# Autonomy within a given Scope, the Opinion of Rabbi Shlomo Zalman Auerbach

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The moral-medical problem presented by the dying patient is hardly new and has been a continuing source of debate and controversy in societies of differing ethnicity and religion.[1] In recent years, however, the issue has become even more acute, and it is not difficult to understand why. The great advancement of modern medicine and technological intervention has made it possible to prolong life in situations that were in the past unthinkable. Most people in contemporary Western societies die in institutions rather than at home. Their medical and institutional caretakers often have value systems, particularly regarding the sanctity and even the definition of life, that differ from their own. There is also a more pronounced involvement in medical-ethical decision making by society, which must account for allocation of life-sustaining resources that are consumed in large quantities by the terminally ill.[2] But some weighty issues have not changed. Extending life is often complicated by the suffering of the dying patient. Semantically for some, "extending the patient's life" becomes interchangeable with "prolonging his or her death." Absorbing all of these considerations, contemporary thinking often pulls in different directions. One modern trend in medical ethics has been to focus on patient autonomy, allowing the patient to decide whether he or she desires life-extending treatment. But,

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1 Paul Ramsey, *The Patient as Person*, p. 116 (Yale University Press 1970).

2 Avraham Steinberg, *Encyclopedia of Jewish Medical Ethics*, p. 1062 (Feldheim 2003).

there have also been calls to curtail this power, grounded in a sense of arbitrariness and the need to ration precious medical resources.[3]

This essay examines the perspectives on these weighty issues of the twentieth century Jewish sage Rabbi Shlomo Zalman Auerbach.

Rabbi Auerbach (1910-1995) was the dean of a rabbinical school for decades and a preeminent, though untitled, decider of Jewish law in Israel. He was well known and respected for tackling cutting-edge *halachic* issues, particularly with regard to medicine and technology. His analysis was at all times rooted in *halacha*, the Talmudic Jewish legal system, although he was keenly aware of the challenges and stresses to the system posed by contemporary medical and scientific advances. Notwithstanding his loadstar of supreme fidelity to *halacha*, he was particularly sensitive to the modern human condition.[4] It is this quality which made Rabbi Auerbach a unique authority on the care of the dying patient in Jewish law.

**Secular Medical Ethics and Considerations of Autonomy**

The physician-patient relationship often raises complex legal, ethical and personal issues. Nowhere are these issues more pronounced than in "end of life" situations. At this juncture medicine has expended its ability to cure with reasonable confidence. The physician is left to either palliate, attempt experimental treatment that is often invasive and painful with little prospects of success, or simply maintain basic bodily function without appreciable quality of life.

Advances in modern medicine have made both physician and patient choices in these circumstances at once more varied and more vexing. Cardiac-pulmonary resuscitation (CPR), defibrillation, pacing, ventilation and the like may prolong life while effecting no positive change in patient condition. Should they be implemented for the terminal patient, and if so at what cost to the patient and society? Treatment in the intensive care unit (ICU) is a case in point. The costs of ICU care are substantial. By one

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[3] Alan Jotkowitz "'May it be Your Will that Those Above Overcome Those Below' Rav Moshe Feinstein and Rav Eliezer Waldenberg on the Care of the Dying Patient", The Jakobovits Center for Jewish Medical Ethics, Faculty of Health Sciences, Ben Gurion University of the Negev, Beer-Sheva, Israel.

[4] Aharon Lichtenstein, "A Portrait of Rav Shlomo Zalman Auerbach zt"l", *Leaves of Faith* p. 247 (Ktav 2003).

estimate, they comprise 34% of the budgets of hospitals in the United States.[5] "While many patients benefit from ICU care, one-fifth of all Americans now die after ICU care some time during a terminal hospital admission."[6] Implicit in these statistics is the dilemma of applying scarce ICU resources to the care of the terminal patient, prolonging life at significant societal cost while not necessarily benefiting patients and their families.

Beauchamp and Childress[7] identified four ethical principles that inhere in the physician-patient relationship. These are:

- Non-malfeasance – the obligation of the physician to avoid doing harm;
- Beneficence – the affirmative obligation of the physician to do good;
- Autonomy – the right of patient self-determination;
- Justice – an over-arching moral principle that goes beyond the particular patient and implicates broad social considerations.

The first two principles are of ancient vintage. The Hippocratic Oath, for example, speaks of beneficence and non-malfeasance,[8] but does not advocate autonomy or broader principles of justice. Childress and Beauchamp attribute developments in Western philosophical thought to the introduction of autonomy and general moral principles into medical ethics. For example, Immanuel Kant believed in individual choice as a driver of ethical conduct. John Stuart Mill likewise philosophized on the ability of the individual to select and act upon moral principle. Together, these viewpoints empower the individual to chart his or her own course of conduct, particularly in matters of personal consequence.

It is not surprising that these ideas have found their way into the medical arena. According to Luce and White,[9] both British and American common law early on recognized the right of a patient to refuse or consent to treatment – although not on the basis of what

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5 Multz et al., quoted in Luce JM and White DB, "A History of Ethics and Law in the Intensive Care Unit", *Critical Care Clinics* 25 (2009).

6 Angus et al., in "A History of Ethics and Law in the Intensive Care Unit", *Critical Care Clinics* 25, 2009, p. 221

7 Beauchamp TL and Childress JF, *Principles of Biomedical Ethics* (Oxford University Press, 2d ed. 1982), p. 61.

8 *Ibid.*, p. 106.

9 See Luce and White *supra.* p. 223

is now referred to as informed consent. By the early 20th century, the courts began to address more nuanced issues of patient rights and physician obligations, such as informed consent and the withdrawal of terminal life support at the request of the patient or the patient's medical proxy.

The concept of individual autonomy appears as an important consideration in these cases. For example, in the seminal case of *Schloendorff v. Society of New York Hospitals*,[10] the New York Court of Appeals in a decision authored by Justice Benjamin Cardozo stated that any adult patient "sound of mind has the right to determine what shall be done with his body." This case established the principle of informed consent, with later decisions expanding its contours and addressing such issues as disclosure of physician conflicts and alternative treatment options. In an almost natural evolution, the patient rights cases have gone on to address withholding and termination of medical treatment in accordance with the wishes of the patient or the patient's family. *In re Quinlan*[11] a New Jersey Supreme Court case from the mid 1970s, was first to hold that life-sustaining medical treatment could be discontinued in certain circumstances. The case was significant not only because it authorized medical caregivers to disconnect the mechanical ventilator of a comatose patient. It also expanded the principle of patient autonomy to allow a family member – here the patient's father – to make critical treatment decisions when the patient was incapable of doing so. Subsequent cases have reinforced these rulings.[12]

By now, individual autonomy as a guiding principle for determining the scope and intensity of treatment is a pillar of mainstream secular medical ethics. What may be less appreciated is that concepts of autonomy have also made their way into medical *halachic* decision-making. This is somewhat surprising, since Jewish law, at odds with much of contemporary secular legal thinking, does not bestow ownership to a person over his physical being. It is nonetheless the case that at least certain *halachists* have allowed principles of patient autonomy to influence the care options for the terminal patient.

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10 211 N.Y. 125, 105 N.E. 92 (1914).
11 70 N.J. 10, 355 A.2d 647 (1976).
12 For a general discussion, see Luce and White *supra*.

**Competing Views in Halacha**

Not surprisingly, the medical ethical issues confronting secular ethicists and the courts have also preoccupied *halachic* decisors, particularly regarding the care of a terminally ill patient. The basic questions are the same. How aggressive should the treatment be? How invasive? How expensive? How discomforting? How prolonged? The care-giver must necessarily weigh the severity of the patient's symptoms, the patient's remaining life expectancy, the pain or discomfort being experienced by the patient and the efficacy or at least the palliative effects of a proposed treatment regimen. For the observant Jewish patient and his or her family, however, all of these considerations are overlaid with difficult questions of *halacha*.

Two twentieth century rabbinic decisors, Rabbi Eliezer Waldenberg (1915-2006) and Rabbi Moshe Feinstein (1895-1986), have taken polar *halachic* positions on the care of the terminally ill patient.

Rabbi Waldenberg visits these issues in his work *Ramat Rachel. Halacha* and medicine intersect principally in two arenas. One is the care of the dying patient. The other is the Sabbath, where the *halacha* addresses the circumstances, terms and conditions under which the prohibitions against *melacha*, loosely translated as work, may be waived for medical treatment. Rabbi Waldenberg connects the two disciplines. To the same extent as one may desecrate the Sabbath to care for the dying patient, known in *halacha* as a *gosses*, one is commanded to undertake measures to prolong the life of a terminally ill person. Rabbi Waldenberg explains that the dispensation for otherwise forbidden acts to save a life on the Sabbath is not based on a utilitarian calculus. Rather, it is mandated by the principle of "You should live by them and not die by them" (see Babylonian Talmud *Yoma* 85b). One may desecrate the Sabbath even to care for a terminal patient experiencing intense suffering. *Ipso facto*, according to Rabbi Waldenberg, one is required to extend care to this patient.[13] It is not a patient or family decision whether to accept or reject treatment. According to Rabbi

[13] Responsa *Ramat Rachel* vol. 5 no. 28. Rabbi Waldenberg gives further proof and rationalization for extending the life of the terminal patient in Responsa *Tzitz Eliezer* vol. 9 no. 47 and vol. 14 no. 80.

Waldenberg, the physician must labor to extend life at all costs, irrespective of patient or family wishes.[14]

Rabbi Feinstein adopts a position at the other end of the *halachic* spectrum. He concludes, "If a physician is unable to alleviate a patient's suffering, and [his efforts] just extend the patient's suffering life with medications, he should not do so."[15] Rabbi Feinstein explains that a physician has no obligation to heal where he cannot cure. In such a circumstance, the physician's religious obligation shifts to palliating pain and suffering.[16]

**Rabbi Auerbach's Position**

Rabbi Auerbach's approach lies between these two extremes. He allows extraordinary measures to be implemented for the benefit of a terminal patient. But he also permits the patient to refuse such interventions. He writes: [17]

> Many debate the question of treatment of a terminal patient (*gosses*).[18] There are those who think just as one desecrates the Shabbat for temporary life (*chayei shaah*) so too one is obligated to force a patient [to accept the treatment], for he [the patient] does not own himself to forgo even one minute [of life]. However, it is reasonable to conclude that, if the patient suffers from great pain and suffering, or even from very strong emotional pain, [while] it is required to give the patient food and oxygen even against his will, it is permitted to refrain from giving medications that cause pain to the patient if the patient requests this.[19,20]

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[14] Responsa *Tzitz Eliezer* vol. 18 no. 62.

[15] Responsa *Iggerot Moshe*, *C.M.* Part 2 no. 74:1.

[16] Ibid.

[17] Responsa *Minchat Shlomo* Part 1, ch. 91 no. 24:2.

[18] The question of whether a *gosses* is the equivalent of a medically terminal patient is beyond the scope of this article.

[19] Professor Avraham Steinberg published a guide on treatment of patients in an ICU. He states that his protocols were reviewed and approved by Rabbi Shlomo Zalman Auerbach and Rabbi Shmuel Wosner, another contemporary *halachic* decisor. The following is a loose translation of Dr. Steinberg's protocols:

(1) The protocols pertain to patients in the ICU that fulfill the following criteria:

(i) The patient was accepted to the ICU on the assumption that the life of the patient could be saved.

(ii) The patient received intensive care, including mechanical ventilation, treatment for infections, treatment to sustain blood pressure, treatment to

prevent clots and bleeding, blood transfusion, parenteral feeding and permanent monitoring of blood pressure, pulse, breathing and oxygen saturation.

(iii) Despite the intensive treatment, the patient experienced irreversible failure of at least three vital organ systems.

(iv) All treating physicians, includes the ICU doctors and medical specialists brought in on a consulting basis, have concluded that there are no prospects for saving the patient's life.

(v) Death is expected in a short time.

(vi) And, specifically, the patient is in pain, and it can be assumed that the patient does not want to endure constant suffering.

(2) The protocols apply to all patients in an ICU, whether they are adults, children or newborns.

(3) The key *halachic* principles balance the obligation to save life, the prohibition against actively shortening life and the imperative to mitigate unending suffering.

(4) In these circumstances, the following protocols should be observed:

(i) New treatment that will lengthen a life of suffering should not be commenced.

(ii) New tests, such as blood tests to asses the status of the patient, which cause patient suffering and are without purpose, should not be administered.

(iii) There is no purpose in monitoring and stabilizing a patient in this condition, including checking blood pressure, pulse and oxygen saturation, notwithstanding that these are done automatically with machines that were previously connected to the patient. There is no need to treat the condition of the patient based on the displayed values; since the patient is suffering, there is no purpose in these tests.

(iv) The patient should continue to be treated with pain killers to alleviate pain and suffering.

(v) Any action that will lead to the immediate death of the patient is prohibited. Even action that questionably will lead to the immediate death of the patient may not be performed.

(vi) Therefore, it is prohibited to disconnect a patient from a respirator, if in the opinion of the doctors breathing is completely dependent on the machine. It is prohibited to immediately and completely stop medications such as dopamine, which are intended to maintain the blood pressure of the patient, if in the opinion of the doctors it is possible the blood pressure will precipitously fall leading to immediate death.

(vii) Changing or discontinuing therapy is permitted, if in the opinion of the doctors the patient will not die immediately, even though as a result the patient will die in a matter of hours, so long as the doctors determine that the patient is suffering. The changes should be implemented in stages, with the state of the patient being assessed after each stage.

(viii) Therefore, it is permitted to lower the respirator setting to the rate at which the patient breathes spontaneously; it is permitted to lower blood oxygen concentration through mechanical perfusion to the 20% level, which is the ambient oxygen concentration; it is permitted to lower the level of dopamine, so long as there is no serious change in the patient's blood pressure, or, even if there is a change, so long as it will not lead to the immediate death of the patient; it is permitted to eliminate totally parenteral nutrition and revert to a nasogastric tube or an IV drip of water and glucose; it is permitted to discontinue anticoagulants such as heparin or medications to prevent internal bleeding such as H2 blockers; it is

Contrary to Rabbi Waldenberg, here Rabbi Auerbach does not see in the permission to violate the Sabbath in order to save a *gosses* an absolute mandate to treat the dying patient, whether on a Sabbath or a weekday. He decouples the two issues, but offers no explanation for doing so.[21]

Importantly, however, Rabbi Auerbach adds:

> If the patient is God-fearing, and this will not disturb his mind excessively, it is preferable to tell him that one hour of repentance in this world is preferable to all of life in the next world, as seen in [Babylonian Talmud Tractate] *Sotah* (20b)[22]; and that there is "merit" in suffering for seven years rather than dying immediately.

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permitted to discontinue insulin administered to lower the level of glucose in the blood; provided in all cases that the patient is suffering.

(ix) Also, therefore, it is permitted to refrain from refilling medications or to discontinue administration of treatments that are given on a discrete rather than a continuous basis; for example, it is permitted to discontinue dialysis, to refrain from replacing a completed bag of IV dopamine, and to refrain from replacing a completed bag of IV antibiotics.

(5) These protocols are valid only for instances in which the patient is suffering. The protocols are applicable only to patients whose condition satisfies each of the enumerated criteria. In any other case, a competent rabbinic authority must be consulted.

[20] Avraham Steinberg, "Rules Governing a Doctor in an ICU" (Hebrew), *Assia* 63-64, pp. 18-19 (Schlesinger Institute 1998).
Professor Abraham S. Abraham maintains that Rabbi Auerbach did not agree with all of Professor Steinberg's protocols. See Abraham S. Abraham, *Nishmat Avraham*, *Y.D.* 320 D:1, p. 320.

[21] Rabbi Auerbach often does not articulate the precise reasoning in support of his positions, and the reader is left to reconstruct his rationale.

[22] The Talmud states that a Sotah – a woman determined through a Temple ritual to have committed adultery – endures an extended period of suffering prior to her death. Based on this, Maimonides offers the following description of the demise of a Sotah: "A Sotah who has merit of learning Torah, even though she is not obligated in it, does not die immediately… but suffers greatly for a year or two or three according to her merit and dies with a swollen abdomen and her limbs falling off." (*Mishne Torah*, Laws of *Sotah* 3:20). Rabbi Waldenberg adduces proof from this account that life must be extended at all costs. *Tzitz Eliezer* vol. 14 no. 80. Indeed, he takes this idea further, expanding upon the principle, "It is better one hour in this world spent in repentance and Torah study then the entire world to come" (*Sotah* 20a). The law of Sotah, according to Rabbi Waldenberg, implies that suffering brings about atonement, which can be achieved even in the unconscious patient. Thus, Rabbi Waldenberg recognizes the supreme value of life even in a case where the patient is no longer conscious and has no prospect of regaining consciousness. Such a patient is unable to engage in Torah, mitzvot and repentance, yet Rabbi Waldenberg would apply the full panoply of *halachic* protection to preserving and even extending the patient's life.

This latter idea is reinforced in another of Rabbi Auerbach's responsa, in which he comes much closer to the position of Rabbi Waldenberg. He does not dispute Rabbi Waldenberg's central thesis that the worth of human life is immeasurable and agrees that treatment should be pursued in many situations where life appears pained, unproductive, or potentially "not worth living." He writes:

> Even where it is simple and clear that the life of a [fully] paralyzed person is not worth living… we are commanded to extend [that life], and if he is sick we are commanded to desecrate the Sabbath, because the concept of "life" has no measure to gauge its worth… Furthermore, it seems to me even if the sick person is really suffering, so that according to *halacha* one is commanded to pray that he die, as was written by the Ran [Rabbi Nissim of Gerondi (ca. 1320-1380)] on [Babylonian Talmud Tractate] *Nedarim* 40a and quoted by the decisors, even while praying for the patient to die, one must repeatedly labor to save the patient's life and desecrate the Sabbath to save him.[23]

The cited imperative to pray for the early demise of a dying patient in great distress is based upon a story in Babylonian Talmud Tractate *Ketubot* 104a. The Talmud relates:

> On the day that Rebbi [Rabbi Judah the Prince, author of the Mishna, late second century CE] was dying the Rabbis instituted a fast and begged for mercy and proclaimed that anyone who said that Rebbi is dying should be stabbed with a knife. The housemaid of Rebbi climbed to the roof and said 'the heavens are requesting Rebbi and the earth is requesting Rebbi. May it be your will that the earth should overcome the heavens.' When she saw how many times Rebbi had to use the bathroom and remove his phylacteries and the suffering involved, she said 'may it be your will that the heavens will overcome the earth.' When she saw that the students continued to pray she took an urn and threw it to the ground. The students stopped praying [because of the sound of the urn breaking] and Rebbi's soul departed.[24]

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[23] Responsa *Minchat Shlomo* Part 1, ch. 91 no. 24:1.

[24] Babylonian Talmud Tractate *Ketubot* 104a.

The story implies that there are instances where death is preferable to life. Indeed, based on this account, Rabbi Feinstein concludes there are times when a patient should refuse certain medical treatments if they will serve only to extend his suffering.[25]

It is unclear why Rabbi Auerbach above chooses to rely on Tractate *Sotah* for the categorical principle that a suffering life is morally preferred over a quick and painless death, when Tractate *Ketubot* offers contrary implications. What can be said is that the contradictory imperatives offered by Rabbi Auerbach – pray for the patient to die while laboring to extend his life – is symptomatic of the tensions that the Rabbinic decisor contends with as he ventures to deal with these difficult issues.

However, the resolution of these tensions for Rabbi Auerbach is more nuanced than his statement of general principle would suggest. The case addressed by Rabbi Auerbach in this particular responsa involved a woman facing life-saving surgery that would likely render her a quadriplegic. Rabbi Auerbach concluded that this was a case where non-intervention was a *halachic* option. Relying upon God's mercy, the patient could, he said, elect not to undergo the surgery.[26]

Reconciling principle with practice in this responsum is not easy. Rabbi Auerbach appears to allow a patient through inaction to choose an almost certain death over an ineffective or painful life. On the other hand, existence in a debilitative stage of a "life not worth living" may not excuse efforts to prolong that life.[27] The important point, though, is that Rabbi Auerbach allows for at least some measure of patient input and autonomous decision to inform the level and quality of care to be afforded in end of life situations.

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[25] Responsa *Iggerot Moshe*, *C.M.* Part 2 no. 73:1

[26] Ibid.

[27] In secular jurisprudence, brain death is widely considered to be legal death. Rabbi Auerbach recognizes brain death to a limited extent. He terms a brain-dead patient a "*safek gosses*" – a patient who is possibly dead or at death's doorstep – which has special *halachic* status (Responsa *Minchat Shlomo Tanina*, ch. 86:5). Such a patient, for example cannot be moved or touched except for the patient's benefit, lest the patient's demise be accelerated. Rabbi Auerbach would allow removal of mechanical ventilation from a brain-dead patient.

**Personal Autonomy and Medical Treatment**

The conventional view in Jewish medical ethics, to which Rabbi Auerbach subscribes, is that a person does not have property rights on his body. A person's body is owned by God.[28] Taken to the extreme, this principle implies that a patient should have no discretionary authority over medical decisions pertaining to his or her life.[29] *Halacha*, as interpreted by competent Rabbinic authority, should in all instances control.

This position is forcefully articulated by Rabbi Yaakov Emden[30], an 18th century (1697 – 1776) Eastern European Jewish scholar. Rabbi Emden addressed the circumstance of an individual who refused medical therapy on the Sabbath and held that he may be compelled to accept treatment He wrote:

> In the case of an illness or wound which is exposed and about which the physician has certain knowledge and clear recognition and deals with a proven medication, it is certain that we always, in every matter and manner, impose therapy on a patient who refuses in the face of danger, because the physician has been granted permission [by the Almighty] to cure, for example, to do surgery, to open abscesses, and to splint a limb, even to amputate a limb, in order to rescue the individual from death. In all such cases, we perform the surgery even against the will of the patient because of [its life-saving character]. We ignore his will if he does not want to suffer and prefers death to life, and we even amputate a full limb if this is necessary to save his life, and we do all that is necessary for the saving of life against the will of the patient. This obligation is incumbent on every individual because of the command to "not stand idly by your friend's blood." And the decision does not depend on the opinion of the patient and he doesn't have the right to commit suicide.[31]

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[28] Responsa *Minchat Shlomo* Part 1, ch. 91 no. 24:2; Rabbi Shlomo Zalman Auerbach, "Consent for Medical Decisions," in *Bracha l'Avraham* pp. 135-136 (Schlesinger Institute, Jerusalem 2008).

[29] *Encyclopedia of Jewish Medical Ethics*, *supra*, p. 1055.

[30] Shimon Glick, "Who Decides: the Doctor, the Patient or the Rabbi?", *Jewish Medical Ethics Book* Vol. 1, the Schlesinger Institute, Jerusalem, 2004.

[31] Rabbi Yaakov Emden, *Mor u-Ketzi'ah*, *O.C.* no. 328. Translation by Shimon Glick.

It would seem that Rabbi Auerbach would take issue with this uncompromising position and allow that autonomy is a viable basis on which to render medical decisions. In some cases, it may even be the primary mechanism to do so.

As we have seen, in the case where life-saving surgery could induce quadriplegia, Rabbi Auerbach ruled it *halachically* permissible for the patient to decline medical intervention.[32] Rabbi Emden would likely have compelled the surgery. While living the life of a quadriplegic, the patient could have engaged in Torah study, introspection and repentance, using a body belonging to God, albeit an impaired one, to engage in activities of ultimate religious worth. Nonetheless, Rabbi Auerbach would seemingly allow for the substitution of a potentially morally undesirable option, as determined by a literalist application of the supreme value of human life, for what appears to our sensitivities to be a morally preferable one.

In another responsum Rabbi Auerbach allows a terminally ill patient to take a pain reliever such as morphine[33] that will lower his breathing rate and therefore shorten his life, using the rationale of *shomer petaim Hashem* – God watches over fools – and the commandment to "Love thy neighbor as thy self."[34] He writes:

> Being that suffering is very hard on a person and difficult to tolerate, as we see from the Talmudic dictum, "Had Chananya, Mishael and Azariah been tortured they would have acceded,"[35] it is evident that we must have mercy on the patient and lessen his suffering and palliate his pains, in particular because it is possible that strong pains weaken and harm a patient more than the

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32 Responsa *Minchat Shlomo* Part 1, ch. 91 no. 24:2.

33 *Nishmat Avraham Y.D.* 399 D:1, p. 321.

34 Responsa *Minchat Shlomo Tanina*, ch. 86:2, Shimon Glick, "Questions with Rabbi Shlomo Zalman Auerbach: Shortening the Life of Dangerously Ill Patients," *Assia* 59-60, pp. 46-51 (Schlesinger Institute 1997).
Another contemporary *halachic* authority, Rabbi Avigdor Nebentzal, has disputed this position. See, Avigdor Nebentzal "The Giving of Medication to a Dangerously Ill Patient in Order to Mitigate Pain," *Assia Book* 4, 260-262 (Schlesinger Institute). On the other hand, Rabbi Eliezer Waldenberg, despite his uncompromising advocacy for extending the life of a terminally ill patient, allows administration of pain medication that may hasten death. He bases this position on the verse "And you shall surely heal" (Exodus 21:19), from which *halacha* derives the physician's permit and imperative to minister to the sick. See Jotkowitz, *supra*.

35 Babylonian Talmud Tractate *Ketubot* 33b.

> medications [to ease the pain]. If the patient is conscious, I believe that it is necessary to tell the patient what is being done to him, if in any event he knows his present state. However, even if he is not aware [of his state], [we may apply the principle] found in [Babylonian Talmud Tractate] *Sanhedrin* 84b, as explained by [the Talmudic exegete] Rashi, "Love thy neighbor as thyself – Israel is prohibited to do to others what they themselves would not want for themselves."
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> In the case before us any patient would prefer to palliate his pains even if this would hurt his body; therefore we have a presumption that this is the will of the patient. It is self-evident that this is so only when the purpose is palliative in nature, and the fact that this hastens his death is likened to a *pesik reisha* [inevitable side-effect] that is undesirable. We also find in the Talmud many places where people do many things that are dangerous; however, since many [are willing to accept the risk] (*lit.* tread upon it) it is considered *shomer peta'im Hashem* [God watches over fools]. Since it is the way of all patients to do this, it is good to apply the principle of *shomer peta'im Hashem* in our case, and we must palliate the pain. May God have mercy.[36]

Here, Rabbi Auerbach appears to advance the idea of patient autonomy a step further. Not only do we act upon the express wishes of the patient, we may make treatment decisions based upon the patient's presumed will.

**Right of Consent**

In a recently republished responsum written to Professor Avraham Steinberg, Rabbi Auerbach extended the level of autonomy of a patient further, requiring patient consent for certain medical treatment. Rabbi Auerbach responded to the question of whether a doctor is considered to have committed battery if he or

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[36] Responsa *Minchat Shlomo Tanina*, ch. 86:2. Rabbi Auerbach's position here is very similar to the Catholic concept of double effect. See John Paul II, "Euthanasia," in *On Moral Medicine* p. 443 (Eerdman's 1989). Rabbi Auerbach, however, limits his position to cases where the medication will not result in the patient's immediate death.

she applies therapy beyond the norm or without appropriate consent. Rabbi Auerbach wrote:

> It seems to me that if the therapy was beyond accepted practice then the doctor has assaulted the patient, even if this was done with the best of intentions… I think that even in an extreme situation a doctor cannot perform a dangerous surgery, or amputate a hand or foot, without the consent of the patient, even if the doctors are certain the procedure is necessary. If the patient is unconscious, the family members may consent on behalf of the patient based on their understanding of what the patient would want. However, if there is no danger whatsoever the patient himself must consent. [37]

Rabbi Auerbach qualifies this right of consent. He notes that there is presumed consent for most therapies in a hospital setting, since patients are generally hospitalized of their own will, although "for a surgery or a difficult (painful) test, consent may be needed."[38] The consent need not be what we would regard as "informed." A doctor can say simply, "This is my recommendation and if you don't want to follow my advice you can go to a different doctor or a different hospital."[39] Also, Rabbi Auerbach allows treatment against the will of a psychiatric patient, though it is preferable to obtain a family member's consent. [40]

**Resolving the Conceptual Conflict**

Steinberg addresses the seeming contradictions in Rabbi Auerbach's medical jurisprudence, at once affirming the supreme value of life and recognizing divine ownership of our corporeal being but also empowering the patient to decline life-saving treatment. There is a tension, he explains, between the obligation

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[37] *Consent for Medical Decisions*, *supra*, pp. 135-136. Rabbi Auerbach commented here in regarded to the responsum of Rabbi Emden quoted above. Rabbi Emden's response was cited to Rabbi Auerbach in a question posed to him by Professor Steinberg.

[38] Ibid.

[39] Ibid.

[40] Ibid. Rabbi Abraham quotes Rabbi Auerbach as saying that a pregnant woman can elect to abort a fetus that is endangering her life. She can say, "I do not wish to provide nutrition to this fetus." See *Nishmat Avraham*, *C.M.* 425 (A), "Abortion," no. 6 p. 285. This is another apparent instance of Rabbi Auerbach's support for patient autonomy in medical decision making.

to save life and the obligation to alleviate suffering, but each has its scriptural source.[41] The obligation to mitigate pain derives from the commandment of "Love thy neighbor as thyself." (Leviticus 19:18) The obligation to save a life is based on imperative of "Thou shall not stand by thy neighbor's blood." (Leviticus 19:16) The tension between these two imperatives creates a grey area that gives patient autonomy a sphere of influence. This swath of patient autonomy afforded by Rabbi Auerbach, at least in some cases, approaches what is advocated by conventional medical ethicists.

Benjamin Freedman offers other explanations that may provide insight into Rabbi Auerbach's approach. Freedman acknowledges a universal commandment to provide care and healing to a sick person, but posits that this obligation rests first and foremost on the patient and his family. The closer the relationship to the patient the greater is the *halachic* obligation of care. For this reason, for example, a family member may be required to do all, that he or she is able to impress upon a relative to quit smoking, while the family physician may have no such obligation. With responsibility, however, comes authority. Having the greater *halachic* responsibility for the welfare of the medical patient, the patient and secondarily his or her family is also afforded greater say in treatment.[42]

Resolution of the conceptual conflict lies in the relationship between the individual and his or her body. While it is true that our bodies are property of the Almighty, we are stewards of our physical existence, commanded to care for and eventually return it to its Maker. As a guardian, we are permitted and even required to make intelligent and insightful decisions regarding the bailment entrusted to our care. This is not to say that an individual is given free reign over his or her life, and a patient may not refuse prudent medical care under normal circumstances. However, in cases where death is inevitable or imminent and there is a conflict between the

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[41] *Rules Governing a Doctor in an ICU, supra*; *Encyclopedia of Jewish Medical Ethics*, *supra*, p. 1052.

[42] Benjamin Freedman, *Duty and Healing: Foundations of a Jewish Bioethic*, pp. 139-142 (Routledge 1999).

duty to palliate pain and the commandment to preserve life,[43] the patient is the authorized arbitrator.[44]

Left to be resolved is the seeming conflict between the dispensation to violate the Sabbath on behalf of a terminally ill patient in life-threatening distress and the autonomy that allows the patient to decline medical care in these same circumstances. Rabbi Waldenberg cannot accept the notion of a physician's desecrating the Sabbath to treat a patient authorized by *halacha* to refuse that treatment. Rabbi Auerbach is prepared to live with this dichotomy, perhaps because he views the seemingly conflicted *halachic* concepts as directed to different actors.[45] The precept of "Thou shall live by them and not die by them" (Babylonian Talmud Tractate *Yoma* 85b) is directed to man as caregiver. It is unqualified and precludes application of Sabbath laws that will lead to a patient's death, even if death is in any event imminent or unavoidable. But it is not necessarily directed to man as patient. The patient may rely on another *halachically* sanctioned principle. "The heart knows the bitterness of the soul," say the Rabbis. (Babylonian Talmud Tractate *Yoma* 83a) This principle mandates feeding a dangerously ill patient on Yom Kippur on his own say-so,

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[43] It is obvious to Rabbi Auerbach that a patient ordinarily can be forced to accept treatment that offers more then a fleeting extension of life. This is based upon the "immeasurable value of life." See Responsa *Minchat Shlomo* Part 1, ch. 91 no. 24:1.

[44] It is possible that Rabbi Auerbach does not have full confidence in medical science and believes that a patient may have more insight into his condition than the physician. Rabbi Abraham Isaac Kook (1865-1935), who officiated at Rabbi Auerbach's wedding, also questioned the certainty of medical diagnosis. See Rabbi Abraham Isaac Kook, *Daat Kohen*, ch. 140, p. 259.
In what may be a similar vein, Rabbi Auerbach resisted medical definition of death. He wrote, "One is not to rely on medical science to establish definitively whether a patient has died. And it is a wonder [to me that a doctor should presume to establish death], because the certainty [of death]… is a matter between a person and his Maker." Responsa *Minchat Shlomo Tanina* ch: 86:5; 4th of *Cheshvan* 5753 part 2.

[45] The idea of what may be termed conjugate conflicting concepts in Jewish ethical thought has been attributed to Rabbi Israel Salanter (1810-1883). As an example, scripture terms a delinquent borrower a *rasha*, a bad person. (Psalms 37:21) Yet *halacha* obligates a lender to avoid confronting a delinquent borrower so as not to cause the borrower consternation or embarrassment. See Maimonides, *Mishne Torah*, Laws of the Lender and Borrower 1:3. Rabbi Israel Salanter would resolve the seeming conceptual conflict by observing that the concepts are directed to different actors. The first is directed to the borrower, who must know that his failure to repay is wrong. The second is directed to the lender, who must nonetheless accord basic dignity to the borrower (transmitted in the name of Rabbi Chaim Y. Goldvicht, late dean of Yeshivat Kerem B'Yavneh).

even where the expert physician opines that feeding is unnecessary.[46] Perhaps it also supports exercise of autonomy to decline treatment, where the patient believes the benefits of treatment are outweighed by the degradation[47] in the physical and emotional state of being that such treatment would entail.

This dichotomy can seemingly function in the opposite direction as well, according to Rabbi Auerbach. Where a terminal patient experiences constant and unremitting pain, the principle of "Love thy neighbor as thyself" may compel the physician to desist from care that extends a patient's suffering, to the point of following a palliative regimen that will actually shorten the patient's life. Rabbi Auerbach nonetheless recommends, but does not require, that the patient elect to live a life of suffering rather then opt for a quick and easy death. This is in keeping with the principle of "One hour lived with repentance and good deeds in this world is superior to all the days of the World to Come." (Mishna Tractate *Avot* 4:17) Rabbi Auerbach would say that there is no contradiction here, since the individual physician and patient would be following his or her own Torah directive. The optimum religiously ethical course may be a continued life of suffering lived in the ways of the Torah. The patient is urged to choose this course. But the physician cannot be righteous at the patient's expense.

**Principles**

It may be useful to outline the ethical imperatives to which Rabbi Auerbach subscribes and which emerge from this discussion.

1. Life is of immeasurable value –

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[46] *Shulchan Aruch*, *O.C.* 618:1

[47] Contemporary *halachic* decisors also address the competition of the terminally ill patient for scarce medical resources. Rabbi Auerbach (Responsa *Minchat Shlomo Tanina*, ch. 86:1) responded to an inquiry by a South African doctor whose hospital proscribed the use of ventilators for terminally ill patients, so that the devices would be available for patients who had prospects for cure. Rabbi Auerbach held that the doctor was required to adhere to hospital policy, although he was unsure whether the hospital policy was justifiable. In contrast, Rabbi Wosner (Responsa *Shevet ha-Levi C.M.* 242) ruled that the doctor should not abide by the hospital policy, while Rabbi Moshe Sternbuch (Responsa *Teshuvot v'Hanhagot C.M.* 858) seems to concur with the policy. All rabbinic decisors agree if a terminal and a curable patient are competing for a single available ventilator, the ventilator should be given to the curable patient. Similarly, all agree that a terminal patient may not be disconnected from a ventilator so that the device can be used for a curable patient.

- the sanctity of life is a paramount ethical consideration; and
- extending life is desirable in all circumstances, as it allows for repentance and Torah study.

2. A patient has a right of autonomy, defined as a right to choose among treatment options, including the right to decline treatment in certain circumstances.
3. Mitigating patient suffering – correlating with the value of beneficence in the vernacular of medical ethics – is a valid *halachic* treatment consideration.

In cases where these principles conflict, there is room for different *halachic* outcomes depending on individual circumstance and preference.

**Conclusion**

Rabbi Shlomo Zalman Auerbach addressed end-of-life treatment in a number of responsa. He employed a variety of principles to adjudicate the very difficult and heart-rending cases that often arise in this area. What is striking about Rabbi Auerbach's approach is the significance he ascribes to the wishes of the patient, what has been called patient autonomy. Rabbi Auerbach's approach evidences at once a fierce commitment to the *halachic* system as well as a keen sensitivity to the human condition.

Source: ***ASSIA – Jewish Medical Ethics,***

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