can easily mask highly immoral activities.³¹

Because we can maintain people on life-support systems, and because we still cannot accurately predict the moment of a person’s death, the only way to use the category of גוסס at all in these matters is to define a גוסס not in terms of the remaining hours of his or her life, but rather as anyone who has been adjudged by the attending physicians to have an irreversible, terminal illness. Some Orthodox and Conservative rabbis in recent years have moved in this direction.³² (In a very broad sense, of course, life itself is an “irreversible, terminal illness,” but that stretches the term “illness” beyond recognition – and, more importantly – beyond the experiences which we intend to denote by using the term “illness” in contrast to the term “life” in the first place.)

While I am in sympathy with those who want to broaden the meaning of גוסס in order better to address the difficult medical decisions we face, it is really playing fast and loose with the category. Rabbinic sources commonly compare the life of a גוסס to a flickering flame,³³ and therefore, for fear of extinguishing the flame, one must not even move such a person. This describes neither the condition of, nor proper medical treatment for, a terminally ill patient, who may have many months or even years to live after correctly being diagnosed as having an irreversible, terminal illness.

If there were not other ways to respond adequately to modern medical conditions, I would nevertheless be willing to stretch the category of גוסס to include everyone with a terminal illness – and indeed, in an earlier writing of mine, I suggested just that.³⁴ There is, however, a better way in Jewish law to conceive of most of the cases with which we are concerned. As Daniel B. Sinclair has pointed out, however we define the category of גוסס, all agree that the person in that category is still considered alive. Therefore, any withholding or withdrawing of treatment from such

people always comes with not a small amount of ambivalence and guilt. The halakhic category which describes these situations much more accurately and appropriately, he suggests, is that of *טריפה*, a person with an incurable disease. Such a person is, according to medieval authorities, a *גברא קטילה*, an already dead person, and consequently one who kills him or her is exempt from human punishment although subject to divine and extra-legal penalties.³⁵

When applied to animals other than human beings, the term “*טריפה*” refers to one suffering from a fatal organic defect, such as a pierced windpipe or gullet.³⁶ It is presumed that a *טריפה* animal will die within twelve months.³⁷ A human *טריפה* is also defined on the basis of medical evidence- specifically, as Maimonides says, “it is known for certain that he had a fatal organic disease and physicians say that his disease is incurable by human agency and that he would have died of it even if he had not been killed in another way.”³⁸ Since the death of a *טריפה* is inevitable, evidence of *טרפות* is equivalent to evidence of death, and therefore, according to the Talmud, the deserted wife of a *טריפה* may remarry.³⁹ According to most authorities, twelve months must elapse before permission to remarry may be granted, analogous to the presumption regarding animal *טריפות*.⁴⁰ *Tosafot*, however, argue that fundamental physiological differences between humans and other animals (and, I would add, the expenditure of considerably more human energy and resources in caring for sick humans) often enable people to survive for a longer period.⁴¹ These factors underscore the fact that for all of these authorities, the twelve-month period with regard to humans is only an estimate, and the crucial factor in the definition of *טריפה* is the medical diagnosis of incurability. As Sinclair says, then:

The outstanding feature of the category of human *טרפות* for the current debate concerning the treatment of the critically ill is the exemption of the killer of a *טריפה* from the death penalty. This feature focuses attention upon the fact that a fatal disease does detract from the legal status of a person, and also introduces a measure of flexibility into the issue of terminating such a life. This is in direct contrast to the category of *גוסס*, which is based on the premise that a *גוסס* is like a living person in all respects. Indeed, almost all the laws of the *גוסס* confirm his living status and, as already observed, can only be appreciated against the background of the domestic deathbed. The category adopts a different perspective (the effects of the critical illness upon a person’s legal status), and as such, it is much closer to the current debate on the termination of the life of a critically ill patient.⁴²

This is not, of course, to say that an incurably ill person is entirely equivalent to a dead person. On the same page of the Talmud on which Rava says that “all admit” that the killer of a טריפה is exempt from human legal proceedings, he also asserts that one who has illicit sex with a terminally ill person is liable. As the Talmud goes on to explain, the liability derives from the fact that the sexual act performed with an incurably ill person will still produce pleasure, while the same act with a dead person would not do so since, as Rashi says, all of a dead person’s warmth and moisture (humors) have been lost.⁴³ One must also note that the exemption from prosecution stems from two converging reasons, only one of which is relevant to our concerns. The factor discussed in the Talmud is that the expected death of the person makes his testimony irrefutable (עדות שהיא אתה יכול להזימה); it is only explanations in Rashi and other medieval sources which add the consideration that the incurably ill person is considered as if already dead (גברא קטילה).

Moreover, while one may be exempt from punishment (פטור) for intentionally killing an incurably ill person, one is still forbidden to do so (it is not מותר); indeed, one is still, according to Maimonides, subject to divine sanction and to extralegal sanctions by the court or king. With regard to all people guilty of bloodshed who, for some reason, cannot be convicted of a capital crime under the usual rules, the king may, if it is necessary to reinforce the moral standards of the society, execute them on his own authority. If he chooses not to do so, he should, says Maimonides, “flog them almost to the point of death, imprison them in a fortress or a prison for many years, or inflict [some other] severe punishment on them in order to frighten and terrify other wicked persons” who specifically plot to commit bloodshed in a way not subject to court action.⁴⁴

In sum, then, as Rashi is careful to say, the טריפה is considered a dead person (גברא קטילה להשיב לה); that is, the incurably ill person is made analogous to a dead person, not equated to one. This makes the entire category of טריפה exactly parallel to the state of health which concerns us. The Talmud records a disagreement as to whether an incurably sick animal can or cannot live for another twelve months, and this resembles the ambiguity of the situation each moment with regard to incurably sick humans as well. Interestingly, in one place in the Talmud, it is the selfsame Rava who claims that the טריפה can live a year, and in another Rava is identified with the reverse position. Tosafot therefore describe this as one of several discussions in the Talmud in which names have been reversed when recorded in different places, and they claim that the correct version is the one in which Rava claims that a טריפה can live an additional year.⁴⁵ Critical students of the Talmud might have yet another answer. For me, though, the very existence of this confusion in the

Talmud concerning the status of the טריפה is just right: we are confused as to how to think of an incurably ill person, especially in the last stages of life, now more than ever.

The parallel case is that of the fetus. Since the fetus is not considered a full human being (נפש) with the attendant legal protection against murder, Jewish law carries no criminal sanction for feticide.⁴⁶ Consequently, a Jew who kills a fetus is exempt (פטור) from normal legal sanctions. Non-Jews, however, according to Jewish law, are governed by the seven laws given to all descendants of Noah. While the general assumption of rabbis over the centuries has been that Jews are held by God to a standard higher than non-Jews by virtue of the many additional obligations in the Covenant of Sinai, there are a few cases in which the Noahide laws governing non-Jews were at least initially interpreted to be more stringent than Jewish laws governing Jews. This is one of those cases, for feticide is, according to the rabbis, prohibited as a capital offense under the Noahide prohibition of bloodshed, based on Genesis 9:6. Embarrassed by this, some authorities assert that Jews who commit feticide are subject to a range of extra-legal penalties similar to that which Maimonides prescribes for killing an incurably ill person.⁴⁷

With regard to abortion, though, there are many who see clear-cut grounds to override this general prohibition and its extra-legal penalties to permit, or even require, feticide. The intriguing question, then, is whether there might also be grounds to override the general prohibition against killing an incurably ill person to permit withholding or withdrawal of life-saving machines or medications, at least in some cases.

The law of siege may well provide such a precedent. The Tosefta describes a case of a group of travelers threatened by brigands. The latter demand that the travelers give up a specific person in their group to be killed. The Tosefta permits the group to hand over the individual.⁴⁸ Later sources understandably qualify this provision. According to one view, the specified individual may be delivered only if the whole group is otherwise faced with certain death.⁴⁹ Another interpretation maintains that the designated person may only be handed over if he or she is guilty of a capital crime. Maimonides and most commentators after him rule according to the latter reading.⁵⁰

What if the designated person were a טריפה? Rabbi Menahem Meiri says:

It goes without saying that in the case of a group of travelers, if one of them was a טריפה, he may be surrendered in order to save the lives of the rest, since the killer of a טריפה is exempt from the death penalty.⁵¹

Meiri specifically does not extend this to a גוסס. This is surprising, for a גוסס is typically closer to death than is a person who has just been diagnosed as having an incurable illness. Nevertheless, one can understand Meiri's reasoning: the גוסס, after all, is a living person in all respects, and hence any complicity in his or her death would be tantamount to murder. The טריפה, on the other hand, is, as it were, already dead, and hence killing a טריפה does not entail capital punishment. These facts mean, for Meiri, that in a case in which many lives might be saved as a result of the death of a טריפה, the latter's life does not possess the same value as that of the other, viable persons.

Put another way, the Talmud establishes the general principle of the sanctity of each and every human life by posing the rhetorical question, "How do you know that your blood is redder? Perhaps the blood of the other person is redder!"⁵² As Rabbi Joseph Babad says, the Meiri is effectively asserting that a טריפה is one exception to this tenet of the equality of all human lives; that is, a טריפה's blood is "less red" than that of a viable human being.⁵³

This is in keeping with a passage in the Talmud. That passage refers to animals, and so it is not directly on point, but it compares a טריפה to a fetus, and it discusses whether a טריפה continues to belong to its own species. Specifically, B. Shabbat 136a records a dispute between Rabbi Eliezer and the Rabbis as to whether a calf born after eight months of gestation, rather than the usual nine, is to be considered a טריפה or not. Rabbi Eliezer says it is, while the Rabbis claim it is not. The reason for the Rabbis' position, though, is that a טריפה had a period of fitness for slaughter before it contracted the disease which made it a טריפה, while a calf did not. Thus a טריפה from birth is, for the Rabbis, not considered ever to have attained the status of being a calf; it has never been "of its kind," its species. Similarly, the Meiri is suggesting that a doomed person is no longer considered a full member of its category of being.

In light of the gravity of the subject of this ruling, it is not at all surprising that later authorities variously agreed and disagreed with it. Probably the sharpest demur came from Rabbi Ezekiel Landau, who, in a case involving embryotomy to save the life of the mother, said, "Who was permitted to kill a טריפה to preserve a viable life? We have never heard of such a thing."⁵⁴ Even though I shall side with the Meiri against Landau in this, notice that Landau also equates the case of a fetus with that of a טריפה and rightly concludes that whatever one says about the former has direct implications for what one says about the latter.

Following a number of modern authorities in Jewish law, Sinclair suggests that the Meiri and Landau may possibly be reconciled. Landau, after all, is dealing with a case of actively taking the life of the fetus; Meiri, on the other hand, is talking about handing over a טריפה for

others to kill. It is not at all obvious that Landau himself would object to the indirect homicide involved in the case of the travelers when the lives of the rest of the group are at stake.⁵⁵ Even if he does, the Mishnah, the Talmud, and the vast majority of rabbis after them permit, and even require, abortion to save the life of the mother.⁵⁶

The case of the fetus and the *טריפה* are, however, dissimilar in several ways. A *טריפה* may presumably be killed, even for the Meiri, only in an indirect fashion, while the fetus must (may) be actively killed when threatening the life of its mother.⁵⁷ On the other hand, while a *טריפה* may be sacrificed for the sake of any viable life, the fetus is generally killed only to preserve its mother's life.⁵⁸

Even so, the fetus and the *טריפה* are both cases of human beings whose blood is indeed judged to be "less red" than that of viable people. This led to specific rulings during the Holocaust which permitted people to smother crying infants if that was necessary to preserve the lives of adults who were trying to escape – not only on the grounds that the babies were pursuers, but also because those less than thirty days old were not yet indubitably viable. In a parallel way, rabbis permitted Jews to acquiesce to Nazi commands to throw victims of the gas chambers into crematoria rather than be shot themselves, despite the fact that the gassed people still exhibited some signs of life. As people with terminal illnesses, the lives of the gassed could be sacrificed for others who were not.⁵⁹ Notice that in this last case, the distinction between active and passive action was blurred, and, as mentioned above, as medical technologies become more complex, it may increasingly become a distinction without a clear technical or moral difference.

None of the above considerations, of course, permits us to kill either fetuses or terminally ill people on whim; the prohibition of bloodshed applies, after all, to both categories and may not be lightly ignored. Certainly, anyone who wants to do so bears the burden of proof that it is justified in this particular case – and the burden is as heavy as they come. Maimonides, remember, spoke of extra-legal and/or divine penalties for the killer of the *טריפה*.

In our own time, the institutions have changed, but American society has, over the years, developed several institutional frameworks to insure that these actions are not taken lightly. The courts are one. There have been court cases on these issues in virtually all states, with widely publicized higher court rulings in California, Connecticut, Massachusetts, Missouri, New Jersey, and New York. In addition, in June, 1990, the United States Supreme Court ruled on one aspect of this complex of issues in the Cruzan case, on appeal from Missouri.

Courts have the advantage of being able to apply the sanctions of the law against homicide and malpractice, and they are seen as the

ultimately authoritative bodies to resolve disputes, but there are real drawbacks in using them. If all such cases threaten litigation, physicians will increasingly refuse to treat such patients or will choose other specialties entirely – a phenomenon we are already witnessing with obstetrics. Moreover, it is not at all clear that courts have the required expertise in these matters to make proper decisions. Some court decisions on these issues, in fact, have been roundly criticized by the medical community, the legal community, and/or experts in bioethics.⁶⁰ The standards which courts set are often the minimum of what will be accepted by the legal system; one would hope, though, that medical practice would follow the higher standard of what is appropriate medical care, and the definition of that probably must come from some other forum. One wants, after all, the best decision for the patient and society, not just a minimally justifiable one. The time frame of courts is also not helpful: courts often take months or years to make decisions which are needed for specific patients in hours or days.

The legislative arena offers the opportunity to take more time and to involve more professional experts in formulating policy in these areas. It also, however, poses the danger of directing medical practice on the basis of the political advantages politicians can reap from taking highly public, but medically ill-advised, stances on these issues. In practice, state legislatures have largely left these matters to the courts, probably sensing that the complexity of these cases and the wide range of opinion on them do not lend themselves well to the form of legislation as a remedy and the processes of political compromise necessary to achieve it.

For all these reasons, the medical profession itself has sought to formulate appropriate standards in these difficult areas, to be applied to specific cases at the discretion of the attending physicians. As early as 1983, the *President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research* published its report, *Deciding to Forego Life-Sustaining Treatment*. The Commission consisted primarily of physicians, but also included lawyers and ethicists. Subsequently, regions of the American Medical Association have made their own recommendations in these areas. In light of the substantial effects of the law on medicine nowadays, sometimes these efforts have included official participation by the legal community. For example, "Principles and Guidelines Concerning the Foregoing of Life-Sustaining Treatment for Adult Patients," a report of their joint Committee on Bioethics, was adopted on December 13, 1985 by the Board of Trustees of the Los Angeles County Bar Association and on January 6, 1986 by the Council of the Los Angeles Medical Association. Hospital ethics committees, which usually include representatives of the broader community, ethicists, and lawyers as well as physicians, have assumed

an increasingly significant role in shaping policy in these matters. Their varying policies bespeak a healthy pluralism in approaching these difficult matters. We hope that greater experience with many alternatives in caring for the dying will gradually provide us with the moral wisdom we need.

In the meantime, no forum is totally satisfactory; the high stakes and excruciating vagaries of these issues will inevitably leave many dissatisfied, no matter who decides an issue and no matter what the decision may be. The point, though, is that the kind of extra-legal agencies which Maimonides envisaged have evolved, although not specifically in the form which he knew at his time.

As a result, with proper precautions to insure that such decisions are taken seriously, and with the institutions in place to shape appropriate policies and to punish those who kill fetuses or terminally ill people without appropriate justification, a decision to remove modes of medical intervention from such people in given cases may be taken in good conscience and in consonance with Jewish law, even though such action will lead to their deaths. The diminished status of these categories of people, coupled with the precedents on siege, justifies the conclusion that the lives of the terminally ill may be – and in some cases must be – sacrificed to preserve the lives of others. As Sinclair puts it:

It would appear that where the indirect termination of the life of a critically ill patient would result in the saving of a viable life, as in the case of organ transplants or the allocation of scarce medical resources, Jewish law would, in principle, legitimate such an act, provided that an institutional framework existed for assessing the effect of such a deed upon the moral fabric of society and for administering discretionary punishments. In all cases involving the killing, either directly or indirectly, of a טריפה, the killer would be exempt from the death penalty and his fate would be decided by extrajudicial bodies. These bodies would have at their disposal a whole range of sanctions, including death. Presumably, where proof was brought to the effect that the death of the טריפה had been brought about in an indirect fashion for the sake of saving viable life, those involved in the relevant acts would not be subject to any sanction.⁶¹

As indicated above, life-support systems may also be removed to relieve a terminally ill person of excruciating pain. I will detail below when and how each of these justifications becomes operative.

D. Some Applications of These Concepts and Policies

1. Hospice Care. One clear consequence of the last policy described in Section B is that hospice care is Jewishly legitimate. “Hospice care” is a mode of medical care for those with an irreversible, terminal illness in which the goal is not to do that which has been deemed to be medically impossible – that is, to reverse the progress of the primary, terminal illness and cure the patient – but rather to enable the patient to be as active and as free of pain as possible in the remaining days, months, or years of his or her life. It is a form of medical care, and so Jews who choose this option are fulfilling their obligation to avail themselves of such care; it is just that the goal of the treatment has changed. Instead of spending days on end in the hospital undergoing painful and deforming treatments, the patient remains at home, amid family and friends, doing as much of what he or she can do for as long as possible. As indicated above, one may, according to Jewish law, exert every effort in seeking a cure – including those with low probability and high risks – but one need not do so.

As we learn more about the dying process, hospice care becomes not only a permissible option, but, at least in most cases, the Jewishly preferable one. As a result of research on the psychology of dying and increasing experience with modes of dying outside hospital settings over the last several decades, it has become widely known that dying patients usually do not fear death as much as they fear pain, isolation, physical deterioration, and infantilization. Therefore hospice care, which keeps the person at home and in other familiar settings as long as possible and does not impose the burden of long, frequent, and often painful visits to the hospital, has a much better chance than a hospital does of addressing the real needs of the dying. After all, in hospice care the patient is more likely to know the people surrounding him or her, thus affording a sense of familiarity, security, and comfort. They, in turn, are more likely to know the patient’s likes and dislikes, style of life, and values, and they are also more invested in insuring that the patient’s social, emotional, and religious needs are met. Even the person’s physical needs are probably better served through hospice care. One enters a hospice program fully aware that death cannot be avoided; therefore the goal of both the person and the attending health care personnel is no longer confused by unrealistic wishes but is rather clearly focused on pain management. Since Judaism generally is interested in the whole person and not just the body, and since even care of the body is greatly influenced by a person’s psychological well-being, rabbis should explore it with the terminally ill and their families, and where appropriate, recommend it.

2. *Withholding and/or Removing Medicine and Other Forms of Medical Intervention from the Terminally Ill.* Another clear implication of these principles is that, when the patient has an irreversible, terminal illness, medications and other forms of therapy may be withheld or withdrawn. Because withdrawing treatment requires a positive act, some physicians are more morally queasy about that than they are about withholding treatment in the first place, but actually it is easier to justify withdrawing a treatment which has proven not beneficial than not to try a possibly beneficial therapy at all. Moreover, since the physical condition of patients may change over time, the goals of treatment and the methods used to attain those goals need to be continually reassessed, and that may easily involve discontinuing some therapy and beginning another. Only if little or no chance exists that a treatment will benefit the patient - or, if, as explained below, triage issues require that a treatment not be provided - may it properly be withheld. When the patient has an irreversible, terminal illness, however, even withholding treatments is justified: we need not do that which the attending physicians judge to be medically futile.

Even when a decision is made to withhold or withdraw aggressive modes of therapy, of course, the patient may not be abandoned. All appropriate forms of pain therapy and all relevant humanitarian support systems must be maintained.

If the *גוסס* category is to be used to regulate care of the terminally ill, this policy permitting the withdrawal and withholding of aggressive treatments from such patients invokes the Jewish tradition's distinction between sustaining the life and prolonging the death of the moribund (Policy #B-3 above). The definition of the person to whom it applies (the *גוסס*), however, is broader than most Orthodox rabbis make it - but, I think, more in keeping with the intent of the tradition, as discussed above.

If the *טריפה* category is to be used to guide our thinking on these issues - and that category does more accurately describe the vast majority of situations in which questions arise nowadays - withholding or withdrawing treatment from the terminally ill represents a permissible failure to act, in the case of withholding treatment, or a permissible act of bloodshed, in the case of withdrawing treatment, in order to save the life and health of the viable and/or to alleviate the pain of the dying. The justification for this ruling in each of the latter two cases follows.

a. *Scarce Resources.* Scarcity really involves two related, but somewhat different, issues: rationing, where there are effective, beneficial therapies which cannot be given to everyone and which must therefore be allocated according to some formula; and allocation of resources, where

there are questions as to the effectiveness and/or benefit of a given therapy for a specific person or group of people and therefore doubts as to whether to spend time, energy, and money on it for those people or whether to assign those limited resources to other health care needs – or to other matters altogether. Dealing with both of these limitations on our ability to do all that we want to do is often emotionally wrenching for us, and the truth is that no matter what we do, we shall have pangs of conscience.

In the first case, when a given therapy would benefit two or more people but there is only enough for one, physicians must first decide whether it would benefit all the possible recipients more or less equally. If not, those who are likely to benefit most from the treatment should have first priority to receive it. If all potential recipients would benefit roughly equally from the therapy, then one should determine the recipient on the basis of “first come, first served,” by random lottery among those who need it, or by any other procedure which similarly preserves the theological and moral equality of all human beings.⁶²

In the cases which concern us here, this means that when one patient has an irreversible, terminal illness, and other, viable lives are at stake, the traditional sources on siege, coupled with the terminal status of a *טרייפה*, provide a warrant, and perhaps even a demand, for switching scarce resources from those dying of an irreversible, terminal illness to those for whom the treatment may lead to recovery. It is as if all of us are besieged by the Angel of Death, who calls specific ones of us (those who have irreversible, terminal illnesses) to be sacrificed for all the rest of us. Since terminally ill people are already “under a sentence of death” (albeit a medical one, not a legal one), it is permissible, although often heartrending, to suspend our efforts to prolong their lives in order to preserve the lives and health of others.

Similar remarks apply to the second of our situations, the allocation of scarce resources to the various needs of society. Recent statistics on American health care clearly indicate that comparing our medical situation to a siege is not stretching matters much at all. Americans spent more than six hundred billion dollars on health care in 1989 – that is, 50% more than we spent on education, many times more than we spent on other social welfare programs, and even double the amount we spent on defense. Even so, infants die at a higher rate in America than in twenty-one other countries, and American life expectancy ranks only sixteenth in the world. Medical experts estimate that up to one-third of all medical services now performed are of questionable value. Most of these are performed on the terminally ill. Of heart bypass operations, for example, the Rand Corporation has determined that 14% were totally inappropriate and another 30% were of equivocal value.⁶³ If we were

instead to spend our time and money on preventive measures and health care education for the viable, we would preserve the lives and health of many more people, thereby carrying out much more effectively our mandate to be God's partners in healing. In fact, we would be even more successful in preserving people's life and health if, instead of engaging in any specific health care measures, we would assure people food, clothing, and shelter.

The figures are even more startling if we look worldwide. According to a recent report of the World Health Organization, annual health care expenditures in the poorest countries average about \$5 per person, compared with \$460 in Western Europe and \$1900 in the United States. Many of the forty million people who die annually from disease "could be saved by shifting a small amount of resources to health care." For example, more than 8,000 children die each day from diseases that could have been prevented by immunization, and almost 11,000 die each day of dehydration caused by diarrhea, according to the report. Further, an additional 8,000 die every day of pneumonia. Approximately \$2.5 billion spent annually to immunize all children and provide medication for dehydration and pneumonia would save the lives of an estimated 7.5 million children annually. Changes in lifestyle could eliminate at least half of the 12 million deaths annually associated with cardiovascular disease, including the 3 million who die from diseases associated with tobacco. Educational programs to prevent smoking and wean people from the habit will not only save lives, but cost considerably less than the expensive operations we try later to reverse the results.⁶⁴

This is not simply a numbers game, nor a suggestion that the old and infirm are somehow less valuable to God than the young and healthy; it is rather a recognition of the reality that allocation of resources for expensive and often futile treatment for the terminally ill in preference to providing basic health care, food, clothing, and shelter for the viable is a direct threat to the latter's lives. The social and political problem, of course, is that money saved in restricting expensive operations and the like will not necessarily be allocated for improved health and living standards for the masses. Indeed, we Americans as individuals spend inordinate amounts of money each year on cosmetics, alcohol, and junk food. Nations might allocate money from elsewhere in their budgets for health purposes (defense budgets are the usually mentioned target), but we must remember that, for better or for worse, states will inevitably-and often properly balance their health-related expenses with those for other desires and needs. The money spent on saving lives may increase somewhat, but ultimately there will be a limit.

In these circumstances, we are at least permitted, if not commanded, by the sources on siege to desist from aggressively treating those whose

lives we have little chance to save (specifically, the terminally ill) so that we can turn our energies and resources to saving those we can. Specifically, if we were to order our health priorities according to the Jewish demand to afford health to as many of society as possible, the order of services a community should provide would probably be something like this, in descending order of importance: (1) sufficient food, clothing, and shelter for everyone; (2) preventive care in the form of immunizations and health education; (3) treatment of acute and life-threatening, but reversible illnesses; (4) medical care for illnesses, whether acute or chronic, which are treatable and not life-threatening; and, finally, (5) treatment of irreversible, life-threatening illnesses.

It is not fair to ask physicians to make these decisions; they must focus on benefiting the individual patients for whom they are responsible. Moreover, the burden of giving up access to scarce therapies cannot legitimately be put on the shoulders of individual patients; society as a whole must determine when it will provide a given type of medical care and when not. Indeed, Jewish sources indicate that while individuals may devote all of their own resources to an attempt to save their lives, however unlikely the chances of success, a community must be more circumspect in its allocations, taking into account the welfare of all of its members.⁶⁵

Americans, with a “can do” attitude toward medicine as well as toward most other things, find it extremely difficult to acquiesce to the inevitable, and our medicine is therefore considerably more aggressive than the medical practices in other, Western countries such as France and England.⁶⁶ The Jewish penchant to “fix the world” makes American Jews even more reticent than other Americans to let nature take its course. While such aggressiveness may generally promote the progress of medical research and may often be in the best interests of patients as well, we may not have, or may not be able or willing to mobilize, the resources to treat everyone to the maximum—even when such treatment has some chance of benefiting a given individual. In such conditions of scarcity, we as a society must make difficult triage decisions.

We should make these difficult allocation decisions with forethought about the totality of social needs rather than on the basis of emotional reactions to individual cases, and, hopefully these decisions will be determined by a calculation of how we can best carry out our social and religious mandate to maintain the health of the members of our society. Certainly the potential success of treatment would be a more ethically and, therefore, halakhically acceptable criterion than others, such as social worth or the ability to pay. Ultimately, a careful consideration of these decisions is not only a social, medical, and legal necessity, but a

theological one: we must face the fact that we are not God, but human beings, with limited medical abilities and limited resources.

b. *Pain*. The argument for withholding or withdrawing treatment from a terminally ill patient does not rest exclusively on concern for the health and welfare of others; even attention to the best interests of the patient would sometimes permit (maybe even require) removal of life-support systems from the terminally ill. If a person with an irreversible, terminal illness is experiencing severe pain, it should be considered permissible not only to manage the pain with whatever medications are necessary, but also to withhold or remove life support systems so as to allow the person to die. The warrant for this comes both from our compassionate attention to the best interests of the patient and/or from precedents in Jewish law on abortion.

In Section B-4 above, I presented the case for using the best interests of the patient as the criterion for selecting appropriate therapy. “Best interests” are, in each case, to be defined by the patient him/herself, if possible – presumably in consultation with others – like the person’s physician, family, and rabbi-or otherwise, by the physician together with the patient’s family or surrogate. In the latter case, all of the parties involved should take into consideration the patient’s sensitivities and values as applied to his/her current medical condition. If the best interests of the patient are accepted as the ground for making Jewish decisions on medical care, we would have a relatively clear criterion for making decisions in many of the agonizing cases which face us today. Difficult judgment calls would still have to be made in every case, and the danger of making a decision on the basis of incorrect medical assessment or inappropriate motives always remains, but at least the standard which should be applied is clear, humane, and Jewishly grounded.

Rabbi Reisner and many others, however, think that the obligation to be compassionate, the duty to love others as ourselves, and the patient’s right to refuse a mode of treatment which he or she cannot tolerate all pale in the face of the prohibition against suicide; they think, in other words, that life, even if it is excruciatingly painful, is better than no life. I do not agree, but I certainly appreciate the gravity of the decision to withdraw life support systems and how that may lead people with moral sensitivity and Jewish commitment to take this stand firmly. Even those who take this position, however, might permit withdrawal and even withholding of life-support systems from the terminally ill on the basis of another justification which I embrace, coming from precedents in Jewish law on abortion.

The reader will remember that the closest analogy in Jewish law to the terminally ill patient is the fetus. The lives of both are protected by the sanctions of Jewish law. In the case of all human beings, however, under some circumstances homicide is permitted or actually required (e.g., as an act of self-defense, in war, or upon the decree of a court). The burden of proof which must be borne to justify the killing of a fetus or a terminally ill person, while certainly heavy, is somewhat lighter than that required for killing other persons; as we have seen, their status as a fetus or a terminally ill person (טרייפה) makes their blood “less red” than that of other people. With regard to abortion, this has meant that feticide is justifiable not only to maintain the physical life and health of the mother, but, since the eighteenth century, her mental health as well. Rabbi Eliezer Waldenberg and others have permitted aborting a fetus stricken with Tay-Sachs disease on the grounds of the mental anguish of the mother.⁶⁷ This precedent and the others based on the mother’s mental health could reasonably be extended, it seems to me, to justify the withholding or withdrawal of life-support systems from the terminally ill in cases where the pain, even with all the drugs, is unbearable: just as a mother may, under such circumstances, injure herself and take the life of the fetus within her, so may any adult, when in unbearable agony with no reasonable hope of recovery, direct that life-support systems be discontinued, and those who oblige commit a justifiable homicide.⁶⁸

Those who find either or both justifications for this ruling convincing must nevertheless use the permission it provides with extreme caution. First, efforts must be redoubled to insure that the patient’s request to withhold or remove life-support mechanisms is not a result of abnormal, psychological depression or a misplaced desire not to be a burden on others. Clearly, people in this condition often have good reason to be depressed, and their care is in fact a burden on others; but one must try to buoy up the patient’s spirits through visits and perhaps even with anti-depressant drugs, and one must assure him or her that the burden of care is being willingly borne. The last thing we want to do is to rob people of reasonable hope. If the patient, in asking that life-support systems be removed, is honestly responding to the pain of his or her existence, however, then his or her status as a טרייפה, coupled with a desire to accommodate his or her “great need,” would justify removal of life support mechanisms. (The same considerations and procedures would apply if a surrogate were making the decision for a mentally incompetent patient, but then one must additionally insure that a morally responsible and sensitive process to make the decision is in place.)

Finally, a word on the distinction between action and inaction (or “negative acts”). Philosophical discussions in contemporary theory of action increasingly challenge the reasonableness of distinguishing

between actively causing a result and passively letting it happen—including the matter of withdrawing and withholding treatment.⁶⁹ After all, we commonly hold people accountable for their failure to act in situations in which they could reasonably be held responsible to do something—as, for example, rich people who do not give charity commensurate to their wealth, or a physician who fails to treat a disease of his or her patient which clearly should have been treated. Ethicists therefore sometimes suggest that there is no difference between withholding treatment and withdrawing it. Some go further, suggesting that active euthanasia be allowed, at least in those cases where the patient has an irreversible, terminal illness, and perhaps also in those cases where the patient is not suffering from a physically terminal illness but is leading a degrading life due to Alzheimer's disease or the like.

It is true that inaction sometimes is morally blameworthy. Nevertheless, inaction usually brings less culpability than action. We say, for example, that those who oppress the poor verbally or financially are more blameworthy than those who avoid them and give them nothing. The latter surely have failed in their responsibility to do something, but the former bear greater guilt. Therefore the Talmud's advice to remain passive (שב ואל תעשה) in morally impossible situations still makes good sense.

This means that we would still assert a morally relevant distinction between withholding and withdrawing treatment. On the one hand, it is, as we asserted before, more difficult to justify withholding a possibly effective therapy than it is to withdraw it once tried, for in the former case one has done what one can and has not relied on one's estimate of what will happen. On the other hand, once a therapy has been tried, there is a moral repugnance and a psychological burden in removing it, for one then actively disconnects that which is sustaining a person. Thus Rabbi Jakobovits' advice to physicians to use timers with treatments they are not sure will work in specific cases (such as intravenous drips or machines) so that they will be discontinued automatically if they prove ineffective, while generally mocked by physicians, does diminish the moral onus of stopping the treatment. Even if this is not done, however, it may also be justifiable actively to withdraw a form of therapy, and indeed it is so, according to Jewish law, if it is not effective in achieving the desired medical result and/or if conditions of scarcity require that it be transferred to another patient.

3. Cardiopulmonary Resuscitation. These considerations would also be relevant to cardiopulmonary resuscitation applied to those with a terminal, irreversible illness. CPR was originally intended for heart attack victims who are otherwise in good health, and it has the greatest

chance of effectiveness with them. Even then, in a recent study, 80% of all those who suffered heart attacks, regardless of age, died of the arrest, either immediately or while under the subsequent intensive hospital care. Another 10% died during follow-up care, and only 10% survived beyond three years. Among those seventy years of age or older, figures for surviving to hospital discharge range in various studies from 0% to 15%, and the prognosis is even more dismal for those over eighty-five.⁷⁰ Other studies have produced somewhat more hopeful results, but even they make clear that our ability to resuscitate patients in cardiac arrest through CPR is severely limited. Moreover, one must recognize that CPR, especially in the elderly, commonly requires breaking ribs as well as other untoward results, each with its attendant pain and risks.

Those who advocate trying CPR under all circumstances point out that all pain and risks undertaken in the process are, after all, in the name of trying to save the person's life, and that certainly is true. Nevertheless, since the success rate of CPR is sufficiently less than 50% in all patients, it is considerably more probable that it will not work than that it will. Consequently, it should be considered halakhically optional to administer it since no patient need undergo a medical procedure which is more likely to fail than to succeed. This is especially true for patients in categories where CPR's success rate approaches zero-specifically, those in whom the cardiac arrest occurred outside hospital setting, unwitnessed, or associated with asystole or electromechanical dissociation, sepsis, cancer, or advanced age.⁷¹ In line with the discussion above, one may choose to ask for CPR in the event of cardiac arrest, just as one may ask for other therapies whose effectiveness is unproven or even unlikely, but one need not do so. Thus when treating people in advanced stages of cancer or heart disease, for example, who mercifully suffer a heart attack, we may let nature take its course, and "Do Not Resuscitate" orders may properly be written for such people.

4. Removal of Nutrition and Hydration from the Terminally Ill. Applying these principles to two other cases is harder and more controversial, but we must address them. While most would agree that, at least at some stage, withdrawing or withholding medications from the terminally ill is halakhically justifiable, there is considerably more debate concerning artificial nutrition and hydration. Every person must be afforded normal food and liquids. This is an obligation of the community with regard to the poor,⁷² and if a sick person cannot afford normal food and liquids, it becomes part of the duty of the community and its agent, the physician, to provide them as part of the individual's medical care.

When the person cannot or will not ingest food and liquids through the mouth, however, may the community – or must it – feed the patient

through tubes? In the Cruzan case, the United States Supreme Court determined that it did not have enough evidence of how Ms. Cruzan would want to be treated if comatose. That was relevant because if there were a sufficiently clear expression of her will, the justices needed to balance the American values of personal autonomy and liberty against the state's rights to assure the welfare of its citizens. The Jewish question, however, is somewhat different. It is this: in light of the individual's duty to take care of God's property (Policy #B-1), may an individual, or a person acting on his or her behalf, refuse to ingest nutrition and/or hydration intravenously or enterally (that is, through the intestines) when it is not possible to do so orally?

Most rabbis who have written on this issue have answered negatively, even if the patient is terminally ill. They draw a distinction between medications, on the one hand, and nutrition and hydration on the other, permitting the withdrawal or withholding of the former but not the latter. They reason that medications are, by definition, an unusual substance introduced into the person's system to cure an illness, and therefore they may be removed or withheld if they have little chance of functioning in that way. Nutrition and hydration, however, are needed by everyone. Therefore the burden of proof shifts: one needs to justify the use of medications, but one needs to justify the failure to provide nutrition and hydration.

I accept this analysis, but I think that its burden can be met in one of three ways:

(a) First, one should note that what we are calling "nutrition and hydration" fulfills the function of normal food and water, but in form and administration it is much closer to medication. We are, after all, talking about inserting tubes into a patient and running liquids through them into the patient – just as we introduce medications when the patient cannot swallow. This would argue for assimilating nutrition and hydration, administered intravenously or enterally, to medications rather than to normal food and water.

Furthermore, there are halakhic grounds for such an analogy. The Torah, after all, expressly forbids us several times from eating blood (e.g., Genesis 9:4; Deuteronomy 12:16), but we are nevertheless permitted to accept blood transfusions because from the Talmud on, we, in contrast to Jehovah's Witnesses, do not consider the insertion of blood through tubes to be a case of "eating" interdicted by the law.⁷³ (Even if it were, of course, we would permit eating blood to save a life, but we do not need to use that justification because our tradition has already restricted "eating" to what we swallow orally.) Similarly, I would argue, intravenous or enteral administration of nutrition and hydration is essentially different from providing food and water in the

usual sense, which we must do. If the patient cannot swallow normal food and water, however, we may, but also may not, administer such nutrition and hydration intravenously. The decision is a medical one, based upon the likelihood of the patient to be cured or at least to benefit – just as it is with all other medications.

(b) Even if one does not want to accept the above line of reasoning, one could still argue for withholding or withdrawing nutrition and hydration from a terminally ill patient on the grounds of the elevated risks of infection to the patient. Starvation, of course, is a much more certain and severe risk than the aspiration and infections which gastro-intestinal and other tubes may cause, but we would still offer normal food and liquids to the patient (even though, by hypothesis, the patient is not in a state to ingest them). The question, then, is only whether we must also offer a form of nutrition and hydration which, by its very nature, exposes the patient to elevated risks of life-threatening illness.

When thought of this way, the issue reduces to the risk-benefit calculus in many critical-care medical decisions, where the crucial question is whether there is a reasonable goal for which the patient should be exposed to the elevated risk. All such decisions, including this one, are properly and justifiably left to those involved, who alone can know the patient's threshold of pain and danger, can accurately assess all other relevant aspects of the particular situation, and can then apply the patient's understanding of "reasonable risk" and "benefit" under such circumstances to the situation at hand. Such people would include, first and foremost, the patient (presumably by a previous expression of his or her will in some form) or surrogate, but it should also include consultations with the physician, family, rabbi, and other relevant parties.

Some forms of injecting nutrition and hydration bear greater risks than others. As a result, this argument will vary in its strength, depending upon the degree of risk which the patient must assume to be fed in a particular way.

(c) We are, of course, being more than a little disingenuous in offering the patient food and liquids which we know he or she cannot ingest and then treating artificial nutrition and hydration as a strictly medical decision to be determined by a risk-benefit calculus. It would be neater if the physician's decision could be based straightforwardly on the criterion of what is in the patient's best interests (לטובתו). We have discussed above (Section B-4) the talmudic, medieval, and modern sources which support using that standard, together with its problems and advantages.

Patients for whom removing nutrition and hydration is a question usually can no longer make decisions on their own, and therefore determining the patient's best interests in such cases is especially difficult. We must rely on previous expressions of the patient's will or on

the interpretations of his or her will by surrogates or family. Provisions can be made to guard against abuses in making this judgment, but even so, this remains a major worry.

On the other hand, this approach does not require, as the previous one did, that one be sly in applying the categories of the legal theory to the case at hand. Moreover, it would empower one to make decisions even in cases where there is no shortage of facilities and where the patient feels no pain – Alzheimer’s patients or unconscious patients in the last stage of life, for example. All such cases will clearly involve decisions and dangers of utmost gravity, but medical care of the terminally ill often requires that such decisions be made, and we can, in fact, make at least some relatively confident moral judgments in these cases.

(d) If all of the above arguments prove unacceptable, physicians, in fulfilling their role of saving life, would be required by Jewish law to prescribe artificial nutrition and hydration when the patient can no longer swallow. As Rabbi Reisner points out, however, ultimately all Jews must decide whether or not they will follow the law. Under the hypothesis that none of the above arguments justifies withholding or removing artificial feeding tubes, obeying Jewish law in this case amounts to following the physician’s directions to use them. Patients for whom this is prescribed, however, are often already unconscious, and therefore it would have to be the surrogate or family member who would be refusing the therapy on the patient’s behalf. If the patient had been sufficiently clear about his or her wishes while conscious, such a third party might properly make such a decision as the patient’s representative. It would be for the delegate, however, as it would be for the patient if conscious a decision which the decisor had the power to make, but not the legal sanction to make again, under the assumption that none of the above arguments is effective to alter the substance of the law. I, for one, think that one or more of them in particular (c) should be accepted as a ground to permit removal or withholding of artificial nutrition and hydration, thereby making such disobedience unnecessary.

5. Removal of Nutrition and Hydration from Those in a Persistent Vegetative State. All of the above is with regard to a person with a terminal, irreversible illness. A much harder case is the person in a persistent, vegetative state (PVS). If the patient meets the criteria for neurological death, we can, on good authority, consider the person dead within the terms of Jewish law. There is by no means unified opinion to accept the neurological standard, but no less than the Chief Rabbinate of Israel has approved heart transplants on this basis, and many others agree, including some of our own colleagues who have written on this issue.⁷⁴

In many cases, however – especially after accidents or strokes – some brain wave activity persists, but little else. The patient in these instances does not have a terminal illness, and so the permission to withhold or withdraw treatment so as not to prolong death does not apply. The patient may be sustained through the use of heart and lung machines, but many, like Karen Ann Quinlan and Nancy Cruzan, manage to survive even when such machines are removed. Since these patients clearly cannot ingest food and liquids orally, the question quickly turns on whether we must administer artificial nutrition and hydration, and, if so, for how long.

This case is complicated in Jewish law by virtue of our strong stance against making judgments on the basis of the quality of a given life. Every life is precious in God's eyes, we aptly say, and so we may not decide to remove or withhold treatment from people just because we would prefer not to continue living under such circumstances. This principle serves the crucial role of reminding us that people handicapped in some way must be treated with the full respect which their divine image warrants, that, indeed, we must bless God for such variations among creatures, even if (or, especially if) we would much prefer not to be like them.⁷⁵

When it comes to the person in a persistent vegetative state, however, this principle is tested in the extreme. Arguments based upon minimizing pain to the patient become less plausible since the patient has lost all neocortical function and thus, by definition, is incapable of experiencing pain. Similarly, with regard to a non-terminal patient it would be hard to make the case that, because of the elevated risks of infection involved, intravenous feeding effectively hastens the patient's death rather than extending his or her life ([4b] above); the patient, after all, is not in the process of imminently dying, and so we cannot plausibly talk of hastening his or her death. Triage considerations would apply to heart and lung machines and other advanced technology, but the tubes necessary for nutrition and hydration *per se* are generally not in short supply.

There are, then, only two arguments which I can see to justify removal of nutrition and hydration from such patients. One is a version of (4a) above. That is, if nutrition and hydration are to be categorized as medicine, one might argue that, since they are not curing the patient, they may be removed, as long as we offer normal food and water to the patient, even though we know he or she cannot possibly ingest them.

Dr. Nevins, the subcommittee's consultant whom I mentioned earlier, urged us to take this line. We should recognize, he told us both orally and in writing, that in all cases of people in a persistent vegetative state, it is the underlying disease that causes the death rather than the

withholding or removal of treatment – even though the latter action would, of course, be the proximate cause of death. The same is true for people with advanced Alzheimer’s disease. In such patients, the failure of the swallowing reflex should be seen as a system failure which the feeding tube seeks to circumvent. Thus, even though such a person is not dead by the standards of either cessation of respiration and circulation or cessation of whole brain function, he or she should be allowed to die. Treatment of such a person, then, including artificial nutrition and hydration, should, in his opinion, be considered optional.

The other possibility is to follow those in the medical community who would define brain death as the irreversible cessation of the functions of the neo-cortex (the upper brain) rather than of the whole brain. Permanently unconscious people would then be classified as dead, and nutrition and hydration tubes could be removed.⁷⁶ As Rabbi Avram Reisner points out in his paper on these issues, Maimonides may provide a basis for this line of reasoning through his concept of ensoulment. Maimonides writes:

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 a human being in Our image, after Our likeness” (Genesis 1:26). This means that the human being 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.⁷⁷

Rabbi Reisner argues against this line of reasoning, pointing out that this would impugn the sanctity of the vessel that carried God’s image. Moreover, he points out the risk inherent in this theology of medicine, as it were, for if followed, one could easily argue that one should discontinue treatment of the mentally ill, who, after all, do not exhibit the rational soul of which Maimonides spoke. I agree with Rabbi Reisner’s objections to this approach.

Like Dr. Nevins, however, I do think that the first analysis of this situation (that tubes are medication and therefore may be removed as an inappropriate medical intervention in some cases, even when the patient is not terminal) should make it unnecessary to use nutrition and hydration tubes to treat PVS and advanced Alzheimer’s patients. Like him also, I think that the slippery slope can be contained; indeed, as I have stated previously, the essence of developing moral sensitivity is to recognize that moral principles cannot be applied indiscriminately, that

acute moral judgment must be used in deciding when and how to apply and balance our moral concerns. Such careful balancing of goods is, in fact, essentially our understanding of the nature of the halakhic process—at least when the halakhah is addressing predominantly moral issues.

I recognize, though, that there is something which is, minimally, highly unaesthetic in removing feeding tubes from such patients. After all, since their brain stem is intact, they are, by hypothesis, still breathing on their own. Clearly, then, in line with current practice, PVS patients should be maintained on nutrition and hydration at least for some time—especially if they need no scarce resources – to guard against the possibility that they were misdiagnosed as being PVS patients and were instead in a reversible coma. Triage considerations do apply to the other machinery necessary to sustain such patients; but, like many physicians, I would give up on such patients only reluctantly and after trying to revive them for some time. I am, in any case, comforted by Dr. Nevins' point that these cases are extremely rare, that in 25 years of practice he himself never had one and that he knows of only one in his hospital.

6. Living Wills and Durable Powers of Attorney. Finally, let me address the issue which brought us to this point in the first place. Once we determine our position on the matters above, it seems to me that instructing physicians and surrogates to follow a person's desires through one or the other of these written instruments is perfectly acceptable halakhically in those areas where we determine that a person may choose among forms of therapy. The fact that these instructions are given in advance of the illness, or that they are in written form, does not affect their legitimacy. As Rabbi Seymour Siegel, may his memory be for a blessing, said some time ago:

It is clear that where death is imminent and where the procedure cannot bring a cure or even a significant amelioration of pain, what is best for the individual (especially if he expresses his opinion through a will) is to allow him to die naturally. . . . What the Living Will makes possible is the giving of the privilege to the patient himself to stop those things "that delay the soul's leaving the body." The developments of medical technology have caused problems which our ancestors could hardly have foreseen. We must not forget, in our loyalty to tradition, the welfare of the suffering patient who, when the Giver of Life has proclaimed the end of his earthly existence, should be allowed to die in spite of our machines.⁷⁸

NOTES

I would like to thank Professors Arthur Rosett, Louis Newman, and Judith Wilson Ross; Rabbis Daniel Gordis and David Gordis; and Drs. Michael Grodin and Michael Nevins, in addition to the other members of the Subcommittee on Bioethics (Rabbis Kassel Abelson, Amy Eilberg, David M. Feldman, Avram Reisner, and Joel Roth), for their helpful criticism of earlier drafts of this responsum. Their willingness to do this, of course, does not imply agreement with what I say here or responsibility for it.

In the following notes, these notations designate classical rabbinic texts:

M. = Mishnah; T. = Tosefta; J. = Jerusalem (Palestinian) Talmud; B. = Babylonian Talmud; M.T. = *Mishneh Torah*; S.A. = *Shulhan Arukh*.

1. Louis E. Newman, "Woodchoppers and Respirators: The Problem of Interpretation in Contemporary Jewish Ethics," *Modern Judaism* 10:1 (February, 1990), pp. 17-42.

2. Tosafot, *Mo'ed Katan* 11a; Jacob ben Moses Mollin, *Yalkutei Maharil* (Segal), cited in Fred Rosner, *Medicine in the Bible and the Talmud* (New York: KTAV, 1977), p. 21; Solomon Luria, *Yam Shel Shelomo*, "Kol Basar," Section 12; Joseph Caro, *Kesef Mishneh* commentary to M.T. *Hilkhot De'ot* (Laws of Ethics) 4:18; Abraham Gombiner, *Magen Avraham* commentary to S.A. *Orah Hayim* 173.

3. David Ellenson, "Religious Approaches to Mortal Choices: How to Draw Guidance from a Heritage," in Barry S. Kogen, ed., *A Time to be Born, a Time to Die: The Ethics of Choice* (New York: Aldine De Gruyter, 1991), pp. 219-232. Also printed in Elliot N. Dorff and Louis E. Newman, eds., *Contemporary Jewish Ethics and Morality* (New York: Oxford University Press, 1995), pp. 129-139. The paper was delivered at the Starkoff Institute conference, "A Time to Be Born and a Time to Die: The Ethics of Choice," at Hebrew Union College in Cincinnati, on October 15-17, 1989. I want to thank Rabbi Ellenson, my friend and colleague, for sharing his paper with me. The articles he cites as articulating one form or another of this approach are these: Daniel H. Gordis [a Conservative rabbi], "Wanted - The Ethical in Jewish Bio-Ethics," *Judaism* 38:1 (Winter, 1989), p. 28-40; Irving Greenberg [an Orthodox rabbi], "Toward a Covenantal Ethic of Medicine," in Levi Meier, ed., *Jewish Values in Bioethics* (New York: Human Sciences Press, 1986), pp. 124-149; David Hartman [an Orthodox rabbi], "Moral Uncertainties in the Practice of Medicine," *The Journal of Medicine and Philosophy* 4 (1979), pp. 100ff; and Eugene B. Borowitz [a Reform

rabbi], *Choices in Modern Jewish Thought* (New York: Behrman House, 1983), especially pp. 367-368, and “The Autonomous Self and the Commanding Community,” *Theological Studies* 45 (1984), pp. 48-49.

4. See my article, “The Interaction of Jewish Law with Morality,” *Judaism* 26:4 (Fall, 1977), pp. 455-466.

5. B. *Bava Batra* 131a. To see how this text and others like it were used in the Middle Ages, cf. Elliot N. Dorff and Arthur Rosett, *A Living Tree: The Roots and Growth of Jewish Law* (Albany: State University of New York Press, and New York: Jewish Theological Seminary of America, 1988), pp. 383-395.

6. Matthew (Menachem) Maibaum, “A ‘Progressive’ Jewish Medical Ethics: Notes for an Agenda,” *Journal of Reform Judaism* 33:3 (Summer, 1986), p. 29. He is definitely right, though, in his call for Conservative, Reconstructionist, and Reform rabbis to articulate their respective views on medical matters in written form and anthologize them into easily accessible collections so that lay Jews do not mistakenly think that the only Jewish views on these matters are those of the Orthodox, simply because they are the only ones in print. (The Orthodox, who publish books with titles like “Jewish Bioethics,” certainly do not let on that there are other possible Jewish approaches!)

7. *Ibid.*, p. 29.

8. Ronald Dworkin, *Taking Rights Seriously* (Cambridge, MA: Harvard University Press, 1977), p. 22. His characterization of the distinctions among rules, principles, and policies appears on pp. 22-31. (This chapter of his book originally appeared in the *University of Chicago Law Review*, 1967).

9. As Dworkin points out, sometimes courts muddy the waters yet further by interpreting rules with words like “reasonable,” “significant,” “just,” and the like, which invoke the principles or policies that led the legislature to enact the rule in the first place. “But they do not quite turn the rule into a principle, because even the least confining of these terms restricts the kind of other principles and policies on which the rule depends.” *Ibid.*, p. 28.

10. The Torah mandates executing people for a long list of offenses. Largely through specifying stringent evidentiary rules, the Rabbis narrowed the scope of this punishment considerably (cf. M. *Makkot* 1:10), but they retained it, at least in theory. The Talmud (if not the Bible) requires that, even at the cost of killing the attacker, we defend both ourselves (Exodus 22:1; B. *Berakhot* 58a; *Yoma* 85b; *Sanhedrin* 72a) and even others (the law of רודף, B. *Sanhedrin* 72b-73a; M.T. *Laws of Murder* 1:6-7; S.A. *Hoshen Mishpat* 425:1). The duty to give up one’s own life when the alternative is to commit murder, idolatry, or incest is specified in B. *Sanhedrin* 74a.

11. Daniel B. Sinclair, *Tradition and the Biological Revolution: The Application of Jewish Law to the Treatment of the Critically Ill* (Edinburgh: Edinburgh University Press, 1989), pp. 80-81, 88-89. This distinction is parallel to one commonly cited in Anglo-American law between absolute and rebuttable assumptions of the law.

12. Umberto Cassuto has made this point with reference to biblical law codes, which, he says, “should not be regarded as a code of laws, or even as a number of codes, but only as separate instructions on given matters.” See his *A Commentary on the Book of Exodus* (Jerusalem: Magnes Press [Hebrew University], 1967), pp. 260-264. The Babylonian Talmud in B. *Eruvin* 27a and B. *Kiddushin* 34a expressly objects to treating the Mishnah’s general rules as inviolable principles; moreover, in practice it routinely interprets general principles announced in the Mishnah (with phrases like זך כלל) not as generalizations at all but rather as additions of further specific cases. See Jacob Elyahu Efrati, *Tekufat Hasaboraim V’Sifrutah* (Petaḥ Tikvah: Agudat Benei Asher [New York and Jerusalem: Philipp Feldheim, Inc., distributors], 1973), Part II, pp. 157-278 (Hebrew), who demonstrates this with regard to the 85 unrepeated instances in the Mishnah where this expression occurs and who claims that these discussions, limited to the Babylonian Talmud, are Saboraic in origin (i.e., from 500-689 C.E.). (I want to thank my colleague at the University of Judaism, Dr. Elieser Slomovic, for this reference.) See also Dov Zlotnick, *The Iron Pillar-Mishnah: Redaction, Form and Intent*, for a shorter, but sufficient, discussion of this in English. With regard to the genre of Jewish codes, its methodological pros and cons, and its origins in medieval systematics, see Elliot N. Dorff and Arthur Rosett, *A Living Tree: The Roots and Growth of Jewish Law* (Albany, New York: State University of New York Press and The Jewish Theological Seminary of America, 1988), pp. 366-401.

13. The more radical option of instituting revisions in the law (*takkanot*) is also an available alternative within the methods of classical Jewish law, and, given the radically new realities of contemporary medical practice, one might reasonably argue that such revisions can be more easily justified in this area than in most others. I would agree, but I share the tradition’s reticence to employ this method unless absolutely necessary (cf. Dorff and Rosett, *ibid.*, pp. 402-420). We do not have much experience in dealing with many of the morally excruciating questions posed by modern medicine, and so at this point we have not yet had time to see if instituting revisions is required. I, for one, think that the classical methods of legal exegesis and analogizing, if used creatively and sensitively, are fully capable of producing appropriate guidelines to modern Jewish medical decisions, and I certainly think that

we owe it to the tradition to try to use these more conservative methods for a period of time before resorting to *takkanot*.

14. Carol Gilligan, *In A Different Voice* (Cambridge, MA: Harvard, 1982).

15. "Milwaukee," *Encyclopedia Judaica* 11:1590.

16. Cf. my article, "The Interaction of Jewish Law with Morality," *Judaism* 26:4 (Fall, 1977), pp. 455-466.

17. Stanley Hauerwas has probably been the preeminent exponent of this in the Christian world; cf. his *Character and the Christian Life: A Study in Theological Ethics* (San Antonio: Trinity University Press, 1975); *Vision and Virtue* (Notre Dame, IN: Fides Publishers, 1974); *Truthfulness and Tragedy* (Notre Dame, IN: University of Notre Dame Press, 1977); and *A Community of Character: Towards a Constructive Christian Social Ethic* (Notre Dame, IN: University of Notre Dame Press, 1981). Cf. also Alasdair MacIntyre, *After Virtue* (Notre Dame: University of Notre Dame Press, 1981); James William McClendon, Jr., *Ethics* (Nashville, TN: Abingdon, 1987); and Paul Lauritzen, "Emotions and Religious Ethics," *The Journal of Religious Ethics* 16:2 (Fall, 1988), pp. 307-324. (I am indebted to Professor Louis Newman for this last reference.)

18. God's creation and ownership of all creation, including our bodies: Genesis 14:19, 22 (where the Hebrew word for "Creator" [קוֹנֵה] also means "Possessor," and where "heaven and earth" is a merism for those and everything in between); Exodus 20:11; Deuteronomy 10:14; cf. also Leviticus 25:23, 42, 55; Deuteronomy 4:35, 39; 32:6. The resultant duty to take care of oneself through proper hygiene, diet, exercise, and sleep is summarized best in M.T. *Hilkhot De'ot* (Laws of Ethics), chs. 3-5, but it derives from many talmudic precedents which mandate specific measures to prevent illness. A discussion of those, and of this first principle of my list generally, can be found in my article, "The Jewish Tradition," in *Caring and Curing: Health and Medicine in the Western Religious Traditions*, Ronald L. Numbers and Darrel W. Amundsen, eds. (New York: Macmillan, 1986), pp. 20-23 on this point, and pp. 9-20 on the general principle.

The general principle that "endangering oneself is more stringently [prohibited] than the [explicit] prohibitions [of the law]" is in B. *Hullin* 10a (חמירא סכנתא מאיסורא), and the Talmud includes many injunctions which apply that principle in practice, as, for example, the command not to go out alone at night (B. *Pesahim* 112b) and the many medical measures enjoined to prevent illness, noted above. (Many, but not all, contemporary rabbis have used this to prohibit smoking and/or hallucinatory drugs.) That the physician both may and must heal:

B. *Baba Kamma* 85a; B. *Sanhedrin* 73a; Shulhan Arukh *Yoreh Deah* 336:1. That Jews may live only in communities where physicians are available: J. *Kiddushin* 66d; B. *Sanhedrin* 17b. The mandate to violate the Sabbath to save a life: M. *Yoma* 8:6 (83a); B. *Avodah Zarah* 28b.

These and other sources clearly establish that one may avail oneself of medical care, but that one must do so is only implicit in the Talmud. As Dr. Fred Rosner summarizes, “From these and other Talmudic passages, it seems evident that an individual is undoubtedly permitted and probably required to seek medical attention when he is ill.” (Fred Rosner, “The Physician and the Patient in Jewish Law,” *Jewish Bioethics*, Fred Rosner and J. David Bleich, eds. [New York: Sanhedrin Press, 1979], p. 54.) Rabbi J. David Bleich provides an extensive list of medieval and modern rabbis who affirm that duty, but that very list indicates that he too fails to find the duty explicitly established earlier; cf. his *Judaism and Healing: Halakhic Perspectives* (New York: KTAV, 1981), pp. 9-10 (note 9). Some of these later authorities attach it to their interpretation of Deuteronomy 4:9, 15, first interpreted metaphorically in B. *Berakhot* 32b, but, as the Maharshah notes on that passage, neither the biblical text nor the rabbinic interpretation there institute the rule.

On these matters generally, cf. also Rabbi Immanuel Jakobovits, *Jewish Medical Ethics* (New York: Bloch, 1959, 1975), chs. 1 and 3.

In American law, adults do not have a duty to avail themselves of medical care, but they do have a legal obligation to provide such care for their children. The Supreme Court has even mandated some specific forms of care for children, as, for example, its insistence that Jehovah’s Witnesses allow their children to receive blood transfusions when medically necessary, despite the parents’ belief that that is prohibited as an act of eating blood. Along these lines, the duty in Jewish law for adults to seek medical care can also be seen – if one will pardon a little modern Midrash here—as an implication of the fact that we are all God’s children.

19. Rabbi Avram Reisner, “A Halakhic Ethic of Care for the Terminally Ill,” [see responsum in this volume]. He draws upon B. *Bava Metzia* 85b, where Rabbi, suffering from an eye disease, refused two medications proposed by his physicians, saying “I cannot endure it,” and ultimately accepted only their third prescription. As Rabbi Reisner emphasizes, this source legitimates the patient’s refusal to undergo a given therapy only when another, medically viable alternative is available; the patient does not have the right to refuse a course of therapy when it constitutes the only, or by far the best, chance to cure the disease.

The permission to choose among physicians is clearly stated in B. *Bava Kamma* 85a. Nahmanides, however, asserts a duty to choose the most

competent physician available (see his *Sefer Torat Ha-adam* [B'nei Brak, Israel: *Mif'al Ha-sefer*, 1979], “שער הסכנה” [although this edition may have mistakenly combined this section with the one previous to it, such that it should be “שער הרפואה”], p. 18, and the Joseph Karo (S.A. *Yoreh Deah* 336:1) also rules that a person “should not engage in medicine unless he is expert and there is nobody there [in that location] greater than he, for if this is not the case, he spills blood [murders!].” These rulings are apparently based on J. *Nedarim* 4:2 (38c), which is cited approvingly by Rabbenu Asher (the Rosh) in his comment to B. *Nedarim* 41b. Those sources, however, seem to be saying the very opposite, namely, that it is a mitzvah for a physician to tend to a patient, even if there is someone else available to heal him, “for not from everyone does a person merit to be healed” – i.e., people can be healed most effectively by specific physicians (presumably ones they know and trust), even if other available physicians are as skilled or even more so. Thus it certainly is mandatory that physicians become expert in their art before practicing and even gain the permission of the court to practice (the early equivalent of licensure), but it is not clear that a Jew must use the most competent physician at all times. Indeed, if that were so, a few physicians would be very busy, and others would have very little to do!

The recognition that people have free will to disobey the law is embedded in the very nature of the Jewish doctrines of sin and return (חשובה).

20. *Sefer Ḥasidim* (attributed to Rabbi Judah the Pious), #723, 234; S.A. *Yoreh Deah* 339:1, gloss. The story of Rabbi Ḥananyah ben Teradiyon in the Talmud (B. *Avodah Zarah* 18a) also suggests this distinction (since Rabbi Ḥananyah refuses actively to hasten his own death but both he and the Voice from Heaven approve the removal of impediments to death), but that is not in a medical context, and these latter sources are.

21. Tosafot, B. *Avodah Zarah* 27b, s.v., לחיי שעה לא חיישנן.

22. I can imagine someone arguing that I should construe this comment of the *Tosafot* according to the hermeneutical rule of כלל ופרט (a generalization followed by a specification), where one is to interpret the generalization as being limited by the specific example. I would point out, however, that *Tosafot* follow their discussion of the two examples with another generalization – namely, that we abandon the certain and adopt the uncertain course of action (in order to act for the patient’s benefit). Thus this is actually an instance of כלל ופרט וכלל (a generalization followed by a specification followed, in turn, by another generalization), and then the generalizations, rather than the examples, determine the scope of the author’s meaning.

23. The sources he cites – some of which clearly support this position, while some do only if one accepts Rabbi Shapiro’s reading of these – are these (in the order he discusses them): *Responsa Avnei Nezer*, *Hoshen Mishpat* #193; *Reponsa Maharsham*, Part I, Section 54; B. *Ketubbot* 33b (with the commentaries of Tosafot [s.v. אַלמלאַ] and Rabbi Yaakov Emden); Numbers 11:15 and the commentary of the Ramban thereon; I Kings 19:4; Jonah 4:3; the Ran on B. *Nedarim* 40a; the story in B. *Gittin* 56b of the woman who threw herself off the roof after seeing her seven sons die, followed by the approbation of her act by a heavenly voice, even though her suffering was solely psychological and not physical; the story of Rabbi Shimon and Rabbi Ishmael in the Yom Kippur Martyrology, in which each pleads “Kill me first” in order not to witness the execution of his colleague; *Yalkut Shimoni*, *Ekev*, #871; Rabbi Moshe Hershtler, *Halakhah U’refuah*, Vol. 2, pp. 32-33. Another important contemporary authority who supports using the benefit of the patient as the criterion of appropriate medical care is Rabbi I. Jakobovits (in his article in *Noam* VI, pp. 271 ff).

Rabbi Shapiro also suggests using the טריפה category in these cases; I shall discuss that at some length and apply it below. The sources which Rabbi Shapiro adduces in regard to that category are M.T. *Laws of Murder* 2:8; *Minhat Hinnukh*, Mitzvot #34 and #296. Rabbi Shapiro notes that Ezekiel Landau (*Noda Be’yehudah*, *Hoshen Mishpat* #59), the author of *Tiferet Zvi*, *Orah Hayyim*, #14, and others cited by Rabbi Eliezer Waldenberg in *Tzitz Eliezer*, Vol. V, #28 (and the Tosafot in B. *Niddah* 44a-b, as Rabbi Reisner points out in n. 19 of his responsum) all dispute the ruling of the *Minhat Hinnukh* (and that of the Meiri, which Rabbi Shapiro does not mention but which I shall discuss below), but he claims that B. *Nedarim* 22a and the Rosh’s comment thereon support the former, permissive opinion, as do the *Or Hayyim* on Exodus 31:16; *Responsa Beit Yaakov* #59; and, in our own time, Rabbi G. A. Rabinowitz (*Halakhah U’refuah*, Vol. 3, p. 113) and Rabbi N. Goldberg (cf. Rabinowitz, *ibid*, Vol. 2, pp. 146-147).

24. I think that it can be fairly said that, among contemporary Orthodox rabbis, Rabbi J. David Bleich usually articulates the most extremely conservative positions in medical ethics. Nevertheless, even he permits the use of hazardous drugs and other therapies for the alleviation of pain, and he specifically includes in this permission cases which do not involve a terminal illness. Part of his argument is based upon what is, in our present state of knowledge regarding pain therapies, a weak argument, in my opinion – namely, the statements of Nahmanides and Rabbenu Nissim Gerondi that all medications are hazardous, and so once the Torah permits medical treatment, the degree

of hazard makes no difference. He also invokes, however, precedents by Rabbis Meiri and Isserles which speak more directly to this issue. Despite the Torah's prohibition of children wounding their parents (Exodus 21:15), when there is no other physician available, a child may perform an amputation or bloodletting to ameliorate the condition of a father who is "in pain." (Meiri on B. *Sanhedrin* 84b; S.A. *Yoreh Deah* 241:13, gloss.) See J. David Bleich, "The Obligation to Heal in the Judaic Tradition: A Comparative Analysis," in *Jewish Bioethics*, Fred Rosner and J. David Bleich, eds. (New York: Sanhedrin Press, 1979), p. 32 and pp. 28-33 generally; reprinted in a somewhat different form (but with no substantive changes on this issue) in his *Judaism and Healing: Halakhic Perspectives* (New York: KTAV, 1981), pp. 116-122; cf. also pp. 137-138 there. Rabbi Immanuel Jakobovits agrees, and so do the rabbis he cites, i.e., I. J. Unterman and M. D. Wollner. Cf. Immanuel Jakobovits, *Jewish Medical Ethics* (New York: Bloch, 1959, 1975), p. 276. My treatment of hazardous therapies closely follows that of David M. Feldman and Fred Rosner, *Compendium on Medical Ethics: Jewish Moral, Ethical and Religious Principles in Medical Practice* (New York: Federation of Jewish Philanthropies of New York, 1984) pp. 94-103.

25. All responsible ethicists want to prevent cases in which family members seek to discontinue treatment for selfish, immoral reasons ("We want Granny dead so that we can inherit her fortune.") Even when such malevolence and malfeasance are not at issue, however, the uncertainties of medicine make it difficult for the most loving and responsible of relatives to make an appropriate decision in these matters. An emotionally compelling instance of this was reported by Nancy Gibbs in "Love and Let Die," *Time*, March 19, 1990, pp. 70-71. Rev. Harry Cole, a Presbyterian minister, faced a hard dilemma when his wife fell into a coma after a massive stroke. Unlike the Nancy Cruzan case, it was not the state, but Rev. Cole himself, who would have to pay the bills for continued care. "If she were to go on that way," he is quoted as saying, "our family faced not only the incredible pain of watching her vegetate, but we also faced harsh practical realities." The cost of nursing home care was likely to exceed \$30,000 a year. "How could I continue to send three kids to college with the additional financial strain?" Under advice from physicians that Jackie Cole would never recover, and after consulting his three college-age children, Rev. Cole went to court seeking to have her respirator removed. The court agreed, but since Mrs. Cole had been in a coma for too short a time to diagnose her coma as permanent, the court stayed its order for a period of time, and six days later Jackie, against all expectations, woke up with minimal brain damage. According to the article, she does not blame Harry for wanting to pull

the plug. “I know he loves me. I know he was never trying to do away with me.” But the story highlights the dilemma both family members and judges face. “I thought my decision was well planned, well thought out, responsible,” said Rev. Cole. “It was what Jackie asked me to do.”

26. Cf. Dallas M. High, “Quality of Life and Care of the Dying Person,” in *Medical Treatment of the Dying: Moral Issues*, Michael D. Bayles and Dallas M. High, eds. (Cambridge, MA: Schenkman Publishing Co., 1983), p. 101.

27. The closest Judaism gets to advocating subjecting oneself to pain is on the Day of Atonement and, by rabbinic extension, on historical fasts such as the Ninth of Av. (Some pietistic Jewish communities encouraged personal fasts for specific reasons as well.) According to the Torah, God commands Jews to “afflict your souls” on Yom Kippur, which was understood in the tradition to involve fasting, sexual abstinence, and other forms of physical self-denial.

These were abstentions from pleasures otherwise enjoyed, however, and not submission to positive pain; the latter was reserved for the court’s punishments for violations of the law. Moreover, in each case abstinence is restricted to the given day and is designed to call attention to the theme of the day; it is not invoked with the idea that pain itself effects atonement or historical memory. Thus, if a person’s life is medically endangered on Yom Kippur, the most restrictive day of the Jewish year, the law itself requires that abstinence cease and appropriate measures be taken to assure life and health (Leviticus 23:32; M. *Yoma* 8).

The Rabbis do speak of “punishments out of love” (יסוריין של אהבה) (cf. B. *Berakhot* 5a), but that is only to justify God when a person’s suffering seems to be undeserved; it is certainly not used to advocate pain as a religious desideratum in the first place. On the contrary, the Rabbis also say that suffering only comes from sin (B. *Shabbat* 55a), which is certainly not a goal of the rabbinic tradition! Moreover, the very mandate to engage in medicine is, in essence, a command to relieve suffering.

Most forms of Christianity saw suffering as either penalties for sin or as a way of God’s teaching us humility and other important religious lessons. Some, however, actively sought suffering as a means to salvation (cf. *Caring and Curing: Health and Medicine in the Western Religious Traditions*, Ronald L. Numbers and Darrel W. Amundsen, eds. [New York: Macmillan, 1986], pp. 53, 59-60, 96-97, 121-122), and the Inquisition, after all, was justified, in part, as a way of inflicting pain in this world so as to attain salvation in the next.

28. Cf. Jakobovits, *ibid.* About seven years ago, when Rabbi Jakobovits addressed a large group of physicians and rabbis at

Cedars-Sinai Medical Center in Los Angeles, he specifically said that physicians need feel no compunctions in removing machines or medications which have not effected the hoped-for medical results. If they do feel such compunctions, however, he recommended setting such machines on timers so that the therapy will automatically be terminated unless the physician makes a conscious decision to renew it.

29. See note 19 above.

30. Cf. Bleich, *Jewish Bioethics*, p. 34 and the contemporary rabbis he cites in n. 120; Bleich, *Judaism and Healing*, pp.141-142. His main classical sources for this ruling are *perishah*, Tur *Yoreh Deah* 339:5 and the ruling in S.A. *Yoreh Deah* 339:2 that one must begin observing the laws of mourning three days after the onset of גסיסה.

31. Cf. J. Rachels, "Active and Passive Euthanasia," *New England Journal of Medicine* 292 (1975), pp. 79 ff; I. Kennedy, "Switching Off Life Support Machines: The Legal Implications," *Criminal Law Journal* (1977), pp. 443 ff.; G. Williams, "Euthanasia," *Medico-Legal Journal* 14 (1973), pp. 14 ff.; R. Veatch, *Death, Dying and the Biological Revolution* (New Haven: Yale, 1976), pp. 93ff; J. Glover, *Causing Death and Saving Lives* (New York: Penguin, 1982), pp. 109, 112; J. Harris, *Violence and Responsibility* (London: Oxford, 1980), ch. 4.

32. I first suggested this in print in my article, "'Choose Life:' A Jewish Perspective on Medical Ethics," *University Papers* (Los Angeles: University of Judaism, February, 1985), pp. 19-21. The section of that article on issues at the end of life was reprinted in a somewhat different form in my article, "Rabbi, I'm Dying," *Conservative Judaism* 37:4 (Summer, 1984), pp. 37-51, esp. pp. 45-48.

In light of our contemporary ability to keep people breathing and palpitating artificially, Rabbi Eliezer Waldenberg of Jerusalem has reinterpreted גסיסה to make it independent of its traditional symptoms. Instead, a "final-phase גוסס", according to him, is a person who has lost all capacity for basic physiological functioning where the loss is irreversible. In that state, Rabbi Waldenberg argues, all forms of life-support, including mechanical aids to respiration and heartbeat as well as artificial nutrition and hydration, constitute impediments to the person's dying and may be removed. It is also unnecessary, according to him, to resuscitate a clinically dead person. Cf. Responsa *Tzitz Eliezer* 13, #89 and 14, #80.

Cf. also Immanuel Jakobovits, *Jewish Medical Ethics* (New York: Bloch, 1959, 1975), p. 124 and n. 46; Daniel C. Goldfarb, "The Definition of Death," *Conservative Judaism* 30:2 (Winter, 1976), pp. 10-22; Seymour Siegel, "Updating the Criteria of Death," *ibid.*, pp. 23-30; and their discussion, *ibid.*, pp. 31-39.

33. M. *Semaḥot* 1:4, cited in many later sources, including *Siftei Kohen* and *Be'er Hetev* to S.A. *Yoreh Deah* 339:1.

34. Elliot N. Dorff, “Choose Life:” *A Jewish Perspective on Medical Ethics* (Los Angeles: University of Judaism, 1985), pp. 19-20.

35. B. *Sanhedrin* 78a; M.T. *Hilkhot Rotzeah* 2:8. Cf. also B. *Bava Kamma* 41a, according to which the owner of an ox which kills a person who has a fatal organic disease is not considered forewarned (מורע) in regard to the animal’s likelihood to kill healthy persons and need not be put to death; and B. *Shevuot* 34a, which repeats that a person who kills a טריפה is exempt from human penalties. Sinclair, *Tradition and the Biological Revolution*, at n. 6 above.

The term גברא קטילה occurs four times in the Babylonian Talmud. According to *Sanhedrin* 71a, once a person has been sentenced to death, he is immediately a גברא קטילה, a killed man. Because of that, *Sanhedrin* 81a deals with the possibility that one might think that a person sentenced to one of the more lenient forms of execution, since immediately presumed dead, could not subsequently be sentenced to a harsher form of execution for another crime. It rejects that conclusion, but in the meantime reaffirms the description of a doomed person as a dead one. *Sanhedrin* 85a adds the consideration that one sentenced to death, since considered an already killed person, is no longer “abiding among your people” in the terms of Exodus 22:27. And, perhaps most relevant to our purposes, *Pesahim* 110b says that a person who drinks more than 16 cups of wine is a גברא קטילה. There it is medical, rather than judicial, factors which make the person thought of as dead.

Rabbis who explicitly call a טריפה person a גברא קטילה (or the Hebrew equivalent, כמת) include Rashi, B. *Sanhedrin* 78a, s.v., שהוא פטור; *Hokhmat Shelomoh* on B. *Sanhedrin* 78a, s.v., מאי טעמא חייב; *Minḥat Hinnukh* #34 and #296; and *Mitzpeh Eitan* on *Sanhedrin* 78a. In addition, the Midrash, in *Canticles Rabbah* 4:1, translates טרף in Genesis 8:11 as קטיל, comparing it to Genesis 37:33, Jacob’s shriek that “Joseph has surely been mangled [torn up].”

Rabbi Morris Shapiro also suggests, at one point in his responsum, using the category of טריפה to deal with these cases, and he lists a number of people who do so (cf. n. 22 above), but he does not develop the argument further. We are, however, clearly thinking along the same lines!

36. M. *Hullin* 3:1; B. *Hullin* 42a; M.T. *Hilkhot Sheḥitah* 10:9; S.A. *Yoreh Deah*, *Hilkhot Terefot* generally.

37. B. *Hullin* 58a; M.T. *Hilkhot Sheḥitah* 11:1; Tur, *Yoreh Deah* 57; S.A. *Yoreh Deah* 57:18; *Siftei Kohen*, S.A. *Yoreh Deah* 57:48.

38. M.T. *Hilkhot Rotzeah* 2:8.

39. B. *Yevamot* 120b-121a; M.T. *Hilkhot Gerushin* 13:16-18; Tur, *Even Haezer* 17; S.A. *Even Haezer* 17:3-32.

40. Cf. M. *Yevamot* 16:4; Ramban, *Yevamot* 120b, s.v. *umi matsit*; Rashba, *Yevamot* 230, DSN – right number? s.v. *umi matsit*; Maggid Mishneh, *Hilkhot Gerushin* 13:16, s.v. *vekakh nireh*; Kesef Mishneh, *Hilkhot Gerushin* 13:16, s.v. *vekhen im*; Tur, *Even Haezer* 17; S.A. *Even Haezer* 17:32. Also see *Responsa Mishpetei Uziel*, *Even Haezer* #79; *Responsa Tzitz Eliezer* I, #23.

41. Tosafot *Gittin* 57 b, s.v. *וניכר במוחו*; Tosafot *Eruvin* 7a, s.v. *כגון שדרא*. Cf. also Kesef Mishneh, *ibid.*; Tosafot *Yom Tov*, M. *Yevamot* 16:4.

42. Sinclair, *Tradition and the Biological Revolution*, p. 22. Cf. also pp. 71-75.

43. B. *Sanhedrin* 78a. Cf. Rashi there, s.v. *ḥayyuv* and *v'ha eit lei hanaah*.

44. M.T. *Hilkhot Rotzeah U'Shmirat Haguf* (Laws of Murder and Care of the Body) 2:8; cf. 2:2-5; *Hilkhot Melakhim* (Laws of Kings) 9:4. Cf. also *Mekhilta Derabbi Yishmael*, “*Massekhta D'Nezikin*,” 4, ed. H. Horowitz, I Rabin, p. 263; and R. Moses Feinstein, Resp. *Iggrot Moshe*, *Yoreh Deah* #36). As Maimonides explains, homicides which cannot be classified as murder for some reason (specifically, the evidentiary rules are not satisfied, the perpetrator committed the act through an agent, the victim is the killer himself [suicide], or the victim is a *טריפה*) are nevertheless prohibited as acts of bloodshed under Genesis 9:6. Sinclair discusses at length why such offenses are punished as a capital offense for non-Jews under Noahide law while the remedy is left to God for Jews; cf. Sinclair, *Tradition and the Biological Revolution*, pp. 22-35.

Sinclair also points out that the Midrash (*Genesis Rabbah* 34:14) only includes the first three cases mentioned above as subject to divine penalty as bloodshed. Maimonides, though, includes killing the *טריפה* also because bloodshed is one of the Noahide laws, all of which, for him, are based on reason, and consequently any act which can reasonably be identified as the shedding of blood should come under the sanctions of the Noahide laws, even if there is no formal source for doing so. This also follows from the general talmudic principle that there is nothing permitted to an Israelite which is prohibited to a Noahide (B. *Sanhedrin* 58 b; cf. Tosafot there, s.v. *מי איכא*, and Tosafot, B. *Hullin* 33a, s.v. *אחר* (עובד כוכבים)).

The extra-legal penalties specified by Maimonides are not mandated by the law for all such cases, rather, God, the human court, and the king, in applying such punishments, have considerably greater latitude in deciding whether to punish at all and, if so, how; and, in the case of the

human court and king, their decision must be based on how this one act affects the general moral standing of the society. As Rabbi Solomon Duran, a fifteenth-century Algerian authority, noted in a polemic defense of Jewish law, this approach is preferable to the usual method by which legal systems deal with this problem – i.e., making the perpetrator liable under the law but eligible for judicial or executive pardon – because the latter approach obscures the true grounds for not administering capital punishment and leaves the public believing that justice was simply not done. The halakhic approach, on the other hand, excludes the death penalty in this type of case from the very outset, so that the public can know that the law has been upheld in court, but it affords society the ability to rid itself of such behavior if it needs to. Cf. R. Solomon Duran, *Milḥemet Mitzvah* 32b, s.v. עור השיב, and p. 35. Sinclair makes a similar point in comparing Jewish law to Anglo-American law; cf. Sinclair, *Tradition and the Biological Revolution*, pp. 57-59.

45. The dispute is recorded in B. Ḥullin 42a. Rava claims that the טריפה can live in B. *Terumah* 11b (and cf. *Tosafot*, s.v. *Rav Hisda* there), while in B. *Bekhorot* 3a he claims the reverse. *Tosafot*, s.v. *Rav Hisda*, on this last page argue that the version associating Rava with the position that the טריפה can live is the correct one. *Tosafot* on B. *Sanhedrin* 78a, s.v. ההורג את הטרופה פטור, suggest substituting Rabbah for Rava in these passages since Rabbah, and not Rava, is the contemporary and the common sparring partner of Rav *Hisda*, but this would still leave the conflict in the other two sources intact.

46. It does, however, provide for civil penalties for the injury to the mother, in accordance with its usual laws of tort. Cf. Exodus 21:22-25; M. *Bava Kamma* 8:1.

47. That feticide is a capital crime under Noahide Law for non-Jews: B. *Sanhedrin* 57b; cf. *Genesis Rabbah* 34:13. That Jewish law does not provide an independent criminal sanction for feticide: Rashi, B. *Sanhedrin* 72b, s.v. יצא; Yad Rama, *Sanhedrin* 57a, 72b; Meiri to *Sanhedrin* 72b; Ramban, *Hiddushim* to B. *Niddah* 44b; see David M. Feldman, *Birth Control in Jewish Law* (New York: New York University Press, 1968) [subsequently published under the title, *Marital Relations, Birth Control, and Abortion in Jewish Law*], pp. 251-294, esp. pp. 254ff. That feticide nevertheless bears civil penalties: Exodus 21:22; B. *Arakhin* 7a; *Responsa Tzitz Eliezer* IX, 51:3. That therapeutic abortion is permitted to, and, in some cases, even required of, Jews: M. *Ohalot* 7:6; M.T. *Hilkhot Rotzeah (Laws of Murder)* 1:9; S.A. *Hoshen Mishpat* 425:2; and cf. Feldman, *Birth Control*, pp. 275-284. That abortion unjustified by therapeutic concerns, despite the lack of specific criminal

penalties, is forbidden to Jews: *Tosafot*, B. *Sanhedrin* 58a, s.v. מי איכא; B. *Hullin* 33a, s.v. אחד עובר כוכבים; cf. Feldman, *Birth Control*, pp. 284-294. That it carries divine penalties (and perhaps extra-legal ones) similar to killing the טריפה: R. Meir Cohen, *Or Sameah* on M.T. *Hilkhot Issurei Biah* 3:2; *Meshekh Hōkhmah, Parashat Vayakhel*, s.v. שבת שבתון. Also note the words of R. Menahem Meiri (B. *Sanhedrin* 57b) to the effect that Israelites are exempt from capital punishment for bloodshed “since the king can punish them.” Cf. also J. David Bleich, *Contemporary Halakhic Problems* (New York: KTAV, 1977), pp. 331, 367.

48. T. *Terumah* 7:20; cf. S. Lieberman, *Tosefta Kifshutah, Terumah* 7, p. 148. Cf. J. *Terumah* 8:4; *Genesis Rabbah* 94:9; and *Leviticus Rabbah* 19:6. For a general discussion of these sources, see David Daube, *Collaboration with Tyranny in Rabbinic Law* (London: Oxford University Press, 1965), and for a discussion of how Rabbi Joel Sirkes (the “ב”ח”) used them in 1620 in a specific case, cf. Elijah Judah Schochet, *A Responsom of Surrender* (Los Angeles: University of Judaism Press, 1973). The main legal distinctions arising out of these sources are discussed by Shmuel Shiloh, “Sacrificing One Life for the Sake of Saving Many Lives,” in *Hevrah Vehistoriah*, Yehezkel Cohen, ed. (Jerusalem: World Zionist Organization [Office of Education and Culture], 5740 [1970]), pp. 57-62.

49. J. *Terumah* 8:4. Cf. Daube, *ibid*, and Shilo, *ibid*.

50. M.T. *Hilkhot Yesodei Hatorah* 5:5 The basis for this ruling is discussed in Kesef Mishneh there; *Responsa Habah Hayeshanot*, #43; *Responsa Seridei Esh* 2, #78. Those who rule with Maimonides include Bah”, Tur, *Yoreh Deah* 153; Taz, *Shulhan Arukh, Yoreh Deah* 157:7; *Responsa Noda Be’yehudah* 2, *Yoreh Deah* #74. The Tosefta and its variations were used also in responsa to determine how a Jewish community should supply men for the army; cf. Schochet, *A Responsum of Surrender*, pp. 47-48.

51. Meiri, *Sanhedrin* 74a, s.v. יראה לי (p. 271). Also see Tiferet Yisrael, *Yoma* 8:7, s.v. ונראה לי, and Hayyim Benveniste, *Seyarei Knesset Ha-Gedolah* on S.A. *Yoreh Deah* 156, #36.

52. B. *Sanhedrin* 74a.

53. *Minhat Hīnukh* #296, s.v. והנה בגוף דין.

54. *Responsa Noda Be’yehudah, Tinyana, Hoshen Mishpat*, #59. Landau is reacting to a statement *She’elot u’Teshuvot Binyamin Zeev*, #403, which justifies embryotomy on the grounds that one may push aside a doubtful life, i.e., that of the fetus, in order to preserve an established life, i.e., that of the mother.

55. Sinclair, *Tradition and the Biological Revolution*, pp. 49-51. Among those he cites who suggests this differentiation between Meiri’s

case and Landau's are *Responsa Yabia Omer* 4, *Even Haezer*, #1 and R. Benjamin Rabinowitz-Teumim, "Extradition to non-Jewish Authorities," *Noam* 17 (5734), p. 357 (Hebrew). He also notes a number of other Jewish legalists who draw this distinction independent of the Meiri-Landau context, including Levush Mordekhai, *Yoreh Deah* 157:1; Tiferet Yisrael, *Yoma* 3:3; Shilo, "Sacrificing One Life," p. 60; A. Enker, "Homicide committed in circumstances of duress and necessity in Jewish Law," *Shenaton Hamishpat Haivri* 2 (5737), p. 171 (Hebrew); and E. Ben-Zimra, "Bloodshed by Necessity in Jewish Law and Israeli Law," *Shenaton Hamishpat Haivri* 3-4 (5736-7), p. 142 (Hebrew).

56. M. *Ohalot* 7:6; B. *Sanhedrin* 72b; and cf. T. *Arakhin* 1:4; T. *Yevamot* 9:5; B. *Niddah* 29a; J. *Sanhedrin* 8:9; S.A. *Hoshen Mishpat* 425:2; and, more generally, David M. Feldman, *Birth Control*, pp. 251-294. That the rationale for justifying abortion is that the fetus is not a person: Rashi, B. *Sanhedrin* 72b, s.v. יציא; Ramban on B. *Niddah* 44b, s.v. והא דיתנין; Ramban, *Torat Ha'adam*, "ענין הסכנה," s.v. ובהלכות; Meiri on B. *Sanhedrin* 72b, s.v. ubarah; Ran, B. *Hullin* ch. 3 (19a) s.v., ולענין; Yad Remah, *Sanhedrin* 72b, s.v. אבל כל זמן.

Maimonides (M.T. *Hikhot Rotzeah* 1:9) justifies the Mishnah's instructions to abort a fetus endangering the life of its mother on the grounds that the fetus is a pursuer (רודף) of the life of the mother, but many commentators have pointed out, among other objections to this theory, is that the pursuer principle applies to full human beings being threatened by others, while the Mishnah's permission to abort is specifically restricted to the stage prior to birth. To rescue Maimonides (and Landau) from this objection, some suggest that even Maimonides was suggesting the pursuer principle as only a second, additional reason to permit (require) an abortion, but even for him the primary reason is that the fetus is not yet a viable human being while the mother is.

As Sinclair suggests, the indirectness of killing the טריפה is then parallel to the pursuer argument with regard to the fetus: both are secondary justifications for the permission to commit bloodshed or indirectly abet it, while the primary justification is the medical status of the fetus or טריפה as "less red" than a viable human being. See Sinclair, *Tradition and the Biological Revolution*, p. 73.

57. Given that both the fetus and the טריפה are considered to have "less red" blood, one might argue that direct killing of the טריפה ("active euthanasia") should be permitted. There are specific biblical and mishnaic texts permitting (mandating) the active killing of the fetus, however, and that is not true for the טריפה. Moreover, as Sinclair suggests, "the effect upon society of the direct killing of a טריפה who is capable of 'eating, drinking, and walking about on the streets' is much

more traumatic than that of directly destroying a fetus which is threatening its mother's life." Sinclair, *ibid*, p. 52.

58. This is normally the situation in which the possibility of an abortion arises. During the First World War, however, Rabbi Isser Unterman permitted a Jewish doctor to commit feticide rather than be killed by the Germans ordering him to do so on the grounds that the absence of a biblical prohibition against feticide makes martyrdom unnecessary. See R. Unterman, *Shevet Miyehudah* (Jerusalem, 5715), p. 29; and R. Michael Stern, *Harefuah Leor Hahalakhah* (Jerusalem: 5740), Part 1, Section 1, Chapter 3. The fetus, like the טריפה, therefore consistently is considered to have "less red" blood.

59. R. Simon Efrati, *Responsa Migei Haharigah*, #1 (where he permits taking the infant's life but says that one who chooses martyrdom instead is a "holy person"); E. Ben-Zimra, "Halakhic Decisions Relating to the Sanctity of Life and Martyrdom in the Holocaust Period," *Sinai* 80 (5737), p. 151 (Hebrew).

These heart-rending cases are instances of broader precedents within Jewish law. The questionable viability of newly born infants, due, at least in part, to doubts as to whether they were premature or full-term, led Jewish law to exempt one who kills a child less than thirty days old from human prosecution, just as it treats the person who kills the טריפה. [T. *Shabbat* 15:7; B. *Shabbat* 135b; B. *Niddah* 44b; Tosafot, *Shabbat* 136a, s.v. גמיהל. The Mishnah which subjects the killer of a day-old baby to the death penalty was taken by later halakhists as a theoretical rule only since whether the child was premature or full-term could never be conclusively known; cf. M. *Niddah* 5:3; *Responsa Noda Beyehuda* 2 Hoshen Mishpat #59.] According to R. David Hoffman, one may even intentionally sacrifice a newly born infant to preserve the life of its mother [*Responsa Melamed Leho'il* #69]. Here again, then, in the infant less than thirty days old, we have a category of human being whose questionable viability makes it subject to bloodshed if – but only if – another person's life could be saved by so doing.

Sinclair also points out that Jewish law treats both the fetus and the טריפה in a parallel manner with regard to the Sabbath laws: in both cases, saving the life of the fetus or the טריפה at the cost of violating the Sabbath is a moot point, with opinions going in both directions. Since this is never a question with regard to other people, these Sabbath laws further demonstrate that the lives of both the fetus and the טריפה are "less red" than those of viable people.

On all of this, cf. Sinclair, *Tradition and the Biological Revolution*, pp. 53-7.

60. This has occurred with regard to several decisions, but perhaps most vociferously in reaction to the decision of the Massachusetts Supreme Court in the case of *Superintendent of Belchertown State School v. Saikewicz* (1977) 373 Mass. 728, 370 NE 2d. 417, in which the judges attempted to define the criteria by which physicians should determine the quality of life. The decision was sharply attacked by the medical profession; e.g., W. Curran, "The Saikewicz Decision," *New England Journal of Medicine* 270 (1978), pp. 500 ff; A. Relman, "The Saikewicz Decision: Judges as Physicians," *New England Journal of Medicine* 270 (1978), pp. 509ff; cf. C. Baron, "Medical Paternalism and the Rule of Law," *American Journal of Law and Medicine* 4 (1979), pp. 337 ff.

61. Sinclair, *Tradition and the Biological Revolution*, pp. 62-63.

62. For general, ethical discussions on this, cf. Daniel Callahan, *Setting Limits: Medical Goals in an Aging Society* (New York: Simon and Schuster, 1987); N. Rescher, "The Allocation of Exotic Medical Lifesaving Therapy," *Ethics* 79 (1969), pp. 173-186; J. Childress, "Who Shall Live When Not All Can Live?" *Soundings* 53 (1970), pp. 339-355.

In accepting the criterion, used by most ethicists, that physicians first determine which patients can benefit from a treatment most, I am disagreeing with Feldman and Rosner (see their Compendium on Medical Ethics [in n. 23 above], p. 105), who claim that "since, in Judaism, all human life is equally sacred, including each moment of an individual's life "Is your blood redder than your brother's?" – Talmud *Pesahim* 25b), therefore no selection is justifiable among those with the need for, and the possibility, however slim, of cure." In cases of people with irreversible, terminal diseases, their blood is, indeed, less red according to Jewish law, as we have demonstrated. Even in cases where all the potential patients involved are not terminally ill, however, Jewish law must surely allow (actually, require) physicians to apply scarce therapies to those who can benefit from them most. To say otherwise would make Jewish law require that treatment which is of questionable medical value to one person be given to that person while denying it to another person for whom its value is quite certain. All living people without terminal illnesses certainly do have lives which are equally sacred, but that does not mean that we should do that which is medically inappropriate in securing those lives. I am agreeing with Feldman and Rosner, however, on how the triage decision should be made if there is no difference in the expected benefits among the potential patients – namely, with respect to the ultimate equality of all human beings – at least those without a terminal illness.

The Mishnah records an order of triage based upon social worth (M. *Horayot* 3:7-8). The Talmud and codes, however, limit this to people

whom one can save in addition to oneself, for one must first save oneself (B. *Horayot* 13a; Tur/S.A. *Yoreh Deah* 242 and 252). In the context of medicine, of course, the assumption is that the health care personnel are in no danger themselves. Nevertheless, the Mishnah is singularly unhelpful. Even if one has no objections to the ruling of the Mishnah itself (and one certainly might), one must reckon with the fact that it does not address what one should do if some of the people on its list had a better chance of survival than others. I have therefore ruled here without taking this Mishnah into account, choosing instead to invoke the principles of effectiveness and fairness embedded in Jewish law generally and in Jewish medical law in particular. (Cf., in addition, the article by Dr. Fred Rosner in n. 65 below.)

63. See, for example, “America’s Scandalous Health Care,” *U.S. News and World Report*, March 12, 1990, pp. 24-30, esp. pp. 25 and 27.

64. Marlene Cimon, “Premature Deaths Held Preventable,” *Los Angeles Times*, April 30, 1990, Section A, p. 6.

65. Cf. Fred Rosner, “The Allocation of Scarce Medical Resources,” in his *Modern Medicine and Jewish Ethics* (Hoboken, N.J.: KTAV, 1986), Chapter 23, pp. 339-354.

66. Cf. Lynn Payer, *Medicine and Culture* (New York: Henry Holt, 1988).

67. *Responsa Tzitz Eliezer*, vol. 13, #89, and vol. 14, #80. Cf. *Responsa Rav Paalim, Even Haezer #4* and *Responsa She’elat Ya’avez #43* for some of his sources for permitting an abortion when the woman would have “great shame” if she were to deliver the baby or when she has “great need” of it. Rabbi Moshe Feinstein disagreed strongly with Rabbi Waldenburg’s position; cf. R. Moses Feinstein, “On the Law Concerning the Killing of a Fetus,” in *Rabbi Ezekiel Abramski Memorial Volume*, ed. M. Hirschler (Hebrew) (Jerusalem, 5735), pp. 461-469. For a point-by-point analysis of the two positions, cf. Sinclair, *Tradition and the Biological Revolution*, pp. 93-98.

68. Sinclair (*ibid.*, pp. 76-79) has suggested this line of reasoning, although he says that the question must “be left open in the hope that it will eventually be addressed by halakhic authorities.” I move that we address this!

There are those who justify the abortion of a deformed or genetically diseased child, not on the basis of the mother’s reaction to the child’s condition, but directly on the grounds of the child’s medical condition. For those who hold that position, the analogy of taking the life of a fetus and a terminally ill patient would be even stronger. Those who take this position on aborting diseased children include: E. Waldenberg, *Responsa Tzitz Eliezer* 9:51 (1967) and 13:102 (1978); S. Israeli, *Amud Hayemini*,

#35, cited in *No'am* 16 (K.H.) 27 (note); L. Grossnass, *Responsa Lev Aryeh* 2:205; cf. Alex J. Goldman, *Judaism Confronts Contemporary Issues* (New York: KTAV, 1978), Ch. 3, esp. pp. 52-62.

69. See, for example, John Casey, "Actions and Consequences," in *Morality and Moral Reasoning*, John Casey, ed. (London: Methuen, 1971), pp. 165ff; James Rachels, "Active and Passive Euthanasia," *New England Journal of Medicine* 292 (1975), pp. 78-80; J. J. Thomson, "Killing, Letting Die, and the Trolley Problem," *The Monist* 59 (1976), pp. 204-217; John Ladd, "Positive and Negative Euthanasia," in *Medical Treatment of the Dying: Moral Issues*, Michael D. Bayles and Dallas M. High, eds. (Cambridge, MA: Schenkman Publishing Company, 1983), pp.105-127.

70. Donald D. Tresch, R. K. Thakur, Raymond G. Hoffmann, David Olson, and Harold Brooks, "Should the Elderly Be Resuscitated following Out-of-Hospital Cardiac Arrest?" *The American Journal of Medicine* 86 (February 1989), pp. 145-150. Cf. also the editorial by William R. Hazzard on pp. 143-144 of that issue. In another study, none of the patients over 70 years of age survived to hospital discharge; cf. George E. Taffet, Thomas A. Teasdale, and Robert J. Luchi, "In-Hospital Cardiopulmonary Resuscitation," *Journal of the American Medical Association* 260:14 (October 14, 1988), pp. 2069-2072 (and see footnotes for other studies); cf. also commentaries on the results beginning on pp. 2094, 2096, and 2098 of that issue. For studies of the old-old (over 85 years of age), cf. Gary E. Applebaum, Joyce E. King, and Thomas E. Finucane, "The Outcome of CPR Initiated in Nursing Homes," *Journal of American Geriatrics Society* 38:3 (March, 1990), pp. 197-200 (and see footnotes 1-8 there for other studies); Donald J. Murphy, Anne M. Murray, Bruce E. Robinson, and Edward W. Champion, "Outcomes of Cardipulmonary Resuscitation in the Elderly," *Annals of Internal Medicine* 111:3 (August 1, 1989), pp. 199-205 (and see footnotes there for 30 other studies), MA: Schenkman Publishing Company, 1983), pp. 105-127.

71. Murphy, et al., *ibid.*, p. 199; Taffet, et. al, *ibid.*, p. 2069.

72. Cf. my article, "Jewish Perspectives on the Poor," in Gary Rubin, ed., *The Poor Among Us* (New York: American Jewish Committee, 1986), pp. 21-55, esp. 33-44.

73. B. *Sanhedrin* 63a.

74. See Daniel C. Goldfarb, "The Definition of Death," *Conservative Judaism* 30:2 (Winter, 1976), pp. 10-22; Seymour Siegel, "Updating the Criteria of Death," *ibid.*, pp. 23-30; and "Discussion," *ibid.*, pp. 31-39.

75. Cf. Carl Astor, *Who Has Made People Different: Jewish Perspectives on the Disabled* (New York: United Synagogue of America, Department of Youth Activities, 1985).

76. Stuart J. Youngner and Edward T. Bartlett, "Human Death and High Technology: The Failure of the Whole-Brain Formulations," *Annals of Internal Medicine* 99 (1983), pp. 252-258. I owe this citation and the next, together with the suggestion of this line of reasoning, to Rabbi Avram Reisner. While he articulates it, he is not willing to endorse it. I am certainly not eager to permit removal of nutrition and hydration tubes from PVS and advanced Alzheimer's patients – such cases are always tragic, no matter what you do – but I do think that, after trying to revive such patients for some time, it is permissible and probably appropriate to do so.

77. M.T. *Hilkhot Yesodei Ha-Torah* (Laws of the Fundamental Principles of the Torah) 4:8.

78. Seymour Siegel, "Jewish Law Permits Natural Death," *Sh'ma*, Vol. 7 #132, April 15, 1977, pp. 96-97.