



# BIO-ETHICS

## PROGRAM/CASE STUDY

CASE STUDY II - April, 1989

### AUTONOMY: MY RIGHT TO LIVE OR DIE

Perhaps the area of Bio-Ethics that impacts on the greatest number of congregants is the area of the end of life.

The advances in life prolonging treatments continue to raise questions and expand options.

The second case confronts some of the issues from the point of view of the concerns over an individual's right to choose. Rabbi Dayle A. Friedman, Chaplain at Philadelphia's Jewish Geriatric Center, has suggested a case drawn from her rabbinate.

Mrs. M. raises questions that focus on her right to choose as opposed to a physician's mandate to heal. Also implicit in the case are questions such as the role of one's family in decision making (especially if the patient is unconscious), the right of an individual to have control of one's own body and life; the legality of Living Wills and the always present concept of "quality of life."

In addition to Rabbi Friedman's comments, Dr. Walter Jacob and Rabbi Bernard Zlotowitz have added their own insights reflective of their study.

To aid in the presentation of this case additional Reform Responsa on associated concepts are included as well as references for supplemental resources from Jewish and secular sources. Part of this Responsa is a brief collection of the total subject of Euthanasia that is instructive in that it reflects a three decade span. Note carefully the difference in technology and the variations on the "definition of death" and that definition's impact upon decisions to terminate machines that prolong life.

We hope that this case will provide the basis for further congregational programming and study.

L'hitraot.

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## "ELDERLY PATIENT REFUSES DIALYSIS" - CASE STUDY II

Mrs. H.M., an intelligent, articulate 83 year-old widow, received a diagnosis of renal disease eight years ago. Mrs. M., at the time living independently in her own apartment, refused to accept dialysis for her kidney condition. She continued to live independently, though her generally deteriorating health (hip fracture, incontinence, heart disease) over time rendered her unable to cope, even with hired home health aides and helpers. Six months ago, Mrs. M. entered a nursing home. She was mentally alert and cognitively intact, though physically frail due to her end-stage renal disease and congestive heart failure.

Mrs. M. was again offered dialysis upon admission to the nursing home. Even after physicians, nurses and psychiatrists repeatedly explained to her that her refusal of dialysis would hasten her death, she adamantly refused this treatment. Always a proud, independent person, Mrs. M. rejected the idea of a life dependent on machines, and claimed that the quality of her life (institutionalization, dependency) was unacceptable. In written and verbal communications to staff and her brother, her only relative, Mrs. M. made clear that she wanted no life-extending treatment (CPR, mechanical ventilation, feeding tubes, I.V. antibiotics) but rather, wished to "die peacefully and without pain." Mrs. M. was evaluated by psychologists and psychiatrists, and was determined to be mentally competent and free of psychosis or major depression.

One of Mrs. M.'s physicians feels strongly that he is obligated as a medical professional to save Mrs. M.'s life. He argues that he cannot stand by and allow her to die of kidney disease, and advocates imposing dialysis upon Mrs. M. Should Mrs. M. be forced to undergo dialysis? What are her rights and obligations, and what should be done if they conflict with those of the physician?

RESPONSE: Rabbi Dayle A. Friedman ©

A physician's obligation to heal is well-established in our tradition. According to Maimonides (commentary on Mishnah, Nedarim 4:4), the physician's duty to provide service to a person in a life-threatening situation is a binding religious obligation. According to the Shulkhan Arukh, (Yoreh De'ah 336:1), one who shirks the task of healing another is guilty of bloodshed (shfikhut damim.) Clearly, the physician's sense that he must "help" Mrs. M. by providing her with the available treatment has some support from the tradition.

But what of the patient? In general, a person is obligated to seek medical treatment, though there are important exceptions. One is obligated to avail oneself of treatment, provided its utility is well-proven. A treatment whose efficacy is uncertain (refu'ah lo bedukah) is not incumbent upon a patient, even if no potential hazards are known (R. Jacob Emden, Mor u-Kezi'ah Orah Hayim 328.) Dialysis is a treatment which, while it clearly can compensate for kidney malfunction, carries significant risks. Hemodialysis, the procedure for which Mrs. M. would be a candidate, requires a surgical insertion of a catheter in the arm. Risks include: sepsis (blood infection,) heart attack, hepatitis/AIDS from blood transfusion, nausea, pain and metabolic derangement.

On these grounds alone, it might be argued that the physician's obligation to treat is overridden by the patient's right to refuse a treatment which poses significant risks to the patient. However, even if the physician were to argue that the risks were minimal, that the treatment's curative power was well-established, we could not support imposing treatment on Mrs. M. against her wishes. This conviction emerges from analysis of this case, as well as from the principles of Reform Judaism.

### 83. QUALITY OF LIFE AND EUTHANASIA\*

**QUESTION:** Does Jewish tradition recognize the "quality of life" as a factor in determining medical and general care to preserve and prolong life? I have four specific cases in mind. In the first the patient is in a coma, resides in a nursing home and has not recognized anyone for several years. In the second, the patient is in a nursing home, completely paralyzed and can not speak or make his wishes known in any way. The third is a victim of a stroke, sees no hope for recovery or even major improvement, wishes to die and expresses this wish constantly to anyone who visits. The fourth is slowly dying of cancer, is in great pain and wants a prescription which will relieve her of pain but will probably also slightly hasten death. All of these patients are in their early eighties; none is receiving any unusual medical attention. Should we hope for a new medical discovery which will help them? (Rabbi R. H. Lehman, New York, NY)

**ANSWER:** The considerations which govern euthanasia have been discussed by the Committee in a recent responsa (W. Jacob, *American Reform Responsa*, #79, 1980). The conclusion of that responsum stated:

"We would not endorse any positive steps leading toward death. We would recommend pain-killing drugs which would ease the remaining days of a patient's life.

"We would reject any general endorsement of euthanasia, but where all 'independent life' has ceased and where the above-mentioned criteria of death have been met, further medical support systems need not be continued."

The question here goes somewhat further as we are not dealing with life threatening situations, but with the general question of prolonging life when its quality may be questionable. In none of these situations has any current extraordinary medical attention been provided. In two of the cases the cognitive and/or communicative ability seems to have ended. In the third there is a strong wish for death. In the fourth, the primary concern is relief from pain. Let us

address these cases individually.

For the patient in a coma and the one completely paralyzed and unable to communicate, a segment of the brain which provides intelligence seems to be damaged beyond repair. Judaism does not define human life only in terms of mental activity. Every person has been created in the image of God (Gen. 1.26), and so even those individuals who may be defective, i.e. the retarded, the blind, the deaf, the mute, etc., have always been considered as equally created in the image of God; their life is as precious as any other. It is necessary to guard their life and protect it just as any other human life. This is also true of an elderly individual who has now lost some of her mental ability or power of communication. In fact, we owe a special duty toward these individuals who are weak and more likely to be neglected by society just as to the orphan, the widow and the poor (Deut. 11.29, 27.13, Jer. 7.6; Is. 1.17; Shab. 133b; Meg. 31a; San 74a; Yoma 82b).

Let us turn to the individual who seeks death and constantly reiterates his wish to die. Although some rabbinic authorities feel that neither an individual nor his family may pray for his death (Hama Palagi Hiskel Lev, Vol. I, Yoreh Deah #50), most of our tradition would agree that a person may ask God to be relieved of suffering. The decision, of course, lies with God. A servant of Judah Hanasi prayed for his release (Ket. 104a). Other ancient authorities pointed to similar examples (Ned 40a and Commentaries). We would, however, discourage the individual from such prayer and rather seek to encourage a different attitude toward life. The growing field of psychology for the aged, has succeeded in developing a variety of techniques for dealing with such long term depression. We would encourage the family and the patient to utilize these methods or any other form of counseling and therapy available.

The individual who seeks relief from her pain should receive drugs which may help, even though they may slightly hasten death. As this is a very long term process, the drug can not be seen as actually causing her death. Suffering itself has never been seen as an independent good by Judaism. Even criminals destined for execution were drugged to alleviate their suffering (San. 43a). Similarly the executioner of the martyr Hanina ben Teradyon was permitted by him to increase the temperature and remove wool sponges from his heart in order to make death a little easier, though Hanina was unwilling to pray for his own death as his disciples suggested (A. Z. 18a). We

## PROGRAM DISCUSSION STARTERS

Refer to the case studies and the following Responsa.

1. "Does anyone have the right to decide another person's quality of life?"
2. How can we best understand the term "prospect for recovery?" (See Responsa on allowing a terminal patient to die.)
3. How should/ought issues of quality of life reflect decisions to treat or not to treat?
4. How do we best understand the concept of "Independent Life," especially as compared to the 1950 CCAR report on the subject of Euthenasia (see following Responsa.)
5. To what extent has the sanctity of human life and the supreme value of the individual been affected by medical technology growth in the area of prolonging life?
  - a. Should the sanctity of human life and the supreme value of the individual be affected?

From  
**H I P P O C R A T E S**  
The Magazine of Health & Medicine - May/June 1988

JES

THE END OF LIFE

From *Health and Medicine in the Jewish Tradition*, Rabbi David M. Feldman, New York: Crossroad, 1986.

Nothing may be done to hasten death even by a moment, for this is murder. The soul is likened to the flame on a candle; to touch a flickering candle is to put out the flame prematurely.

The patient has no "autonomy," and life is not "his" to take, certainly not anyone else's to take. Withdrawal of artificial support systems is, in principle, no different from withdrawal of food from a starving person. Under what circumstances, then, may one "pull the plug"?

A striking narrative in the Talmud offers some guidance on this subject. The passage has to do with the martyr's death of Rabbi Hanina ben Teradyon, (who was) executed by the Romans for the sin of teaching Torah. The Romans placed him in the fire for execution but covered his chest with wooden sponges drenched in water. This was to keep him alive longer while the fires burned and

thus to prolong his agony. His disciples pleaded with him to overcome this evil device by opening his mouth wide so that he might be asphyxiated by the smoke, die more quickly, and be spared the pain. He refused, says the Talmud, on the grounds that that would constitute suicide. "Only He Who gave life can take it away; I may not do it myself," he replied. "Well, then," the executioner himself, who took pity on him, offered, "let me remove these moistened sponges from around your heart." That, he answered, is permissible. [This] was a case of removing an impediment, artificially supplied, that delayed the expected process of dying. The executioner did so, and Rabbi Hanina's agony ended.

While physicians, then, may not disconnect life-support systems where they shorten life thereby, they may do so to shorten the death process. Since, however, we "begin dying the moment we are born" and, more to the point, it is difficult to tell the difference between shortening life and death, the principle is a moral one more than a practical one.

PREPARING FOR THE END OF LIFE

• PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH Superintendent of Documents, U.S. Govt. Printing Office, Washington, DC 20402-9325 • Book "Defining Death: Medical, Legal, and Ethical Issues in the Determination of Death" (040-000-00451-3) — \$6.50.

HASTINGS CENTER (address above) • Book "Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying" — \$14.50 plus \$1.50 postage.

OLDER WOMEN'S LEAGUE 730 Eleventh St. NW, Ste. 300, Washington, DC 20001 • Booklets "Death and Dying: Staying in Control to the End of Our Lives" — \$1.00; "Taking Charge of the End of Your Life: Proceedings of a Forum on Living Wills and Other Advance Directives" — \$4.50.

MINNESOTA NETWORK FOR INSTITUTIONAL ETHICS COMMITTEES Minnesota Hospital Association, 2221 University Ave. SE, Ste. 425, Minneapolis, MN 55414 • Booklet "Advance Directives: Purpose, Types, Some Considerations" — \$1.00.

NEW YORK STATE TASK FORCE ON LIFE AND THE LAW 31 West 34th St., 3rd fl., New York, NY 10001-3071 • Reports "Life-Sustaining Treatment: Making Decisions and Appointing a Health Care Agent" — \$8.50; "The Determination of Death" — \$4.00; "Do Not Resuscitate Orders" — \$6.50.

KENNEDY INSTITUTE OF ETHICS (address above) • Reports "Withholding or Withdrawing Nutrition or Hydration" and "The Living Will, or Death With Dignity: Legislation and Issues" — \$3.00 each.

CONCERN FOR DYING 230 West 57th St., New York, NY 10107 • Books "Deciding to Forego Life-Sustaining Treatment: Ethical, Medical, and Legal Issues in Treatment Decisions" — \$5.00; "The Living Will and Other Advance Directives: A Legal Guide to Medical Treatment Decisions" — \$3.00. Pamphlets "A Living Will" and "Questions & Answers About the Living Will" — free.

SOCIETY FOR THE RIGHT TO DIE 230 W. 57th St., New York, NY 10107 • Books "Handbook of Living Will Laws" — \$8.00; "The Physician and the Hopelessly Ill Patient: Legal, Medical, and Ethical Guidelines" — \$5.00. Pamphlets "What You Should Know about Durable Power of Attorney," "You and Your Living Will," "Living Will Declaration" (distributed in states without living will laws) — free; "Artificial Nutrition and Hydration" — \$1.00. Booklet "Right-to-Die Court Decisions" — \$10.00.

AMERICAN CIVIL LIBERTIES UNION (address above) • Book "The Rights of the Chronically Ill" — \$3.95 plus \$1.00 postage.

NATIONAL HEMLOCK SOCIETY PO Box 66218, Los Angeles, CA 90066 • Book "Euthanasia and Religion: A Survey of the Attitudes of World Religions to the Right to Die" — \$10.00.

AMERICANS AGAINST HUMAN SUFFERING PO Box 11001, Glendale, CA 91206 • Booklet "A Humane and Dignified Death Act: A New Law Permitting Physician Aid in Dying" — \$3.00 plus 50 cents postage.

ISSUES IN LAW & MEDICINE National Legal Center for the Medically Dependent & Disabled, P.O. Box 1586, Terre Haute, IN 47808-1586 • Reprint "The Uniform Rights of the Terminally Ill Act": A Critical Analysis" — \$1.00.

which would hinder the soul from a departure, so Sefer Chofetz (723) stated that if a dying person was disturbed by wood chopping, it should be halted so that the soul might depart peacefully. Isseries (to Sh.A., Yoreh De-a 339.1) stated that anything which stood in the way of peaceful death should be removed. Solomon Elger, in his commentary to the same passage of the Shulchan Aruch, stated that one should also not use medicine to hinder the soul's departure; he based himself on Belt Ya-akov (50). Clearly, as long as some form of independent life persists, nothing should be done to hasten death and all medicines which may be helpful must be used. Once this point has been passed, it is no longer necessary to utilize further medical devices in the form of drugs or mechanical apparatus.

We must now attempt to define the turning point, when "independent life" has ceased, and we can best do so by looking carefully at the Jewish and modern medical criteria of death. The traditional criteria were based on a lack of respiratory activity and heart beat (M. Yoma 8.5; TBM, III, Shab. 2.19; Sh.A., Orach Chayim 329.4). Lack of respiration alone was considered conclusive if the individual lay as quietly as a stone (Responsa Chofetz Sofer, Yoreh De-a, 738). All of this was discussed at some length in connection with the provision of the Shulchan Aruch that an attempt be made to save the child of a woman dying in childbirth; even on Shabbat a knife might be brought to make an incision in the uterus in order to remove the fetus (Sh.A., Orach Chayim 330.5). This statement, however, conflicted with the prohibition against moving a limb of someone who was dying, lest that hasten the death (Sh.A., Yoreh De-a 339.1). If one waited until death was absolutely certain, then the fetus would also be dead.

Absolute certainty of death, according to the halachic authorities of the last century, had occurred when there had been no movement for at least fifteen minutes (Gesher Chayim I, 3, p. 68) or an hour (Responsa Yismach Lev, Yoreh De-a, 19) after the halt of respiration and heart beat. On the other hand, a recent Israeli physician, Jacob Levy, has stated that modern medical methods change this criterion, and the lack of blood pressure as well as respiratory activity should suffice (Hama-a-yau, Tamuz, 5731).

This discussion was, of course, important in connection with the preparation for burial, as well as other matters. When death was certain, then the preparation for burial had to begin immediately (Chofetz Sofer, Yoreh De-a 118, Azulai's Responsa Chayim Shaul II, 27). In ancient times it was considered necessary to examine the grave after a cave burial to be certain that the

individual interred had actually died. This was recommended for a period of three days (Semachot 8.1). This procedure was not followed after Mishnaic times.

In the last years, it has been suggested that Jews accept the criteria of death set by the ad hoc committee of the Harvard Medical School, which examined the definition of brain death in 1968 (Journal of the American Medical Association, vol. 205, pp. 337ff). They recommended three criteria: (1) lack of response to external stimuli or to internal need; (2) absence of movement and breathing as observed by physicians over a period of at least one hour; (3) absence of elicitable reflexes; and a fourth criterion to confirm the other three, (4) a flat or isoelectric electroencephalogram. They also suggested that this examination be repeated after an interval of twenty-four hours. Several Orthodox authorities have accepted these criteria, while others have rejected them. Moses Feinstein felt that they could be accepted along with shutting off the respirator briefly in order to see whether independent breathing was continuing (Igerot Mosheh, Yoreh De-a II, #174). Moses Tendler has gone somewhat further and has accepted the Harvard criteria (Journal of the American Medical Association, vol. 238, #15, pp. 165.1ff). Although David Bleich (Hapardes, Tevet 5737) and Jacob Levy (Hadarom, Nisan 5731, Tshri 5730; Noam, 5.30) have vigorously rejected this criterion, we can see that although the question has not been resolved by our Orthodox colleagues, some of them have certainly accepted the recommendations of the Harvard Medical School committee. We are satisfied that these criteria include those of the older tradition and comply with our concern that life has ended. Therefore, when circulation and respiration only continue through mechanical means, as established by the above-mentioned tests, then the suffering of the patient and his/her family may be permitted to cease, as no "natural independent life" functions have been sustained.

We would not endorse any positive steps leading toward death. We would recommend pain-killing drugs which would ease the remaining days of a patient's life.

We would reject any general endorsement of euthanasia, but where all "independent life" has ceased and where the above-mentioned criteria of death have been met, further medical support systems need not be continued.

Walter Jacob, Chairman  
Leonard S. Kravitz  
W. Gunther Plaut  
Harry A. Roth  
Ray. A. Soloff  
Bernard Zlotovits



## WHEN THE LAW PLAYS DOCTOR: TEN CRITICAL CASES

**S**INCE the early 1970s, a generation of unprecedented arguments over parents' rights has come before the courts. Some actions have given new power to parents or their families; others have taken power away. All the cases cited here have influenced medical and legal decisions far beyond the states where they began.

### ROE V. WADE

U.S. SUPREME COURT, 1973

A resident of Texas, called "Jane Roe" by the court, sought to end her pregnancy. She could not openly request that a doctor perform an abortion, however, because state law made the operation a crime. Roe challenged the law on the grounds that it interfered with her right of privacy.

**THE RULING:** The court found that the right of privacy covers a woman's decision to have an abortion. But her rights must be balanced against a state's interest in protecting her health and the "potentiality of human life."

During the first trimester of pregnancy, the court ruled, a state may not interfere in a woman's treatment. But when the fetus becomes old enough to live outside the womb (at 27 weeks), a state may forbid abortions.

### QUINLAN

SUPREME COURT OF NEW JERSEY, 1976

When she spontaneously and inexplicably stopped breathing, 21-year-old Karen Ann Quinlan suffered severe brain damage and lapsed into a deep coma. Because she continued to show some brain activity, however, she could not be declared legally dead and was kept alive on a respirator. Quinlan's father asked the court to authorize her doctors to end life support.

**THE RULING:** The court ordered that Quinlan be removed from the respirator—provided that the doctors and hospital agreed. The judgment held that a patient's right to refuse treatment is part of the right of privacy. And a patient who is no longer able to

speak can still exercise that right through a guardian or family.

### SAIKIEWICZ

SUPREME COURT OF MASSACHUSETTS, 1977

Joseph Saikewicz—67 years old, severely retarded, and confined to an institution—had developed incurable leukemia. His doctors were prepared to prolong his life with chemotherapy, for a few months at most, but his guardian asked that he not be treated.

**THE RULING:** The court held that the pain and fear Saikewicz would suffer outweighed the treatment's benefits. The ruling stood on what Saikewicz would have said if he could. The court recognized that the right to refuse treatment applies not only to people who were once conscious and rational, such as Quinlan, but also to people who have never been able to make rational judgments for themselves.

This ruling has been widely interpreted to mean that in cases where treatment could help prolong a patient's life, only the court had the right to decide to end care. (Later judgments in Massachusetts held that sometimes families and physicians could make such decisions without being forced into court.)

### BROTHER FOX

NEW YORK COURT OF APPEALS, 1982

Brother Joseph Fox, an 83-year-old monk, lapsed into a coma during an operation and did not regain consciousness. His superior in the Catholic order knew that Fox had taught ethics, had been aware of Karen Quinlan's case, and had said—in accord with Catholic doctrine—that he

would not want his own life prolonged by extraordinary measures. The superior asked the court to authorize Fox's doctors to remove the respirator.

**THE RULING:** The court told the hospital to remove the respirator, finding that Brother Fox's refusal of treatment, expressed while he was conscious, was legitimate and should be honored.

### JEFFERSON

OHIO SUPREME COURT, 1982

Jessie Mae Jefferson was 39 weeks pregnant when her doctor told her that because of a blocked birth canal, she could deliver her baby only by cesarean section. She refused, citing unspecified religious beliefs that forbade surgery. The hospital asked the court to intervene.

**THE RULING:** The court gave the hospital permission to perform the operation, holding that the unborn child's right to live outweighed the mother's right to practice her religion.

### BABY DOE

SUPREME COURT OF INDIANA, 1982

Baby Doe was born with both Down's syndrome and a defect that hampered his breathing and prevented swallowing. The defect could be corrected by surgery, but the parents decided simply to relieve the baby's pain until he died. The county prosecutor asked the court to remove the infant from his parent's custody and authorize lifesaving treatment.

**THE RULING:** The court upheld the parents' decision. Baby Doe was not given the surgery, and he died just before an appeal reached the U.S. Supreme Court.

The judgment prompted a federal law, passed in 1984, that now prohibits withholding "medically indicated" treatment from any disabled newborn. However, a subsequent judgment

—the Baby Jane Doe case in New York—found that parents of an infant with spina bifida and other disabilities could choose a "passive" treatment of good foods, antibiotics, and sterile dressings.

### BARBER

CALIFORNIA COURT OF APPEALS, 1983

Clarence Herbert, a 55-year-old Southern Californian, suffered a heart attack after surgery and lapsed into a permanent coma. His family asked his doctors to remove the respirator keeping him alive. After two days the doctors also discontinued intravenous feeding; a week later, Herbert died. His nurses, alarmed at the events, called the district attorney. The doctors, Neil Barber and Robert Neidl, were charged with murder.

**THE RULING:** A lower court convicted the doctors, but the appeals court reversed the decision on the grounds that withholding life support was a passive omission, not an aggressive action.

### CONROY

NEW JERSEY SUPREME COURT, 1988

Claire Conroy, an 84-year-old woman living in a hospital, could be fed only through a tube and, though conscious, was confused and unresponsive. Her nephew—her closest living relative—sought court permission to have the feeding tube removed. Conroy died while still in care, but the court ruled on the case.

**THE RULING:** The court set sharp guidelines for withholding care: When the patient clearly would have refused treatment, when some evidence suggests the patient would have refused treatment, and the burdens of continuing care outweigh the benefits, when no evidence says the patient would have refused treatment, but the burdens of the care outweigh the benefits, and the

patient would be in such pain that continuing it would be inhumane.

#### **BROPHY**

**SUPREME COURT OF MASSACHUSETTS, 1988**

When a blood vessel burst near his brain, 45-year-old Paul Brophy suffered extensive brain damage and lapsed into a permanent coma. His family wished to have his feeding tube removed, but the hospital and doctors refused. The family asked the court to order them to comply.

**THE RULING:** The court found that Brophy would have wanted the feeding tube removed and that he had the right to refuse it. But the court also recognized the doctors' ethical objections and held that they could not be forced to assist. The family was ordered to move Brophy before life support could be ended.

#### **BOUVIA**

**CALIFORNIA COURT OF APPEALS, 1986**

In 1986, Elizabeth Bouvia, a 28-year-old quadriplegic with cerebral palsy, bedridden in a hospital and in constant pain, wished to end her life. The hospital staff had earlier decided she was not eating enough to survive and, against her wishes, had begun feeding her through a tube. She asked a court to order that the tube be removed. The court rejected her request. Bouvia appealed the decision.

**THE RULING:** The judgment, coming closer than any other to authorizing a suicide, held that a patient need not be comatose or near death to refuse treatment. The patient may decide, based on her right of privacy, whether the quality of life gained would justify further treatment. The court found that Bouvia's motives should have no bearing on its decision, and it ordered the tubes removed. She is now surviving on a liquid diet.

PHOTO BY FRANK L. SEA BANGS PHOTO

## GUIDE TO THE LIVING WILL

To get a copy of your state's living will you have to ask, request one from your hospital, nursing home, physician, lawyer or state government or write to the Society for the Right to Die, 250 West 57th Street, New York, New York 10107. Filling out a living will should not in any way affect the provisions of your life insurance policy.

Thirty-eight states and D.C. have living wills. All the remaining states (KY, MA, MI, MN, ND, NE, NJ, NY, OH, PA, RI, SD) are considering living will law statutes. Living wills are binding only within state boundaries, but some states honor those from elsewhere. If your state does not have a living will or if you are traveling, you can get a generic form from the Society for the Right to Die that you can use to express your wishes, though it may not be binding. Keep a copy of your living will on file with your next of kin, lawyer or physician.

Except in CA, where they must be renewed every five years, living wills are effective until they are revoked. Still, it's considered a good idea to initial and date your living will every few years to show that it still expresses your wishes.

"Life-sustaining procedures" are those that only prolong the process of dying. Most states include feeding and hydration tubes in this definition. But CO, CT, GA, ID, ME, MD, and WI specifically rule them out, though courts in CO have affirmed a patient's right to have feeding tubes disconnected.

"Imminent" is used on many living wills to express the inevitability and timing of death, but it is open to varying interpretations. A recent VA court decision found that it does not necessarily mean "immediacy, at once, within a few days," and that a comatose person who is within a few months of death falls within the definition.

Except in CA, ID, and OR, living wills have a space to specify treatment you do or don't want. Ask your physician what to include here.

- You can:
- ask for or prohibit use of artificial feeding tubes, cardiopulmonary resuscitation, antibiotics, dialysis, and respirators;
  - ask for pain medication to keep you comfortable;
  - state whether you would prefer to die in the hospital or at home;
  - designate a proxy—someone to make decisions about your treatment when you are unable;
  - donate organs or other body parts.
- If your directions are contrary to state law they will be ignored, but the rest of the document will stand.

You can revoke or amend your living will at any time simply by making a statement to a physician or nurse or other health care worker.

TEXAS

### DIRECTIVE TO PHYSICIANS

Directive made this \_\_\_\_\_ day of \_\_\_\_\_ (month, year). I, \_\_\_\_\_ being of sound mind, wishfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have an incurable condition caused by injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my attending physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

Other directions: *(See reverse side for suggested Proxy Designation form.)*

This directive shall be in effect until it is revoked.  
I understand the full import of this directive and I am emotionally and mentally competent to make this directive.  
I understand that I may revoke this directive at any time.

Signed \_\_\_\_\_  
City, County, and State of Residence \_\_\_\_\_

The declarant has been personally known to me and I believe him/her to be of sound mind. I am not related to the declarant by blood or marriage, nor would I be entitled to any portion of the declarant's estate on his/her decease, nor am I the attending physician of the declarant or an employee of the attending physician or a health facility in which the declarant is a patient, or a patient in the health care facility in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his/her decease.

Witness \_\_\_\_\_ Witness \_\_\_\_\_

In some states a physician who will not carry out a patient's wishes must make a "good faith effort" to locate a doctor who will; other states require the physician to actually find someone and specify penalties—in some cases jail terms—for failure to do so.

In AZ, CO, ME, TN, VA, DC, LA, NM, NC, OR, VT, WV the living will is valid for pregnant women. Others exclude women during all or part of their pregnancy, although that has been challenged on the grounds that a woman's right to privacy doesn't end when she becomes pregnant.

Eight states (AR, DE, FL, LA, TX, UT, VA, WV) provide for the appointment of a proxy. In CA, RI, IL, ME, and NY, decisions may be delegated through a document called a Durable Power of Attorney. These forms are commonly used instead of living wills in RI, which has no living will law, and CA, whose law is extremely restrictive.

In HI, ID, NH, NC, OK, SC, TN, WV your signature must be notarized. Elsewhere, the signature of the witnesses is adequate, although if you are in a hospital or nursing home in some states you may need as an additional witness the chief of staff or medical director.

# Patients' Rights



**M**Y DOCTOR put me on a beta blocker," a friend told me last week. "I hate the side effects, but I couldn't argue with him." Many, perhaps most, patients feel that way; they don't really have much say in the matter. Yet, according to a famous New York Court of Appeals decision in 1914, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." A doctor who does anything to the patient without consent can be sued for having committed battery, malpractice and civil-rights violations (unless the patient is incapable of giving consent).

In other words, you and I have certain rights we should know about — and, when necessary, insist upon. Here, then, is a bill of patients' rights.

## The Right to Choose Your Treatment

First, you have a right, established in a series of landmark cases, not to have anything done to you without your informed consent. Nevertheless, 50 percent of doctors polled by a Presidential commission take that to mean no more than informing patients about their condition and treatment; they ignore the consent.

Still, you have an absolute right to reject the recommended treatment and ask for another. Does that mean you can require a treatment the doctor doesn't believe in? Most experts say no. As Daniel Callahan, head of the Hastings Center of bioethical studies, says, that would deny the doctor his rights.

Can a doctor simply refuse to take care of you if you reject the recommended treatment? Generally not. A doctor who fails to continue to provide care until you are accepted by another physician can be charged with abandonment and sued for malpractice. (You might have to tell this to the doctor.)

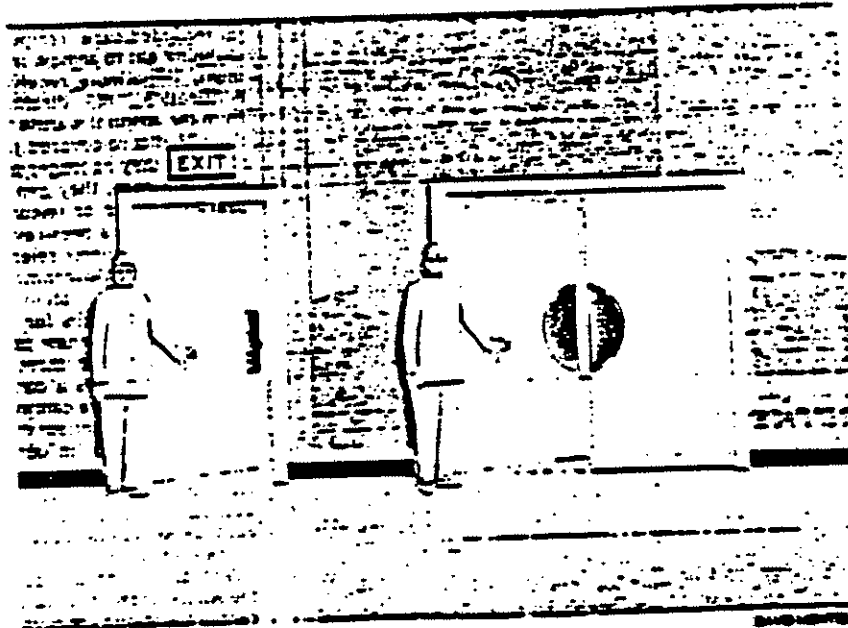
Even in a hospital, you can say no to X-rays, laxatives, excessive probing and puncturing of your body. Few have the courage to do so. A 1983 study found fewer than five patient refusals of any procedure during the course of 100 days of patient treatment. As Prof. Vincent Barry of Bakersfield College says, patients "are inclined to act in ways they think will please the doctors and nurses."

The right of refusal extends to hospitalized mental patients: 43 states have laws giving them a qualified right to reject antipsychotic medications, many of which have serious side effects. In most cases, patients must ask a review board to find that they are mentally competent to decide.

## The Right to See Your Records

The right of informed consent implies a right to know the truth.

Learning this may mean more than asking the doctor



questions; it may necessitate seeing one's medical records — X-rays, lab reports, other data. But doctors and hospitals have traditionally refused to let patients see such records. Not until 1984 did the American Medical Association say that doctors should make them available to patients on request. However, 15 states patients now have a specified legal right to see doctors' records, and, in 23 states to see hospital records. Still, a patient may have to fight for that right. Dr. Sidney Wolfe of the Public Citizen Health Research Group, says, "It is much easier to obtain copies of our C.I.A. or F.B.I. files than to get our medical records."

Doctors justify withholding records on the ground that it often confusing or harmful to patients to know the facts. In four recent studies found to seeing records had most favorable effects. Even the news is terrible.

## FREEDOMS

Freedom to ask questions.

Freedom to see records.

Freedom to demand emergency treatment.

Freedom to demand politeness, respect.

Freedom to say no to X-rays, laxatives, excessive examination.

Freedom to ignore advice.

Freedom to demand that care continue.

Freedom to have control between heart arrest.

Freedom to refuse medication.

Freedom to die.

10 eminent doctors recently declared in *The New England Journal of Medicine*, "The anxiety of dealing with the unknown can be far more upsetting than the grief of death with a known, albeit tragic, truth."

## The Right to Considerate Care

This is the very first item in the American Hospital Association's recommended (but not legally binding) *Patient's Bill of Rights*, published in 1973. But, 10 years later, many patients are subjected to inconsiderate and disrespectful treatment, such as unnecessarily long waits in the doctor's office or being told to undress in an inner office and wait. It is annoying to be seen by the doctor when checking out paper given around one's examination. Some doctors still treat patients like children. My wife described her symptoms one specialist in medically precise terms, to which she smartly replied: "Let's not use fancy words. Why don't you just call things by their everyday names?"

Experts agree that there is usually no way to force medical professionals to be considerate and respect you can only walk out. But in a few specific areas, the right is enforceable.

In hospitals, says John Robertson of the University of Texas Law School in "The Rights of the Critically Ill," the patient objects, medical and other hospital personnel not connected with the patient's case may not enter the room to observe. (Teaching hospitals may be an exception.) The patient's right here stems from the basic right to privacy, which also makes the doctor-patient relationship confidential; generally, a doctor can be sued for revealing medical information about a patient without the patient's consent. (An exception is made in many states when conveying the information is necessary to protect others from contagion, crime or other harm.)

## The Right to Hospital Treatment

Congress has recently taken steps to combat "a

Merton Hunt writes frequently about medicine.

lished system of positive law. Our exposition of the case of David is thus borne out by Maimonides' conception of the law.

I should like now to add the following: We do not intend here to present an historically correct interpretation of the case of David. I am well aware that at the time of David the law may have been different, and David did not have to follow the law as it evolved at a much later period. Our intention is merely to present an existentially correct picture of the legal case of David as it has been understood by the existing legal tradition. Jewish law was an existing and living force in Israel and underwent a long process of development, but it always attempted to present new ideas and conceptions as if they had existed previously. Our exposition of the legal aspect of David's reaction in the light of the legal tradition as developed later is meant merely as an existential interpretation of the living legal tradition and its relation to the case of David.

Thus, in the light of our understanding of Jewish law, an act of euthanasia is to be considered a violation of the commandment "Thou shalt not kill." Therefore, the Amalekite's slaying of the dying Saul was an offense against this commandment. For an act of euthanasia, however, there can be no capital punishment. Since the murdered person is deficient and not whole, the principle of "nefesh tachat nefesh" cannot be applied. In the light of modern medicine, so it seems to me, there should be no difference in this respect between terefa and gozes, for both have organic deficiencies. David, however, meted out capital punishment for an act of euthanasia on the basis of political considerations and in the interest of the State, just as he deviated from the legal procedure for the sake of preserving the unity of the State.

Rabbi Israel Bettan: The discussion has taken a peculiar turn. The committee was instructed to study the question from the Jewish point of view. The committee has fulfilled its task. I am rather startled to find teachers of religion bemoan the fact that religious idealism comes too high. Idealism has always called for sacrifice and painful struggle. Martyrdom is a most frightful price to pay for a religious ideal, but the martyr was a man who placed a very high valuation on his religious ideals. You and I are not called upon to be martyrs, but as religious teachers, we are committed to the principle that no cost is too high to preserve a religious ideal. All your committee asks you to do is maintain that attitude. We as religious

teachers ought to have the courage to say: This is where we have stood for two thousand years and this is where we intend to stand.

#### 79. EUTHANASIA (1980)

QUESTION: A patient has terminal cancer and has sunk into a deep coma. Only the artificial life support systems are keeping him alive. Would Jewish tradition permit these systems to be shut off? What is the Jewish attitude toward euthanasia? (Dr. N.H., Philadelphia, Pennsylvania)

ANSWER: Jewish tradition makes a clear distinction between, on the one hand, positive steps which hasten death, and on the other hand, avoiding matters which may hinder a peaceful end to life. It is clear from the Decalogue (Ex. 21:14; Deut. 5:17) that any kind of murder is prohibited. The only Biblical case of euthanasia was King Saul (I Sam. 31:1ff; II Sam. 1:5ff), who asked his servant to slay him after his own attempt at suicide failed (II Sam. 1:5ff).

In the Tannaitic period, the Mishnaic tractate Semachot (1.1) considered a dying person (goses) as a living individual in every respect. That point of view has been followed by later codes such as Maimonides' Yad and Caro's Shulchan Aruch. It is clear from the Mishnaic statement that none of the acts usually performed upon the dead should be done to the dying, nor should a coffin be prepared or matters of inheritance be discussed. The additional later discussion made it clear that no positive acts which may hasten death were to be undertaken, so the Sefer Chasidim (723) stated that an individual should not be moved to a different place even if that might make dying easier.

It is further quite clear that we must use any medicine or drug which may help an individual. All Shabbat laws may be trespassed to save a life (Yoma 85a; Sh.A., Orach Chayim 196.2, 319.17; Ex. 31:14; Lev. 18:5), and even the death of an individual who is seriously ill should not be hastened (Sh.A., Yoreh Dea 339.1). In all these instances, some vague hope remained. However, these injunctions were modified with a dying individual (goses) in the throes of death. In that case, it was considered appropriate for an individual to stop praying for the lives of those dear to him or pray for their release (Ket. 104a; Ned. 40a; Rema to Sh.A., Even Ha-ezer 121.7 and Choshen Mishpat 221.2). Furthermore, it was thought appropriate to stop acts

ides believed that he had reached the pinnacle of the science of medicine; therefore, his medicine is part of Halacha. Our medicine would accordingly be part and parcel of our Halacha. In this respect, we will have to modify the law, but it will be a change in the letter of the Halacha for the sake of preserving its spirit. And Maimonides would subscribe to our medicine which is the result of a higher development of scientific thought. Consequently, the distinction between goses and terefa does not apply to us, and the former will have to be treated in the same manner as the latter. In this respect, there is room for development, and the application of Talmudic-Rabbinic law to our times should be brought up to date in agreement with the latest development of scientific thought, for even Maimonides would agree that our present-day medicine should serve as the basis of the law, and not his medicine, which is out of date. But while we will have to identify terefa and goses, it means only that there is no consequent punishment for an act of murder in both cases; but the law "Lo tirtsach" ("Do not murder") which prohibits the act of cutting short a life which has in it the potentiality of creativity, obtains with regard to terefa as well as in respect to goses.

With reference to Dr. Freehof's statement on the law that a person who takes life away from the terefa does not suffer the consequences of capital punishment, but still has to render an account before God, I would suggest the following definition of the legal basis of the law. Taking life away from a terefa is an offense against the commandment, "Thou shalt not kill," for which, however, there is no consequence of capital punishment, since the murdered person is deficient and not whole. The law of "nefesh tachat nefesh" ("a soul for a soul") cannot be applied. For there are two aspects governing the case of murder. There is first the principle of "a soul for a soul," which does not apply in the case of the murdered person being a terefa (and, in our view, also in regard to a goses), and there is no capital punishment involved. Then there is the ethical-religious principle expressed in the commandment "Thou shalt not kill." This law is valid even in relation to a terefa and goses because of the potential activity of human life, the value of which is absolute, independent of the time element involved, and cannot be measured by the criterion of time.

I should now like to refer briefly to the Biblical story of King Saul and David's order that the Amalekite be killed for his slaying of Saul, which has a bearing on Saul had thrown himself upon his sword and

yet David ordered capital punishment for this act of an Amalekite. This is contrary to Jewish law as explained above. The solution to this difficulty seems to be this: David's reaction to the Amalekite's report of his slaying of King Saul was motivated by political consideration, and he acted in the interest of the State. David had to show indignation at the slaying of Saul, thus dissipating any suspicion of his disloyalty to Saul which might arise in the mind of the people. In order to preserve the unity of the State and his kingship, David had to show loyalty to Saul, as is evident from his remark: "Wast thou not afraid to stretch forth thy hand against the Lord's anointed?" (II Sam. 1:16). It was thus an act of statesmanship on the part of David; it cannot therefore serve as a basis for the legal consideration of our problem.

As a proof to the correctness of this interpretation of David's act, I would like to point out another difficulty in the legal aspect of David's reaction. David meted out capital punishment on the basis of the Amalekite's confession, saying: "Thy blood is upon thy own head, for thy mouth has testified against thee," which is contrary to Jewish law, that capital punishment can be meted out only on the basis of testimony of witnesses and not on that of confession (Sanhedrin 9b). Maimonides solves this difficulty by establishing the principle that a king is entitled to accept self-confession as sufficient evidence (Mishot Sanhedrin 18.6). And just as David was entitled to deviate from the law with regard to confession, so we may conclude that he was entitled to ignore the fact that Saul was a dying man and, according to law, no capital punishment is involved in such a case.

That a king is permitted to deviate from the law does not mean, however, that a king stands above the law and is not subject to it. Only in cases of national emergency is the king entitled to deviate from the law (Maimonides quotes the law of the Mishna [Sanhedrin 2.4] that a king is entitled to break a way through anybody's property without interference and comments that it refers only to time of war). It may seem at first thought that there is a contradiction involved in Maimonides. As it clearly follows from his exposition of the law in Mishna Sanhedrin, a king is subject to law and bound by it, and yet with reference to David's acceptance of confession as sufficient testimony, Maimonides declares that a king is entitled to deviate from the law. This apparent difficulty dissolves itself on the basis of our explanation that David acted in the interest of the State. It was a case of national emergency where the king can make his own law and deviate from the estab-

euthanasia, must be a question on which there is no set certainty as to where the truth lies. You cannot dispose of the problem of euthanasia by calling attention to the abuses which occurred in Germany. If we were to judge moral questions by the possibility of abuse, there is hardly any type of injunction which would stand. It is not true that society stands upon the principle that human life is completely sacred. As long as there is capital punishment in a state, that is an obvious exception to such a rule. I happen to be opposed to capital punishment; the trouble is that many of the religious bodies which put down as an absolute principle that human life can never be taken also sanction capital punishment. Even in our own tradition, capital punishment is sanctioned in many cases, which obviously constitutes an exception to the general moral rule which Rabbi Netan enunciated. It is not a question of whether there is a place for suffering. The question is what shall be done with people where medicine is as certain today as it can possibly be that there is no chance for their survival. It is the custom today in the case of people who are dying of some incurable disease to induce unconsciousness with some of the drugs that are available. In effect, those people die long before the actual cessation of life. It seems to me that it would have been wise to submit simultaneously with this report a statement as to the moral status of this problem today, and I hope that we will take no action at the present moment.

#### Opinion of Dr. Samuel Atlas

The two previous speakers have placed the problem of euthanasia on a purely moral and religious basis, so I would like to point out that apart from the legal aspect there is a philosophical question involved. When we speak of euthanasia, the question actually depends upon our attitude towards life: What is life? Can life be measured from the point of view of suffering and balancing the suffering with pleasure--the suffering of the patient and the suffering of those nearest to the patient against the amount of pleasure they had seeing their dearest one still living? Now, on the basis of a certain philosophy of life, as well as from a Jewish point of view, life cannot be measured in such terms. A Jewish thinker has said that "Life is more than mere living," the implication being that while the life of species other than man is a merely biological function, human life implies something more. It is the element of creativity which is the distinguishing mark of human life. A person is ill and about to die, and the idea

of repentance arises in that man's mind, that is worth more than an eternity of static existence. It is sufficient to recall the statement in *Pikrei Avot* that one hour of repentance is worth more than the whole future life. Why is one hour of repentance worth more than the whole future life? Is it because of the consideration that repentance is an act of creativity, and one hour of creative life is worth more than an eternity of static bliss? Consequently, it is wrong to deprive a hopelessly sick person of the opportunity for repentance which may arise in his mind. No man or doctor can decide that issue. And euthanasia cannot be justified on the basis of such a concept of human life.

As to the Halacha, if I may say a word on that, it has been pointed out that there is a distinction between *terefa* and *goses*. According to Jewish law, if one murders a *terefa*, there is no consequence such as capital punishment which is due to all murderers, but a *goses* is considered a normal human being with all due consequences. *Goses* means a person who is dying a natural death; *terefa* means a person in whose organs there is a deficiency. Here is a place, to my mind, for a change in the Halacha, which would be in the spirit of the Talmudic Halacha, for I am convinced that the Talmudic Halacha is so flexible that it can be made a living force and compatible with modern scientific concepts of medicine. The Halacha in itself demands an adjustment of certain elements in it which are the result of scientific conceptions of an older time no longer compatible with modern scientific developments. Only in this way could the Halacha be made existential, and a guide for life. The very meaning of the word Halacha implies a way of life, as it is derived from the Hebrew verb meaning "walking." Now, according to modern scientific conceptions of medicine, the distinction between *terefa* and *goses* has no validity whatsoever. A *goses* means one who dies a natural death; but what is natural death in medicine today? While the ancients thought that no organic change occurs in the body of a person dying a natural death, modern medicine maintains that the cause of death is always, even in the case of a very old man, the result of some deficiency in some of his organs. Consequently, there is no distinction between *goses* and *terefa*.

Maimonides, in the beginning of his Code, in *Sefer Hamada*, has a section dealing with medicine. You will ask, how does medicine come into a code? The reason is simply this: medicine is closely connected with law. Since there is a commandment in the Torah to preserve life, medicine is a part of that commandment; for in order to preserve life we must know medicine. Maimon-

expresses the same principle. A woman was dying of some lingering disease, and her husband and son were trying by every means--including prayers in the synagogue--to keep her alive. She called them to her bedside and said that she was grateful for their efforts, but asked that they please refrain from such prayers because her life was no longer bearable. The rabbi was asked whether this would be permitted, and he answered that to refrain from praying is permitted, but that nothing positive could be done to shorten her life. The law in Shulchan Aruch states that you may not even move a pillow from underneath the head of a dying person in order to hasten his death. Hence the Conference committee is perfectly justified in saying, "You may refrain from doing anything that will prolong a miserable life," but to do something to terminate life is forbidden by Jewish law.

Rabbi Dudley Weinberg: I merely wish to ask some questions, the answers to which should be included with the responsa. I wonder about the latter part of the passage regarding the death of Rabbi Chananiah ben Teradion.

In that case, the executioner offered to make his death easier and speedier by building up the flames and removing some protective tufts of wool from vital areas of his body. Rabbi Chananiah agreed that if the executioner did these things, he would be admitted to the Olam Haba. After taking these steps, which hastened the death of Rabbi Chananiah, the executioner leaped into the flames and perished. The text then states that a bat kol declared that the executioner had been admitted to the Olam Haba, thereby giving approval to his action.

Is it not also necessary to deal with the passage which states, if memory serves me correctly, that "Hakol modim shehahoreg et haterefa patur"? It seems to me that the passage is relevant to the discussion.

Rabbi Israel Bettan: The passage you refer to is correct. Chananiah would not inhale the fire to hasten his own death, but he allowed the executioner to remove the sponge from his heart. The sponge, keeping him alive, was an artificial means which could be removed, but nothing of a positive nature would be permitted. The other reference is not quite relevant. We are not discussing the question as to whether, if a man kills one who is about to die, he should be legally punished. The Talmud decides that the death sentence cannot be imposed upon him, but Haimonides is of the opinion that while an earthly court can impose such a penalty, the man stands condemned in the eyes of God.

Rabbi Jonah B. Wise: The question of euthanasia today is not one that can be discussed on the basis of the opinion of one who lived in Smyrna in the 17th century or of our distinguished Rabbinical predecessors in Talmudic times. The moral question involved has, of course, been discussed by Dr. Bettan, but the world has progressed since that time; conditions have changed. The advances in human knowledge, which I am sure our distinguished Halachists would have recognized, are a very important factor in making a decision. It is entirely possible that had these Rabbis been aware of the circumstances which confront us, they would have changed their attitude. They passed no real legislation; the references are not to cases in which the practice of euthanasia was discussed. We have any number of records in Jewish history of Jews who took their own lives and were not thereby put into the class of those who committed immoral acts. During the Roman Wars, many committed suicide rather than fall into the hands of the Romans. They were not criticized either in the Talmud or in any other subsequent literature. During the Middle Ages, many Jews killed their wives and children rather than have them fall into the hands of the Crusaders. I believe we should very carefully weigh our decision before we act on the paper which has been presented. The paper is of great interest, but the conclusions to which it comes, and the decisions which it asks us to make, are not the kind which the Central Conference of American Rabbis should present to the American public. The time may come when we may decide that euthanasia is undesirable or immoral, but that time is not yet here. Euthanasia is not practiced in the United States; it is not legal in any of our states. The Central Conference of American Rabbis is probably the most liberal body of religious leaders in the world today, and for it to base a decision on the argument brought by Rabbi Bettan would be extremely unfortunate. I therefore hope that the report will be received with thanks, but that it will not in any way be approved as the decision and policy of this progressive body of men.

Rabbi James G. Heller: I sincerely hope that the Central Conference of American Rabbis will not take action today on this subject. Though I think there is no controverting the historical side of the report, I do not believe that the treatment that was accorded to the question as a moral issue in our day measured up to the factual side of the statement in regard to Jewish sources. It is quite obvious to me that a matter upon which there is a deep division of opinion among people who cannot be ranked with Adolph Hitler in regard to



ond century, was condemned by the Romans to be burned at the stake, his disciples counseled him, as the fires began to flare, to let the consuming flames surge into his frame and thus put a speedy end to his suffering. In reply, the celebrated martyr is reported to have said: "It is best that He Who hath given the soul should also take it away; let no man hasten his own death" (Avoda Zara 18a).

Both of these statements, while seemingly made in casual manner, were by no means the stray utterances of individual teachers; they sprang from a common ethical tradition. They are closely related to a principle of faith that lies at the foundation of Jewish ethics. Human life is more than a biological phenomenon; it is the gracious gift of God; it is the inbreathing of His spirit. Man is more than a minute particle of the great mass known as society; he is the child of God, created in His image. "The spirit of God hath made me," avers Job in the midst of his suffering, "and the breath of the Almighty gives me life" (Job 33:4). Thus, human life, coming from God, is sacred, and must be nurtured with great care. And man, bearing the divine image, is endowed with unique and hidden worth and must be treated with reverence.

This principle--which is basic to Judaism, and to which we probably owe whatever spiritual progress there has been made through the centuries--finds clear embodiment in the Halacha, in Rabbinic law. The Rabbis were no inflexible legalists; they recognized that not under all circumstances could we condemn unfeelingly the man who chose the way of self-destruction to escape from his hard lot. Yet in formulating the law, they proved uncompromising. The formal rites of mourning, they declared, shall be suspended in the case of one of sound and mature mind who deliberately and of his own volition has laid violent hands on himself; only those rites may be performed the omission of which would give undue offense to the bereaved family (Semachot 2.1-5). Likewise, in the case of one who is in dying condition, the law prohibits anyone else from employing any positive and direct means to hasten his death, no matter how what protracted an ailment he may suffer (Yoreh Dea 339). To abridge in some positive and direct manner the duration of life by a single second is tantamount to the shedding of blood (Shab. 151b).

Yet Rabbinic law sanctions the use of indirect and negative means to facilitate a peaceful death, such as the elimination of noise and the withholding of stimulants (Yoreh Dea 339; Avoda Zara 18a). In the eyes of those which may retard the natural process

may therefore be removed. Not so, however, when that which is withheld is a natural physical requirement and essential to sustain life. No nourishment, however little the amount required, may be denied a dying patient whose condition seems hopeless and his pain great, in order to hasten his death (Tel Talpiyot, Letter 42, vol. 30, 1923, Budapest).

Of course, we liberal rabbis have always claimed the right, in the interest of a progressive faith, to modify Rabbinic law and to remove what we regard as an obstacle in the advance of the spirit. And, indeed, we have eliminated many an old restriction which, though meant to safeguard Judaism, proved to obscure its essential nature. But we have never sought to nullify an effective Rabbinic implementation of a vital spiritual principle.

The Jewish ideal of the sanctity of human life and the supreme value of the individual soul would suffer incalculable harm if, contrary to the moral law, men were at liberty to determine the conditions under which they might put an end to their own lives and the lives of other men.

Israel Bettan

This report was received and referred to the Executive Board, by a vote of 109 to 56.

### Discussion

Rabbi Solomon B. Freehof: Dr. Bettan's report is in consonance with the main line of Jewish Halacha. The Halacha is never so absolutely consistent that exceptions or partial exceptions cannot be adduced. There is no question, however, that the distinction which Rabbi Bettan made is essentially correct, namely, that nothing positive must be done to shorten life. It is permitted to refrain from doing something positive to continue life when it seems insupportable. This is based upon the story in the Talmud telling that when Judah the Prince had such a difficult time dying and the Rabbis were gathered to pray for the continuation of his life, his beloved servant threw down some object from the roof to disturb their prayers so that they should not continue to pray to extend his unhappy life. I might quote a very interesting responsum by Rabbi Chaim Pallagi, Rabbi of Smyrna, who lived at the end of the 1700s, which

done gently, the objection of the Taz would be obviated. Perhaps it would be better still if the tubes were not removed at all until the patient were dead. There might also be some question if the intravenous feeding would be continued automatically until the physician gives a direct order that it be stopped. It would be less objectionable if it is the practice in the hospital to have each day's intravenous feeding kept up by the direct daily order of the physician, and if, on that particular day, he simply refrains from ordering it to be continued. Thus, in no way would he be taking any direct action. Here, then, the principle (Eruvin 100a) "Shev ve-al ta-aseh adif" would certainly apply.

To sum up: if the patient is a hopelessly dying patient, the physician has no duty to keep him alive a little longer. He is entitled to die. If the physician attempts actively to hasten the death, that is against the ethics of Jewish law. In the case as described, the term used in the question, "to hasten death," is perhaps not correct, or at least should be modified. The physician is not really hastening the death; he has simply ceased his efforts to delay it.

Solomon B. Freehof

78. EUTHANASIA  
(Vol. LX, 1950, pp. 107-120)

QUESTION: At the convention of the Central Conference of American Rabbis, held in Kansas City, Missouri, 1948, the following resolution emanating from the Commission on Justice and Peace, was adopted:

This Conference notes that a committee of two thousand physicians in the State of New York has drafted a bill for presentation to the New York Legislature seeking to legalize the practice of orderly scientific euthanasia. We recommend that a special committee of the Conference be appointed to study this important question in the light of Jewish teaching and to bring in a report at the next meeting. (Yearbook, vol. 58, p. 129)

ANSWER: To carry out the mandate of this resolution, the President of the Conference appointed a committee consisting of the Committee on Responsa and Rabbis Abram V. Goodman and Leon Fram. This committee submits the following report.

Neither in its theoretical nor in its practical aspects does euthanasia present anything new. Among certain primitive peoples, as Westermarck has pointed out, some form of euthanasia has always been prevalent. In ancient Greece, euthanasia was countenanced in some city states, and in Sparta it was rigidly practiced by the state itself. Plato and Aristotle, we know, endorsed it in principle. In the Renaissance period, no less important a person than Sir Thomas More advocated the practice of euthanasia in its voluntary form. He made special provision for it in his Utopia. In modern times, during the brief rule of the Nazis, systematic euthanasia, involving the lives of the "useless" and the incurably ill, was authorized by the head of the State and prosecuted with customary ruthlessness (New Republic, May 5, 1941; Berlin Diary, William L. Shirer, pp. 454-459).

It is a curious but incontrovertible fact that the theory of euthanasia, even in its most restricted construction, has never invaded Jewish thought, though "sufferance is the badge of our tribe." In the history of our people, from remotest antiquity to days most recent, we come upon pages that tell of men in agony and despair turning to self-destruction for relief. We also read of men in high places counseling their followers, when faced with sure defeat by a cruel enemy, to welcome self-inflicted death rather than to submit to capture and disgrace. But nowhere do we encounter the suggestion that such examples merit praise and emulation.

The Bible, which affirms religious doctrine more often by implication than by direct command, leaves no doubt as to what the religious man's attitude toward a life of affliction should be. He will accept the lot apportioned to him. He surely will not tamper with the life given him. When Job's wife, herself prostrate at the sight of her husband's overwhelming affliction, cried out, "Dost thou still hold fast thine integrity? Blaspheme God, and die," Job indignantly replied, "Thou speakest as one of the impious women speaketh. What? Shall we receive good at the hand of God, and shall we not receive evil?" (Job 2:9-10).

Later, in the early Rabbinic period, the same religious temper was evidenced by a famous rabbi who suffered martyrdom for his religious convictions. When Chananiah ben Teradion, a Tannaitic teacher of the sec-

bound to force him to live a few more days or hours. This law is based on the famous incident in B. Ketubot 104a. Rabbi Judah the Prince was dying in great suffering. The Rabbits insisted on ceaselessly praying so that he might thus be kept alive a little longer. But his servant-woman (who is often referred to with honor in the Talmud) threw down an earthen jar from the roof of the house into the midst of the praying Rabbits, in order to stop their prayers so that Rabbi Judah might peacefully die. The Spanish scho'ar Nissim Gerondi (to Nedarii 40a, top) says that while it is our duty to pray for a sick person that he may recover, there comes a time when we should pray for God's mercy that he should die. So, too, Sefer Chasidim (#315-318, edition Frankfurt)-- basing its opinion on the statement of Ecclesiastes, "There is a time to live and a time to die"--says as follows: "If a man is dying, we do not pray too hard that his soul return and that he revive from the coma; he can at best live only a few days and in those days will endure great suffering; so there is a time to die." (See other such references in Reform Response, pp. 117ff). In other words, according to the spirit of Jewish tradition, just as a man has a right to live, so there comes a time when he has a right to die. Thus, there is no duty incumbent upon the physician to force a terminal patient to live a little longer.

But what, under these circumstances, is a physician permitted actually to do? Here again the law is clear. He may do nothing positive to hasten death. The Mishna (in Shabbat XXIII.5) says that we may not close the eyes of a dying patient. The Talmud (Shabbat 151b) compares the dying patient to a guttering candle that is about to go out. If a man touches his fingertip to the candle flame, it will go out at once. This he must not do. In other words, he must not hasten the death of a dying patient by closing his eyes. The Talmudic discussion is elaborated on in the post-Talmudic treatise, Semachot, chapter 1, and finally is codified in the Shulchan Aruch, Yoreh De-a 339, where it is clear that no action must be taken to hasten death, i.e., you may not remove a pillow from under his head. However (see Isserles, ibid.), if someone outside is chopping wood and that rhythmic sound focuses the mind of the dying patient and prevents his soul from departing, you may stop the wood-chopping so that the patient may relax and die in peace. Or, if there is salt on the patient's tongue and the tartness of the salt focuses his mind and keeps him from relaxing into death, you may wipe the salt from his

tongue and thus allow him to die. The Taz expresses some doubt about the permission to wipe the patient's tongue, for that would shake and disturb the patient and would be an overt act.

The fullest discussion as to what is a permitted act and what is a non-permitted act is found in Shiltei Hagiborim (Joshua Roaz) to Mo-ed Katan, third chapter (in Milin edition, Alfasi, 16b). He concludes that while you must not do anything to hasten death, you may remove the causes of the delay of death. He bases his discussion upon the Sefer Chasidim (edition Frankfurt, #315), which says: "We may not put salt on his tongue in order to prevent his dying." And so Isserles in the Shulchan Aruch (loc. cit.) sums up what is permitted and what is not permitted by saying that such things are permitted "which do not involve action at all, but merely remove that which hinders the death."

All this brings us to a clearer understanding as to the limits of freedom of action of the physician in relation to the hopelessly dying patient. He may not take any overt action to hasten death, such as giving him, perhaps, an overdose of an opiate, but he may refrain from doing that which will prevent his dying. Of course, in this case, if he ordered the removal of the intravenous apparatus, there may be some ground for objection if the removal of the apparatus was a rather forcible procedure and shook up the patient. But if, for example, the removal of the apparatus was so gentle as not to disturb him, it would be like the wiping off of the salt on his tongue, which Isserles permits. If he does not even do this, but merely gives the order that the bottle containing the nutriment not be refilled when it is emptied out, then, too, he committed no sin at all. He is merely, as the law says, preventing that which delays the death.

We have mentioned that Isserles states (in Yoreh De-a 339.1) that one may remove that which prevents the person from dying, and thus, one may stop someone who is chopping wood outside because the regular sound concentrates the patient's mind, and one may also remove some salt from his lips. The Taz objects only to wiping away the salt from the lips, because this action might move or shake the patient, and this would be an overt action hastening his death.

On the basis of this objection of the Taz, there might be some question, as we have mentioned, about removing the tubes from his arm through which the intravenous feeding enters his body. Of course, if this is

would, therefore, see no objection to relieving the suffering of the woman who is dying from cancer and for whom the drugs are not life threatening.

It is clear that in each of these cases, and in others like them, we should do our best to enhance the quality of life and to use whatever means modern science has placed at our disposal for this purpose. We need not invoke "heroic" measures to prolong life, nor should we hesitate to alleviate pain, but we can also not utilize a "low quality" of life as an excuse for hastening death.

We can not generalize about the "quality of life" but must treat each case which we face individually. All life is wonderful and mysterious. The human situation, the family setting and other factors must be carefully analyzed before a sympathetic decision can be reached.

December 1985

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CENTRAL CONFERENCE OF AMERICAN RABBIS  
AMERICAN REFORM RESPONSA

77. ALLOWING A TERMINAL PATIENT TO DIE  
(Vol. LXXIX, 1969, pp. 118-121)

**QUESTION:** A terminal patient was dying as a result of a series of strokes. Two physicians, one of whom was the patient's son, decided--with the consent of the family--to hasten the end by withdrawing all medication and fluids given intravenously. Is such procedure permitted by Jewish law?

**ANSWER:** This is a complex question and, therefore, is not quite clear in the law. However, there is enough in the legal literature to permit us to arrive at a conclusion.

First, let us dispose of a secondary question. It is not altogether irrelevant that one of the physicians, a noted surgeon, was the son of the patient. There is a great deal of discussion in Jewish law as to the relationship between a physician and a patient who is his father. There are many responses which--even nowadays--discuss the question whether a son who is a surgeon may operate on his father.

The basis of this legal debate is Exodus 21:15, which states that he who smites his father must be put to death; and the law is that "smiting" is not considered so grave a sin unless it creates a wound. Therefore it is the creating of a wound on the body of one's father which is considered a grave sin. Hence the Mishna (Sanhedrin XI.1) and the Talmud (Sanhedrin 84b) discuss whether a son may perform the operation of blood-letting on his father as part of his work as a physician, or make a wound on his body. This is discussed by Maimonides in Yad, Hilchot Mamrim, V.7, and in the Shulchan Aruch, Yoreh De-a 241.3. In the Shulchan Aruch, Caro states the law that a son may not operate on a father, but Isserles says that if there is no one else available for the operation, he may do so. Isserles bases his opinion on the opinion of Maimonides (loc. cit.). This would be the general conclusion of the law. All this, of course, is incidental to our question.

The real question is: What is the limit on the freedom of action of a physician with regard to a dying patient? By "dying patient" we do not mean a patient who is in danger of death but only who can yet be healed. If, for example, a person has a heart attack and can be healed (as many are from one attack or even two), or if a patient has been rescued from drowning and can be saved with resuscitation (but if no resuscitation is given he will die)--such dying patients, all of whom have a prospect for recovery, must be given the full resources of medicine in the attempt to save them. One may even risk a remedy that might possibly kill them, provided there is a fair chance that the remedy might save them. Thus, the Talmud, in Avoda Zara 27b, says clearly that one may risk otherwise forbidden remedies (e.g., from a heathen healer) if the dying patient has a chance to be cured by the remedy. See the full discussion of this permission to risk death if there is a fair chance to cure in Shevut Ya-akov III.75 (Jacob Reischer of Metz, d. 1733).

But in the case under consideration we are not dealing with a dying patient who has a chance for recovery if given the proper medication. We are dealing with a patient with regard to whom all the physicians present, including his own son, agree that he has no chance for recovery. In other words, he is a terminal patient. What, then, are the limits of freedom of action of a physician with a terminal patient?

Is it the physician's duty to keep this hopeless patient (who is also in all likelihood suffering great pain) alive a little longer, maybe a day or two? Jewish law is quite clear on this question. He is not in duty

situation to minimally prolong life (S. B. Freehof, Modern Reform Responsa, #34 and #35). In most instances in which this has been discussed the terminal patient is no longer capable of making rational decisions and must rely completely on those who are providing treatment. In this instance we are dealing with an individual who has made her wishes known.

We may understand the role which the patient and the physician play in their inter-relationship by looking at the frequently discussed theme of treatment for illness overriding various religious obligations. It has long been permitted to violate the Sabbath laws not only in order to save a life but even for someone who is dying. (Yoma 84b; I. Lampronti Pahad Yitzhag Holeh B'shabbat, etc.) The general principle is that if either the physician or the patient believe that a treatment is required and there is some risk to life then the normal religious legislation is suspended. (Shulhan Arukh Oran Hayim 328.5, etc., and commentaries). The decision favored the patient who considered a treatment necessary even if a hundred doctors considered it not sufficiently urgent to override religious obligations, "because a heart knows its own bitterness". This and other discussions indicate that the patient is heavily involved in the treatments and not merely a quiet and subservient recipient.

In the instance of our patients proper persuasion

might have brought the widow to dialysis eight years ago. The fact that she lived eight years without dialysis at this advanced age may indicate that she choose the appropriate path for herself. Now as she is suffering from end stage renal disease as well as congestive heart failure, it is not a question of saving her life, but possibly prolonging it at the expense of her dignity and with some pain both physical and psychological.

This patient rejected dialysis while living independently at home; and should not have dialysis imposed upon her now that she is dependant upon the services of a nursing home. Her attitude has led to a full, long life. Additional medical attention which she does not wish should not be forced on her; it is only likely to shorten her life.

The physician has done his duty by suggesting the treatment. The patient who knows that she is close to the end of her life with or without the treatment and is not obliged to accept the suggestion.

Walter Jacob, Chairman

Responsa Committee

thinks that there is a reasonable hope for recovery (San 73a; A.Z. 27b; J. Reischer, Shevut, Yaakov, III, #85; Eleazer Waldenberg, Tzitz Eliezer, 10, #25, Chap. 5, Sec. 5; Moshe Feinstein, Igrot Mosheh, Yoreh Deah 2, #59; I. Y. Unterman, Noam 12, page 5; W. Jacob, ed., American Reform Responsa, Nos. 75, 76, 77, 79; W. Jacob, Contemporary American Reform Responsa, Nos. 77, 85). We have gone somewhat further and permitted a patient who understands the risks, to be part of a dangerous medical experiment in which the chances of recovery are slim (W. J., Contemporary American Reform Responsa #17).

Patients have certainly always been encouraged to use physicians and to follow the Biblical dictum "Heal yourself". Physicians have been held in high regard from early times onward. (Ben Sirah 38.1; Tobit 2.10, Micah, Exodus, Rabbah 21.7) See also I. Jakobovits, Jewish Medical Ethics, pp 201ff. On the other hand skepticism about physicians has also played its role in Jewish life; the Mishnah quotes R. Judah, "The best among physicians is destined for hell", (M. Kid 4.14). All of these sources establish the physicians duty to heal as well as the patient's obligation to maintain good health and to do whatever is considered reasonable to regain health.

It has been established that nothing positive may be done to hasten death even in a terminal patient, yet, there is also no obligation to intervene in a hopeless

#345 An Elderly Patient Who Refuses Dialysis

Question: An intelligent, articulate, eighty-three year old widow has renal disease which can be treated by kidney dialysis. She was diagnosed eight years ago and refused dialysis. Since then her health has generally deteriorated with a hip fracture, incontinence and heart disease. She has now entered a nursing home and suffers from end-stage renal disease as well as congestive heart failure. She has made it clear to her brother as well as those at the nursing home that she wishes no drastic treatments (CPR, mechanical ventilation, feeding tubes, etc.) but wants to die peacefully and without pain. One of the attending physicians feels a strong obligation to save this patient's life. He argues that he cannot let her die of renal kidney disease and wants to impose dialysis upon her. Should she be forced to undergo dialysis? What are her rights and obligations and what are those of the physician in this case. (Rabbi Dayle Friedman, Philadelphia, PA)

Answer: A good deal has been written about the obligations of a physician to heal. Our tradition from Talmudic times onward has encouraged the use of every possible medical procedure in order to save lives (The discussions were based on "He shall cause him to be thoroughly healed" (Ex. 21.20) and "You shall not stand idly by the blood of your fellow" (Lev. 19.16). Even risky procedures may be undertaken if the physician



To further re-enforce this view Justice Cardozo held that every person "of adult years and sound mind has a right to determine what should be done with his own body." (Schloendorff v. Society, N.Y. Hospital, 211, N.Y. 125, 129-Bd, 105, N.E. 92).

In Jewish law there is an overriding principle that enables an observant Jew to submit to the primacy of secular law when the halacha is in conflict with secular law. This principle is called dina d'malchuta dina, (the law of the land is supreme.) Therefore, the wishes of Mrs. H. M. cannot be followed, if we strictly follow the Court's reasoning in O'Connor. But, on the other hand, if the decision in the Matter of Storar is followed, her wishes should be complied with because she knows what she wants and is competent.

It is my suggestion that in order to reconcile the Court's decisions and halacha, Mrs. H. M. should write a "Living Will," expressly indicating which life-sustaining measures she does not want, specifically naming "dialysis." Thus, Mrs. H. M.'s wishes will be respected and the physician will not violate his professional responsibility, or be held liable for not treating Mrs. H. M.

Rabbi Bernard M. Zlotowitz

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I am thankful to Prof. Jane Kaplan of the City University of New York for bringing to my attention the decisions of the Appellate Court.

maid threw down an earthen jar, which distracted the Rabbis from their prayers and at that moment Rabbi Judah's soul departed from his body and he went to his eternal rest in peace. (Ket. 104a).

Though in our case death is not imminent, nevertheless our sources indicate that a person does have a right to refuse treatment. The physician is not required to give treatment to a patient who refuses it.

Incidentally, a recent New York Court of Appeals' decision held that a patient has to enumerate the life-sustaining measures which he or she refuses to have applied, in order to have a physician respect his/her wishes. Unless there is "clear and convincing evidence" of the patient to undergo dialysis, the doctor has a right to order dialysis treatments. "If there is error," the Court ruled, "in understanding the patient's wishes on the subject, it should be made on the side of life." (Matter of O'Connor, Oct. 14, 1988).

In other words, according to this recent decision, since Mrs. H.M. did not specify "dialysis," as the exact life-sustaining system which she refuses to have applied, the doctor has a responsibility to take over and administer treatment through dialysis. However, in another court case, the Matter of Storar, 1981, Court of Appeals decision, the Court held that "a competent adult has a common-law right to decline or accept medical treatments, a violation of which right results in civil liability for those who administer medical treatment without consent, despite the fact that the treatment may be beneficial or even necessary to preserve a patient's life, as the patient's right to determine the course of his own medical treatment is paramount to which might otherwise be the doctor's obligation to provide needed medical care; therefore a doctor cannot be held to have violated his legal or professional responsibilities when he honors the right of a competent adult patient to decline medical treatment." (Public Health Law ss2504, 2805-d; CPLR 4401-a).

QUESTION: Does an elderly patient have the right to refuse dialysis?

ANSWER:

We are dealing here with two conflicting moral and ethical imperatives. What is the patient's responsibility to life and what is the physician's responsibility to fulfill his oath regarding maintaining life.

The ailment (renal disease) of the 83-year old widow, Mrs. H. M., was diagnosed 8 years ago. Notwithstanding her refusal to undergo dialysis for her kidney condition, she is still alive. She doesn't want to suffer at her age the indignities of mechanical ventilation, feeding tubes, etc., that would be required. In addition, she may be concerned, though this is not indicated in the case study, with the side effects of the treatment, which can be as painful and harmful as the disease itself.

According to our rabbis, one should pray for the recovery of a person and do everything possible to preserve life. In fact, except in three cases (murder, idolatry and sexual offenses), preservation of life takes precedence over all other Jewish values (Sanh. 74a). One may violate the Sabbath to preserve life (Yoma 85b). But there comes a time when you have to let nature take its course (Nissim Gerondi-- to Nid. 40a).

Moses Isserles states that in the case of a dying person one is permitted to do such things "which do not involve action at all, but merely remove that which hinders his death." (Shulchan Aruch, Yoreh Deah 339:1). Thus, if we understood Isserles correctly, the doctor may not take overt action to hasten a person's death, but he can certainly refrain from doing that which will delay the death of an individual. The Talmud tells us that while Rabbi Judah the Prince was suffering an excruciating death, the Rabbis prayed to keep him alive. But in order to allow the Rabbi to die peacefully, Rabbi Judah's

requires us. (and Mrs. M.'s physician) to respect even choices which might seem to conflict with our understandings of the values of the tradition. As Reform Jews, we are called to respect individuals, and to enable them to make conscientious, autonomous decisions in the agonizing choices presented in dilemmas like that of Mrs. M.

the principle holds even more urgency in ethical matters, and especially for the question at hand. If one should have autonomy in making choices which affect only the manner in which one's very life and well-being are at stake? Who other than the individual could possibly claim authority here?

Our position in the case at hand is simple: Since she is the person who bears the burdens, benefits and risks of the various courses of action before her, Mrs. M. is the most appropriate person to decide whether or not to face these risks. Only she can appropriately weigh the Jewish values of preservation of life against these risks.

Lest this discussion be perceived to be heading down a "slippery slope" which leads inevitably to validating any choices, including suicide, it should be noted that respect for Mrs. M.'s autonomy does not bar her family, physician, or rabbi from engaging her in dialogue about her choice, or even from openly disagreeing with her. Certainly, her physician is not obligated to act in a way which violates his own sense of duty; if he cannot abide Mrs. M.'s choice, he can arrange for her case to be transferred to another physician. Moreover, permitting Mrs. M. to decline dialysis is not comparable to facilitating suicide, as she is not actively hastening her death, but rather desisting from staving it off. Her actions, if anything, are no more self-destructive than the person who smokes cigarettes or overeats while suffering from obesity.

What is being proposed here is that the value of autonomy must be a guiding principle in a Reform Jewish discussion of choices in medical ethics. In the instant case, based on the principle of autonomy, we would have to hold that the patient, a competent, mature adult, has made a decision which must be respected. We would hope that the decision which such a person had made would emerge from a confrontation with the values expressed in Jewish tradition, both Halakha and Aggadah. Ultimately, however, the principle of autonomy

Ethical decisions often become clarified when we examine the consequences of the choices before us. Imagine, for a moment, that Mrs. M. were compelled to undergo dialysis. To receive dialysis, Mrs. M. would be forcibly transported three times a week to a facility outside of the nursing home. Initially, she would undergo surgery to insert a catheter in her arm, a procedure which would almost certainly have to be repeated as the skin graft would break down over time. On each visit, she would spend two to four hours with a large-bore needle inserted in the catheter in her arm, during which time she might be nauseous and in pain. This would go on for the rest of her life. Her most likely cause of death would be complications from the dialysis, either heart attack or blood infection.

This scenario is most disturbing, as it depicts a violation of this individual's wishes, her privacy and her body. The sense that violating Mrs. M. in this way would be wrong is supported by the Reform Jewish principle of autonomy of the individual. In contrast to our heteronomous tradition, Reform Jews have held that individuals have a direct, personal relationship with God in addition to their relationship via the Jewish people's covenant with God. "Autonomy of the individual" is a principle explicitly affirmed in the statement, Reform Judaism: A Centenary Perspective. We Reform Jews champion the right of individuals to make choices regarding their own conduct, including the "right of conscientious dissent" from the dictates of tradition when mandated by individual conscience, or by individual understanding of contemporary circumstances (Borowitz, Choices in Modern Jewish Thought, p. 269). We reject imposition of specific choices from external authorities, either contemporary or historical.

Discussion of the value of individual autonomy in Reform Judaism has most surrounded matters of ritual observance. Autonomy has not been asserted as a factor in Reform writings on questions of medical ethics. However, it seems clear that

dumping" — turning away emergency cases by private hospitals and redirecting them to public ones if patients are uninsured or cannot guarantee bill payment.

New Federal laws governing Medicare and Medicaid provide that any hospital participating in such programs must accept and treat emergency cases, whether or not they have sufficient funds. Nearly all acute care hospitals do participate in Medicare and Medicaid.

In 1986, Medicare policy was modified to assure hospitalized Medicare recipients of their right to enough treatment. If patients receive a notification of discharge from the hospital stating that their Medicare-covered time is up and they no longer need in-patient care, they can appeal by writing or telephoning their state's peer-review organization, panels selected and paid by the Government.

If they appeal, Medicare must pay their bills for two more days; the review panel must reply within three. If the panel approves a continued stay, Medicare continues to pay; if not, the patient pays. And the patient with unpaid bills of \$200 or more has a right to appeal an adverse decision to a Social Security administrative law judge.

#### The Right to Die:

A recent poll conducted for the A.M.A. found that 73 percent of the public approves of withdrawing life-support systems from hopelessly ill or from irreversibly comatose patients if they or their families have requested it.

More leading doctors are writing in medical journals that maintaining the lives of such patients is cruel and that suspending treatment is morally justifiable.

In a number of court cases, patients or their representatives have won the right to stop unwanted treatment. Most important, in recent years legislators in 38 states and the District of Columbia have enacted laws granting patients some control over whether they are to receive life-sustaining treatment. Many of these laws are based on "living wills" — documents signed by patients while they are mentally competent, stating their wishes. Some laws permit a patient to execute a "durable

power of attorney," giving power to some trusted person to refuse treatment, on the patient's behalf, if he becomes incompetent.

Even without a living will or power of attorney, family members or other appropriate persons can in some states act for an incompetent patient by stating that, in their judgment, the patient would not have wanted to be kept alive in the present condition; or, if the patient's preference is not known, stating that it is not in the patient's best interest to be maintained on life-support systems. Despite law or precedent, if doctors or hospitals think the case is not clear-cut, they are likely to insist on sustaining life until the patient's family or lawyer gets a court order. Details of your state's laws or court decisions on the right to die can be obtained from most state health departments.

**A**NOTHER CRUCIAL step to insure this right: "Tell your doctor once a year if you really don't ever want to be on a respirator," says Fenella Rouse, director of legal services at the New York City Society for the Right to Die. "If you do care about your right to die, it's up to you to pursue it."

#### The Right to Ask Questions.

This is the simplest but probably the most important right, in the sense that it is the one the patient should energetically exercise most often.

It is hard to do so. Asking doctors questions implies that the patient has a right to share in the decision-making, yet a centuries-old tradition holds that "doctor knows best." Many doctors resent having their advice questioned, and many patients are afraid to question it.

Despite all that has been said and written about patients' participation in decision making, both the American Hospital Association's Patient's Bill of Rights and the A.M.A.'s judicial council hold that the doctor may withhold information when he deems it medically advisable. "Sick human beings," asserts Dr. Richard Sherlock, a medical ethicist, in *The American Journal of Medicine*, "want, often desperately, to entrust themselves and their care to the physician."

So the point must be re-emphasized: the law grants patients the right to understand their own cases. How much knowledge, how many questions does that imply? "What the patient has a right to, as established by many court decisions," says Prof. Robert Veatch of the Kennedy Institute of Ethics at Georgetown University, "is as much information as a 'reasonable person' would need to feel that he or she is capable of giving informed consent."

You need accept no less. ■

ADDITIONAL RESOURCES

1. A THEORY OF MEDICAL ETHICS  
Robert M. Veatch - Bass Books, New York  
"A Principle of Autonomy" p. 190 ff.
2. CCAR YEARBOOK - Vol. XCVI  
Personal Autonomy and Sense of Mitzvot  
Peter S. Knobel
3. THE QUINLAN CASE: A Jewish Perspective  
J. David Bleich  
  
JEWISH BIOETHICS  
Rosner and Bleich, Ed.  
Sanhedrin Press, New York, 1979
4. MODERN MEDICINE AND JEWISH ETHICS  
Fred Rosner, M.D.  
K'tav and Yeshiva University Press, New York, 1986  
"Heroic Measures to Prolong Dying," p. 289  
"Euthanasia"
5. HASTINGS CENTER FOR LIFE SCIENCES QUARTERLY  
Various articles and case studies on  
definition of death, euthanasia, etc.
6. ENCYCLOPEDIA OF BIOETHICS  
Kennedy Institute of Bioethics,  
Georgetown University