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Jewish Law and End-of-Life Decision Making: A Case Report

Craig D. Blinderman

Craig D. Blinderman, MD, MA, is an Attending Physician on the Palliative Care Service, Massachusetts General Hospital, Boston, and a Fellow in Medical Ethics, Harvard Medical School, Boston, cblinderman@partners.org. ©2007 by *The Journal of Clinical Ethics*. All rights reserved.

CASE SUMMARY

Mr. G, a 77-year-old Jewish man with Alzheimer's dementia, hypertension, and coronary artery disease, was admitted to a New York City (NYC) hospital with altered mental status, fevers, and decreased oral intake. After undergoing an extensive workup for fever of unknown origin and altered mental status, no cause was found. The patient eventually developed severe aspiration pneumonia and bacterial sepsis with subsequent respiratory failure requiring intubation. The patient was unable to be weaned from the ventilator. A tracheostomy and PEG (percutaneous endoscopic gastrostomy) were surgically required for continuous mechanical ventilation and artificial feeding, respectively. While in the intensive care unit (ICU), the patient developed VRE (vancomycin-resistant *Enterococcus*) and MRSA (methicillin-resistant *Staphylococcus aureus*) infections as well as multiple deep (stage IV) necrotic sacral, hip, and back pressure ulcers requiring surgical debridement, daily dressing changes, and antibiotics. The patient was comatose, responding to painful stimuli only.

The family consists of two daughters, Ms K and Ms G. Ms K, who is a secular Jew and lives in Montreal, wanted all "aggressive" care stopped, saying that this is not what her father would want. The second daughter, Ms G, who is an Orthodox Jew living in NYC and Mr. G's healthcare proxy via a co-guardianship document, wished that all treatments be continued as consistent with her Jewish beliefs and with *halacha*, or Jewish law. According to the patient's co-guardianship document, legal decisions regarding the patient's estate were entrusted to his lawyer, and decisions regarding his medical care were entrusted to Ms G. Although Ms G had wanted all treatments to be continued, including mechanical ventilation and artificial nutrition, she agreed that the patient should have a do-not-resuscitate (DNR) order and receive hospice care and comfort measures. The patient was transferred to a separate institution that provides hospice care for mechanically ventilated patients.

Upon initial evaluation of the patient on the in-patient hospice unit, it was determined that the PEG feeds were not being adequately absorbed (large residual volume of feeds were aspirated from the stomach and feeds were excreted from the tracheostomy site). The feeds were temporarily held pending a family meeting to discuss goals of care and pending a nutritional consult. Upon recommendations from the nutritionist, the feeds were changed, and the volume

infused was reduced. However, the patient still did not absorb the feeds, and a large residual volume was noted. At this point, the feeds were held. The team continued to discuss the possible harms of continued feeds with the patient's daughter, including aspiration, increased secretions, and the lack of benefit to the patient, as the nutrients were not being adequately absorbed. Ms G was distressed by the decision not to continue PEG feeds, as she felt giving artificial feeds was part of routine care; not giving feeds was equivalent to starving her father, and, according to her rabbi, once a life-sustaining therapy is started, it cannot be stopped.

CASE ANALYSIS

Before beginning the ethical analysis, we need to understand the religious beliefs and moral framework that the patient's daughter, Ms G, was trying to articulate.

INTRODUCTION TO HALACHA

Halacha is the term used to describe the collective body of Jewish religious law. It includes biblical, Talmudic, and rabbinic law, as well as customs and traditions. *Halacha* is derived from the Hebrew word "to walk," and may be understood as a guide on one's way through life. Indeed, *halacha* provides the observant Jew guidance in all aspects of religious practice as well as many aspects of day-to-day life, including medical decision making.

The majority of Orthodox Jews accept the Shulchan Aruch (Code of Jewish Law), composed in the sixteenth century by Rabbi Joseph Caro, as the accepted, authoritative, and binding code for the practical application of *halacha*. However, since the publication of the Shulchan Aruch, there have been large political and sociological changes affecting Jewish life, including scientific progress and medical inventions, which have raised complex *halachic* questions.¹ As a result, a *responsa* literature from rabbinical authorities, for example, the Rabbinical Assembly Committee on Jewish Law and Standards, has developed to provide *halachic* answers to these new questions. These rabbis are expected to have a deep understanding of all the *halachic* sources — the Torah, Mishna, Talmud, the codes, and the Shulchan Aruch — as well as sufficient technical knowledge of the subject in question, whether it be medical, legal, scientific, et cetera. However, it should be noted that there is no final authority or supreme judicial body with the authority to make *halachic* decisions that are binding for all Jews. Thus, which rabbi's decision is accepted is dependent on a variety of factors — clarity of argument, authoritativeness, personal qualities, as well as social and political factors — and has not been formalized.²

JEWISH LAW AND END-OF-LIFE CARE

Judaism is grounded in the concept of the supreme sanctity of human life and the dignity of man created in the image of God.³ The preservation of human life, *pekuach nefesh*, is a divine commandment in Judaism. This concept is derived from several sources. The *halachic* basis for this concept is found in the Torah's commandment, *lo ta'amod al dam rei'ekha*, "You shall not stand idly by the blood of your neighbors" (Leviticus 19:16). The Talmud provides another source in Sanhedrin 73a, which restates this prohibition into a positive *mitzvah*, or commandment. It does this by relating the duty to intervene in life-threatening situations to the commandment in Deuteronomy 22:1 regarding restoration of lost property (*hashavat aveidah*): "every individual, insofar as he is able, is obligated to restore the health of a fellow man no less than he is obligated to restore his property."⁴ Indeed, *pekuach nefesh* takes precedence over almost all other religious obligations and considerations, including keeping the Sabbath.

Is there a limit to *pekuach nefesh*? Are physicians obligated under Jewish law to provide treatment even if the treatment has limited chance for improving survival or if the treatment is associated with pain and suffering? The issue is not whether the therapy is effective, that is, achieves expected physiological ends, but beneficial to the patient, that is, is consistent with the patient's interests, values, and quality of life. There are some sources in Jewish tradition that argue for considering the patient's best interests as the guiding principle in undertaking a particular therapy. The Talmud, in Avodah Zarah 27b, introduces a discussion regard-

ing "the life of the hour" (*chayei sha'a*), which is thought to be the time a person lives after having been diagnosed with a terminal illness. The discussion concludes that we are "not to be concerned with the life of the hour," that is, we are not required to cure a person who, as far as we know, cannot be cured. In *Yoma*, a treatise in the Mishnah regarding the divine service on the Day of Atonement, we learn that we should violate the Sabbath to remove debris from a person buried under it in an attempt to try to save the person even if we have little hope he is alive.⁵ Thus, in this case, we do care about "the life of the hour." In *Tosafot*, a commentary on the Talmud, the authors reconcile these two seemingly contradictory precedents regarding the value of "the life of the hour" and conclude that in every case we act for the patient's benefit. Benjamin Freedman, in his commentary on these sources, wrote, "Excavating a person from the rubble on the Sabbath is to his benefit, hence it is permitted; allowing a person who will otherwise die to risk his life for a chance of a cure is also to his benefit, hence it too is permitted. In other words, in these cases, a patient-centered risk-benefit analysis serves as the basis for determining whether an action is permissible, rather than some other autonomic formula."⁶

In addition, Rabbi Moshe Feinstein, perhaps the most renowned of twentieth century American *halachic* authorities, states that for a patient with pain and suffering who cannot be cured and who cannot live much longer, it is not obligatory for physicians to administer medical therapy to prolong his or her life of pain and suffering; nature may be allowed to take its course.⁷ Therefore, it seems there are limits to the general principle of *pekuach nefesh*. Accordingly, when life-sustaining therapies are being considered, we should take into consideration the patient's subjective assessment of what is beneficial.

According to Jewish law, are we permitted to withdraw life-sustaining treatment in a dying Jewish patient? The patient's daughter argued that, according to her rabbi, once a treatment is started, it cannot be stopped. Is this consistent with Jewish medical ethics? It is interesting that Jewish law sanctions the withdrawal of any impediment that may delay a moribund patient, or *goseis*, from dying. A *goseis*, according to rabbinic references, denotes someone who is imminently dying, that is, within three days or less. Rabbi Moshe Isserles (Ramah) writes: "If there is anything which causes a hindrance to the departure of the soul such as the presence near the patient's house of a knocking noise such as a wood chopping or if there is salt on the patient's tongue; and these hinder the soul's departure then it is permissible to remove them from there because there is no act involved in this at all but only the removal of the impediment."⁸

On the other hand, the Talmud clearly objects to euthanasia, as the *goseis* is regarded as a living person in all respects.⁹ Although we may be justified in removing obstacles that are delaying death, we may not perform any act that may hasten the death of a dying patient. The question then arises, is the withdrawal of artificial nutrition in a dying patient a justified act intended not to prolong his dying, or is it in fact an act that is hastening the patient's death and therefore forbidden?

ARTIFICIAL NUTRITION AND HYDRATION

An often-cited belief about artificial nutrition and hydration is that it is not a medical therapy, but must always be provided as an example of routine care. Is artificial hydration and nutrition ethically equivalent to other medical therapies, or is there something unique about this intervention that requires a different analysis?

In the palliative care literature, the issue of artificial hydration in end-of-life care is controversial.¹⁰ It is thought that dehydration in the terminal phase may be associated with delirium and therefore artificial hydration may be of benefit to the dying patient, although this has not been confirmed in randomized, controlled studies. On the other hand, the role of artificial nutrition in a severely demented patient is thought to be of little clinical benefit and may be associated with unnecessary suffering.¹¹ Artificial nutrition's "special status" is present in most contemporary traditional Jewish commentaries. Rosin and Sonnenblick argue that every patient must be fed since "food is a requirement of nature, for all people and even for animals, in order to sustain life."¹² Food is also believed to be necessary for the comfort of the patient, and is associated with strong cultural beliefs, including, but not limited to, its relationship to caring. While most contemporary

traditional Jewish commentators claim that food and fluids must always be provided, there are some *halachic* authorities that believe artificial nutrition is no different than any medical treatment.¹³

A CASE OF MEDICAL FUTILITY?

How do we take into consideration the physician's clinical assessment that the intervention is not benefiting the patient and may even be causing harm? As Steven Miles, MD, points out, physicians, even when requested by family members, are not obligated to provide treatments that are "fruitless or inappropriate."¹⁴ While the issue of possible harm is inherent in nearly every medical intervention, the risk-benefit ratio is used to assist physicians in determining which treatments are appropriate in a given clinical scenario. In this case, it is hard to find any medical benefit to the patient, so we are left only with the risks associated with the intervention. Indeed, one may even consider this to be an example of a medically futile treatment.

The question of whether artificial nutrition in this case is actually futile requires pause to consider the multiple definitions of medical futility. Four conceptual types of futility have been identified: physiologic futility (the intervention does not have its intended physiologic effect), imminent demise futility (the patient will die before discharge regardless of the intervention), lethal condition futility (the patient has an underlying disease that is not compatible with long-term survival, regardless of the intervention, even if the patient could survive to discharge from this hospitalization), and qualitative futility (the resultant quality of life is too poor).¹⁵ Another way of construing qualitative futility is when the treatment "merely preserves permanent unconsciousness or cannot end dependence on intensive medical care."¹⁶ Futile care may also be defined quantitatively, "when physicians conclude (either through personal experience, experiences shared with colleagues, or consideration of reported empiric data) that in the last 100 cases, a medical treatment has been useless."¹⁷ In this case, artificial nutrition was physiologically futile, as the patient was not absorbing the feeds, even at a reduced volume.

Alluding to physiological futility, Rabbi Immanuel Jacobovits in a 1985 lecture at Cedars-Sinai Medical Center in Los Angeles stated, "physicians need feel no compunctions in removing machines or medications that have not affected the hoped-for medical results."¹⁸ Most commentators on Jewish law would agree that physicians are not required to provide ineffective treatments or treatments that lack a reasonable chance of being of benefit to the patient.

ETHICAL ANALYSIS

The first issue to consider is respect for the patient's autonomy. Since the patient is without decision-making capacity as a result of his medical illness, we must rely on surrogate decision makers. Mr. G gave the legal authority to his Orthodox Jewish daughter, Ms G, to make healthcare decisions for him in the event he loses capacity. Can we assume that the surrogate's religious beliefs and practices should form the basis for healthcare decision making? Unfortunately, we do not know whether Mr. G shared his daughter's Orthodox Jewish interpretations of *halacha*, nor do we know if he would want such interpretations applied to his own medical care. Indeed, we learn that the patient's second daughter, Ms K, does not believe that he should have been kept alive with aggressive treatment and that he would have preferred that all treatments be stopped. Although legally Ms G is the appointed healthcare agent and her input is crucial in guiding her father's end-of-life care, we must distinguish between *legal agency* and *moral agency*. Ms K may, in fact, be acting on behalf of the patient's best interests, while Ms G, the legally appointed healthcare agent, may be articulating her own religious beliefs, as if they were in accordance with her father's wishes. The fact that Mr. G chose Ms G, rather than Ms K, does not allow us to infer that his values are identical to his religious daughter; indeed he may have chosen her based on other considerations, including proximity and personal affinity. Finally, we must ask how much of Ms G's insistence on continuing the feeds is a reflection of her religious commitments and how much is a reflection of her own misconceptions about "starvation," cultural or familial beliefs about feeding, or other psychological factors that impact end-of-life decision making. A family meeting to assess not only the daughters' understanding of their father's wishes, but for the healthcare providers to better understand the daughters' differences and to help them cope with their loss is clearly indi-

cated. In this way, we may actualize what Carol Gilligan describes as the "care orientation," which more readily leads to a model of shared decision making, emphasizing response and relationship, rather than rules and rights.¹⁹

By extending Gilligan's observation, we may argue that our obsessive focus on preserving the patient's autonomy is not sufficient for arriving at ethically appropriate decisions involving healthcare agents. There are, as Nancy Dubler points out, obligations to the proxy.²⁰ The healthcare team is obligated to consider the proxy's welfare and provide support and guidance. This is especially true when the decisions are a matter of life and death, and the proxy primarily shoulders the burden. Moreover, John Arras has argued that patients with severe neurological injuries (for example, persistent vegetative state — PVS) seemingly have "no interests," and that a shift in focus to the interests of the family and surviving loved ones should become paramount.²¹ Thus, our obligation to Ms G, both as a proxy and as the patient's daughter, would have us consider her moral struggle and well-being, given her father's grave condition. We could certainly reframe the ethical dilemma, by focusing on Ms G's *duty* to honor her father and uphold Orthodox *halachic* principles that involve respecting the sanctity of human life, while at the same time considering the medical opinion that artificial nutrition be withheld, given its lack of benefit and risk of harm.

In attempting to reconcile this ethical dilemma, we could examine Ms G's conclusion about what she believes is acceptable under Jewish law, namely that artificial nutrition must be provided and to not do so is effectively starving her father and forbidden. One might argue that in fact Mr. G was actively dying and his nutritional support was prolonging his death. According to Jewish law regarding a *goseis*, all impediments that prolong death should be removed. If even the knocking noise of a woodchopper outside is believed to prevent the soul from departing, perhaps continuous feeds into a gastrostomy tube could be thought to have the same effect. Aside from the technical challenge of accurate prognostication of death within three days, the assumption that the feeds were "preventing death" under Jewish law is merely speculative, although consistent with previous examples of impediments to death as cited earlier.

A more compelling argument is whether under Jewish law the feeds could be discontinued since they were providing no medical benefit and appeared to be causing harm (for example, excessive secretions, aspirations). The proposed withholding of artificial nutrition turns on it being considered a medical therapy versus routine care that should always be provided. According to one *halachic* analysis, if artificial nutrition is considered a medical therapy, and that medical therapy provides no benefit and is in fact causing suffering, the terminally ill patient is not obligated to receive it.²²

CONCLUSION

We began the analysis with a query as to whether autonomy is truly respected in this case. The difficulty in answering this question may be due to the fact that the patient's belief system and values, which would likely guide his end-of-life decision making, are not clearly known, nor are they stated in an advance directive. However, we do have a legally appointed healthcare proxy, his Orthodox Jewish daughter, Ms G. Her struggle with making end-of-life care decisions for her father is apparent. She is obligated to both act on behalf of his best interests and abide by Jewish law, which is based on centuries of rabbinical interpretations. In view of the difficult decision she was asked to make, and in part by our duty to help guide her as proxy, it seemed necessary to involve a third participant — the rabbi — "to give halachic guidance and pastoral support to the patient and physician in their critical decision-making process, and to bring to bear the external values of the Jewish tradition."²³

After discussing the case with two rabbis from the hospital (both of whom supported the clinical assessment and plan on the grounds that the artificial nutrition was no longer benefiting this dying patient), and after further discussion with Ms G, the medical team decided to temporarily hold the feeds and contact her community rabbi to help facilitate a consensus among the medical team and the patient's daughter. Unfortunately, since this was attempted on Friday morning, as the Jewish Sabbath was approaching, we were unable

to schedule a meeting with Ms G's rabbi. The feeds were held over the weekend, and the patient expired the following day.

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MASKING OF THE CASE

The case presented in this article has been changed to protect the identity of the patient and the patient's family members. The names of the patient and family members have not been used; instead, random letters have been used to designate family members. Other details have also been modified to protect their identity.

NOTES

1. D. Bollag, "Jewish Religious Law," in *Jewish Ethics and the Care of End-of-Life Patients*, ed. J. Hurwitz, J. Picard, and A. Steinberg (Jersey City, N.J.: KTAV Publishing House, 2006), 13-30.

2. Ibid.

3. F. Rosner, "Jewish Medical Ethics," *The Journal of Clinical Ethics* 6, no. 3 (Fall 1995): 202-17.

4. J.D. Bleich, *Contemporary Halakhic Problems*, vol. 4 of the Library of Jewish Law & Ethics (New York: KTAV, 1977), 95; J.H. Prouser, "Hesed or Hiyuv? The Obligation to Preserve Life and the Question of Postmortem Organ Donation," in *Life & Death Responsibilities in Jewish Biomedical Ethics*, ed. A.L. Mackler (New York: Louis Finkelstein Institute, 2000), 446-70.

5. E.N. Dorff, "End-Stage Medical Care: Halakhic Concepts and Values," in *Life & Death Responsibilities in Jewish Biomedical Ethics*, see note 4 above, pp. 309-37.

6. B. Freedman, *Duty and Healing: Foundation of a Jewish Bioethic* (New York: Routledge, 1999), 274.

7. M. Feinstein, Responsa Iggrot Moshe, Choshen Mishpat, part 2, no. 73-75, in Rosner, "Jewish Medical Ethics," see note 3 above.

8. M. Isserles, Gloss of Ramah on Karo's Shulchan Aruch, Yoreh Deah, no. 339:1, in Rosner, "Jewish Medical Ethics," see note 3 above.

9. See the Babylonian Talmud, Semachot 1:1-3 and Shabbat 151b.

10. R. Fainsinger and E. Bruera, "The management of dehydration in terminally ill patients," *Journal of Palliative Care* 10, no. 3 (1994): 55-9; R. Fainsinger et al., "The use of hypodermoclysis for rehydration in terminally ill cancer patients," *Journal of Pain and Symptom Management* 9 (1994): 298-302.

11. T.E. Finucane, C. Christman, and K. Travis, "Tube feeding in patients with advanced dementia: A review of the evidence," *Journal of the American Medical Association* 282, no. 14 (1999): 1365-70.

12. A. Rosin and M. Sonnenblick, "Autonomy and paternalism in geriatric medicine. The Jewish ethical approach to issues of feeding terminally ill patients and to cardiopulmonary resuscitation," *Journal of Medical Ethics* 24 (1998): 44-8.

13. Z. Shostak, "Jewish ethical guidelines for resuscitation and artificial nutrition and hydration of the dying elderly," *Journal of Medical Ethics* 20 (1994): 93-100.

14. S. Miles, "Informed demand for 'non-beneficial' medical treatment," *New England Journal of Medicine* 325, no. 7 (1991): 512-5.

15. B.A. Brody and A. Halevy, "Is futility a futile concept?" *Journal of Medicine and Philosophy* 20 (1995): 123-44.

16. L.J. Schneiderman, K. Faber-Langen-doen, and N.S. Jecker, "Beyond futility to an ethic of care," *American Journal of Medicine* 96 (1994): 110-4.

17. Ibid.

18. Dorff, "End-Stage Medical Care," see note 5 above; also see I. Jakobovits, *Jewish Medical Ethics* (New York: Bloch, 1959, 1975).

19. C. Gilligan et al., ed., *Mapping the Moral Domain* (Cambridge: Harvard University Press, 1988).

20. N.N. Dubler, "The Doctor-Proxy Relationship: The Neglected Connection," *Kennedy Institute of Ethics Journal* 5, no. 4 (1995): 289-306.

21. J.D. Arras, "Beyond *Cruzan*: individual rights, family autonomy and the persistent vegetative state," *Journal of the American Geriatrics Society* 39, no. 10 (1991): 1018-24; J.D. Arras, "The severely demented, minimally functional patient: an ethical analysis," *Journal of the American Geriatrics Society* 36, no. 10 (1988): 938-44.

22. M.R. Gillick, "Artificial nutrition and hydration in the patient with advanced dementia: is withholding treatment compatible with traditional Judaism?" *Journal of Medical Ethics* 27 (2001): 12-15.

23. S. Glick, "Who decides — the patient, the physician or the rabbi?" *ASSIA — Jewish Medical Ethics* 6, no. 2 (2004): 20-30.