

# PERI- AND NEO-NATOLOGY: THE MATTER OF LIMITING TREATMENT

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

## שאלה

When are we justified, if ever, to allow a malformed newborn to die without applying maximum technological efforts to save that child or to extend its life?

## תשובה

Developments in the field of peri- and neo-natology are coming apace and nothing written today can hope to digest developments on the morrow. This said, there are certain general judgments that can be made.

First some terminological matters. For some time, the field of treating high risk babies was known as neonatology and consisted of the treatment of damaged, pre-mature and low birth weight infants. In the last decade, however, the fields of genetic testing, intrauterine diagnosis and microsurgery have all expanded dramatically, offering the possibility of diagnosing fetal flaws in the womb and intervening in that environment to correct them.<sup>1</sup> Consequently a new term has entered the field to describe treatment of

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<sup>1</sup> A particularly striking example is at the heart of the popular book, *The Baby Doctors*, by Gina Kolata (New York: Delacorte, 1990), reporting on some of the pioneering attempts at fetal surgery. Many newborns were dying, with little hope of successful intervention, due to respiratory insufficiency. No respirator or incubator therapy could replace the lung maturity that was absent. Stunningly, a significant subset of these children were found to be suffering from diaphragmatic hernias, wherein the diaphragm had failed to close properly in early fetal development and the intestinal organs had migrated up through the hole, effectively preventing the later developing lungs from forming in the cavity they now filled. By learning to operate in utero to draw down the migrating intestines and close the hole in the diaphragm, the perinatal surgeons were able to forge room for the lungs to develop and the children would be born healthy. Effectively, a small mechanical problem was killing large numbers of babies

an infant both before and after birth, that term, perinatology, has been added to the older term in the literature.<sup>2</sup> As a result, it is necessary today to speak of treatment of the fetus as well as of the newborn.

### *The Status of the Fetus*

As David Feldman sets out in his magnificent *Birth Control in Jewish Law*,<sup>3</sup> the unborn child is not seen as a separate and full life under Jewish law. It is protected, however, as potential life and may be aborted only for maternal causes. Concern for potential pain and burden on the unborn child cannot be a reason to choose abortion; not because that would be murder, but because to do so would be to meddle in God's domain, whereas treatment of the mother is in ours. Nevertheless, any and all acts that we might undertake to heal or strengthen the potential life of the fetus are in order. As with human life, we are enjoined to heal. That is part of the divine mandate.

Often, however, the mother's interests intervene in any calculations regarding the fetus. Unlike the potential life of the fetus, the mother's life is established. As such it takes clear precedence under Jewish law. The Mishnah in Ohalot (7:6) clearly permits abortion, even at a very late date, to save the mother's life. No calculation of viability is material here: only birth. With this as the primary precedent, Jewish legal sources included the health and even the mental well-being of the mother as potential reason to permit abortion. Some have argued that these precedents may be stretched to include the child's own disabilities where they would severely and negatively impact the mother's mental composure, her family situation, or even the economics thereof.<sup>4</sup> The upshot of this literature is to permit abortion for cause, but not simply by unsupported choice. What constitutes sufficient cause is a decision to be made on a case by case basis by the parents and their rabbi. This position is stated clearly in the definitive rulings by the CJLS on this subject on August 23, 1983.<sup>5</sup>

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and a comparatively simple procedure could be devised to save them (although nothing is truly simple in intrauterine surgery due to the size and speed of growth of the fetus).

<sup>2</sup> The *Random House College Dictionary* (1982), p. 892, defines neonatology as, "the branch of medicine that specializes in care of newborn children, especially those that are premature," and a neonate as, "a newborn child, or one in its first 28 days." (Note the similarities to Rabban Gamaliel's thirty-day measure in Tosefta Shabbat 15:7.) That dictionary does not yet attest "perinatology," although it is clearly built on the Greek root "peri" meaning "around." Thus the new term "perinatology" connotes treatment around birth, before, as well as after.

The introduction to the first chapter of *Behrman's Neonatal-Perinatal Medicine* (St. Louis: Mosby, 1983) defines the field as follows: "The term 'perinatal' is used to designate the period from the twelfth week of gestation through the twenty-eighth day after birth." The "neonatal period" is defined as "the first four weeks of life and is the period of the greatest mortality in childhood." In practice, an active neonatologist offers this definition: "The perinatal period extends from the beginning of the third trimester until the end of the first postnatal week. The neonatal period begins immediately after birth and extends until the end of the fourth postnatal week. A perinatologist is an obstetrician with added subspecialty training who cares for the mother and fetus. A neonatologist is a pediatrician with added subspecialty training who cares for high risk newborns" (personal letter from Dr. Charles Paley to R. Stephanie Dickstein, 6 Sept. 1995).

<sup>3</sup> For the details of this position, see David M. Feldman, *Birth Control in Jewish Law* (New York: NYU Press, 1968), chs. 14 and 15, and *infra*. Schocken published a paperback reprint in 1987 under the new (and more accurate) title *Marital Relations, Birth Control and Abortion in Jewish Law*.

<sup>4</sup> See R. Eliezer Waldenberg, *Tzitz Eliezer*, 2d ed. (Jerusalem, 1985), vol. 9, no. 51.3; vol. 13, no. 102; vol. 15, no. 43. His positions are summarized in A. Steinberg, *Hilkhot Rofeim u'Refuah* (Jerusalem: Mossad HaRav Kook, 1978), pp. 30-46. See also Feldman, n. 3, above.

<sup>5</sup> *PCJLS 80-85*, pp. 1-37.

Much more can be done for the fetus in utero today, however, than in the past, and even more will be possible in the future. Are we required to offer medical assistance to this fetus even when we do not recognize the fetus as a fully vested life and could conceivably abort it? The upshot of these permissive (but not pro-choice) rulings is that where aiding the fetus could have negative ramifications for the mother, any and all medical assistance for the fetus may be foregone. Any manipulation of the fetus, whether surgical or medicinal, would, in fact, entail some risk to the mother. Whereas the results are uncertain and the risks are real it is appropriate to forgo endeavors to aid the fetus.

But forgoing medical treatment of the fetus in utero, while permissible, is not required. The mother's desire to undertake some risk for her child and the true extent of that risk must be considered in every case. We would, without much hesitation, permit a kidney donation to a relative, although life with only one kidney is clearly more precarious than with two. We would encourage sea rescues, despite the risk of drowning, because we understand the risk is small when measured against what may be gained. The desire to aid the fetus is very real and should be considered. Action to save a life, even a potential one, is meritorious, and proceeds even at the cost of Shabbat transgressions.<sup>6</sup> But fetal life is just that, potential life not yet actualized, not, as the tradition claims, within the category of **נפש אדם**, a human life. Efforts to aid are subject to that inequality between the mother's status and the fetus'. It should be noted that even when other human lives are at stake, there is a point when rescuers are restrained from reentering a burning building, although they had done so before, because, assessing the situation, we determine that the risk has grown too great. All the more so here.

There is a second issue which enters here, the issue of viability.<sup>7</sup> It appears to me that a viability standard at the end of the seventh month (31-32 weeks)<sup>8</sup> when survival approaches 85%, must be extended to the fetus if we speak of the presumption of life potential for medical purposes. That correlates well with the abilities of peri-natology today. This is not to say that a late term fetus has attained the status of a full life, but that greater concern for the potential life of the fetus is in order. Rabbi Waldenberg, at least, seems to hint at such

<sup>6</sup> This conclusion is based, primarily on the notion: **חלל עליו שבת אחת כדי שישמור שבתות הרבה** – One should transgress this one Shabbat in order that he may observe many (Shabbat 151b). This would apply well to a fetus, even though the fetus is not yet alive. See Feldman, p. 264 and Waldenberg, vol. 13, no. 102, section 3.

<sup>7</sup> On 3 June 1992 the CJLS approved a paper by Rabbi Stephanie Dickstein on "Jewish Ritual Practice Following the Death of an Infant Who Lives Less Than Thirty-One Days," below, pp. 439-449. The CJLS approved an alteration of the law of mourning from the cautious view of Rabban Simeon ben Gamaliel that mourning is not required of an infant that dies in those first thirty days (Shabbat 135b), in favor of the more subjective measure of the Mishnah in Niddah 5:3.

תניק בן יום אחד... הרי הוא לאביו ולאמו ולכל קרוביו כחתן שלם.

[Even] a day-old infant is considered by his father and mother and all its relatives as a full bridegroom.

In "Kim Li: A Dissenting Concurrence," below, pp. 450-451, I argued that the measure was incorrect. If we seek to measure the subjective considerations of the parents, it is more realistic to try to measure their expectations than their hopes. Not all children, born, are, in fact, expected to live, even by their parents. In fact, a likelihood that the child would live is not established by a 50-50 chance but by some significant preponderance of the chances that the child would live.

I proposed a 31-32 week threshold, corresponding to the end of the seventh month by obstetrical count. I remain convinced of that position.

<sup>8</sup> The vagueness inherent in establishing a 31-32 week threshold rather than a date certain is intended to convey that obstetrical count is itself notoriously fallible (although with ultrasound measurements it is much firmer than it has historically been), and that we always are bound to the best judgment of the physician. Said flexibility should be permitted to push the date back as far as the beginning of the third trimester (27-28 weeks) where the doctor feels that his neonatal unit reaches eighty-five percent viability that early.

a standard when he writes of abortion on account of Tay-Sachs disease:

יש לדעתו להתיר הפסקת הריון כזה לפחות עד שבעה חודשים.

It appears to me that such an abortion may be permitted at least through the seventh month.<sup>9</sup>

Surgical and medical treatment of the fetus in utero, at this late date, should be encouraged if there is a good chance of curing the fetus and little risk to the mother.

*This is not in conflict with the permission we have granted abortion for cause.* Thirty-one to thirty-two weeks is the end of the seventh month by obstetrical count, or well into the third trimester. Abortion at that late date is exceedingly rare and will not be performed except where the mother's health is endangered, or in cases of rape or incest where the mother's mental well-being is at issue, or where there are genetic indications which occasion it (where again we would permit abortion readily based on the mother's well-being). Indeed, the law of the land supports such a distinction, ruling in *Roe vs. Wade* that states may not prohibit abortion in the first two trimesters, but that they may do so in the third.

Nor do we prohibit abortion even in the eighth and ninth month. But it is correct that the claim on life of the fetus should grow closer to that of its mother in those latter days, and treatment questions as well as abortion questions should be weighed in that light.<sup>10</sup>

### ***The Status of the Newborn***

Birth is the defining moment with regard to the status of the infant. Nevertheless, there are substantial misgivings in the halakhic literature concerning even the viability of newborns. The Talmud accepts as a given that a seven or nine month child may live, but that an eight month child will not. Thus, Shabbat circumcision is required of a seven and nine month child, but prohibited for an eight month child or for one about whom we hold a significant question. The same would not be true of a doubtful eight month birth with regard to medical treatment, wherein health needs override Shabbat regulations even in the event of uncertainty. But it would be true, according to the classical halakhah, that even medical treatment could not be given on Shabbat to a verified eight month baby, of whom the Tosefta writes:

הרי הוא כאבן. ואין מטלטלין אותו, אבל אמו שוחה עליו ומניקתו.

He is like a stone. One does not move him [on Shabbat], but his mother may bend over him to suckle him.

(The commentators are quick to add: מפני צער החלב שמצערה – “due to her pain of engorgement,”<sup>11</sup> not due to our concern for that infant's life.)

Indeed, Rabban Simeon ben Gamaliel's dictum that a child is not considered to be viable until the thirty-first day after birth is itself apparently predicated on this uncertainty.<sup>12</sup>

The notion that an eight month baby cannot live and therefore does not merit our attention is profoundly disturbing (yet it is indicative of our options to withhold care from

<sup>9</sup> Waldenberg, vol. 13, no. 102, sect. 5, and see sect. 1.

<sup>10</sup> Dr. Charles Paley, in his correspondence with R. Stephanie Dickstein, notes that this is largely a theoretical permission of abortion. In reality, he notes, a fetus of this age would have a substantial potential for survival. Consequently, most crises related to the mother's ability to proceed with the pregnancy would be resolved not by abortion but by Caesarean section.

<sup>11</sup> Tosefta Shabbat 15.5-7. B. Shabbat 135a, J. Yevamot 4.2, S.A. Orah Hayyim 330.5ff. See also the lengthy pilpul in this regard by R. Yitzhak Yaakov Weiss, *Minhat Yitzhak*, vol. 4, no. 123.

<sup>12</sup> Shabbat 135b. See above, n. 7.

hopeless cases, to which we will return in a moment). It is disturbing because it does not correlate with our best science and would ask us to withhold critical care from those infants we might save. Furthermore, the eight month infant in question is in his ninth month by obstetrical count, since this is a count of months *completed*.<sup>13</sup> Yet viability in the ninth month, today, approaches 100%!

Candor would have us simply state that the Talmud's eight month rule cannot stand in light of current understanding. Indeed, the well respected sage, Avraham Karelitz, known as Hazon Ish, argued tentatively:

כמדומה דעכשיו נשתנה הטבע וכפי בחינת הרופאים.

It seems that now nature has changed and we follow the discernment of the doctors.

While this opinion was not yet current in the early literature,<sup>14</sup> it seems to have gained current assent.<sup>15</sup> Concerning the laws of mourning, the Committee on Jewish Law and Standards has opted to waive Rabban Simeon ben Gamaliel's argument in

<sup>13</sup> That the count is of *completed* months is clear from the Tosefta's definition (15.7):

איהו בן שמונה כל שלא יצאו לו חדשיו.

Which is an eight month infant? One who has not completed his months.

and by the Talmud's use, on Shabbat 136a, of:

קום לי ביה שכלו לו חדשיו.

I am certain that he has completed his months.

as a synonym for a viable, full term baby. Otherwise he would need assert only that the baby had reached the ninth month. Many modern halakhic writings refer to the eighth month by obstetrical convention and assume the non-viability of the eight month child to refer to that. (See, for instance, R. Neria Gatal, "haPagut l'Or haHalakha," *Assia*, no. 44 (vol. 11, no. 4), pp. 5-30 and in notes 1 and 2 to his second installment of that article, *Assia*, no. 45-6 (vol. 12, no. 1-2), p. 97. This appears to me to be insupportable. But Dr. Steinberg, ever reasonable, understands the count to be of completed months and thus cites the Talmud, "A baby born *after* [my emphasis] eight months of gestation is non-viable" (Dr. Abraham Steinberg, "The Defective Newborn – Halachic Considerations" in Dr. Fred Rosner, *Medicine and Jewish Law II* [Northvale, NJ: Jason Aronson, 1993], p. 125).

It is further the case that obstetric and Jewish count are discrepant month by month. Obstetrical count assumes a beginning at the last menses and an extent of 40 weeks or 280 days. These amount to 9 months and one week of the secular calendar's 30-31 day months (To wit: every three months is, on average, 91 days.  $3 \times 91 + 7 = 280$ ).

The Rabbinic count begins at conception, roughly two weeks later than the obstetrical count, and is just 271 days. This extent is determined by the Talmud, Niddah 38b, on the basis of the numerical value of the word הרייון (pregnancy). Months, however, are lunar, set for this purpose at 30 days each. Nine months equals 270 days, with the birth presumed to be on the following day. The ninth month thus differs a bit accordingly.

(This is the traditional Rabbinic count. I prefer to believe that the rabbis, who knew quite well that the lunar month approximates 29.5, not 30, days, and who consequently alternated months of 29 and 30 days on their calendar, knew 9 months to be somewhat shorter (to wit:  $9 \times 29.5 = 265.5$ ), which would better match the obstetrical count of 280 days which begins 14 days earlier. That they allowed 271 days to stand, I think, was in light of the gematria and their certain knowledge that any number, here, is a gross approximation of a number quite variable, in fact.)

<sup>14</sup> Thus Magen Avraham, S.A., O.H. 330.16, represents those who obviated the Talmud's ruling by finding all but the most certain of cases to be uncertain, therefore to be treated even on Shabbat. Indeed, even in a case similar to the one he finds certain, it would be possible to adjudge the infant of uncertain gestational age, (א) because it is possible that the infant was formed in order to be born after seven months and he tarried (see Lieberman *Tosefta Kifshuta*, Shabbat, p. 249) or (ב) because she might have been mysteriously impregnated (נתעברה באמבטי) – see Hagiga 15a).

<sup>15</sup> Hazon Ish, Yoreh De'ah 155.4. I have not seen the original, but have seen Hazon Ish cited in *Sefer Assia* 4, p. 44 and in *Assia*, no. 45-6 (vol. 12, no. 1-2), p. 108, n. 37, and again in *Bishvilei haRefuah* 9 (Tevet 5749): 84. See also Steinberg, p. 125, n. 7, and the other citations cited there.

favor of the more subjective standard of **אביו ואמו**. With regard to medical treatment we should waive it as well, in order to correspond to the reality which greets us.<sup>16</sup>

Medical treatment of a viable newborn (see next) should therefore proceed as strenuously as it would for an adult. Those treatments that would be appropriate for an adult must be provided a newborn (save where the medical requirements of a newborn dictate otherwise). Where it is appropriate to withhold or withdraw treatment from an adult, it would be appropriate also to do so for a newborn.<sup>17</sup>

### **Genetic Abnormalities**

With regard to the fetus, we have already said that abortion is permitted for cause. Clearly, genetic factors affecting that fetus can and will have an effect on the mother's emotional well-being and will factor into any abortion decision that may be made. It is when a child is born with unexpected genetic deficiencies or is severely premature that we are faced with the awful choice of whether and to what extent to extend treatment. May we consider the viability of that child in making treatment decisions and forgo treatments where they are considered unlikely to promote the child's long-term survival? Both Rabbi Waldenberg and Dr. Jakobovitz, writing on this precise question, assume the newborn should be treated exactly as would be any patient.<sup>18</sup> Yet in light of the Talmud's treatment of the eight-month birth and in light of the extended discussion in the gemara of the third chapter of Niddah concerning the status of varying types of concepti, there might be room to consider the basic nature of the infants in question. In the words of the Mishnah:

חכמים אומרים: כל שאין בו מצורת האדם אינו ולד.

The sages say: Whatever does not have the aspect of a human being is not [considered] a birth.<sup>19</sup>

<sup>16</sup> Rabban Simeon ben Gamaliel's opinion is not so easily dismissed. What differentiates a newborn from an older child, he claims, is that **חוקת חיים**, a presumption of life, does not yet inhere in a newborn. But the Mishnah of abortion, in Ohalot 7:6, which forbids abortion the moment the head or majority of the body has exited the birth canal, is explicit in arguing that the presumption of life does apply immediately upon birth, "and we do not set aside one life for another."

Certain other areas of halakhah stand to be impacted by our desire to waive Rabban Simeon ben Gamaliel's ruling were we to do so across the board as the realia dictate that we do. These are discussed by R. Yitzhak Zilberstein in "פגים ונפלים ביחידה לטיפול נמרץ," *Sefer Assia* 6, pp. 42-45. Regarding **יבום** and **חליצה** (levirate marriage and its ceremonial rejection), waiving the thirty day rule would be salutary, as it would exempt more women from these requirements. Regarding **פדיית הבן** (Redemption of the First Born), however, it might require redemption of the parents of an infant who died prior to thirty days (if not in our most extreme category) whereas present regulations exempt. One could, however, rule with Tosafot that the thirty day limit regarding redemption is established by Scripture independent of viability and thereby hold on to the simple ruling of exemption if any infant dies prior to thirty days. In any case, the exemption of further births is not dependent on the viability of that first infant, for any infant, even a stillbirth, would exempt future children from redemption. Nor would it affect inheritance. See Zilberstein for further detail.

<sup>17</sup> See R. Avram Reisner, "A Halakhic Ethic of Care for the Terminally Ill," *PCJLS* 86-90, pp. 13-64, and see also R. Elliot Dorff, "A Jewish Approach to End-Stage Medical Care," *PCJLS* 86-90, pp. 65-126.

It is, of course, impossible to speak of the patient's autonomous will in the case of newborn infants. Family and physicians function under the constraints of unappointed surrogates, seeking the best course of treatment.

That a dying newborn whose situation is futile would be treated as would an adult in a similarly futile state is stated clearly, most recently, in the article by Dr. Steinberg, in Rosner, p. 123.

<sup>18</sup> R. Eliezer Waldenberg, Tzitz Eliezer, vol. 13, no. 88. Dr. Yoel Jakobovits, *Tradition*, vol. 22, no. 3 (Fall 1986): 13-30.

<sup>19</sup> Mishnah Niddah 3:2.

On its face this would appear to exclude “monstrosities;” as delineated by the Mishnah, this would include “fish-like creatures,” “insect-like creatures,” “animal-like creatures,” etc. and exclude apparently normal children. But Baraitot and amoraic dicta in the gemara extend this category to include one whose “forehead, eyebrows, eyes, cheeks and chin (or jaw?) are not of a piece,” and establish a further extension which rests on non-viability.<sup>20</sup> Thus, a woman who miscarries an infant whose esophagus is sealed (but not where it is simply perforated), whose (lower?) body is closed,<sup>21</sup> whose skull is malformed,<sup>22</sup> or whose face is crushed, is considered not to have given birth to a child. These extensions, it seems to me, permit the question, is there some level of non-viability at which the defective newborn should be permitted to expire?

The problem before us in relying upon this Talmudic material is the generic problem of scientific knowledge. We do not know precisely what situations the Talmud sought to describe, nor the extent of their medical discernment. To say that of the Talmud is, of course, not generally allowed. But the commentators and decisors were not at all unwilling to say that of themselves. Thus, this material does not appear in codified law, not because it is inappropriate to include it, but because the decisors did not feel they could draw practical conclusions therefrom. In the relevant section of Shulhan Arukh (Yoreh De’ah 194:3), we read:

עכשיו שאין אנו בקיאים בצורות חוששת לולד.

Now, when we are not expert in the formation [of the fetus], [the birthing mother] must consider these births.

But to be fair to the extraordinary advances of medicine in our day, it might precisely be said that today, as never before, we *are* expert in this area.

With much trepidation, I conclude that there are, in fact, such situations. Anyone who works in the field of neonatology can confirm episodes where, in the judgment of the medical team, an infant was too severely malformed to attempt any rescue.<sup>23</sup> Similarly, in the case of anencephaly, a neural tube defect by which the conceptus is born without a developed brain in which case the infants do not have a life expectancy beyond one month, the child should be considered akin to the Talmud’s conceptus with the malformed skull. In such a case there seems to me to be no requirement on the part of the physician to engage in attempts to save the child. Similarly, the major chromosomal

<sup>20</sup> Niddah 23b-24a:

אמר רבא... ושטו אטום אמו טהורה. ת"ר: המפלת גוף אטום אין אמו טמאה לידה. ואיזהו גוף אטום? רבי אומר: כדי שינטל מן החי וימות. וכן אמר רב גידל אמר רבי יוחנן: המפלת את שגולגלתו אטומה אמו טהורה.

Rava says: If his esophagus is sealed, his mother is pure [i.e., it is not considered a birth]. The Rabbis taught: She who miscarries a sealed [lower?] body, its mother is not impure the impurity of birth. Which is a “sealed body”? Such that were [that portion] taken from the living, he would die. Thus does Rav Gidal say in the name of R. Yohanan: She who miscarries one whose skull is sealed, its mother is pure.”

<sup>21</sup> Maimonides, Mishneh Torah, Issurei Biah 10:11. (He includes this full gemara passage in that chapter.)

Precisely what these conditions refer to is debated by the Amoraim there. This appears to refer to an improperly developed gastrointestinal tract. As to why the other codes do not include this material, see ahead.

<sup>22</sup> The word translated here as “malformed” is אטום in the Hebrew, the same word as is used with regard to the closing of the esophagus and, if I am correct, the intestinal tract. Rashi here, however, translates “missing” under the influence of the prior gemara and, I suspect, his inability to imagine the situation being described. That the reference is to a “collapsed” skull, rather than a missing one, seems to me more likely. See above, n. 20.

<sup>23</sup> This area has occasioned much debate. See the excellent popular study, *Playing God in the Nursery* by Jeff Lyon (New York: W.W. Norton, 1985), particularly the chapter, “Sanctity of Life vs. Quality of Life” and the report of the President’s Commission for the Study of Ethical Problems in Medicine and Biochemical and Behavioral Research.

abnormalities of trisomy 13, wherein the infant suffers severe abnormalities of brain and facial features and most often cannot support breathing on its own, and of trisomy 18, wherein the infants almost always succumb to respiratory difficulties within the first year, may be seen as indications of the non-viability of the infant. Although, fully supported, such children may live a year;<sup>24</sup> upon diagnosis within the first days after birth, it is correct to class these infants as non-viable and end their support. I am unwilling, however, to follow the logic of these Talmudic positions to the extreme conclusion that such children are altogether not considered live births. Were we to do so, there would be no impediment to treating such infants as donors while yet alive. If only due to our humility, but even more so due to our extreme reverence for life, it is unacceptable to do so. Rather we should classify such newborn infants as born dying, and allow the latitude of non-treatment that we would consider appropriate at the end of life.<sup>25</sup> Given the reality of scientific advance, I believe this ruling grants the needed flexibility.

<sup>24</sup> Presentation by Dr. Alan Fleischman, Director of the Division of Neonatology at Weiller Hospital of Albert Einstein College, to the Subcommittee on Biomedical Ethics of the CJLS, 13 Sept. 1989. See also, in detail, D.W. Smith, *Recognizable Patterns of Human Malformation* (vol. 7 in W.B. Saunders, *Major Problems in Clinical Pediatrics*, 3d ed.). Another such case would be chromosomal triploidy, a very rare occurrence in which there is no survival (indeed, most such births miscarry).

As our intervention in the womb grows we must anticipate larger numbers of malformed concepti which were destined to miscarry early in their gestation but which we shall reach alive. While abortion of such flawed concepti is permitted for maternal causes, it is not permitted to abort a fetus due to considerations of its own infirmities or suffering. Whereas, once born, we would countenance withholding of mechanical life support, the fetus' life support in utero is within the natural realm. It cannot be aborted but by an aggressive act on our part which is permissible only in the context of saving another. But see above, n. 5 and n. 6.

<sup>25</sup> See above, n. 17.

Thus use of a respirator or heart-lung machine, or extensive use of dialysis beyond immediate hope of repair of the kidneys or holding toward transplant would be counterindicated. An incubator should be required however, as the function of an incubator is to enhance the biological functioning of the newborn and not to replace those functions mechanically.

It goes without saying that once brain death has been declared such an infant may serve as an organ donor, as may any adult. The same criteria of brain death apply.

This responsum runs counter to the one direct early precedent known to me in this matter. R. Eleazar Fleckeles, in his responsum *Teshuvah MeAhavah* no. 53 (Prague, 1800), is asked about leaving monstrous newborns unattended, even to permit them to starve to death. The questioner, R. David Ber Cohen, effectively sets out the case based on these Talmud texts that monstrous newborns should not be considered human, for which reason, *יש כאן צד היתר לסבב המיתה*. R. Fleckeles dismisses this opinion out of hand, arguing that the gemara deals in matters of impurity, not life and death, and that none of the sub-human monsters included could possibly survive to birth. Furthermore, we do not consider ourselves capable of making this determination. And even if we could make that determination, that conceptus would be classed a *טרפה* or a *גוסס*, neither of whom may be put to death, or, at very least, the equivalent of an animal who may also not be caused gratuitous pain.

We were to cite this responsum as the controlling precedent, as does Pithei Teshuvah to Shulhan Arukh, Y.D. 194, no. 5, or as do R.J. David Bleich in his *Contemporary Halakhic Problems*, vol. 1, p. 366 and R. Immanuel Jakobovitz, *Tradition* 5 (spring 1963): 268, then we would be bound by precedent to rule more restrictively. But a case-by-case consideration of his arguments yields a different result.

As I have said, the extent of our expertise has risen considerably in the two centuries since R. Fleckeles wrote, and he himself was suitably tentative about an opinion offered without substantial support. More important, however, the questioner seeks to rule that said defective newborns are sub-human and to permit their death by starvation on that basis. We have been more cautious. If the Talmud's presentation, in theory, posits sub-human defectives then out of uncertainty we will certainly not entertain actively killing same, but only class these as dying and apply those rules to them. We only allow that that categorization may color our thinking on treatment decisions. In every case we do not draw ultimate conclusions from somewhat strained halakhic argumentation, but only allow it to move us a notch along the spectrum. This is, I believe, a thoroughly traditional model of halakhic decision making. In the instant case, it resolves the rest of R. Fleckeles' concerns, for it does not permit the killing of a *טרפה* nor the equivalent of cruelty to animals but only a measured response to the situation as we understand it.

With regard to severely premature newborns, the medical ground is shifting particularly fast. Lung development now seems to determine the earliest possible survivability, but opinion differs as to whether that is a real boundary or whether it might be overcome by increasing medical innovations.<sup>26</sup> Experimentation with a pseudo-womb environment continues. Therefore, it is prudent to leave the assessment of severely premature newborns to the medical experts. Where a child is found to be so severely premature as to preclude any realistic chance of survival, they may be classed with defective newborns and aggressive efforts to save the life of the child may be forgone. But where a realistic chance of survival exists, all efforts to achieve that result should proceed.<sup>27</sup>

Other abnormalities, including trisomy 21 (Down's syndrome), do not effect the newborn as severely, and the infant should be treated as are all other newborns.<sup>28</sup> As it is impossible to categorize every neonatal possibility, it remains for the doctors and the family's rabbi to determine the appropriate category for the case before them.<sup>29</sup>

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In a recent issue of *B'Or HaTorah* (no. 8 English 1993, p. 10), R. Yitzhak Zilberstein also cites this source and adds two other very contemporary views which, like R. Fleckeles, prohibit euthanizing said creatures but do not seem to address clearly this more cautious approach.

In a related matter, R. Zilberstein himself, in a responsum in *Bishvilei HaRefuah* vol. 9 (Dec. 1988), pp. 81ff. (citing R. Eliezer Waldenberg for support) cannot find a true prohibition against leaving untreated extremely premature newborns, but nevertheless recommends their treatment. He defines extreme prematurity as prior to 24 weeks, viz. the end of the sixth month, understanding the "seven month infant" of the Talmud as "in the seventh month" (see n. 13). Similarly, we treat the extremely premature infant as a subset of all patients, believing it appropriate to give even the slightest ones the best chance we can. Uncertainty (פסד) is not sufficient ground for retreating. When uncertainty is replaced by futility then we would back off. But that is true of any patient, if, perhaps, more likely true of the extremely premature newborn.

Most recently, Dr. Abraham Steinberg in "The Defective Newborn – Halachic Considerations," in Dr. Fred Rosner's *Medicine and Jewish Law II*, p. 125, seems to follow along a similar track, citing Talmudic rulings that are not in effect to justify present day leniencies. Though he cites "recent rabbinic decisors" as holding that the Talmudic ruling of eight month babies is inapplicable, he goes on to state, "The determining factor in the decision as to whether to treat or not to treat a defective newborn depends on its chances of viability, in accordance with the scientific knowledge and technical capabilities at the time. From the pure halachic standpoint, it might be forbidden to desecrate the Sabbath nowadays for any severely handicapped newborn who is expected to die within a few days. An anencephalic newborn falls into this category, since such a baby has the same halachic status as a baby born after eight months of gestation as described in the Talmud." I have preferred to extrapolate from a ruling that was not applied explicitly due to lack of expertise rather than from a ruling voided due to "changed nature." In either case, however, what has really changed is precisely our medical expertise.

<sup>26</sup> New York State Task Force on Life and the Law, Report of the Committee on Fetal Extrauterine Survival, p. 9.

<sup>27</sup> What constitutes "realistic" remains the province of the rabbi to determine. No percentage can be substituted for a judgmental ruling here. As Dr. Steinberg notes (Rosner, p. 131), "There are uncertainties as to the extent of morbidity and its severity. Moreover, there are still very few early prognostic markers for survival and for significant morbidity in individual babies. . . . Even the definition of futility is variable. Therefore, in Jewish Law, an individual baby who has a chance for survival should be treated as vigorously as needed."

It may be asked why our viability measure does not come into play here. The answer, however, is apparent. Concerning a fetus we need a preponderant chance for that fetus to rise near the level of a presumption of life. But a newborn has, in fact, gained a *חזקת חיים*, a presumption of life, by virtue of having been born. Henceforth we would need more than even a preponderant likelihood that the child would die to declare further ministrations futile. See above, n. 16.

<sup>28</sup> Even a "closed" intestinal tract, specified in the Talmud as a non-viable birth (see above, n. 20), might, today, be susceptible to surgical correctives which should therefore be undertaken where possible.

<sup>29</sup> Many cases will not fall clearly into one category or another. In cases of microcephaly, encephalocele and many other genetic abnormalities which may range in their severity, a medical judgment must be made concerning the extent of disability and the rabbi must judge if the weight of the non-viable category is met. See conclusion 6.

## ***Conclusions***

1. Abortion of the fetus is permitted throughout pregnancy for cause.
2. The claim of the potential life of the fetus to our ministrations is greater upon attaining viability, that is after seven months (31-32 weeks by obstetrical count).
3. Ordinarily, newborns must be cared for as we would care for any adult.
4. Severely deformed and compromised newborns are classed as born dying and treatments aimed at their survival may be discontinued. Severe deformity refers to anencephaly, trisomies 13 and 18 or other similar large scale genetic deformities. Jewish law does not insist on aggressive treatment in such cases. The term does not apply to lesser deformities, such as trisomy 21 (Down's syndrome).
5. Prematurity is generally to be considered part of the category of lesser deformities. In cases of severe prematurity the rabbi, in consultation with the family and physician, may conclude that the infant should be classed as unable to survive.
6. In fact, everything said here is said as guidance to the rabbi who must carefully assess the case in consultation with the family and physicians in order to determine the proper course in the instant case.

## **ADDENDUM CONCERNING MOURNING PRACTICES**

The following is not within the purview of this paper, nevertheless I would suggest:

1. A defective newborn who dies within Rabban Simeon ben Gamaliel's thirty day period should not require mourning since the parent did not reasonably expect that child to live. If the parents wish to observe mourning voluntarily they may do so, just as one may voluntarily observe mourning for an in-law.
2. Full mourning should be accepted as a voluntary observance for stillborn children and late term miscarriages (eighth and ninth month).