



BIO-ETHICS

CASE STUDY III - April, 1990

TERMINATION OF TREATMENT

The material presented in the Bioethics Committee's Case Study III stems from the recent UAHC National Biennial held in New Orleans, November, 1989. At that convention the Bioethics Committee dealt with an analysis of the issue of Termination of Treatment. The genesis of the program was an attempt to explore the issues of the removal of feeding tubes from a person in a permanently vegetative state of existence; the competing values associated with that decision; who and how that decision can be made and the role of the "Living Will" in these deliberations.

As technology increasingly affects our lives in these crucial areas, it is important that Reform Jews appreciate and understand how our tradition has approached these issues.

As with the previous case studies, the enclosed material is designed to be used as study material with your congregation, youth group, retreat, etc. A series of discussion starter questions are included, as well as appropriate references and resources pertinent to the subject.

We trust you will find this material challenging and stimulating.

* See Case Study I, "A Time to be Born," Fall, 1988; Case Study II, "Autonomy: My Right to Live or Die," April, 1989.

B'shalom,

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TERMINATION OF TREATMENT
Based on Rabbinic Sources

by

RABBI BERNARD M. ZLOTOWITZ

The unprecedented advances in medical technology have made it possible to keep people alive longer and healthier than at any time in history. On the other hand, they have also allowed some people to survive, but in a comatose or vegetative state. Karen Ann Quinlan comes to mind (although, admittedly, when treatment was terminated she survived for another 10 years), as does Mrs. Sunny von Bülow, who is being kept alive, albeit in a vegetative state, by artificial life supports.

This being the case, using Jewish law as its basis, this paper will address itself exclusively to the ethical dilemma faced by the physician, the rabbi and the family with the alternative of whether to terminate treatment, or not, when dealing with a dying patient, who, in the opinion of sound medical considerations, has no chance whatsoever of recovering.

Judaism believes in the sanctity of life and every means must be taken to preserve life. However, Judaism objects to the use of measures that prolong the act of dying of a hopelessly ill, terminal patient. Here we have to take our guidance from the rabbinic literature.

As Rabbi Chanina ben Teradion was being burnt by the Romans for teaching Torah in violation of their edict, and the flames were enveloping him, his students called out, "Open your mouth so that the fire enters into you (and puts an end to his agony). He replied, 'Let him who gave me (my soul) take it away, but no one should injure himself (i.e. hasten his own death)'." (Avodah Zorah 18a). One cannot hasten his own death.

The tractate Semachot (Joys; the euphemistic title for Ebel Rabbathi, which is found at the end of the 4th Order Nezikin) considered a dying person (goses) as a living person and, therefore, no positive act which may hasten death was permitted: "A dying person (goses) is considered as a living person in all respects.... (Semachot 1.1).

This view is elaborated upon in the text as follows: "One may not bind his jaws, not plug up his openings, nor place a vessel of metal or an object that cools on his naval until he dies, as it is written 'Before the silver cord (i.e. spinal column) is snapped asunder' (Eccl. 12:6; Semachot 1:2).

One may not move him nor may one place him on sand or on salt until he dies." (Semachot 1:3). "One may not close the eyes of the dying person. He who touches it or moves it, is shedding blood for Rabbi Meir used to cite an example of a flickering light. As soon as a person touches it, it goes out. So too, whoever closes the eyes of the dying is as if he has taken his soul." (Semachot 1:4; See also Maimonides [Judges, Laws of Mourning 4:5] and Caro [Shulchan Aruch, Yoreh De'ah, chapter 339].)

This point is emphasized both in the Mishna and Gemara in Shabbath 151b:

Mishnah: "One may not close (the eyes of) a corpse on the Sabbath, nor on weekdays when he is about to die, and he who closes the eyes (of a dying person at the point of departure of the soul is a shedder of blood (i.e. a murderer because he hastens death.)"

Gemara. "Our Rabbis taught: He who closes (the eyes of a dying man) at the point of the departure of the soul is a shedder of blood. This may be compared to a lamp that is going out: If a man places his finger upon it, it is immediately extinguished." Rashi explains that this means hastening death. However, Rabbi Simeon ben Gamaliel suggests a way of getting around this proscription against termination of treatment:

"It was taught, Rabbi Simeon ben Gamaliel said: If one desires that a dead man's eyes should close, let him blow wine into his nostrils and apply oil between his two eyelids and hold his two big toes; they close of their own accord." This is analogous to termination of treatment. However, the weight of opinion is opposed to that of Rabbi Simeon ben Gamaliel. Aside from the Mishnayot and Gemara quoted, Maimonides and the codifiers of Jewish law go even further than the Talmud in proscribing the termination of treatment.

Maimonides teaches that a dying person is regarded as a living person without any qualification: "It is not permitted to bind his jaws, to stop up the organs of the lower extremities, or to place metallic or cooling vessels upon his navel in order to prevent swelling. He is not to be rubbed or washed, nor is sand and or salt to be put upon him until he expires. He who touches him is guilty of shedding blood," then Maimonides continues and uses the same example as in the Talmud: "To what may he be compared. To a flickering flame, which is extinguished as soon as one touches it. Whoever closes the eyes of the dying while the soul is about to depart is shedding blood." The reason for this, Maimonides contends, "One should wait awhile; perhaps he is only in a swoon..." (Maimonides: Judges, Laws of Mourning 4:5; also quoted by Rosner, Fred Rosner & J. Bleich, "Jewish Bioethics," Sanhedrin Press, 1979, p. 262).

Maimonides by stating, "perhaps he is only in a swoon," is raising yet another question of when is a person considered dead? This issue is now in the forefront of medical discussion as a result of the advances of science and will be discussed a little later on in this paper.

The prohibitions against hastening death are enumerated in different rabbinic sources: The Tur, 14th century, lists a series of prohibitions with regard to the dying under the general guideline that "the rule in this matter is that any act performed in relation to death should not be carried out until the soul has departed." (Tur, YOreh De'ah 339).

Caro (whose text is nearly identical to that of the Tur) devotes an entire chapter (Yoreh De-ah, 339) to the laws of the dying person (goses), listing various acts that are prohibited, "lest they hasten the patient's death;" for example, "like moving him by placing him on sand, clay or on the ground" or by "placing on his armchair a dish or a shovel or a flask of water..." The latter is an act of psychological stress in contra-distinction to a physical act, or removing a pillow from under the patient's head.

However, though physical acts or psychological stress is prohibited as it may hasten a patient's death, yet Rabbi Judah ben Samuel, the Pious, in his Sefer Chasidim (13th Century), #723, states one has a right to stop acts which would hinder the soul's departure, "...if a person is dying and someone near his house is chopping wood so that the soul cannot depart, then one should remove the (wood) chopper from there." This is analogous to termination of treatment.

On the basis of this the Rama states "...if there is anything which hinders the departure of the soul, as for example, a knocking noise near the person's home because of chopping wood, or there is salt on his tongue and these prevent the soul from departing, it is permissible to remove them because there is no act involved only the removing of the hindrance;" that is termination of treatment (Rama to Shulchan Aruch, Yoreh De'ah, 339:1). The Talmud and the commentators, including Rama himself (in another place) state that if a person is in the throes of death (goses) one should stop praying for his or her recovery or for their release. (Ned. 40a; Rama to Shulchan Aruch, Even Ha-ezer 121:7 and Chosehen Mishpat 221:2). One of the most famous cases cited is that of Rabbi Judah the Prince, who was in the agony of his death throes. His soul was prevented from leaving his body because of the passionate prayers of his disciples who prayed continuously for him to remain alive. His maid, seeing the agonizing suffering of Rabbi Judah threw down an earthen jar to distract the rabbis from their fervent prayers which then allowed the soul to depart from the Rabbi's body so he might die in peace. (Ket.104a); that is termination of treatment.

Rabbi Solomon Eiger goes even further in his commentary on the passage in Yoreh De'ah 339:1 when he quotes Beit Ya-akov, 59, that "it is forbidden to hinder the departure of the soul by the use of medicines." This is most certainly advocating termination of treatment. However, other rabbinic authorities, (such as Shevut Ya'akov, 3:13) do not agree with him. Such authorities argue that no positive or direct act may be withheld, even for a second, from a dying person. Any or all medicines and drugs must be used to help an individual recover. All Sabbath laws may be broken to save a life (Yoma 85a; Shulchan Aruch, Orach Chayim 196:2, 319:17; Ex. 31:14; Lev. 18:5) and even the death of an individual who is seriously ill should not be hastened (Shulchan Aruch, Yoreh De'ah 339:1). No nourishment, however little the amount, may be withheld from a dying person whose condition seems hopeless and his pain great in order to hasten his death. Termination of treatment is not permitted. (Tel Talpiyot, Letter 42, quoted by Israel Bettan, "American Reform Responsa," p. 263.)

Thus, rabbinic authorities are divided on whether to terminate treatment or not. Remember, this was an age when medicine was primitive. There were no machines to which one can be connected which would perform life functions. Therefore, there was identifiable independent life even in the throes of death. Today, however, if a person is hooked up to a machine we don't know whether the machinery is preserving life or the person is living on his/her own power. Karen Quinlan is a case in point.

However, the question remains as to when independent life ceases. According to halachah, it is a lack of respiratory activity and heart beat (Yoma 8:5; Yad. Hil. Shab. 2:19; Shulchan Aruch, Orach Chayim 329:4). In the responsum of Chatam Sofer (Yoreh De'ah #38), lack of respiration alone was considered conclusive if "The individual lay as quietly as a stone."

According to some halachic authorities, death has occurred when there is no movement for at least 15 minutes (Gesher Chayim 1, 3, p. 48). Others say 1 hour (Responsa, Yismach Lev, Yoreh De'ah #9

after cessation of respiration and heart beat. Jacob Levy, an Israeli doctor, claims that lack of blood, as well as respiratory activity determines death (Hamayan, Tammuz, 5731).

Recently, because of advances in science, the issue of when independent life ceases has become a matter of dispute. An ad hoc committee of Harvard Medical School set the definition of brain death as having several criteria: "(1) lack of response to external stimuli or to internal need; (2) absence of movement and breathing as observed by physicians over a period of at least one hour; (3) absence of elicitable reflexes; and a fourth criterion to confirm the other three, (4) a flat or isoelectric electroencephalogram." (see "American Reform Responsa." p. 273). Moshe Feinstein (Igerot Moshe, Yoreh De'ah II, #174) felt that the Harvard definition could be accepted if the respirator was shut off briefly to see if there was independent breathing. Moshe Tendler (Journal of the American Medical Association, Vol. 238, #14, pp. 165ff) accepts the Harvard criteria, whereas David Bleich (Hapardes, Tevet 5737) and Jacob Levy ("Hadarom," Nissan 5731) reject it.

Lord Jakobovits points out "...any form of active euthanasia is strictly prohibited and condemned as plain murder... At the same time, Jewish law sanctions the withdrawal of any factor - when extraneous to the patient himself or not -- which may artificially delay his demise in the final phase" only in the case where death is imminent that is in three days or less (Quoted by Fred Rosner, "Modern Medicine and Jewish Ethics," p. 200.)

However, in the Shileti Hagiborim (and according to Solomon Freehof), it is stated that though one may hasten death, the causes of delaying death may be removed on the basis of the rabbinic statement, "We may not put salt on his tongue in order to prevent his dying." (Solomon Freehof, "American Reform Responsa," p. 259). Thus we may conclude from this and from a consensus of the Rabbis that termination of treatment is certainly permissible.

There are yet other considerations to be taken into account: the patient's own feelings if expressed in a "Living Will" (see author's article, The Journal of Aging and Judaism, 3(4) Summer, 1989, pp. 211-213), the anguish and suffering of the family, the pain to the patient and the dignity and value of life. These are all ethical considerations that have to be taken into account. It is Nissim Gerondi (see Nedarim 40a), who teaches that one should pray for the recovery of a person, but there comes a time when one has to pray to God that in His mercy He allow the patient to die. The Sefer Chasidim also (Nos. 315-318) quotes Ecclesiastes: "There is a time to be born and a time to die." (3:2).

SUMMATION:

Jewish tradition affirms the sanctity of life. Yet, when there is no hope for the patient and death is certain, one should not hasten his death, but at the same time, one should not prolong his death throes but permit him to die in peace. This should be done in consultation with the family, the rabbi and the physician, and the patient, if possible, as to whether or not to terminate treatment.

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TERMINATION OF Treatment: MEDICAL ASPECTS

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A discussion of termination of treatment must start with consideration of the level of treatment being provided for the patient. The primary level is treatment directed towards the underlying medical or surgical condition. This treatment may be curative, designed to permanently end or arrest the illness. In most cases withdrawing or failing to offer curative treatment is rarely an issue, although it may be if the condition of the patient and the rigor of the treatment are such that the therapy might lead to the person's death. The treatment may be palliative, designed to slow the progression of the illness or relieve pain or troublesome symptoms, but with no hope of cure. Palliative treatment can prolong life, improve the quality of life, or both.

A second level of treatment is directed towards intercurrent complications of the illness. One group of these is part of the condition, such as serious infections in patients with AIDS or malignancies. Another group includes those complications which are the result of treatment, such as severe anemia induced by drugs used to treat cancer. Serious intercurrent illness unrelated to the primary condition may also occur, and also require that treatment decisions be made.

The third level of treatment is the provision of nutrition and fluids. The patient's condition will mandate whether these can

be provided as a regular or modified diet, or whether they must be administered intravenously or by a tube inserted into the stomach. If the latter option is required, and feedings will be required for a prolonged period, a surgically placed gastrostomy tube is most commonly used.

In the context of this discussion, termination of treatment will be viewed as an action, the outcome of which will be the death of the patient. This action must be examined in the light of two different situations. The first is that of the patient with a terminal disease. In this instance, the outcome is irrevocable and preordained; termination of treatment will merely allow the illness to run its natural course. The second situation occurs when the underlying condition will not, of itself, lead to the patient's death, but where the quality of life is so poor that a decision is made that withholding treatment, including fluids and nutrition, is in the patient's best interest.

Issues Related to Decision Making

The first of the two most common decision making scenarios is that in which the patient is legally competent. The role of the physician is to insure that the patient has all of the information necessary to make an informed decision. These data include the nature of the disease: its rate of progression and the degree of incapacity that will result; treatment options; and the prognosis. Once the patient has a full understanding of

these facts and of the consequences of his decision, he should be free to accept or reject treatment at any level.

The more complicated scenario is one in which the patient is not legally competent and surrogates must make the decision concerning termination of treatment. This commonly occurs when the patient is a child, or has been determined to have irreversible cessation of all brain function (brain death), or is in a persistent vegetative state, or is incompetent because of dementia or other permanent impairment of cognitive function. Analysis of the situation must start, as with the competent patient, with a full understanding of the nature and course of the disease, treatment options, and prognosis. The process is aided if the surrogate decision makers also have some knowledge of the patient's own wishes. If a living will or written personal statement is not available, they must rely on statements made by the individual before he became incompetent. The views of the physician also enter the process, as the family often turns to him or her for guidance as well as factual information. The clergy plays a role in helping the family with the decision making process as well, providing support and interpreting the underlying religious and ethical issues.

A number of external factors often are considered, consciously or unconsciously, by the family and professionals involved with the patient's care. First, the reality of economic issues is often unstated but important. A chronic incapacitating condition may

cause a devastating drain on the family's resources, to the detriment of all other family members. If adequate third party payments for medical and nursing care are not available, the family can be pauperized. A second factor is the utilization of scarce resources. A patient with a hopeless condition utilizing a bed in an intensive care unit makes this bed unavailable for someone whose life might be saved if appropriate care is available. The costs of medical care have become so high that we are now beginning to see rationing of scarce resources, and this situation will undoubtedly become more important in future years.

Third, all organ transplantation programs have a critical need for organs. The usual donors are young, healthy individuals who have suffered a traumatic injury which has left them brain dead. Obtaining organs in good condition, and with the greatest chance for survival, requires removal before the donor's general condition deteriorates. This is best achieved if the patient is pronounced dead and the respirator removed soon after the diagnosis of brain death is documented.

Other external factors that have taken on an increasingly prominent role are institutional policy, state laws, and court decisions. Court decisions, in many cases, set the bounds within which decisions can be made and provide a guide for decision making. Unfortunately, courts in different jurisdictions have handed down diametrically opposed decisions, and this situation remains in flux.

Brain Death and Persistent Vegetative State

The two neurological conditions most often involved in surrogate decision making situations are brain death and the persistent vegetative state. The concept of brain death was nonexistent before the early 1960s. At that time medical and technological advances made it possible to artificially support the activity of the heart, lungs, and other body organs in the face of complete cessation of all brain activity. A new criterion for death was then suggested by an Ad Hoc Committee of the Harvard Medical School.¹ Brain death was defined as the permanent absence of discernible activity of the brain and brainstem. Criteria using the neurological examination and electroencephalogram were developed, and subsequent studies demonstrated the validity of these criteria. Recent modifications of the diagnostic criteria have been made, but the fundamental concept remains intact.

The outcome of the state of brain death is always cessation of the function of the circulatory and respiratory systems, even in the face of maximal effort to maintain them. This usually occurs within one week of the time the diagnosis is confirmed, and continuation of cardiorespiratory function rarely lasts beyond

¹Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death: A definition of irreversible coma. *Journal of the American Medical Association* 205:85-88, 1968

ten days to two weeks. As noted, it is this group of patients who form the largest pool of organ transplant donors.

The persistent vegetative state is distinct from brain death. The patient is unconscious with eyes open and the appearance of sleep-wake cycles. There is no voluntary behavior or activity of any kind, the patient demonstrates no awareness of him- or herself or the environment, and there is no capacity to experience pain or suffering. The persistent vegetative state is not a terminal condition in the strictest sense, and long-term survival is possible if there is adequate provision of fluids and nutrition given by tube or injection. The condition is permanent.

A position statement concerning the continued provision of fluids and nutrition to patients in a persistent vegetative state has been developed and published by the Academy of Neurology.² For the purposes of this discussion, there are two basic concepts developed in this document. The first states that

it is good medical practice to initiate the artificial provision of fluids and nutrition when the patient's prognosis is uncertain, and allow for the termination of treatment at a later date when the patient's condition becomes hopeless.

²American Academy of Neurology: Position of the American Academy of Neurology on certain aspects of the care and management of the persistent vegetative state patient. *Neurology* 39:125-126, 1989.

The recommendation is made that the patient be observed for one to three months, to make certain that recovery will not occur. This also gives the family time to accept the patient's condition and prognosis.

The second concept raises many of the fundamental issues concerning termination of treatment and states that

the artificial provision of nutrition and hydration is a form of medical treatment and may be discontinued in accordance with the principles and practices governing the withholding and withdrawal of other forms of medical treatment.

The statement outlines a number of reasons for considering the provision of food and nutrition, under these circumstances, a medical procedure. Medical judgement is required to determine the specific substances administered and the best method of providing these substances. The patient's tolerance to the nutriment and fluids must be monitored, as must the patient's nutritional status. Placement of a gastrostomy tube is a surgical procedure, and the site of the tube must be monitored for immediate and delayed complications of this procedure.

The family must, of course, agree to termination of provision of nutrition and fluid, and the same procedures must be followed as with the termination of any type of treatment. It is at this point that assistance and support from all of the professionals involved with the patient and the family is needed.

Conclusions

The decision making process around termination of treatment is always a complex one, and takes on an increased level of complexity if surrogates are put in the position of making decisions for an incompetent patient. Physicians can provide a high level of diagnostic precision, especially for the patient with brain death and, after an adequate observation period, for the patient in a persistent vegetative state. An accurate prognostic statement can also be made for the patient with brain death. In the case of a patient with persistent vegetative state, the prognosis for irreversibility is easily made, but the life span cannot be predicted. These patients may live many years if provided with fluids, nutrition, and treatment of intercurrent medical and surgical conditions.

At least one medical organization has put forward the opinion that the provision of fluids and nutrition by injection or tube to a patient in a persistent vegetative state is a medical procedure and can, like any medical procedure, be terminated with the consent of the patient's family. Although this may appear different emotionally than termination of more aggressive therapy, it can be viewed as fundamentally no different.

The tools of medicine are available to help provide a scientific basis on which a decision to terminate treatment can be made. This decision is obviously not value-free, however, and

physicians must engage in a dialogue with representatives of the clergy and other disciplines to find a firm basis with which to help the patient's family in the decision making process.

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Good morning. I want to thank Rabbi Address and the UAHC for inviting me to participate in today's discussion on the right to die and a philosophy of the living will. At the outset, let me state that my remarks on this extremely complex and sensitive area of the law will be cursory due to the time allotted. I shall provide highlights of the subject matter, not to be construed as legal advice, but rather as an overview, focusing on the principal issues which are involved.

Technological advances in medicine have resulted in the ability to sustain life and prolong the dying process through the application of various procedures and equipment, such as ventilators, respirators, feeding tubes and CPR. Within the context of the right to die discussion, legal questions arise as to when and under what circumstances such artificial life-sustaining procedures and/or systems should be withdrawn or withheld.

It should be kept in mind that a patient who is dead within the meaning of that state's death statute is dead, and no further inquiry is necessary to withdraw or withhold treatment or support equipment on that patient. Appropriate documentation in the patient's medical records is, of course, necessary.

Various courts and legislatures, as well as professional, religious, and other societies and organizations, have grappled with these profound issues which strike the hearts and conscience of humanity. Let's briefly examine the judicial response.

The seminal right to die case involving Karen Ann Quinlan was decided by the New Jersey Supreme Court in 1976. It recognized that a person has a constitutional right to privacy which permits an individual to refuse medical treatment absent a higher interest of the state, such as the preservation and sanctity of human life. The state's interest weakens and the

THE TERMINATION OF TREATMENT:
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of Removing Treatment from a Patient -
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“The Legal Perspective”
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individual's right to privacy grows as the degree of bodily invasion increases and the prognosis diminishes. The court recognized the theory of substituted judgment, allowing Ms. Quinlan's father to exercise his daughter's right to privacy on her behalf due to her incompetent state. Still further, the Court chose to honor Ms. Quinlan's statements, made while competent, of not wanting to be maintained on artificial life support should she ever be in a condition necessitating it.

The following year, the Massachusetts Supreme Court recognized the common law right to refuse treatment and extended it to the right to die and to incompetent individuals, adopting the "substituted judgment standard." State interests to be balanced against the right to refuse treatment were identified as: preservation of life, prevention of homicide or suicide, protection of interests of innocent third-parties, and maintenance of the ethical integrity of the medical profession.

Subsequent cases dealing with termination of treatment of terminally ill and not terminally ill patients have enunciated and applied their underlying principles.

Recent cases have also forged into new areas, particularly the right to withhold or discontinue tubal feedings. Some courts have allowed feeding tubes to be disconnected from patients in a persistent vegetative state who were not dead, not terminally ill, not in danger of imminent death and had spontaneous respirations. The right to do so was viewed as overriding the State's interest in life.

And then you may recall the 1986 California case which allowed a competent 28-year old quadriplegic with severe cerebral palsy to have her nasogastric tube and other burdensome life-sustaining equipment removed.

The Court determined that her right to live in dignity and peace outweighed the state's interest in preserving life and preventing suicide.

A month from today, on December 6, 1989, the United States Supreme Court will hear oral argument in Cruzan v. Harmon. This marks the first time that the highest court in the land has agreed to review a right to die case. The Cruzan case, which has received much attention nationwide, focuses on whether a guardian may order that all nutrition and hydration be withheld from an incompetent ward who is in a persistent vegetative state, but neither dead within the state's definition nor terminally ill. In its refusal to allow the disconnection of Ms. Cruzan's feeding tube, the Missouri Supreme Court, after reviewing the jurisprudence and balancing the right to privacy, which it questioned, and the right to refuse treatment against the state's interest, found that, in essence, the state's interest in the preservation of life was an unqualified interest and that quality of life was not the issue. It found that artificial hydration and nutrition are not oppressively burdensome to the patient. It further determined that in the absence of statutory formalities or clear and convincing and inherently reliable evidence, the common law right to refuse treatment and the right to privacy could not be asserted by any other on behalf of an incompetent.

Thus, courts around the country have, in the dawn of Cruzan, recognized the constitutional right of privacy and a common law right to refuse treatment. The right to refuse treatment stems from the common law right of an individual to autonomy and self-determination relating to one's health and welfare. Indeed, the doctrine of informed consent has evolved to reflect the value that society places on a person's autonomy in the protection of his bodily integrity. Any decision regarding medical treatment, whether to accept or

refuse it, must be an informed one, meaning that the person making it has the capacity to reason and make judgments, makes the decision voluntarily and without coercion, and has a clear understanding of the risks and benefits of the proposed treatment alternatives or non-treatment, as well as a full understanding of the nature of the disease and the prognosis.

Courts consider whether the patient is competent to authorize the withdrawal or withholding of life-sustaining procedures. If the patient is incompetent, the substituted judgment standard may be applied to determine who may exercise such decision making on behalf of the incompetent patient. The incompetent patient may have once been competent and expressed his views on the matter, may never have been competent, may have been competent but never expressed his views. Clearly, the easiest case is when the patient is competent, next, when he is incompetent but has made known his wishes, particularly if in writing, or has had a guardian or family member who has made treatment decisions for him in the past. The toughest case arguably involves the patient who has suddenly become incompetent without having ever expressed his views or without a guardian. And, there is a lot of gray area in between.

A trend noted in the jurisprudence has been away from focusing on the types of treatment and rather on whether the burden of treatment outweighs the benefit to the patient to render such treatment inhumane. The extraordinary has become ordinary. Artificial feeding devices pose unique issues--is the patient in more or less pain with or without the tubal feedings? Some argue that artificial feeding devices provide comfort care and maintain life, while others maintain that they, like mechanical breathing devices, are medical procedures or interventions, which could be withdrawn if they have no

curative effect. The burdensomeness, and pain, is weighed against the benefits to the patient.

Juxtaposed against the jurisprudence on the right to die, living will legislation has been enacted in a majority of the states in response to the inherent dilemma in treating a person with a terminal and irreversible condition who would otherwise be indefinitely maintained on life-support systems. It is contemplated that some of the delicate issues which have been discussed in the court cases can be more effectively dealt with in the calm of reason without judicial intervention and tremendous emotional overlay.

A living will is a legal document whereby an individual may declare his wishes and intentions for the withdrawing and/or withholding of various life-sustaining procedures should he become incompetent and in such necessitous circumstances. The first Natural Death Act was established in the State of California in 1976, the same year that Quinlan was decided on the opposite coast. Since then, a Model Act has been devised and adopted by various states.

Louisiana, the state with which I am most familiar, enacted an exemplary living will statute in 1984, amended in 1985, setting forth the parameters for decisions regarding the withholding or withdrawal of life sustaining medical procedures and interventions. Statutory recognition is given to the fundamental rights of all persons to control decisions relating to their own medical care and to protect themselves against the potential loss of individual personal dignity which may result from a terminal and irreversible condition. Such rights can be exercised by persons suffering or who may in the future be suffering from a terminal and irreversible condition through the making of a declaration instructing their physicians to withhold or withdraw life sustaining procedures. They can also designate another to make such treatment

decisions on their behalf. The statute further allows for and specifies other individuals to make a declaration for the withholding or withdrawing of life sustaining procedures from an adult patient who is not able to make such decisions for himself due to incompetence, comatose status, or other physical or mental incapability, as well as for a minor who lacks capacity.

The declaration may be written, oral or nonverbal. Written declarations may be executed at any time before or after diagnosis of a terminal and irreversible condition. An oral or nonverbal declaration may be made any time after the diagnosis of a terminal and irreversible condition. The physician must document why it could not be written. There are other formalities. Under the Louisiana statute, the declarant or the one making the declaration, bears the responsibility for notifying his or the patient's attending physician that the declaration has been made. Once informed of the existence of a declaration, the law requires the attending physician to take the necessary steps to provide for a written certification of the patient's terminal and irreversible condition so that the patient may be deemed qualified in accordance with the law. A second physician must also certify this. The patient must be qualified before any order is entered on the patient's record for the withholding or withdrawing of any life sustaining procedures.

A physician who refuses to comply with a qualified patient's declaration must make a reasonable effort to transfer the patient to another physician who will follow the patient's wishes.

The law allows one to change his mind. Anyone who makes a living will may revoke it at any time regardless of the mental competence of the declarant at the time of the revocation. The attending physician should be notified of the revocation because it does not become effective until the

physician is notified. The physician should promptly note the existence, time and date of the revocation in the patient's medical record.

For the purposes of the statute, terminal and irreversible condition is defined as a condition caused by injury, disease or illness which within reasonable medical judgment would produce death and for which the application of life sustaining procedures would serve only to postpone the moment of death. Life sustaining procedures are defined as any medical procedures or interventions which within reasonable medical judgment would serve only to prolong the dying process for a person diagnosed as having a terminal and irreversible condition. In Louisiana, a life-sustaining procedure does not include any measure deemed necessary to provide comfort care.

The statute in Louisiana contains immunity provisions protecting healthcare facilities, physicians, and other persons acting under the direction of the physician in the withholding or withdrawal of life sustaining procedures from a qualified patient with a terminal or irreversible condition from criminal prosecution and civil liability. However, civil penalty provisions are in place for the willful concealment or destruction of another's declaration without the declarant's permission or the falsification or forgery of a revocation or declaration. Criminal prosecution can follow falsification or forgery of a declaration with the intent to cause withholding or withdrawal of life sustaining procedures against the wishes of the declarant thus hastening death.

The statute clearly states that there is no legislative intent to legalize euthanasia. Nor is this suicide. Insurance should not be thus affected. Any declarations made under this law are presumed to have been made voluntarily. There are also allowances for other mechanisms which demonstrate good faith reliance.

It must be kept in mind that living wills will vary from state to state. Thus it is imperative that one become familiar with whether one's state has a living will statute and if so, what its legal requirements are, so that they may be complied with in the protection of one's rights.

The debate continues. The growing national concern over how these decisions are being made and legislation enacted is evidenced by the input of numerous professional and religious organizations. Various policies, statements and opinions have been prepared by the American Hospital Association, the American Medical Association, the President's Commission for the Study of Ethical Problems in Medicine, to name a few.

From a legal perspective, which parallels the religious, philosophical, ethical and medical considerations, the focus is on the individual's constitutional, State or Federal, right to privacy and the common law right to self-determination, balanced against the state's interest to protect life. Considerations factored into the analysis are: who can and will make these decisions--the competent person, someone on behalf of an incompetent person, and if so whom, or the State?

There are no final, clear-cut, black and white answers at this time. Cases will continue to be decided on an individual basis relative to the particular facts of the case and the law of the state in which the patient resides. Living will legislation--allowing for "advanced directives"--provides hope that one's right to privacy and exercise of self-determination in the expression of his wishes shall be protected and respected should he become unable to make such decisions on his own behalf and without placing a heavy emotional burden on his family members and physicians or upon the courts.

Cruzan is on the horizon. And, here we are today.

PROGRAM DISCUSSION STARTERS

Refer to Termination of Treatment Based on Rabbinic Sources

by: Rabbi Bernard M. Zlotowitz

1. Examine the traditional definition of the "goses" (p.2) in light of modern medical technology.
2. How can we understand the concept of "imminent death" given the strides of technology?
3. How do you relate to Judah b. Samuels' concept of the "chopping of wood" (p. 4) as analagous to termination of treatment?

Is this the same as the removal of the feeding tube? If so, does this idea lead us down a "slippery slope" that opens the door for active euthanasia?

4. Compare Rabbi Zlotowitz' position to that of Rabbi Moshe Feinstein who states:

"The AMA is thus clearly on record as concluding that nutrition and hydration by intravenous lines or nasogastric tubes constitute medical treatment no different from antibiotics, transfusions or other forms of medical intervention, including respirators or other mechanical means of life support, and that such treatment should be used only if it benefits the patient. Why the sudden "about face" in our ethical, medical and legal thinking? Where does one draw the line? Can oral feeding and hydration also be withheld from patients who are able to eat and drink? What about ice sucking or lip moistening? Why is the practice of withdrawing or withholding fluids and nutrition gaining support from bioethicists, physicians, nurses, and other health care providers? Why is this practice no longer considered to be morally objectionable? Why is feeding a patient different from alcohol rubs, turning him to avoid bedsores, and other general supportive measures?

Is withdrawing nutritional life support a constitutional right of the patient and ethically justifiable, or is it an act of moral or legal murder by the hastening of the patient's death? Judaism views nutrition and hydration by feeding tubes or intravenous lines not as medical treatments but as supportive care, no different from washing, turning or grooming a dying patient."

For the complete argument on Feinstein's approach, see:

Rabbi Moshe Feinstein on the Treatment of the Terminally Ill
Fred Rosner. Judaism: #146 Vol 37. Number 2, Spring, 1988
pp 188-198.

5. Do you agree with the statement of Rabbi Eiger (p. 5) about hindering the departure of the soul via the use of medicines as being analagous to termination of treatment?
6. Discuss the differences between the traditional Jewish definition of death and the Harvard definition. (pp 5 & 6).
7. How valid is the concept of "independent life" as a test to determine when to "terminate?"
8. How correct is it to make a comparison between "independent life" and "quality of life?" (See Responsa on Quality of Life and Euthanasia (p. 14), Case II, or paragraph 83 in "Contemporary Reform American Responsa."

PROGRAM DISCUSSION STARTERS

Refer to Termination of Treatment: MEDICAL ASPECTS.

by: Gerald S. Golden, M.D.

1. In light of the Zlotowitz article, how do you react to scenarios put forth on page 10. Dr. Golden sets forth two cases:
 - a. -death "irrevocable and preordained"
 - b. withholding treatment "in patient's best interests"

Who can decide?

Are (a) and (b) to be considered as "goes"? Or only (a)? If only (a), should different criteria exist?

2. In the discussion of such cases, in your opinion, how valid (how Jewish) are considerations such as:
 - financial resources
 - scarce resources
 - need for organ donation
3. In the discussion on page 13 of the "persistent vegetative state," how do you see the applicability of the traditional concept of the "goes?"

PROGRAM DISCUSSION STARTERS

Refer to The Termination of Treatment: A Look at the Jewish, Medical and Legal Positions of Removing Treatment from a Patient - An Examination of the Philosophy of the Living Will.

by: Roselyn B. Koretzky, Esq.

1. How can/does/should the "constitutional right to privacy" as mandated in the Quinlan case of 1976 compare to and conflict with a traditional Jewish position that God is the ultimate "Judge of truth?"
2. Compare Koretzky, page 19, paragraph "Recent cases... State's interest in life." with the Golden paragraph on the "persistent vegetative state" (p. 13) and the Zlotowitz citations of Rabbis Judah b. Samuel and Eiger (p. 5).
3. Discuss your state's/province's "living will" statute (if one exists). Does it seem consistent with Judaism?

ADDITIONAL RESOURCES:

1. Reform Responsa on:
QUALITY OF LIFE AND EUTHANASIA
ALLOWING A TERMINALLY ILL PATIENT TO DIE
EUTHANASIA
See: UAHC Bioethics Case II - Autonomy: My Right To Die
*April, 1989

or

Appropriate Responsa in American Reform Responsa
ed. Walter Jacob
CCAR 1983 NYC

Contemporary American Reform Responsa
ed. Walter Jacob
CCAR 1987 NYC

2. Audio Tape: Termination of Treatment:
A look at the Jewish, medical and legal positions of
removing Treatment from a Patient.
An examination of the philosophy of the Living Will
UAHC Biennial Convention tapes.
November 1989
available through: Convention Cassettes Unlimited
42-080 State Street
Suite A
Palm Desert, CA 92260
3. The Court and Nancy Cruzan: Hastings Center Report.
January/February 1990
Vol. 20 No. 1
Hastings Center
255 Elm Road
Briarcliff Manor, NY 10510
4. Living Wills and Durable Powers of Attorney:
Advance Directive Legislation and Issues.
Pat Milmo McCarrick.
National Reference Center for Bioethics Literature
Kennedy Institute of Ethics
Georgetown University
Washington, DC 20057
5. The Medical Directive: An Introduction
Emanuel and Emanuel
Journal of the American Medical Association
June 9, 1989. Vol. 261. No. 22.

*Available from: UAHC BIOETHICS COMMITTEE
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