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Precedents for Hospice and Surrogate Decision-Making in Jewish Law

The modern system of hospice or palliative care for the terminally-ill is a relatively recent innovation on the medical scene. The first hospice, St. Christophers, was founded in London in 1967 by Dr. Cicely Saunders, an English physician, and the hospice movement has grown exponentially ever since.[1] The philosophy of hospice is to enable terminal patients and their families to accept death as a part of life, and thus make every remaining day of their lives together as meaningful and comfortable as possible. Hospice teams, consisting of a physician, nurses, social workers, and clergy, supported by nursing assistants, volunteers, and bereavement staff, offer the terminally-ill intensive pain management, symptom control, nursing care and a wide range of psychological and spiritual services. Families, too, avail themselves of the team's expertise to help cope with what is surely among the most traumatic periods of their lives. Central to the hospice philosophy is the belief that where the disease process is irreversible and dying is expected within six months, aggressive medical treatment to "cure" the patient is inappropriate, or futile, and the focus should shift to palliative or comfort care.

Jewish law or halakha projects a pervasively positive attitude toward the value of human life. Every moment of life has intrinsic worth, a Divine gift which is sacred[2] and dare not be terminated prematurely by euthanasia or physician-assisted suicide.[3] In Jewish law, patient autonomy and quality of life are not absolute values which automatically entitle any patient with capacity the "right" to refuse life-sustaining treatment based on his subjective perception of the quality of his existence. Traditional sources suggest that man does not own his body:[4] he has no

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rights to mutilate it by self-inflicted wounds;[5] to endanger it by engaging in harmful or high-risk behavior (e.g., smoking, sky-diving),[6] or to commit suicide.[7] Rather, man has obligations to preserve his life by adopting a healthy life style, seeking good medical care, and, of course, through prayer. Hospice, in contrast, declares that a terminally ill patient need not pursue aggressive medical treatment for an irreversible illness, where known interventions are generally futile and would diminish any quality of life for his remaining days. Indeed, a terminal patient may refuse even life-sustaining treatments such as resuscitation, artificial nutrition and hydration and dialysis. Would halakha, which values the preciousness of every second of life, permit a patient or surrogate to refuse life-sustaining treatment?

These issues frequently come to the fore in the long-term care setting of a nursing home. Under the Federal and New York State Patient Self-Determination Acts, adults with capacity or their appointed health care proxies have "the right to accept or refuse medical treatment, including life-sustaining treatment."[8] They are encouraged to specify their wishes about treatment in advance directives, through a living will or by appointing a health care proxy in written legal documents. In advance directives, patients may refuse CPR if they go into cardiac arrest, a respirator or chemotherapy, and other treatments and procedures. Nursing homes can establish religious policies or philosophies of care which require, for example, that all residents who are unable to be fed orally be placed on feeding tubes; thus, they can legally override an advance directive to refuse a feeding tube, but only if they clearly inform the resident/proxy of the home's policy upon admission and receive written acknowledgment that the resident/proxy is aware of same. If a home fails to inform residents, it may be subject to liability.[9] Consequently, some nursing homes, under Jewish auspices, have established their own policies regarding artificial nutrition and hydration, restricting residents' rights to withhold and certainly to withdraw feeding tubes. Since most halakhic authorities deem a feeding tube to be basic care, rather than a medical intervention, these homes advise residents/proxies that, when warranted, they must consent to a gastrostomy or become subject to discharge, upon dehydration, to a hospital or to another nursing home that will honor their wishes.[10] Is such a policy consonant with hospice, which, in most instances of end-stage terminally-ill patients, regards artificial nutrition and hydration to be a proactive, restorative intervention, rather than a palliative measure? In this setting, would a hospice program be appropriate?

Finally, all heath care facilities are dutibound to honor the decisions of duly-authorized health care proxies on behalf of a patient who no longer has the capacity to make medical decisions for himself. The right of a patient with capacity to determine his future course of treatment, and, by extension, his surrogate to represent his wishes when he has lost capacity, is the essence of patient autonomy, a *sine qua non* of modern medical ethics.[11] Does halakha recognize patient autonomy and permit surrogate decision-making when the patient lacks capacity?

To address these critical issues, Mr. Pesach Konstam, Administrator of the Long Island Care Center, and the author met with Rabbi David Feinstein on August 20, 1998. The following is a memorandum summarizing the meeting, which was reviewed and approved by R. Feinstein:

MEETING SUMMARY

Issues Presented to Rabbi Feinstein:

1. Do nursing homes under Jewish auspices have a halakhic obligation to set policy affecting resident/surrogate decisions to refuse or withhold certain treatments or procedures (e.g., artificial nutrition-hydration, resuscitation, dialysis)?

2. May a nursing home under Jewish auspices contract with a private hospice to provide services to its residents?

Rabbi Feinstein's Responses:

1. A nursing home under Jewish auspices, whether proprietary or not-for-profit, is not obligated to establish policies and procedures which might affect the legitimate rights of the resident/proxy to chose their own course of treatment. Accordingly, a nursing home need not establish a policy whereby a resident/proxy must waive his/her right to refuse artificial nutrition and hydration. Moreover, the facility must respect the resident's wishes to refuse a feeding tube and not send him to the hospital after allowing the patient to become dehydrated in order to shift the responsibility to the hospital.

2. A terminally-ill resident who is alert and oriented and expresses a wish to die should not automatically be referred to hospice. In this case, nursing home staff should make every effort to persuade this resident to live as full a life as possible. A nursing home under Jewish auspices may contract with a private hospice to provide services to its terminally ill residents and make hospice referrals providing that:

a. The resident/proxy voluntarily requests hospice services without the solicitation or recommendation of the nursing home staff, or

b. The resident experiences physical or psychological pain or is semi/completely comatose to the extent that he/she has almost no quality of life.

In this article, we will explore the halakhic sources and precedents for R. Feinstein's rulings.

I. THE PATIENT'S ROLE IN REQUESTING OR REFUSING MEDICAL TREATMENT

Jewish patients, in accordance with halakha, must seek medical treatment; however, there are instances where they may also refuse it. Our sages recognized long ago that one has an obligation to protect his health, based on the Biblical imperative—"Only watch yourself, surely watch your soul . . . "(*Deut.* 4:9) which Maimonides and others say refers to safeguarding one's health.[12] Since the Bible enjoins one to safeguard his body, and physicians are obligated to heal,[13] it follows that one must seek medical treatment from a recognized physician and, of course, pray for his health. It has also been suggested that one who "watches" his health is treated in halakha as a bailee,[14] who must make every effort to protect the article he is given from loss or damage. Consequently, when the obligation of watching the article becomes onerous, as in cases where the costs of sophisticated life support systems or experimental treatments are almost prohibitive, the patient may not be required to avail himself of these measures.[15]

Similarly, the Talmud (*Sanhedrin* 73a) compares restoring one's life and health to the Biblical imperative of returning a lost article to its rightful owner. The Talmud reasons that if one is obliged to return lost property to its owner, then he must certainly restore that "owner's" life and health wherever possible.[16] Based on this passage, authorities conclude that if the owner chooses to abandon his property and not seek its return, the seriously ill patient, too, may forego the restoration of his health, under certain circumstances.[17]

In Jewish law and lore, every moment of life is infinitely precious. Every breath of life is endowed with sanctity, a Divine gift. Nonetheless, preservation of life under any circumstance is not an absolute. There are instances in halakha where a terminally ill or dying patient may request that life support measures or even high-benefit, low-risk treatments be withheld. Halakha sanctions, for example, removing any external impediments to the dying process, such as the noise created by the wood

chopper which prevents the soul from departing.[18] If life were an absolute, then this noise, which indirectly maintains life, should never be interrupted. The Talmud, too, describes how the very aged residents of Luz, a city which was endowed with special life-extending properties, left town when they could no longer tolerate living.[19] A major source for withholding life-support from the terminally-ill patient who is suffering is recorded in the Talmud (*Ketubot* 104a). Rabbi Judah the Prince, known simply as "Rebbe", was dying of a fatal gastrointestinal disease, which compelled him to go to the bathroom frequently and, thus, repeatedly remove and don his phylacteries. Rashi observes that Rebbe's suffered spiritual angst because "he was pained to remove and don [his phylacteries]".[20] The great teacher's students prayed for his life, keeping him alive on a kind of metaphysical life support, until Rebbe's pious maidservant disrupted their prayers and he expired. Since the Talmud does not criticize her conduct, or in any way reject it, Rabbenu Nissim, a major Talmudic commentator, concludes, "There are times when one should pray for the sick to die, such as when the sick one is suffering greatly from his malady and his condition is terminal. . . .[21] Contemporary authorities have applied this passage to the treatment of the critically ill in extreme pain, by allowing them to refuse "extraordinary" lifesaving measures, and to receive intensive doses of pain-killers. [3]

II. PAIN AND SUFFERING

Serious illness, accompanied by pain and suffering, is perceived in Jewish thought as God's purposeful, planned intervention in the lives of patients and their families. Suffering, in general, does not result from chance or bad luck, but reflects the Almighty's personal role in human events. Indeed, pain and suffering may serve as divine instruments to punish man and bring atonement for his sins, to purge and refine his character, and to evoke repentance.[22] The Talmud cites the extreme physical suffering of several illustrious rabbis who endured their pain with great faith and inspired grace.[23] Nevertheless, we pray daily that "we not be put to the test or brought to disgrace," and plead before the Almighty on Yom Kippur: "May it be Your will . . . that I not sin again, and what I have sinned before You cleanse with Your abundant mercy, but not through suffering or serious illness."[24] In medical practice, wherever the physician cannot cure he is mandated, at the very

least, to help relieve pain.[25] In fact, pain management is a cornerstone of palliative care and can be extremely effective in relieving acute pain in the vast majority of cases.[26]

Halakha, according to Rabbi Moshe Feinstein, recognizes that suffering is not limited to physical pain. The subconscious, metaphysical pain of a dying, comatose patient constitutes suffering. R. Feinstein discusses the case of a dying patient where the physicians want to maintain him on life support for a short time in order to harvest his organs at the time of death. Basing his ruling on the *Sefer Hasidim*, R. Feinstein declares that the patient should not be put on a respirator because he is suffering [metaphysically]: "even when the physicians say that he no longer feels pain, we can't rely on them because they could not possibly know that delaying the departure of the soul causes suffering, even if it isn't apparent to us".[27] Metaphysical suffering serves also as the basis for weaning a dying patient from a respirator who may no longer be able to breath spontaneously without it.[28]

The dying patient's physical pain, spiritual/emotional angst, and metaphysical suffering are very significant factors in halakha. Indeed, they are grounds, as we have seen, to withhold life support and provide aggressive pain management. Halakha also allows surrogates, even non-relatives, to represent the dying patient's wishes to refuse treatment when he is no longer able or competent to speak for himself. Witness the fact that it was Rebbe's maidservant—not a family member—who interrupted the life-support, the prayers of his students, to enable Rebbe to die. R. Moshe Feinstein writes about such patients, "it appears reasonable that we are not obligated to heal such a patient who does not wish these medical treatments which merely extend his life of suffering. In general, where it is impossible to ascertain the wishes of the patient (e.g. where he is in a persistent vegetative state or coma, and there are no advance directives), we may presume that the patient does not want (further treatment) and there is no obligation to heal him."[29] Indeed, though R. Feinstein considers artificial nutrition and hydration to be basic care and not a medical treatment, nevertheless where a feeding tube would only sustain his suffering, including the metaphysical pain preventing the soul's departure, we should respect the patient's wishes to withhold it. In this instance, inserting feeding tubes would not reverse the disease process by providing adequate nutrition and hydration. They would not be curative or even palliative.[30] Hence, feeding tubes would only prolong the patient's death by impeding the departure of the soul and causing metaphysical pain.

III. COERCION OF LOW RISK–HIGH BENEFIT TREATMENT

When a terminal patient who has capacity and is not depressed refuses a potentially high-benefit, low risk, life-saving treatment, we may not coerce him to accept it. In the opinion of Rav Moshe Feinstein in a number of responsa,[31] the medical staff and family should do everything possible to convince the patient of the need for the medication or treatment, and, if need be, bring in a top specialist, in whom the patient has confidence, to persuade him. Nonetheless, if the patient still refuses treatment, we must abide by his decision. Whether the patient refuses a feeding tube or an amputation, we must honor his wishes because to thwart them, "however unreasonable [they seem to us] should not be done because the psychotrauma [we might induce by blatantly violating his will] could harm him and also kill him" . . .[32] In another responsum, R. Feinstein cites the precedent of honoring the verbal wishes of a terminal patient as legally binding, even though he has not committed his will to writing.[33] He explains that the reason we honor the patient's verbal wishes is to assure him that we will comply with them fully, even dispensing with the usual legality of putting it into writing. The need to assure the patient forms the basis of our honoring his decision to refuse even food: "though the physician tells him that he must eat and that it's beneficial for him, if he [the patient] thinks it detrimental, it poses a great danger to the patient when others disregard [lit., don't listen to] him." We should also note that R. Feinstein considers nutrition and hydration to be basic care, not medication, "since food is natural, we are compelled to eat to maintain life, and it is a necessity for man and beast. . . ."[34] Nonetheless, R. Feinstein maintains that where the terminally-ill patient with capacity refuses food, despite our best efforts to convince him to eat, we must respect his wishes.

We must also note the opinion of Rabbi Hershel Schachter of Yeshiva University and the late Viener Rav, Rabbi Chaskel Horowitz, who maintain that artificial nutrition and hydration are medical interventions which a terminal patient may refuse. R. Schachter bases his ruling on the opinion of Rabbi Yaakov Emden that the obligation to save lives is comparable to the obligation to restore lost articles (*hashavat aveda*). Just as one who is in extreme discomfort is not required to return a lost article, so may a suffering, terminal patient refuse medical treatment to restore his lost health.[35]

R. Horowitz issued his decision on behalf of the Aishel Avraham

Resident Health Facility in Williamsburg. He considers artificial nutrition and hydration to be a medical therapy on a par with other surgical procedures, which may be refused by critically ill, terminal patients.[36]

We may, therefore, conclude that we may not coerce a terminal patient with capacity to choose a low-risk, high benefit procedure, even tube-feeding which most authorities consider basic care, and we may certainly not coerce according to those opinions who maintain that it is a medical procedure.

IV. STAGES OF TERMINAL ILLNESS IN HALAKHA

R. David Feinstein maintains that if a terminal nursing home resident is alert and oriented, though he or she expresses a wish to die, the nursing home staff may not make a referral to hospice. However, if the resident experiences physical or psychological pain and has almost no quality of life, nursing home staff may make a referral.

In order to better appreciate the basis of R. Feinstein's ruling, we must distinguish between the early stages of terminal illness, where aggressive and/or experimental treatment is still possible and may offer hope, and the advanced stages, where such interventions would be futile. In hospice, the time-frame for life expectancy of a patient is six months or less, while halakha would extend it to a year or less.[37] In the early stages, a patient may well be alert and oriented, self-sufficient, and relatively pain-free. Yet, this patient has a terminal diagnosis with a very limited prognosis. In halakha, this stage might best be defined as *shekhiv mera* [lit., "lying (in bed) as a result of evil (illness)"]. Though the literal translation of this expression would imply that the patient is so ill that he is confined to bed, the Bet Yosef states this patient may also be "one who is seriously ill, even though he can walk."[38] Furthermore, the late Rabbi Shlomo Zalman Auerbach even extends the definition to a patient who is not seriously ill but has full capacity and states that he feels his death is imminent.[39]

At this early stage, halakha permits the patient with limited life expectancy, to request a high-risk procedure, though it might result in his immediate death because there is a possibility of long-term survival.[40] The Talmud (*Avoda Zara* 27b) raises the issue of whether an individual may risk his life by receiving potentially lifesaving treatment from a heathen physician who may kill him. May he risk his certain short-term life of a day or two[41] against the possibility of a long-term

cure? The Talmud rules that he may risk his short-term survival because "we are not concerned about hourly life" when there is a possibility of long-term survival. While the general halakhic principle is that one may not risk a "certainty" in favor or a "doubtful" possibility (*en safek motsi midei vadai*), "in this case, we disregard the certainty (of the patient's short-term life) in favor of the doubtful (long-term survival)".[42] Indeed, "even a remote possibility of saving a life permits one to risk a short-term survival."[43]

At the early stage of a terminal illness, where the patient's relatively good condition makes him a viable candidate for an experimental/aggressive treatment which may yet offer a remission or cure, R. David Feinstein rules that we should not refer him to hospice. Since the patient is virtually symptom-free, he may still be able to avail himself of any medical breakthroughs. To refer to hospice in a situation where hope for a remission or cure may still be possible, would, in R. Feinstein's opinion, violate *lifnei iver*, "placing a stumbling block before the blind."[44] However, in advanced stages of terminal illness, where the patient is suffering physical and/or psychological pain, and the illness has progressed to a point where aggressive/experimental treatments would be futile, then a referral to hospice would be halakhically appropriate. In the words of R. Moshe Feinstein, "those individuals whom the physicians recognize cannot be cured . . . but could receive medications to extend their lives, in which they would suffer, should not be given such medications."[45] Notwithstanding these leniencies in end-stage, irreversible illness, R. Shlomo Zalman Auerbach maintains that a dying patient suffering from metastatic cancer "must receive oxygen, nutrition and hydration, insulin, blood transfusions, and antibiotics—*even if he is suffering and in great pain.*"[46] In this instance, R. Moshe Feinstein, as noted, would permit a hospice to withhold food and fluids from this patient who has refused tube feeding in an advance directive.[47]

The final stage of dying, termed *goses*, presents some of the greatest difficulties in halakhic bio-ethics. At this final stage, when death is imminent, the patient, though agonal, is considered to be very much alive, and caregivers are cautioned not to move him or cleanse his body, since even the slightest movement might hasten his death.[48] Consequently, it is imperative that we determine when the *goses* stage begins and even routine diagnostic procedures, such as doing bloodwork, or taking vitals, would cease. Because the results of the bloodwork or vitals would not lead to any further medical interventions for an agonal

patient, performing these procedures would be futile and constitute unnecessarily moving a *goses*. However, the *goses* may be moved for the purposes of basic care such as repositioning his body to prevent bedsores, providing wound care and administering enemas and flushes.[49]

Various sources would define *goses* as the patient's inability to expectorate mucus lodged in his throat or fluid from his lung; another definition of the onset of goses would be when the patient sounds the death rattle.[50] Surprisingly, these definitions correlate to those found in an authoritative medical dictionary under the subheading "death rattle: a respiratory gurgling or rattling in the throat of a dying person, caused by the loss of the cough reflex and accumulation of mucus; a rare and overdramatized sign."[51] Yet, today, modern medicine renders these definitions virtually useless, since suctioning of a dying patient's mucus is a routine nursing procedure. Indeed, no less an authority than R. Moshe Feinstein writes: "In reference to the signs of *goses*, I have heard that physicians don't recognize them, perhaps, because it makes no difference in the secular world if touching or treating [the dying patient] might be fatal. . . ."[52] Further research into a definitive and authoritative criterion for goses is urgently needed; however, in the interim, the attending physician's clinical assessment must suffice.[53]

V. SURROGATE DECISION MAKING

In hospice, there are many terminally ill patients who are unable to make medical decisions for themselves. These patients lack capacity for "informed consent" to select or reject treatment plans because they may be suffering, for example, from a severe stroke, clinical depression, dementia or are comatose. While we have demonstrated that dying patients with capacity may refuse treatment, do their surrogates have the halakhic rights to make medical decisions on their behalf when they are no longer able to do so?

In halakha, is an adult child authorized to make medical decisions on behalf of a demented parent who has no advance directives? May a parent make medical decisions on behalf of an infant? R. Moshe Feinstein accepts the decision of family members to refuse treatment on behalf of a patient without capacity where medical intervention may increase the life expectancy of the patient somewhat but will not cure him or alleviate pain: "But in the majority of instances, there are family members . . . who are engaged in the medical [decision-making] of the

patient who are more responsible [than others] for his care, even by halakha."[54] Indeed, R. Feinstein observes that in the absence of a leading specialist who would prescribe a cure for this patient, a physician must always obtain consent from family, "since some medications are not only worthless but possibly detrimental. . . ." In the case of a minor, R. Feinstein also indicates that we rely on his/her parent to decide whether certain medical treatments are acceptable. It appears that R. Feinstein's rationale for accepting family decision-making is that the patient himself, presumably (*umdana*), would rely on them and permit them to make medical decisions on his behalf. Nonetheless, family members must remember that they represent the wishes of the patient, particularly if he has previously expressed them, and they should not act on the basis of what is best or expedient for them.[56] Regrettably, families all too often project their own fears and guilt when making medical decisions on behalf of their loved one. They feel they can no longer bear the emotional burden of the visits, the financial drain of high-tech medical care on their assets (or potential estate), and the critical bioethical issues which they constantly face.

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A final thought: Hospice reflects King Solomon's observation: "There is a time to give birth and a time to die. . . ."(*Ecclesiastes* 3:2). A great scholar once noted that the verse doesn't contrast life with death; "there is a time to live and a time to die". Why? Had King Solomon written there is "a time to live", a dying patient's family might feel that "they must do everything to keep him alive", even if it is medically futile. Hospice helps us understand and accept the wisdom that "we are born . . . live . . . and die against our will" (*Avot* 4:29).

Medical science—with all its sophisticated technology—may, at best, postpone the arrival of the Angel of Death; it cannot deny him access forever. Accepting our mortality by acknowledging that our loved one is dying is not an act of abandonment or a lack of faith and love. It is, rather, the recognition of the reality that ultimately each of us must surrender our soul to our Maker. For patient and family, hospice can make those final days together among the most poignant and meaningful they have ever shared.

NOTES

The author is indebted to Rabbi David Feinstein for his review of this article and for his encouragement, as well as to the following individuals for their invaluable comments: Dr. Irving Gomolin, Rabbi Lowell Kronick, Dr. Amitai Oberman, Rabbi Chaim Rabinowitz, Dr. Fred Rosner,and Rabbi Abraham Steinberg, MD.

1. In 1986, there were approximately 500 hospices in the United States. Today, there are over 2,900 hospices. This incredible growth has been spurred by the passage of the Medicare hospice benefit in 1983 and by managed care which favors cost-effective medical alternatives to expensive high-tech treatment, in addition to patients and families who prefer supportive, comfort care at the end-of-life.
2. *Yoma* 83a: *Orah Hayyim* 329:3-4.
3. *Halakha U-Refuah*, Volume 2, p. 189, in an article entitled, "Treatment of a Moribund Patient and Establishing the Time of Death" by Dr. A.S. Abraham.
4. *Mishne Torah. Rotseah* 1:4. See also Radbaz on *Mishne Torah, Sanhedrin* 18:6; *Sefer Hasidim* 723; *Shulhan Arukh HaRav, Nizkei HaGuf VeNefesh* 4; *Shut Rivash* 484; Hazon Ish, *Nezikin*, 19:5; and *Iggerot Moshe, Yoreh Deah*, Volume 2, 174:3.
5. *Bava Kamma* 91b. *Mishne Torah, Hovel U-Mazik*, 5:1. *Hoshen Mishpat* 420:31.
6. *Encyclopedia of Jewish Medical Ethics*, Volume 5, 316.
7. *Mishne Torah Rotseah* 2:2. Responsa *Halakhot Ketanot* Volume 2, 231. *Bet Meir* to *Yoreh Deah* 215:5.
8. "Planning in Advance for Your Medical Treatment", published by the New York State Department of Health, 12/91.
9. In Elbaum v. Grace Plaza of Great Neck, Inc., N.Y.L.J., Jan. 19, 1990 at 26 (Sup. Ct., Nassau Co.), the family of Jean Elbaum, who had become permanently unconscious after a brain hemorrhage, requested that her nursing home discontinue tube feeding based upon her wishes. The facility refused and the family stopped paying for her care. The courts ruled that the nursing home must honor the patient's choice to forgo tube feeding and, moreover, was not entitled to reimbursement for care provided over the patient's objections. In order to be in compliance with the intent of this ruling, nursing homes which have policies regarding withholding/withdrawing treatment must make them known in advance to the residents and have them acknowledge that they are aware of these policies.
10. For a full treatment of these issues, see the author's articles, "Ethical Guidelines for Treatment of the Dying Elderly", *Journal of Halakha and Contemporary Society,* XX12, Fall 1991, and "Jewish Ethical Guidelines for Resuscitation and Artificial Nutrition of the Dying Elderly", *Journal of Medical Ethics,* 1994, 20:93-100.
11. In 1914, Judge Benjamin Cardozo first articulated the concept of patient autonomy, "Every human being of adult years and sound mind has a right

to determine what shall be done with his body. . . ." Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 129-30, 105 N.E. 2nd 92, 93 (1914). See also the author's "Is there Patient Autonomy in Halacha?", *Jewish Medical Ethics* II-2 (1995), 22-27.

12. *Mishne Torah, Rotseah* 11:4.
13. *Yoreh Deah* 336:1, based on *Bava Metsia* 31a. See also *Tsits Eliezer* 15:38, who lists five Biblical sources.
14. As heard from Rabbi Dr. J. D. Bleich, interpreting Ran to *Nedarim* 40a, at a lecture on April 19, 1990.
15. Rabbi Shlomo Zalman Auerbach rules that a terminal cancer patient whose disease has metastasized may refuse extraordinary treatment, such as radiation or chemotherapy. Similarly, a diabetic whose leg was amputated as a result of his illness may refuse the amputation of his other leg, even though gangrene has set in and he will die imminently without the operation. In both these instances, the medical procedure will not reverse the underlying condition, and the patient may therefore refuse it. (Cited by Dr. A.S. Abraham in *Halakha U-Refuah* Volume 2, p.189) See also *Iggerot Moshe, Hoshen Mishpat*, 2:74. The *Shevut Yaakov* (*Orah Hayyim* 1:13) declares that when a physician is unable to reverse a patient's terminal condition and cure him, he no longer has the Torah's sanction to practice medicine on that patient (*reshut lerapot, Bava Kama* 85a), and his treatment does not fulfill the *mitsva* of saving lives. Since the *mitsva* of expending money to save another's life is derived from the verse, "Do not stand idly by the blood of your neighbor" (*Leviticus* 19:16, as interpreted in *Sanhedrin* 73a) and this verse applies only where one is saved from certain death or, as a minimum, has his health restored (i.e., curative, not merely palliative), then we suggest that a terminal patient need not impoverish himself, or spend excessive monies to avail himself of experimental drugs, high-tech treatments and the like. However, if there is a reasonable possibility that his treatment will save his life, he may borrow money and pay interest (*Yoreh Deah* 160:22); indeed, according to Rivash (387), he must expend his entire wealth since he wishes to avoid transgressing a negative commandment thereby. The *Havot Yair* (139), however, opines that in the case of a negative commandment of a passive nature (*lav she'en bo ma'aseh*, i.e., where no overt act is required to transgress), one need not expend more than he normally would to avoid violating a positive commandment (cited in the gloss of R. Akiva Eiger to *Yoreh Deah*, 157:1).
16. Maimonides' Commentary to the *Mishna Nedarim* 6:8. Also, *Teshuvot Atsei Ha-Levanon*, 61, who extends this passage to include restoring health in non-life-threatening situations. See also *Halakha U-Refuah*, Volume 2, pp, 133-134.
17. *Ha-komets Minha* on *Minhat Hinukh*, *Mitsva* 237 and *Hokhmat Shlomo* to *Hoshen Mishpat* 426. See also the article by R. Hershel Schachter, appearing in the *Bet Yitshak Journal*, 5746 issue.
18. *Yoreh Deah* 339:1. See *Iggerot Moshe, Yoreh Deah* Vol. 2. 174:2.
19. *Sota* 36b. See also *Yalkut Shimoni* to *Ekev* 871 and to *Mishle* 943, which relates the case of a very elderly pious woman who prayed daily in the synagogue, but now found her life to be unbearable. She sought rabbinic guid-

ance and was advised not to pray in the synagogue for three days. She followed this advice and, on the third day, she took ill and died!

20. Interestingly, Rashi makes no mention whatsoever of Rebbe suffering any physical pain. In my reviewing this anecdote with gastroenterologists, they suggest that Rebbe may have contracted dysentery, which is not accompanied by end-stage pain (as opposed to colon cancer or Crohn's disease, for example, which often present with end-stage pain) R. David Feinstein, thus, concludes from this source that spiritual angst or psychological pain alone constitutes suffering to withhold treatment from a dying patient. Alternatively, Rebbe may have also experienced physical pain but only his spiritual angst caused him to suffer.
21. Nedarim 40a.
22. "There is no death . . . or suffering without sin." *Shabbat* 53a. Consequently, "if one sees that he is constantly suffering, let him examine his deeds, as it is said: 'Let us search and examine our ways and turn to God.'" *Berakhot* 5a. Indeed, "Just as the olive only produces oil through crushing, Israel only returns to the good through suffering", *Menahot* 53b. Interestingly, even as sin may provoke suffering and premature death, suffering and death atone for one's sins, *Yoma* 85b-86a. Hopefully, though, suffering may spark genuine repentance, by challenging one's faith and purging his character in the process: "The congregation of Israel spoke before the Holy One, blessed be He, Master of the Universe, all the sicknesses that you cause me . . . are done to make me more beloved to you [by returning me to the good, *Matanot Kehuna*]". *Shir Ha-Shirim Rabba* 2:14.
23. Note the description of the deaths of the "Ten Martyrs", recited in the *Yom Kippur* and *Tisha B'Av* liturgies, as well as the afflictions of Nahum Ish Gam-Zu, *Ta'anit* 21a.
24. *Berakhot* 17a.
25. "If a patient near death is in severe pain and no therapeutic protocol holds any hope for recovery, it may be proper to withhold additional pharmacological or technological interventions so as to permit the natural ebbing of the life forces. The physician's role at that point is limited to providing pain relief. Judaism is concerned about the quality of life, the mitigation of pain, and the cure of illness wherever possible. If no cure or remission can be achieved, nature should be allowed to take its course. To prolong life is a *mitsva*, to prolong dying is not." The Bio-Ethics Commission, Rabbinical Council of America, June, 1997, Rabbi Dr. M.D. Tendler, Chair.
26. World Health Organization (WHO). *Cancer Pain Relief and Palliative Care: Report of a WHO Expert Committee.* Technical Report Series 804, Geneva: World Health Organization, 1990: pp. 7-18. V. Ventafridda, M. Tambunini, A. Caraceni, F. DeConno, F. Naaldi, "A validation study of the WHO method for cancer pain relief", *Cancer* 1987: 59: 850-856. American Pain Society of Care Committee. "Quality improvement guidelines for the treatment of acute pain and cancer pain", *JAMA* 1995: 274(23): 1874-1880. M.H. Levy, "Pharmacologic Treatment of Cancer Pain", *N. Engl J. Med,* 1996; 335:1124-1131.
27. *Iggerot Moshe, Yoreh Deah,* Volume 2, 174:3.
28. Ibid. Also see Volume 3, 132 and *Aseh Lekha Rav,* 29, pp. 198-211.

29. *Iggerot Moshe, Hoshen Mishpat* Vol 2, 74:2, 5. Ibid. 74:2.
30. *Iggerot Moshe, Hoshen Mishpat*, Volume 2, 74:3. R. Feinstein's ruling not to feed a dying patient against his will refers to an alert patient who might experience psychotrauma if his wishes are thwarted. However, should he become comatose, we may still not treat him against his previously expressed wishes, "in a situation where he is suffering and there is no known cure even to ease his suffering where in such an instance people would rather die than live such a life of suffering . . . and even where it would be impossible to ascertain the patient's wishes, we may presume that the patient would not want (further treatment) and there is no obligation to heal him", ibid 74:2. Medically, the statement that "tube feeding is ordinary care, like spoon feeding" is a myth. The PEG, percutaneous endoscopic gastrostomy and PEJ, percutaneous endoscopy jejunostomy are still, "invasive procedures that require varying degrees of anesthesia and are associated with surgical risks and complications, sometimes very serious". Moreover, withholding or withdrawing artificial nutrition and hydration does not lead to a painful death. J.C. Ahronheim, "Nutrition and Hydration in the Terminal Patient", *Clinics in Geriatric Medicine,* Volume 12, Number 2, May 1996: 379-391.
31. *Iggerot Moshe, Hoshen Mishpat*, Volume 2, 73:5, 74:3.
32. *Ibid,* 73:5.
33. *Ibid,* 74:3.
34. *Mor U-Ketsia, Orac Hayyim* 328. See also R. Schachter's article in *Bet Yitshak*, 5746 issue.
35. In response to the author's inquiry on June 1, 1991. In support of the contention that tube feeding is a medical procedure, it should be noted that the patient's consent is required for a gastroenterologist to perform a gastrostomy. Also, there are medical complications associated with tube feeding, including pneumonia and aspiration. See J.O. Ciocon, F. A. Silverstone, L.M. Grauer, C.J. Foley, "Tube feedings in elderly patients", *Archives of Internal Medicine,* 1988; 148: 429-433. The authors conclude, on the basis of their research at a major metropolitan geriatric center, that: "tube alimentation in the elderly can be continued for long periods but is associated with a high frequency of complications". R. Dresser, E. Boisqubin, "Ethics, law and nutritional support", *Archives of Internal Medicine,* 1985; 145: 122. V. Pritchard, "Tube-feeding-related pneumonias", *Journal of Gerontological Nursing,* 1988; 14:32-36. See Ibid. 21 and R. Cogen, J. Weinryb, C. Pomerantz, *et al*, "Complications of jejunostomy tube feeding in nursing facility patients", *Am. J. Gastroenterol,* 86:1610-1613, 1991; P.G. Foutch, C.A. Woods, G.A. Talbert, *et al*, "A critical analysis of the Sacks-Vine gastrostomy tube: A Review of 120 consecutive procedures", *Am. J. Gastroenterol,* 83:812-815, 1988; T.W. Hennigan, A. Forbes, "Colonic obstruction caused by endoscopic percutaneous gastrostomy", *Eur. J. Surg.,* 158:435, 1992; W.R. Jarnagin, Q.Y. Duh, S.J. Mulvihill, *et al*, "The efficacy and limitations of percutaneous endoscopic gastrostomy", *Arch. Surg.,* 127:261-264, 1992.
36. To qualify for the Medicare hospice benefit, patients must have a life expectancy of six months or less with a recent study finding a median

length of survival after admission of 36 days. N.A. Christalkis, and J.J. Escarce, "Survival of Medicare Patients After Enrollment in Hospice Programs", *New England Journal of Medicine* 335 (3): 172-178, 1996. In halakha, the life expectancy of a terminal patient is one year or less because his illness renders him a "*terefa*", an internal pathology which is invariably fatal; life expectancy of more than one year is deemed, by comparison, "eternal life". *Iggerot Moshe, Hoshen Mishpat,* Volume 2, 75:2.

37. *Hoshen Mishpat* 32.
38. In response to Dr. A.S. Abraham, as cited in *Nishmat Avraham, Hoshen Mishpat,* 250.
39. *Ahiezer*, 2:16, *Binyan Tsion* 1:11, *Bet Meir (Yoreh Deah)* 339:1. *Tsits Eliezer,* 4:13 and 10:25 and *Iggerot Moshe, Hoshen Mishpat* Volume 7, 74:5. However, note *Shevut Yaakov* 3:75, who qualifies the decision by requiring a majority of expert medical opinion with the approbation of the leading halakhic authority in the city.
40. Rashi, ad loc.
41. *Tosafot,* ad loc. See also Ritva on this passage who notes "that we are not concerned about this (short-term life), since there is a possibility of a complete cure we must do what is best for him". This case, according to the Vilna Gaon, is accepted as the source for the halakhic norm (*Biur Hagra* to *Yoreh Deah*, 155:1, note 5).
42. *Iggerot Moshe, Yoreh Deah*, Volume 2, 58. The halakhic definition of long-term survival is a prognosis of not less than one year. Consequently, a patient may not risk a short-term survival of days or weeks merely to gain a few more months. *Iggerot Moshe, Yoreh Deah*, Volume 3, 36.
43. *Leviticus* 19:14. Admission to hospice requires both a terminal diagnosis and a prognosis of six months or less. Accordingly, referrals to hospice for nursing home residents are generally made by the medical staff of the nursing home, and an individual resident may not access hospice services without this referral. This is a critical factor in the prohibition of lifnei iver, where the Talmud declares that the individual who causes the "blind" man to sin unwittingly is liable only if the blind man could not have sinned without the former's intervention. If, however, the blind man could have sinned without another's assistance, there is no violation. *Avoda Zara* 6b.
44. *Iggerot Moshe, Hoshen Mishpat*, Volume 2, 73:1.
45. *Halakha U-Refuah,* Volume 2:131, 188-189. R. Hershel Schachter finds difficulty with R. Auerbach's contention that one must provide a dying patient who is suffering with nutrition and hydration against his will, while simultaneously praying for his demise to spare him any further suffering. See his article in *Bet Yitshak Journal*, 5746 issue. In a responsum appearing in *Halakha U-Refuah,* Volume 2, p. 131, R. Auerbach presents his rationale: "some maintain that just as we must desecrate the Sabbath to save the life of one who will live only for a brief period of time, (even a few seconds, ibid, footnote 2), so, too, must we compel the (dying) patient to continue this (life-extending medical treatment) since he is not a proprietor of his own body to (allow him to) relinquish even a single moment of this life. However, logically, if the patient is enduring great pain and suffering, even severe psychological pain, (though) I think that it is mandatory

to give him food and oxygen for breathing even against his wishes, it is permissible to withhold medications that cause suffering to the patient if that is what the patient demands. Nonetheless, if the patient is God fearing and has clear capacity, it is most desirable to explain to him that a single moment of repentance in this world is greater than all of the world-to-come, as we find in *Tractate Sota* 20a, that it is a privilege to suffer seven years rather than to die immediately". See also *Minhat Shlomo*, 91:24. Rebbe's extreme spiritual pain resulting from his inability to don his phylacteries apparently justified withdrawing his metaphysical life support (i.e., his student's prayers). Would this be comparable to withholding artificial nutrition or oxygen, or, according to R. Auerbach, only to withholding other medications and treatments which could prolong a life of pain? More troublesome, still, is a most difficult passage relating the tortuous death of Rabbi Hanina ben Teradyon (*Avoda Zara* 18a). When the Rabbi was put to death, they first wrapped him in a Torah scroll and placed bundles of wood around him and set them on fire. Then, to prolong his suffering, they soaked tufts of wool in water and placed them on his chest. Rabbi Hanina's students urged him to open his mouth so that he might expire sooner, to which he replied, "Let He who gave me my soul take it away, but no one should injure himself". The executioner offered, "Rabbi, if I raise the flame and remove the tufts of wool from your heart, will you enable me to enter the world-to-come". "Yes", he replied. After the Rabbi swore that the executioner would receive eternal life, he raised the flame and removed the wool, and Rabbi Hanina's soul departed quickly. In *Iggerot Moshe, Hoshen Mishpat*, Volume 2 74:2, R. Moshe Feinstein addresses the issue of whether the gentile executioner would have been liable for murder. While one might contend that removing the wool was tantamount to "removing an impediment" to hasten death, which is permissible, raising the fire would appear to be a direct act of homicide, which is forbidden even for a patient who is dying imminently. If every moment of suffering in this world is greater than all of eternal life, we might question why Rabbi Hanina acquiesced to the executioner's plea?

46. In discussions with R. David Feinstein on August 20, 1998, R. Feinstein opined that, where warranted, even artificial nutrition and hydration may be discontinued by simply not refilling the bag with solution and/or nutrients. In this manner, one converts a *kum va'aseh* (an act of commission, withdrawal) into a *shev ve'al ta'aseh* (an act of omission, withholding).
47. *Yoreh Deah*, 339:1.
48. *Nishmat Avraham, Yoreh Deah*, 339:3. In a major responsum, R. Shmuel Wasner, a noted Israel authority, rules that one may move a gurney in an emergency room upon which an apparent goses lies to allow passage of a less critical patient. R. Wasner carefully distinguishes between touching a dying patient directly, which is forbidden, and moving him indirectly on a stretcher, which, in this instance, may be permissible. See his responsum appearing in the papers of the Second International Conference on Medicine and Halakha sponsored by Shaarei Zedek Hospital, Jerusalem.
49. *Encyclopedia Talmudit*, Volume 5, 393.
50. *Stedman's Medical Dictionary*, 22nd Edition p. 324.

51. *Iggerot Moshe, Hoshen Mishpat*, Volume 2, 73:3.
52. In an article entitled "Death and Dying and Recognizing Approaching Death" by M.C. Long, appearing in *Clinics in Geriatric Medicine*, Vol 12(2), 1996, the author presents nine signs of impending death, including "gurgling sounds in the chest and throat . . . due to the decrease in fluid intake and the inability to cough up normal secretions". A survey of expert medical opinion might suggest which combination of symptoms determines *goses*, which should then be submitted to leading halakhic authorities.
53. *Iggerot Moshe, Hoshen Mishpat* 2:74, 2. For further discussion on the obligation of a community to provide vital medical treatment to minors, even against the wishes of parents, see *Tsits Eliezer*, 15:40,3.
54. As suggested by R. Hershel Schachter at a lecture on November 15, 1995. R. David Feinstein, in a discussion of this issue, believes that it is not sufficient for family members to presume the patient's wishes. Wherever possible, they must ascertain, in advance, the patient's medical directives and act knowledgeably on his or her behalf.