# The Terminally Ill Patient

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### Introduction

The purpose of this lecture is to present the medical, ethical and social aspects of the problem, as well as a number of halachic principles concerning the terminally ill patient, serving as an introduction to the main part of the session – a halachic analysis presented by Rabbi Zalman Nehemia Goldberg.

### The Extent of the Problem Today

The issue of terminal illness has become a very problematic subject. This is not because we have invented death or because death is a recent phenomenon. We all know that as a result of Adam's sin in the Garden of Eden man became mortal. In the past not a small number of associated problems existed but in recent years the problem has intensified for a number of reasons.

The main reason for the intensification of the problem today lies with technical, medical and scientific developments to lengthen life to an extent unknown in the past. However, an increase in the duration of life is not always accompanied by an improvement in the quality of life.

The second reason is that there is wider involvement in the treatment of patients. It has been calculated that a patient lying in hospital has about a hundred people who know about his case. This obviously includes the various physicians and specialists, the nurses on their different shifts, social workers, admission clerks, laboratory technicians, etc. And of course each person has his own opinion and view, and everyone wants to be involved. The involvement of all of these people heats up the debate, sometimes for the good, other times not.

In addition to those in direct contact with the patient there is also the wider community which becomes involved by means of print and electronic media, through the legal system and through the legislators. All of these add their voices – both in individual cases and with regard to principles – and of course every case

becomes much bulkier and more complicated as more and more people start taking an interest.

At the same time, painful problems of limited resources have arisen. Here again, these problems are not an invention of the modern age, but they have certainly intensified greatly in recent years, and as a result our question in this regard is how much justification there can be for prolonging one person's life with resources that could be used for another purpose.

**Medical Background**

The population we are dealing with includes the aged, patients suffering from a variety of terminal illnesses, and infants born with serious birth defects. In other words, people whose quality of life seems greatly reduced, and whose survival is expected to be short. Our question is what should or should not be done for them.

In order to deal with this question I would like to start with some medical background because we cannot deal with ethical-halachic-legal matters without the facts before us. There is no point in arguing what should be done with a certain patient while we lack the principal medical facts pertaining to his case.

The facts relevant to a halachic-ethical discussion are: What is the diagnosis? Is the situation really terminal (we shall soon discuss the definition of this concept)? What is the prognosis – both in the short term (for example, if we attempt resuscitation, will we succeed) and in the longer term (if the resuscitation is successful, what will the patient's condition be following the procedure)? What options are at our disposal for treatment of this patient?

**1. Placement of the Terminal Patient**

Regarding location, we are witness to a number of changes in today's society which create new halachic questions. In the past, most people died at home in a familiar and comfortable environment. Today most people die in hospitals or in homes for the aged, places which are strange and cold to them and where there is no supportive and loving atmosphere but which, on the other hand, provide better medical treatment than would be available to them at home.

To create a balance between the advantages of the home and those of the hospital, institutions called "hospices" have been established during the past 25 years, providing excellent supportive

treatment – much better and warmer from a human point of view than one would find at a general hospital, but without all the services offered by a hospital. I shall not discuss here the quality of the hospice and the halachic and ethical questions to which the very concept gives rise. However, all this information must be taken into consideration when we weigh up where a particular patient should be placed.

**2. Pain Relief**

Pain is another medical subject. We all fear pain when we imagine the final stages of life, the time when the cancer hurts terribly and when there is pain that is sometimes unbearable. In truth, there is almost no need today for a person in his final stages to suffer any significant amount of pain. If we adopt the correct attitude towards pain and the correct methods in dealing with it, we can prevent much unnecessary suffering.

Pain, or the treatment of pain, is no less respected or sophisticated a specialization than neurology, geriatrics or any other medical field. But I believe that anyone who has ever been in hospital can testify that if a patient arrives with some medical problem, leading medical experts are consulted and they have meetings and discuss what should be done. But if the patient is lying in agony, shouting and screaming with pain, the physician and nurses sit calmly and drink coffee, waiting for the four hours since the last dose of morphine to go by before they come to his assistance. This approach is patently incorrect on the medical level, and obviously creates a critical moral-halachic problem. Today there are extremely effective methods for controlling pain which, fortunately – and contrary to popular belief – have relatively few side-effects and complications.

Even the complication which is obviously inapplicable in these cases – that of addiction – is rare even in absolute terms. The main question which constantly occupies us is whether, administration of pain killers necessarily shortens the patient's life. The facts would seem to show that this is not so if pain killers are administered correctly. I shall not expand here concerning means and methods, but anyone who deals with terminal patients who suffer from pain should familiarize himself with this subject and adopt the appropriate attitude towards it. I shall discuss what should be done when complications do arise.

**3. Resuscitation**

The next medical question is that of resuscitation. The method of resuscitation used today, i.e. external cardiac massage and artificial ventilation, is relatively new. I shall not discuss the historical aspects and Biblical sources which make reference to the actual possibility of performing such a procedure, but the modern method of resuscitation is a relatively new one. It was developed in the 1960s and was originally used for patients who had suffered sudden cardiac arrest or respiratory arrest. Methods were expanded to include treatment of terminally ill patients whose heartbeat and breathing at some point obviously stop.

When dealing with resuscitation we are speaking, *inter alia*, of the meaning of success of the resuscitation. Success can be measured in terms of survival. Will the physician succeed in performing the necessary procedures such that the patient will recover and go home? We can also speak of partial survival. In other words, the patient remains alive but will be connected to a ventilation machine. We can speak of survival with neurological damage as a result of the time that has lapsed without blood supply to the brain, in which case this person will remain alive but severely brain-damaged.

The figures and data about this in medical literature are confusing. The same can be said regarding the extent of damage: some speak of a very low percentage of damage while others speak of higher percentages, such that in effect we have no reliable figures concerning the success rate for resuscitation.

We do have data indicating that in certain well-defined medical situations the success rate for survival is negligible or non-existent, and this fact is taken into consideration on both the medical and halachic levels when deciding whether, under certain conditions, resuscitation should be attempted at all.

There are two more questions regarding resuscitation. One concerns the time factor: for how long should the resuscitation attempt continue before we accept its failure and declare the patient dead? There are those who are prepared to specify a certain time – ten minutes, twenty minutes, thirty minutes of attempted resuscitation. Others claim that no amount of time can be fixed because there have been cases where attempts that lasted longer than thirty minutes were eventually successful, even highly

successful. This question, too, is open to medical debate with halachic ramifications.

Age, too, is a medically controversial issue. Does age alone have prognostic significance with regard to chances of success? Are resuscitation attempts more effective and more successful when performed on a twenty-year old with a certain medical condition than they would be when performed on the same person with the same condition at the age of ninety? This is an open question, and opinions are divided. But most researchers hold that from a medical point of view age is not a deciding factor.

**4. "Vegetative State"**

The last medical subject which I would like to address briefly is what today is termed the "vegetative state." I believe that this is a highly unfortunate, inhuman term. Without going into too much detail, we are speaking of a person whose cerebral cortex is completely destroyed, while his brain stem is completely healthy. Hence his condition is such that he is aware neither of himself nor of his surroundings, but his body continues to perform all the vital functions necessary to continue living. He breathes unassisted with no need for a ventilation machine. His heart beats, he sleeps and wakes, digests food, etc. Generally, healthy people who reach this condition can continue to live like this for many years without any hope of recovering.

The question of pain in this situation is an important one from a moral point of view, but medicine is unable to provide a clear-cut answer. From a medical point of view it would seem logical that if the cerebral cortex has completely ceased to function, pain has no meaning. (Pain is really the perception of pain, awareness of pain, and if there is no awareness, for all intents and purposes there is no pain.) But whether or not this is really true remains unanswered.

Hence some of the questions left open by medical facts give rise to the great dilemma (perhaps the greatest dilemma in medicine): that of the unknown. What are we to do with a person whose diagnosis is unknown, whose prognosis is unknown, and whose chances of survival or risks of neurological consequences are unknown? How are we to relate to statistical data when we apply them to a specific, individual patient?

**General Ethical Principles**

I would now like to move onto a number of approaches within general ethics. Ethicists have defined a number of moral principles which are relevant to our discussion:

**1. Value of Human Life**

Although it is not always considered important today, I believe that the first principle is that of the value of life as an independent principle. I believe that it is clear that, from the Jewish point of view, human life is at least a primary value (even if many hold that it is not an absolute value), and certainly one of the most important values which we are commanded to protect. During recent years no small number of ethicists, even prominent ethicists, have renounced this value. In their opinion there is no longer any value attached to life in and of itself. Instead they have replaced this concept with that of "quality of life." Today they speak of a situation where we have to categorize the value of life and debate whether we are dealing with a life of a certain quality. Only if this is the case does this life have value. If the life is of a lesser quality, then perhaps it has no value at all or at least its value is greatly decreased. I believe that this represents a very serious problem from the point of view of ethical thought.

**2. Autonomy and Paternalism**

The second revolution which has taken place within the conceptual system of ethical thought in recent years is the appearance of the concept of the "autonomy of the patient," which is intended to replace the concept of "paternalism." Hypocrates demanded a relationship between patient and physician based on what is known as the paternalistic model. In other words the physician determines what is good for the patient based on the assumption that he has a better grasp of the situation, the facts, the possibilities, and the complications, and has accumulated experience through treating other such patients, and therefore is in a better position to decide what is good for this specific patient.

This approach has been done away with altogether in the United States, for example, and has been replaced by the concept of the autonomy of the patient. Autonomy of the patient means that only the patient decides what is good for him. Even if he is mistaken, even if what he wants is dangerous, and even if his

decision is stupid, it is his decision that holds, on condition that he is competent in his faculty of judgment and ability to decide, and as long as his autonomous decision does not impinge on the autonomy of others.

This approach, which puts autonomy before anything else, in fact denies the entire system of social values. If every person can decide for himself what his values are, and if he lives according to them, he has no real connection with others or with society in general. If it is taken to its logical extreme the idea of autonomy actually parallels that of anarchy.

The alternative approach is that of paternalism. This approach is also not devoid of problems, particularly as regards serious ethical, moral and halachic issues. Which physician can decide for a patient whether he is worthy of living or unworthy of living? We are forced to seek other approaches.

**3. Beneficence**

I would like to mention another moral principle known as beneficence or loving-kindness *(gemilut chassadim*), according to which a person is obligated to help others. In our context this is quite a problematic concept. What help should a physician administer to a terminally ill patient who is suffering? Should the help take the form of battling for his life using all existing means, thus prolonging his suffering, or should he help him by refraining from treatment and allowing him to die with less suffering?

**4. What is Terminal Illness?**

We have been speaking of a terminal situation, of a terminally ill patient. This concept has no definition. In effect, we are all terminal. The most serious and dangerous disease that a person can contract is called life, because it is the one thing that we know for certain will lead to our death. As regards any other illness, perhaps we shall die of it and perhaps not. So what do we mean when we speak of a terminal situation? What is the definition of terminal illness?

This is a very difficult question. The definition is difficult on the medical level particularly with regard to the amount of time left to the patient. Are we to say that a person is terminally ill if we know for certain that he will die within three days. Or is he

terminally ill if we know that he will die within a month, or in two years time? How do we define "terminal?"

There are no clear answers to this, and the issue is highly controversial. I raise the issue simply to demonstrate the difficulty inherent in the definition.

**5. Futile Treatment**

This term refers to treatment that will not be effective. As a result we may consider the possibility of refraining from it. But how are we to define ineffective treatment? If I resuscitate the patient knowing that as a result of this procedure he will live another two hours, do we say that this treatment was effective or ineffective? In other words, what am I really measuring in order to decide whether treatment is effective? Clearly, the definition of effectiveness must be judgmental rather than factual except where it is clear that the procedure will have no effect whatsoever (physiologic futility). For example, if I attempt to perform resuscitation on someone who has already been dead for a long time, the procedure will achieve nothing. It is clear that attempted resuscitation of a dead person, where the heart stands no chance of starting to beat again (nor can any other sign or definition of life be expected), can be medically defined as futile treatment. But any other definition of futile treatment is really subjective.

**6. Quality of Life**

Quality of life, which I mentioned previously, is also a very difficult concept to define. Even if I can define what quality of life I want for myself, the edges of the decision are clearly problematic. There is a well-known story of a violinist who devoted his whole life to playing the violin. His fingers were accidentally severed. He now claims that his life is worthless: If he can no longer play his violin, his life has no value. I do not believe that any responsible person would accept this as an operative definition indicating that the violinist's life should be terminated.

But a more serious problem is that of defining quality of life as it pertains to others. Physicians treat patients who are retarded, senile, or insane, and whether the quality of each patient's life is good for him or her is a question which no one can answer.

**7. The Right to Die with Dignity**

Recently we have been hearing new ideas about the right to die with dignity. I shall not get into an argument about these ideas because they actually do not mean anything, but there is one point which I do wish to make. Many people have the feeling that we are moving from the stage of "right to die" to one of "duty to die;" from a situation where a person wants society to respect his wish and enable him to die at a certain stage without making an effort to revive him, to a situation where people feel that they are a burden on society, a burden on their families, a burden on the economy, and hence it is their obligation to depart from the world for the benefit of others.

**Practical Aspects**

Having briefly analyzed some of the philosophical principles, let us now turn our attention to the more practical aspects. When we speak of a terminally ill patient and we wish to decide what to do or what not to do, we are really discussing the patient, the treatment, and the final decision-maker.

**1. The Patient**

With regard to the patient, we must distinguish between a number of sub-categories.

The first category consists of those patients who are terminally ill but fully conscious and able to make decisions in the final stages. This is a numerically small group, and one for whom the principle of autonomy has significance. These are people who are already in a terminal situation, they are suffering, and they wish that their life not be lengthened – or even that it be shortened. Their request is an autonomous one, and therefore we have to decide whether to respect it, according to the values of autonomy or paternalism.

The second category includes patients who were once competent, but now when we are deciding whether or perform a certain medical procedure they are no longer competent. They are either senile, unconscious, depressed, etc. We can further divide this group into two sub-categories: one consists of those who, when they were competent, expressed what they wished be done with them when they became non-competent, and the other of those who made no such arrangements. This earlier expression of a wish for the future can be performed in a number of ways. One way is

through a "living will," a document in which a person states that if he reaches a situation where he is incapable of making decisions, he wishes that such and such be done. Such documents have several inherent problems, and in Israel a living will is not binding. There are two main problems: firstly, it may be that a young person – twenty or thirty years old – wanted things that a twenty-year old usually wants. But when he became non-competent he was eighty, and often an eighty-year old person has different concerns in life. Perhaps it was important for him to remain alive a little longer and to see his grandson's bar-mitzvah, which he may not have thought of when he was twenty. And this person may have changed his mind about what he wanted, but simply never got around to changing his "living will." The second problem is that no document can possibly cover all the options and possibilities that may actually occur. Thus when a medical situation arises it is difficult to decide whether that is what the composer of the will had in mind when he wrote it.

As a means of correcting some of these problems the idea of a proxy has been suggested, i.e. appointing someone who will make decisions on behalf of this person who is unable to decide himself. This is also a problematic solution, and I shall not elaborate on it.

Most people who reach the stage we are discussing today once possessed their faculty of judgment but are no longer able to make decisions, and at the time when they were able to do so they did not write or express in any formal and convincing manner what they wished be done with them. Even in the United States, where the writing of a "living will" is possible and legal, the number of people who do so is small.

Dr. Sonnenblick and I conducted research to find out what happens to patients like this, people who once had a faculty of judgment but no longer possess it; we wanted to find out what they would have wanted others to do with them. It seemed logical to ask their children. It turned out that in a large percentage of the families there was no agreement among the children as to what their father or mother wanted. Therefore there is no point in asking a family member, because his brother or sister may well think exactly the opposite – not with regard to what he or she wants to do, but with regard what he or she thinks that the father or mother would have wanted.

The last sub-category consists of those who never possessed a faculty of judgment – babies with birth defects or children who

were born severely retarded. We can never know what they really wanted, and the question facing us is what we should do with them.

**2. The Treatment**

The next practical aspect is that of treatment. What are the treatment options at the disposal of the physician in charge of the patient whose situation is defined as terminal? In principle, there are three possibilities. One is to kill the patient. He seems to be suffering and does not wish to suffer any longer. We can simply inject KCE or cyanide and thereby remove his pain at the expense of his life. This may – and should – sound terrible, but unfortunately this is an option which is actually carried out in Holland, and it has supporters in other Western countries as well. This approach is termed active euthanasia.

The second possibility is the opposite, i.e. the requirement that every effort be made, at every stage and in every situation to prolong every life even if it means prolonging life by one minute or one hour and even if it means prolonging unbearable pain. According to this view, human life is an absolute value, and therefore everything must be done to prolong it. In other words, one should concentrate only on the value of human life with no thought of autonomy, suffering, or any other consideration.

The third approach is a balance between these two or, if you wish, the "golden pathway" between the two extremes. This approach holds that under certain conditions, which must be carefully defined, it is permissible to refrain from prolonging life, but it is always forbidden to perform an action that will actually shorten life.

Now, what can we do in order to choose between these options? As we have said, if the decision in principle is that we should prolong the life of every patient and make every effort with every possible treatment, then no further consideration is necessary. On the other hand, if we are prepared to kill such patients, then again we have no further questions. But if we accept the option which states that we may refrain from prolonging life because of the patient's suffering but may not actually shorten his life, then each case has to be weighed up individually in order to decide which possible treatments we should administer to the patient and which should be avoided. Are we obligated in every case to perform resuscitation, or may we sometimes refrain from it?

Are we obligated in every case to connect the patient to a ventilation machine if he requires it, or are there times when I may refrain from doing so? Must dialysis always be given, or blood transfusions, or antibiotics or other medicines when required? This is a list of problems which confront us on a daily basis. The question of what to do with the patient in front of us, which treatments to try and which not, is a consideration we face continually.

The question, therefore, is how do we decide which of these treatments is appropriate and which not. Is there any type of guiding principle? I shall not list all the suggestions that have been raised. I would like to emphasize the principle which distinguishes between natural and artificial treatment, and – perhaps as a variation – between treatment which is not directly related to the terminal illness and treatment which is directed towards that illness itself (and insofar as we define this illness as fatal, such treatment is ineffective.)

For example, let us assume that a patient is suffering from a malignancy, and the treatment for this is chemotherapy or radiotherapy. In certain situations we are permitted to refrain from administering this treatment. On the other hand, the same patient in a terminal situation may contract pneumonia, which is not related to his malignancy, and he needs antibiotics. This is part of the routine treatment administered to any patient whether his situation is terminal or not, and therefore it falls under the category of natural treatment. And of course provision of food and liquids is always categorized as "natural" treatment.

An additional point is the difference between refraining from life-prolonging treatment (withholding) and termination of such treatment after it has already commenced (withdrawing). For example, a patient arrives in the emergency room suffering from cardiac arrest, and the consensus is that he is not going to survive. The decision is taken not to attempt resuscitation. This decision involves refraining from a certain treatment. But let us suppose that we decide that he does stand a chance of surviving, and therefore we try to resuscitate him and connect him to a ventilation machine. After two or three days on this machine his situation is reassessed and we conclude that he will never breath independently again. Whether or not to disconnect the ventilation machine is a question of terminating a treatment which has already commenced.

Is there a difference between refraining from life-prolonging treatment and terminating it? Rabbi Goldberg will address these questions.

**3. The Decision-Makers**

And finally, we actually have to decide, and the question is who makes the final decision. There is a long list of possible candidates, each with his own advantages and disadvantages. I shall not explain each of them in detail. I imagine that everyone understands them. I shall deal with only three from among the many possibilities:

**a. Family Members**

Rabbi Goldberg will deal with the halachic status of family members in the decision of what to do with a terminally ill patient. I would like to mention that the family sometimes has its own interests at stake in the decision, and sometimes the benefit to the patient is not their only consideration. Such a situation often represents a considerable financial burden, or an emotional one, and the decision is sometimes taken for the benefit of the family and not always for the benefit of the patient.

**b. The Courts**

About ten years ago it was decided in the United States that the courts were best equipped to make this decision. I believe that such a conclusion is problematic. The United States, too, has discovered that this approach is not ideal for various reasons, both practical and moral.

**c. Ethics Committees**

For the above reasons the current approach in the United States is the establishment of ethics committees, in other words committees including representatives of various professions, within the hospital. They are accessible, and they comprise representatives of various relevant professions, not only physicians, but also legal experts, philosophers, religious leaders, ethicists etc. They deal with each case individually.

In Israel, to the best of my knowledge, no such committee exists. I am quite skeptical as to whether such an institution would achieve its goals in Israel. We all know that three Jews have six opinions, and if twenty Jews sat together I imagine that they would

end up with an endless number of arguments that would contribute nothing to solving the problem. But perhaps this solution is really what is required.

All of these solutions are attempts to solve the problem within a pluralistic society comprised of people who have differing views and beliefs and lacking a single common moral basis. Some solution must be sought in order to resolve differences of opinion.

**Halachic Principles**

In the system of halacha the best and most logical solution is to refer such questions to a rabbi. Clearly, the rabbi's halachic decision as to whether to resuscitate is not qualitatively different from a decision as to whether a certain food may be eaten or whether a certain activity is permitted on Shabbat. All of these issues are anchored in the halachic system, and therefore the rabbi's decision in this regard is an ethical and pertinent one for people who live their lives according to halacha.

**1. Halachic Concepts**

I would like to preface the discussion of the halachic aspects with a number of basic principles which will serve as an introduction to Rabbi Goldberg's responses. First of all, from a halachic point of view there are a number of relevant concepts, and I shall not define all of them. I do not believe that they are accurately definable using concepts we have today. But halacha does delineate certain steps in the death process, different situations and different periods of time.

For example, there are those halachic authorities who define as a terminal patient (*tereifah*) someone who will live less than a year, while others say that this period of time defines *chayei sha'ah* (literally "life of an hour") – i.e. someone who has a very short time to live. The situation of "dying" (*gossess*) is defined as being a matter of three or four days. These concepts were defined in terms of periods of time; as mentioned above, the operative definition of exactly what "dying" means is not clear today as it pertains to our situations. Obviously, newer phenomena such as the "vegetative state" and coma require a decision by halachic authorities as to which category they belong to.

Again I repeat that the concept of "terminally ill" is not a halachic term. It is conceptually problematic because, we do not know exactly what we mean by "terminal."

**2. Value of Human Life**

From the point of view of halacha, human life is clearly one of the most important values. But is this value unlimited and absolute, or is there a certain limit to it? This is a debatable question, but certainly it is important to understand that according to halacha life is holy, and the status of the value of human life is such that all the prohibitions of the Torah, with the exception of three, may be transgressed in order to save a life.

**3. Ownership of One's Body**

We have heard the opinion of Rabbi Yisraeli in his argument with Rabbi Zevin as to whether a person has ownership of his body. Even according to Rabbi Yisraeli, it is clear that a person has no right to harm himself. Therefore this principle must be taken into consideration when we discuss suicide or wounding oneself.

**4. The Role and Trustworthiness of the Physician**

What is the physician's mission? Halacha states, 'And he shall surely heal' – from here we learn that permission is granted to the healer to heal." The physician is granted the right to heal, under no circumstances does he have the right to take life. Therefore the physician cannot be society's hangman.

The weighty medical problems which I mentioned earlier have some bearing on the halachic principle known as the "trustworthiness of the physician," or the trustworthiness of medicine. The possibility of a mistaken diagnosis, the possibility of a change in condition, the possibility of new discoveries in medicine (such that even if the situation at present looks terminal, perhaps tomorrow it will look different) – all of these must be taken into consideration when we have to decide questions of life and death.

**5. Attitude Towards Suffering**

On the other hand, halacha certainly takes pain and suffering into account. One example is the concept of a "good death" which, by the way, predated the modern concept of euthanasia. "Euthanasia" means "good death," and I assume that although the

name was taken from halachic sources, its meaning is the opposite. In halacha, "good death" means that if a person is given a death penalty, he has to be allowed to die in the way that will cause him the least amount of suffering. This concept was never meant to refer to killing someone with the least amount of suffering if he was not deserving of the death penalty. But the concept of minimizing pain certainly does exist, and proves that one must consider the issue of pain in the death process.

Moreover, according to the Gemara in Tractate Ketubot, suffering which cannot be alleviated is worse than death. Based on this Gemara, Rabbi Moshe Feinstein ,"ל ruled that we are allowed, and even obligated, to refrain from prolonging life in a situation of severe suffering because such suffering is worse than death. On the other hand, Rabbi Waldenberg – based on a discussion in *Tractate Sotah* – rules that suffering serves to increase a person's merit, and therefore prolonged suffering is a good reason to prolong life, in order to erase sins and to allow the person an opportunity to repent, etc. Suffering is certainly an important consideration, and the modern halachic authorities include it in their discussions of the topics we have covered today.

**6. Options in Treatment**

In revising the three options which I presented, we may summarize as follows:

First, there is the option of actively precipitating in the death – i.e. killing the suffering patient. This is patently forbidden under any circumstances according to halacha, and anyone who hastens death, even by one minute or by one second, or someone who closes the eyes of a person already in his death throes, is termed a murderer and is punished as such. There is no situation which would justify or permit the active hastening of death.

This we learn directly from the story of King Saul and the Amalekite boy [*II Sam.1*]. We are told that Saul "fell upon his sword." (Whether or not this was the correct course of action – i.e. whether this suicide was permitted under the circumstances – is a separate question, and one which is beyond the scope of our discussion.) While lying on his sword and bleeding to death, he requested that the Amalekite boy hasten his death. The boy did so. And when he came to announce proudly to King David that this was what he had done, King David had him killed.

If we try to describe King Saul's medical condition in today's terms, he would be classified as a terminal patient by anybody's standards: he had fallen on his sword and was bleeding to death, and it is clear that he would have died anyway within a few moments. Nevertheless, the active hastening of his death by the Amalekite boy was considered tantamount to murder.

It is true that according to the Rambam, the death sentence passed on the Amalekite boy was an application of "emergency law" (*hora'at sha'ah*) because King David killed him on the basis of his own testimony rather than hearing testimony from witnesses who had previously warned him, as is technically required by halacha. But in principle it is nevertheless quite clear that the Amalekite boy had actively performed a "mercy killing" and that his punishment for this was death.

In contrast with this source, there are three other sources which appear to point to a different conclusion. I shall not analyze them in depth. There is a story in *Tractate Nedarim* about two people of Hozai. The one killed the other by cutting his throat. He then asked Ula if he had acted correctly. Ula was very afraid of him and did not wish to become involved in an argument about morals and ethical behavior, and so he said: "Yes, you acted correctly." And then he added, "And cut all the way through his throat." In other words – you haven't finished cutting; cut a little more. Both the Rosh and the Ran comment on this Gemara that Ula said this because he feared for his own life, as well as in order to hasten the death of the victim. From here it appears that under certain conditions it is permissible to actively hasten someone's death. Many different explanations have been offered; one (suggested by the Me'iri) is that it actually no longer mattered since the victim was obviously going to die anyway, and Ula said this only in order to save himself. Perhaps in weighing up an extra few moments of temporal life against eternal life, this was permissible.

The next source which seems to raise a question is the story of the inhabitants of the city of Luz. This was a city in which no one ever died; the Angel of Death was not allowed into the city. Anyone who was old and did not wish to live any longer would go out of the city, and then he would die. We ask the question: Was it permissible for a person to go out of the city in order to bring about his own death? Here, too, all kinds of explanations have been

offered, although the issue here is not exactly one of mercy killing but rather one of suicide.

Finally, we come to the famous story of Rabbi Hanina ben Teradyon, one of the ten martyrs sentenced to death by Rome. As we know, the Romans burned him, and in order to prolong his agony they wrapped him in wet wool so that he would not be consumed too quickly. What Rabbi Hanina himself wanted is a separate question, but the Roman executioner himself offered to remove the wads of cotton wool and to stoke the fire in order that Rabbi Hanina would die sooner and be saved from his suffering. We are taught that for this act, the Roman earned himself a place in the World to Come. Once again, it appears that this was an active mercy killing. He actively hastened the death of Rabbi Hanina ben Teradyon because he was a "terminally ill patient" who was suffering terrible agony. Rabbi Moshe Feinstein actually rules that this was an "emergency" decision (*hora'at sha'ah*), and does not represent a general principle which we may apply. Others have tried to explain that we may indeed learn from this act, but that it is not pertinent to our discussion. In any event, the halachic authorities conclude – unanimously, I believe – that there is no circumstance in which it is halachically permissible to hasten anyone's death.

The other question is whether there are any circumstances in which it is permissible to refrain from prolonging life. On this issue there are a number of sources which we may consult. Here I am not speaking of actively hastening someone's death, but rather of refraining from certain actions which would prolong his life. Almost all the halachic authorities who have addressed this question refer to the example of the death of Rabbi Yehudah HaNassi who, as we know, suffered terribly throughout his life – apparently from kidney stones – but whose suffering increased close to his death. His students prayed that God would lengthen his life but his maidservant, who witnessed his immense suffering, prayed: "May it be Your will that the Higher Ones prevail over the lower ones." In other words, that the angels above prevail over the students, and that Rabbi Yehuda HaNassi should die. From here the Ran derives that it is permissible for someone to pray that his fellow should die. Here we have an indirect action – prayer, which did not directly affect Rabbi Yehudah's treatment or his person, but brought about the result that his life was not prolonged by the other prayers.

The main source for the permissibility of refraining from life-prolonging medical action in a terminal situation is the concept of "removal of the hindrance," which is mentioned for the first time in *Sefer Chassidim*, and then later on in *Shiltei Gibborim*. The Rama brings it as operative halacha that one may remove an external factor which is preventing the patient in his death throes from dying. We may derive from what the halachic authorities have said that "removal of the hindrance" is not active hastening of the death. I believe that Rabbi Goldberg will deal with this at length.

According to those authorities who permit refraining from prolonging life – and there are many prominent authorities today who permit this – there are a number of points which must be taken into consideration when we decide to refrain from certain actions, as a result of which the patient will naturally die from his illness.

The first question is whether it is permitted or obligatory to refrain from prolonging life. Does the consideration of suffering permit the physician to refrain from prolonging somebody's life, or are we to say that since it is clear that we are unable to heal him we may not prolong his life thus prolonging his suffering? On this issue there is controversy among the authorities.

Is the question of refraining from prolonging life dependent on suffering, or does the same conclusion apply even without suffering? This question becomes very relevant in the case of the patient whom we have defined as a "vegetative state." According to our medical understanding this patient is not suffering. So if he reaches a situation of cardiac arrest, is it permissible to refrain from resuscitating him and allow him to die, or are we obligated to keep him alive because he is not suffering?

**7. Pain Relief**

A word with regard to pain relief. Pain itself is halachically considered as an illness, and if someone is suffering terribly we are permitted to desecrate Shabbat in order to alleviate his suffering – even if the suffering itself does not threaten his life. Hence our approach to pain must be like our approach towards an illness. In the case of any other illness a certain degree of risk is permissible in order to cure the patient (and halacha provides guidelines as to how much risk and which risks.) In the same way, in order to relieve a terminally ill patient of pain, even if there is a certain risk (and the risk of hastening his death by administering the medicines

that he requires is apparently less than one percent), then this risk is permissible and must in fact be taken because it is certainly less risky than, say, an operation to remove a brain tumor or liver tumor, both of which are undertaken daily.

**8. Quality of Life**

Questions of the patient's age, his quality of life, his intellectual level, his social standing, etc. do not in themselves influence our consideration of whether to resuscitate him, or whether to treat him. These are not factors that can influence our evaluation of the patient. Who are we to decide whether an eighty-year old should live another five years or not, or whether a twenty-year old should live to the age of seventy? All agree that such considerations are not pertinent and should not influence our decision in any way.

**Legal Data**

To the best of my knowledge, the first case involving a terminally ill patient that reached the courts in Israel was that of Gideon Nakash, who suffered from ALS (a degenerative disease that attacks the spinal cord, leading to paralysis of the muscles of the respiratory system; patients are eventually unable to breath unless connected to a ventilation machine.) This patient was already connected to a ventilation machine owing to his medical condition, and it was claimed that the way in which he rolled his eyes indicated that he wished to be disconnected. The case was brought before the District Court, then reached the Supreme Court, and was dismissed because the patient had meanwhile died. (It seems that this will occur in many of these cases. By the time the debates and appeals and arguments in the courts are over, the patients are dead.) And so nothing was decided in this case.

The second case was that of Shimon Nahiasi, who also suffered from a degenerative muscular disease. He submitted an early request to the effect that when he reached the stage of needing resuscitation procedures, including connection to a ventilation machine, such procedures should not be undertaken. His case, too, reached the Supreme Court, and was dismissed for other reasons.

The third case involved Yael Shefer, a baby suffering from Tay-Sachs disease. The mother appealed on her behalf to stop the treatments which were prolonging her life on the grounds that she was suffering and was going to die anyway, and should be allowed

to die sooner. I do not know what it was exactly that she requested, but in any event the request came before the Supreme Court, and the case was thoroughly dealt with. The mother's application was refused, and when the Supreme Court publishes its reasons, I imagine that it will become the principle precedent for court rulings in Israel.

The next case was that of Binyamin Ayal, very similar to the case of Nahiasi – i.e. also suffering from ALS. While conscious he requested that when he reached a stage of being unable to take decisions, he should not be connected to a ventilation machine. This time the district court approved his application, and a number of months ago he reached this situation, he was not connected, and he died.

The case of Miriam Tzadok is perhaps a little more complex. She was an Alzheimer's patient who, before reaching the stage of being unable to take decisions, left an audio tape and a declaration in which she requested that she receive no treatment whatsoever when she reached the stage of no longer having control over her mental faculties. The district court approved this, and she died.

The last two cases involve patients who are still alive: Mrs. Saadi and Mr. Rodney, both of which look very strange to me on the basis of the questions that reached the courts. Mrs. Saadi is a diabetic, and her kidney failure required dialysis. Her daughters applied for a court order that she should not be connected to a dialysis machine. In this case she could simply have chosen to go home, remain with her daughters, and not be connected to a dialysis machine. I fail to understand what the claim was, and why it was brought before the court at all. They certainly were not going to tie her to the bed and provide dialysis against her will!

The case of Mr. Rodney is equally strange. This man suffers from a chronic lung disease. He fell, resulting in a fracture in one of the vertebrae of his neck, which in turn caused him difficulty in breathing. He was connected to a ventilation machine. His wife requested that he be disconnected on the basis of his definition as a terminally ill patient. Clearly from a medical point of view there was no indication that his situation was terminal, and in fact his condition has improved, as reported by the press. The courts dismissed the application based on their understanding that the situation was not terminal.

**The Slippery Slope**

In conclusion I would like to deal with a sort of moral lesson derived from a recent historical development, a phenomenon which I refer to as the "slippery slope." It was in 1976, in the case of Karen Quinlan, that the legal question of whether or not it is permissible to disconnect a long-term unconscious patient from a ventilation machine (with the aim and hope that the patient will then die) first arose in the American courts. The courts determined that this was permissible, and since then it has been legal in the United States to disconnect a patient from a ventilation machine, and not only to refrain from connecting him in the first place.

A few years later, applications were submitted in the United States to withhold food and liquids from terminally ill patients. The intention was to bring about the death of patients in a vegetative state who do not require a ventilation machine and for whom in fact the only way to hasten death is to starve them. In 1983 it was ruled permissible.

Holland took this a step further, having already determined in 1980 that if a person requests, while competent and in possession of his mental faculties, that the physician kill him, then the physician may do so, by injecting a substance that will kill him on the spot. This situation is not moral, but nevertheless accepted.

The same year Holland moved further down the slippery slope. From voluntary mercy killing they moved to half-voluntary mercy killing, which in fact means that it was not voluntary. By this I refer to the active killing of babies with birth defects, with the parents voluntarily agreeing, as it were, on the baby's behalf. They also added long-term coma patients as well as those suffering from dementia (e.g. Alzheimer's disease) as candidates for active killing.

The official figures in Holland a few years ago indicated around 3,000 mercy killings per year. These were the official, reported figures. It is quite reasonable to assume that the real figures were far higher.

I believe that as a Jewish democratic state we dare not reach this situation. In order to familiarize us with the Jewish values pertinent to these issues, I call on Rabbi Zalman Nehemia Goldberg to answer the questions which have been prepared.

*Source:* ***The First International Collquium on Medicine, Ethics & Jewish Law,*** *July 1993, pp. 315-333 (Schlesinger Institute, Jerusalem, 1996)*