

# The Living Will

Rabbi A. Jeff Ifrah

## Introduction

From the moment the public realized that much of medical technology is utilized not only to sustain life but also to prolong the dying process, the public has demanded the means to limit such "high-tech" interference according to personal discretion and beliefs. New technology has created unforeseen ways of prolonging life. Consequently, for both Jewish law [halacha], and the state, the parameters of a long-standing presumption mandating the preservation of life in virtually any situation have been complicated.<sup>1</sup>

The opportunity to exercise the right to terminate life-sustaining treatment tends to occur when a patient is unable to express his desire to do so; therefore, courts have advised patients to express their wishes regarding medical treatment before they are rendered incompetent.<sup>2</sup> The expression of one's wishes constitutes a "living will."<sup>3</sup> The document which embodies a person's decision to appoint an agent to carry out his/her wishes is called a "health care proxy."

In order to ensure that a patient's wishes are given legal effect, states are encouraged to promote legislation providing

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1. See, "Comment, Balancing the Right to Die with Competing Interests: A Socio-Legal Enigma," 13 *Pepperdine L. Rev.* 109 (1985).

2. *Matter of Westchester County Med. Center (O'Connor)*, 72 N.Y. 2d 517 reversing 139 A.D.2d 344 (1988). The O'Connor court declared, "[t]he ideal situation is one which the patient's wishes were expressed in some form of a writing, perhaps a 'living will,' while he or she was still competent." *Id.* at 531.

3. For a library of information on articles, books and state statutes relating to living wills, see Buralassi, *Living Wills - The Right to Die: A Selective Bibliography with Statutory Appendix*, 45 *Rec. of the Assoc. of Bar Of City of N.Y.* 816 (1990) [hereinafter Buralassi].

for a patient's advance directive.<sup>4</sup> Many states have legislation either validating living wills or establishing durable powers of attorney.<sup>5</sup> Living will legislation specifically authorizes competent adults to prepare, in advance, a document authorizing the withdrawal or requiring the withholding of "specified medical treatments in the event of a catastrophic illness or condition which renders the declarant incompetent to make such a decision personally."<sup>6</sup> Durable power of attorney legislation, which permits establishing a health care proxy, allows an individual to appoint a friend, relative, legal or religious adviser to make medical decisions in the event that the individual is no longer competent to make them him/herself.

Notably, once the living will is given effect, or the agent is appointed, powers to execute the provisions of the living will or to execute the wishes of the agent are not absolute.

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4. In states, such as New York, task forces have been established by the governor "to develop recommendations for public policy on a range of issues arising from recent advances in medical technology: the determination of death, the withdrawal and withholding of life-sustaining treatment . . . ." The New York State Task Force was charged by Governor Cuomo "to present its recommendations in the form of proposed legislation, suggested regulations or a report describing its conclusions." *Life Sustaining Treatment: Making Decisions and Appointing a Health Care Agent*, The New York State Task Force on Life and the Law, at i, (1987) [hereinafter Task Force].

5. Twenty-Five states and the District of Columbia have elected to enact durable power of attorney statutes which permit a patient to appoint another agent to carry out the patient's wishes. A durable power of attorney "is the agent who 'stands in the shoes' of the patient. It defines the agent's obligations to the patient and the agent's authority in relation to others: health care professionals, medical institutions and the patient's family members." Task Force, *supra* note 4, at 91.

6. Gelfand, "Living Will Statutes: The First Decade," 1987 *Wisc. L. Rev.* 737, 740 (1987) [hereinafter Gelfand].

Indeed, advance directive legislation does not circumvent judicial criteria establishing when treatment can be terminated. In some cases that time occurs when the patient has suffered brain death. Whether or not brain death occurs at the time the patient suffers an irreversible coma as a result of permanent brain damage or whether it occurs at the time of irreversible cessation of all functions, or of circulatory and respiratory functions, of the entire brain, including the brain stem is a question subject to legal, medical and ethical debate.<sup>7</sup>

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7. "Brain dead" is the definition of death constructed by the Ad Hoc Committee of the Harvard Medical School. See, "Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, A definition of Irreversible Coma," 205 *J.A.M.A.* 337 (1968). According to the Committee, death occurs when an individual sustains irreversible coma as a result of permanent brain damage. The committee argued that brain death could be diagnosed by satisfying the following three conditions known also as the "Harvard criteria":

1. Unreceptivity and Unresponsivity - the patient exhibits a total unawareness to externally applied stimuli and inner need and complete unresponsiveness even when exposed to intensely painful stimuli.

2. No Movements or Breathing - total absence of spontaneous breathing or muscular movements or response to stimuli.

3. No Reflexes - absence of elicitable reflexes, e.g., the pupil of the eye is fixed and dilated and does not respond to bright light from a direct source.

The Harvard criteria have come under attack from both ethicists and theologians. See articles on the subject in *Journal of Halacha and Contemporary Society* Vol. 19. See Isaacs, "Death, Where is thy Distinguishing?," 8 *Hastings Cent. Rept.* 5 (Feb. 1978); Bleich, "Establishing Criteria for Death," reprinted in *Jewish Bioethics*, 277-295 (ed. Rosner & Bleich 1979) [hereinafter *Criteria for Death*]. A. Soloveichik, "The Halachic Definition of Death," *Jewish Bioethics*, 296-302 (ed. Rosner & Bleich 1979). Further, proposals have been made to correct the deficiencies of the definition, see e.g., President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Defining Death* (Washington:

Thus, advance directive legislation does not necessarily provide that a patient's wishes regarding termination of life before the onset of brain death, by any definition, will be upheld. However, to the extent that a patient's wishes conform to state standards, advance directive legislation does provide a vehicle to ensure that the incompetent patient's medical decisions are executed. Thus, advance directive legislation allows both relatives and physician to avoid the cumbersome, costly, and time-consuming judicial process that is characteristic of health-care cases where the wishes of the patient are uncertain.<sup>8</sup>

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1981) (recommending the adoption of the Uniform Determination of Death Act ("UDDA") [hereinafter President's Commission] which defines death as occurring when;

1. irreversible cessation of circulatory and respiratory functions, or
2. irreversible cessation of all functions of the entire brain, including the brain stem.)

*Id.*

Over ten states and the District of Columbia have enacted the UDDA by statute. See, e.g., Cal. Uniform Determination of Death Act, amending Health and Safety Code # 7180-7183, 1982 New Laws 4451; Colo. Rev. Stat. # 12-36-136 (Supp. 1981) and D.C. Code Ann. # 6-2401 (Supp. 1982).

8. Notably, while patients have the right to refuse extraordinary means of artificial life support, and while states have enacted living will legislation to permit the patient a means to communicate that desire, courts are always open to hear about circumstances caused by disagreement or misplaced motives or allegations of malpractice. See *John F. Kennedy Memorial Hospital, Inc. v. Bludworth*, 452 So. 2d 921 (Fla. 1984) (reversing a lower courts ruling which held that the guardian of a comatose terminally ill patient did not need to obtain court approval before removing that patient's feeding tube in order for consenting family members, physicians and the hospital to be relieved of civil and criminal liability).

Recently, both New York<sup>9</sup> and New Jersey<sup>10</sup> have joined their sister states in promulgating rules regarding the appointment of health care proxies and the validity of living wills. However, both judicial and legislative action have sparked moral and ethical debate, particularly among those with very stringent religious views.

In this article, the writer will discuss the evolution of the right to privacy. That discussion will serve as a springboard to the legal aspects involved in the honoring of living wills and health-care proxies and the ethical aspects involved in terminating life-sustaining treatment.<sup>11</sup> Finally, this article will briefly review religious response to advance directive legislation and highlight the areas of halachic significance.

### The Evolution of the Right to Privacy

The constitutional right to privacy evolved from the seminal case *Griswold v. Connecticut*.<sup>12</sup> In *Griswold*, the Supreme

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9. New York Public Health Law # 2960 to -2994 (McKinney 1990) which took effect January 18, 1991, provides for the appointment of health care agents and proxies.

10. New Jersey recently approved S-1211, the Advance Directives for Health Care Act, over many religious objections. See e.g. "Right to Die Is Approved By Assembly in Trenton," *New York Times*, June 11, 1991, # B, at 1, col. 2.

11. See generally, *Deciding to Forego Life Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions*, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1983) [hereinafter President's Commission]; see also, Doudera & Peters, *Legal and Ethical Aspects of Treating Critically and Terminally Ill Patients* (1982) [hereinafter Doudera & Peters].

12. 381 U.S. 479 (1965). *Griswold* involved the constitutional right of a married couple to use contraceptives. As a matter of law, *Griswold* held that zones of privacy are created from specific guarantees in the

Court declared that "the First Amendment has a penumbra where privacy is protected from governmental intrusion."<sup>13</sup> The right to privacy as established in *Griswold* was extended to protect a woman's autonomy regarding her decision to carry her unborn fetus to term in *Roe v. Wade*.<sup>14</sup> In *In re Quinlan*,<sup>15</sup> the New Jersey Supreme Court relied upon the *Griswold* doctrine to "recognize that a right of personal privacy exists and that certain areas of privacy are guaranteed under the Constitution."<sup>16</sup> The Court went on to conclude, "[p]resumably

Bill of Rights. *Griswold* relied upon precedent created in cases such as *Pierce v. Society of Sisters*, 268 U.S. 510 (1924) (establishing that the right to educate one's children as one chooses is grounded in the First and Fourteenth Amendments); and *NAACP v. Alabama*, 357 U.S. 449 (1958) (asserting that freedom of association is a peripheral First Amendment right).

13. 381 U.S., at 483. This right existed at common law as well. The most frequently quoted formulation of the self-determination doctrine at common law is that of Justice Benjamin N. Cardozo in *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914):

In the case at hand the wrong complained of is not merely negligence. It is trespass. Every human being of adult years and sound mind has a right to determine what shall be done with his own body; a surgeon who performs an operation without the patient's consent commits an assault, for which he is liable in damages.

*Id.* at 129-30.

14. 410 U.S. 113 (1973). Unlike *Griswold*, the right to privacy in *Roe* involved a more careful balancing, for *Roe* involved a strong State interest in protecting fetal life and maternal health. Nevertheless, the Court found that under certain circumstance a woman's constitutional right to privacy outweighs the State's interest in fetal life and maternal health.

15. 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976).

16. 355 A.2d at 663 (citations omitted). The Court has interdicted judicial intrusion into many aspects of personal decision making,

this right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances . . . ."<sup>17</sup>

The *Quinlan* case involved a family acting as guardians for a patient in a persistent vegetative state. The family believed that their daughter, Karen Ann, would, if able to communicate her wishes, request the termination of life-sustaining treatment. The doctors retorted that Karen Ann did not meet the definition of brain dead, and thus terminating her life-sustaining treatment would be a form of active euthanasia, and, therefore, prohibited. The Supreme Court of New Jersey concluded that,

[u]pon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state and the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital "Ethics Committee" . . . . If the consultative body agrees . . . the present life-support system may be withdrawn . . . without any civil and criminal liability . . . .<sup>18</sup>

In so holding, the court wrestled with definitions of death, active and passive euthanasia and other religious and ethical considerations.<sup>19</sup> Thus, the general public became aware of

sometimes basing this restraint upon the conception of a limitation of judicial interest and responsibility.

17. *Id.* (citations omitted).

18. 355 A.D. 2d at 671.

19. For ethical arguments for and against *Quinlan*, see "The *Quinlan* Decision: Five Commentaries," 6 *Hastings Cent. Rept.* 8-19 (Feb 1975); Annas, "In re *Quinlan*: Legal Comfort for Doctors," 6 *Hastings Cent. Rept.* 29 (June 1976). One consideration of the *Quinlan* court was to determine the true motives of the appointed guardians. For, while a guardian is instructed to merely substitute his or her

the issues regarding withdrawing or withholding treatment from incompetent patients.

The *Quinlan* case in concert with several other related cases, such as *Cruzan v. Harmon*,<sup>20</sup> *Superintendent of Belchertown v. Saikewicz*,<sup>21</sup> *In the Matter of Storar*,<sup>22</sup> and *In Re Conroy*,<sup>23</sup>

judgment with that of the patient, some argue a guardian may have ulterior personal, religious and ethical motives. See e.g., "Family Wishes and Patient Autonomy," 10 *Hastings Cent. Rept.* 21 (Oct. 1980); Gutheil & Appelbaum, "Substituted Judgment: Best interest in Disguise," 13 *Hastings Cent. Rept.* 8 (June 1983). Further, case studies reveal that often a patient facing terminal illness makes clinically inappropriate decisions precisely because sound clinical evaluation and judgment are suspended. Jackson & Younger, "Patient Autonomy & Death with Dignity" 299 *New Eng. J. Med.* 404 (1979). This leads ethicists to question whether dying requests are truly indicative of the patients true desires. See e.g., Boorstin, "When Suicide Is Not a Choice," *New York Times*, Aug. 22, 1991, p. 27. (discussing the effect of depression on the choice to die).

20. 760 S.W. 2d 408 (Mo. banc 1988).

21. 373 Mass. 728, 370 N.E. 2d 417 (1977). *Saikewicz* involved a judicial determination to withhold treatment for a conscious incompetent on the basis that the incompetent would not understand the purpose of his pain from the treatment, when there was no guarantee that the treatment would extend his life and there existed the possibility that it might serve to shorten his life.

22. 52 N.Y. 2d 363, 438 N.Y.S. 2d 266, 420 N.E. 2d 64, cert. denied 454 U.S. 858 (1981). *Storar* basically involved the same facts of *Saikewicz*. However, in *Storar* the New York Court of Appeals held that treatment should be administered against the wishes of the guardian because the necessary blood transfusions were likened to providing food and drink. Notably, the blood transfusions would not have cured the cancer but would have prevented premature death from another cause.

23. 98 N.J. 321, 486 A. 2d 1209 (1985) (holding that artificial feeding through a nasogastric tube is analogous to supplying air artificially through a respirator and, therefore, it can be removed in accordance with the patient's desires *Id.* at 373). For a criticism of the *Conroy*

have demonstrated the need for legislation in the area of termination of life-sustaining treatment. This has prompted over forty states to enact legislation regarding the termination of life-sustaining treatment and the validity of health care proxies and living wills.<sup>24</sup>

### Honoring A Patient's Advance Directive

Whether one advocates the removal of life-sustaining treatment or not, most agree that a living will is desirable.<sup>25</sup> A living will can direct a doctor to withhold treatment or encourage a doctor to take all the means possible to avert death at any cost. A living will may determine whether decisions regarding the patient's treatment are left to members of his family, his faith, or his physician. While the absence of a living will will usually result in the presumption on the side of life, at least one case has revealed the misfortune which results when a physician opts to terminate treatment, in the "best interests of the patient" against the interests of that patient's family.<sup>26</sup>

decision, see Annas, "Do Feeding Tubes Have More Rights Than Patients?" 16 *Hastings Center Rpt.* at 26 (Feb. 1986); Annas, "Non-feeding: Lawful Killing in California, Homicide in New Jersey," 13 *Hastings Cent. Rept.* 19-20 (December 1983).

24. For states with living will legislation, see Burgalassi, *supra* note 3.

25. One writer erroneously asserts that "[i]n essence, Judaism is opposed to the concept of the living will in that the patient may not have the 'right to die'." Rosner, "Jewish Perspective On Issues of Death and Dying," 11 *Journ. of Hal. and Con. Soc.* 50, 68 (1986). Of course, Judaism may be adverse to a living will which advocates early withdrawal of life-sustaining treatment, but a living will properly drawn could be vital for those who wish that their body be given the fullest possible chance of survival.

26. See, "Judge Reject Request by Doctors to Remove a Patient's Respirator," *New York Times*, July 1, 1991, #A, at 4, col. 4 (discussing a

### What Advance Directive Legislation Provides

A generic directive is described in the notes below.<sup>27</sup> In

husband's fight to prevent a Minneapolis doctor from removing the respirator from his 87 year-old wife).

27. To my family, doctors and all concerned with my care:

I, -----, being of sound mind, make this statement as a directive to be followed if I become unable to participate in decisions regarding my medical care.

If I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying. I further direct the treatment be limited to measures to keep me comfortable to relieve pain.

These directions express my legal right to refuse treatment. I especially do not want: -----

(Here list specific treatment not wanted. Examples include: respirator support, intravenous or nasogastric feeding or fluids, cardiac resuscitation, organ transplantation, dialysis, surgery, or psychosurgery.)

Other Instructions: -----

(Here list care that is desired, e.g. pain medicine.)

Proxy Designation Clause: Should I become unable to communicate my instructions as stated above, I designate the following person to act in my behalf:

Name: -----

Address: -----

If the person named above cannot act in my behalf, I authorize the following person to do so:

Name: -----

Address: -----

Signed: ----- (name of person writing the living will)

Date: -----

Witness: -----

Date: -----

Witness: -----

Date: -----

(Generic will available from the Society for the Right to Die, New

most states, a living will can be drafted in substantially the same form as below. However, patients may include specific directions which, if later declared invalid, will not affect other directions of the declaration which can be given effect without the invalid direction.<sup>28</sup> In fact, "Do-it Yourself" living will kits are available in local bookstores.<sup>29</sup>

In general, all states with living will statutes, including New York and New Jersey, require that the person executing the document be competent.<sup>30</sup> In addition, because "the objective of living will statutes was to allow for the euthanatizing of patients with little or no remaining life,"<sup>31</sup> most states require that the patient be diagnosed and certified to be in a terminal condition, or be permanently unconscious.<sup>32</sup> A terminal condition is generally defined as "an incurable or irreversible condition from which, in the opinion of the attending physician, death will occur without the use of life-sustaining procedures."<sup>33</sup>

York City).

28. See e.g., Ala. Code #22-8A-4(c); Ariz. Rev. Stat. Ann. #36-3202C; Ark.Stat. Ann. #20-17-202 (b); Colo. Rev. Stat. #15-18-104; Fla. Stat. Ann. #765.05; Mo. Ann. Stat. #459.015(3) and N.Y. Pub. Hea. L. # 2981 (5) (e).

29. Goodson, How To Prepare Your Own Living Will (1991).

30. See e.g. Ala. Code #22-8A-7; Ark. Stat. Ann. #20-17-202(a); Colo. Rev. Stat. #15-18-104(1); Fla. Stat. Ann. #765.04(1); Mo. Ann. Stat. #459.015; N.Y. Pub. Hea. #2981(1).

31. See Gelfand *supra* note 6, at 744.

32. Some states require that the terminal condition of the patient be certified in writing by two physicians, both of whom have personally examined the patient, and one of whom is the actual attending physician. See e.g. Ala. Code. #22-8A-3(5).

33. Ariz. Rev. Stat. #36-3201(6). The use of terms such as incurable or irreversible are heavily criticized as ambiguous. For example, "[c]onditions such as diabetes are currently incurable, but are reversible through treatment with insulin . . . ." See Gelfand, *supra* note 6, at 745. The term "unconscious" adds further complexities, as Gelfand

Furthermore, most states, such as New York, require that the documents be signed by two witnesses who are neither related to the patient, responsible for the care and expenses of the patient, nor would benefit from the death of the patient.<sup>34</sup>

Unlike other states, New York and New Jersey have language in their statutes which absolves doctors, following a patient's directive, from criminal and civil liability.<sup>35</sup> In some states, such as New York, the doctor and hospital retain the option of transferring the patient to another physician or hospital to perform the required treatment or desired course of action should the dying request violate the hospital's code of ethics, or the physician's sense of morality.<sup>36</sup> Additionally, though not in New Jersey, a doctor is also not required to abide by a living will or health proxy which would permit the death of a pregnant<sup>37</sup> woman.<sup>38</sup> Aside from these two

asserts, "[t]he problem is that not all conscious patients are competent; losing consciousness is not the only way to lose competence." *Id.* at 745.

34. See e.g. Ala Code. #22-8A-4; Ariz. Rev. Stat. Ann. #36-3202A; Cal. Health & Safety Code #7188; Fla. Stat. Ann. #765.04(1); New York Pub. Hea. L. #28981 (3); Tex. Rev. Civ. Stat. 459Oh, #3.

35. See e.g. Ala. Code #22-8A-9; Ariz. Rev. Stat. Ann. #36-3205C; Ark. Stat. Ann. #20-17-208(b); Cal. Health & Safety Code #7190; Colo. Rev. Stat. #15-18-110(b); Fla. Stat. Ann. #765.10(1); Mo. Ann. Stat. #459.045(1); N.Y. Pub. Hea. #2986; Tex. Rev. Civ. stat. 49Oh, #6.

36. See e.g., Ala. Code #22-8A-8; Ariz. Rev. Stat. Ann. #36-3204; Ark. Stat. Ann. #20-17-207; Fla. Stat. Ann. #765.09; Me. Rev. Stat. Ann #5-708; Mo. Ann. Stat. #459.030.

37. This issue has sparked great debate among legal scholars. While it would seem that the Supreme Court's decision in *Roe v. Wade* declared a woman's interest in her maternal health paramount to the state's interest in fetal life, a patient's interest in maternal health, when terminally ill, is insignificant. Thus, some argue that the state's interest becomes compelling. See e.g. Note, "A Matter of Life and Death: Pregnancy Clauses in Living Will Statutes," 70 *Bost. U. L.*

exceptions, a doctor is required to abide by a patient's living will in all circumstances, and in the event that he or she does not, some states will impose criminal penalties.<sup>39</sup> Finally, should a physician decide to give effect to a patient's directive once that patient has lapsed into permanent unconsciousness or lacks the ability to make health care decisions, that physician is required under New York and New Jersey law to consult with at least one other physician.

An advance directive may be revoked at any time by the author of the directive, even if at the time of revocation that patient's decision-making faculties have diminished.<sup>40</sup> New York and New Jersey recognize oral revocations as well.<sup>41</sup> In

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*Rev.* 867 (1990); Note, "The Constitutionality of Pregnancy Clauses in Living Will Statutes," 43 *Vand. L. Rev.* 1821 (1990).

38. The Colorado statute, for example, provides that if the qualified patient be diagnosed as pregnant, "a medical evaluation shall be made as to whether the fetus is viable and could with reasonable degree of medical certainty develop to live birth with continued application of life-sustaining procedures. If such is the case, the declaration shall be given no force or effect." Col. Rev. Stat. #15-18-104(2) (emphasis added). See also, Conn. Gen Stat. #19a-574; Fla. Stat. Ann. #765.08.

39. Various states impose varied penalties, Ala. Code #22-8A-8(c) (Class C Felony); Ark. Stat. Ann. #20-17-209 (Class A misdemeanor); Some states, such as California, Missouri, and Texas, merely refer to the physicians refusal as "unprofessional conduct" but impose no penalty. Cal. Health & Safety Code #7191(b); Mo. Ann. Stat. #459.045; Tex. Rev. Civ. Stat. 490h, #6, #7.

40. It is not necessary for the patient to be declared competent in order for the revocation of any directive to be considered legally valid.

41. Oral revocations are somewhat more complicated but permitted in most states when made in the presence of a witness 19 years or older who signs and dates a written confirmation that such expression of intent was made.

the event that a physician is presented with an unrevoked declaration executed by the terminal declarant before him, the physician may be required to: certify the patient's medical record that such a determination to withdraw or withhold life-sustaining treatment has been made; make a reasonable effort to contact patient's spouse and family or contact the patient's durable power of attorney if assigned.<sup>42</sup> One state provides that "[i]f no action to challenge the validity of a declaration has been filed within forty-eight consecutive hours after the certification is made by the physicians, the attending physician shall then withdraw or withhold all life-sustaining procedures pursuant to the terms of the declaration."<sup>43</sup>

### Termination of Life-Sustaining Treatment

The public's disdain for the unwarranted prolongation of the dying process belies the fact that virtually all states now provide for advance directives. Notably, legislation has not gone so far as to permit advance directives to take effect when an unconscious patient is not terminally ill.<sup>44</sup> Indeed, "[e]very existing living will act requires that the patient's physical condition or prognosis be "terminal" or sufficiently poor in order to bring the provisions of a living will into effect."<sup>45</sup> However, new definitions and procedures in living

42. In Connecticut, consent of next of kin is not merely suggested but is required. In addition, an oral or written advance directive, must be presented to, or in the possession of the attending physician before life-sustaining treatment can be removed. See, Conn. Gen Stat. #19a-571.

43. Colo. Rev. Stat. #15-18-107.

44. However, judicial decision making has recently reached this point. See e.g., *Bouvia v. Superior Court of Los Angeles*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986). For a discussion of the *Bouvia* decision see *infra* notes 72-76 and accompanying text.

45. Gelfand, *supra* note 6, at 740. See, for example, New York

will legislation have prompted both Right-to-Die-advocates, as well as ethicists and religious groups, to advocate changes in present living will legislation.

### Death With Dignity

Any discussion of life-sustaining treatment involves the use of many codes and slogans, including "right to die", "quality of life", and "death with dignity." However, these terms are misunderstood as often as they are used.

Advocates of the right to die generally assert that wishes of the patient are paramount in the event they are declared terminally ill, and must take precedence.<sup>46</sup> Originally this implied that life need not be prolonged; however, medical technology has complicated the definition of prolonging life and denying death.<sup>47</sup>

The death with dignity movement does not believe that all patients have a right to die an aesthetic and peaceful death. This is clearly beyond reach, given the amount of nausea, confusion, and delirium many dying patients experience. Certainly, some uncomfortable situations are unavoidable, and advocates of the right to die do not suggest that patients experiencing such discomfort be provided the opportunity to take their own lives. Rather, death with dignity means that once a patient is terminally ill, he should not be subjected to any medical procedures or treatments which merely prolong the dying process against his will.

The death with dignity movement has, therefore,

Public Health Law #2989(3).

46. Notably, organizations, such as the Society for the Right to Die, no longer advocate active euthanasia. The Society's handbook asserts, "passive euthanasia...[is] the basis of the Society's program today." *The First Fifty Years*, Society for the Right to Die, at 1 (1988).

47. *Id.*

advocated legislation such as living wills and durable powers of attorney statutes. In doing so, advocates seek to provide patients with the freedom to supervise their own health-care decisions. Currently, the main problem confronting right-to-die advocates is the threat that the rights already afforded patients will be diminished.<sup>48</sup> One such right of concern to advocates is the refusal of some states, such as New York, to permit a patient to refuse nutrition and hydration.<sup>49</sup>

### Religious and Ethical Views

While the public maintains that its right to autonomy guarantees its right to make life and death decisions, theologians disagree. For many theologians the decision to make life and death decisions is not personal in nature. For example, Rabbi J. David Bleich asserts, "Judaism recognizes no right to privacy insofar as termination of human life is concerned. Such right is vested solely in the Creator."<sup>50</sup>

In addition to moral offensiveness, some religious groups are opposed to terminating life-sustaining treatment on other grounds. Rabbi J. David Bleich asserts that terminating a patient's life may deny that patient invaluable time for penitence.<sup>51</sup>

48. *Id.* at 6.

49. While *Cruzan* seemed to indicate that it would be unconstitutional to force a patient to continue nutrition and hydration against her will, the existence of legislation denying such a right has yet to be challenged before the Supreme Court.

50. Bleich, "The Quinlan Case: A Jewish Perspective," reprinted in *Jewish Bioethics* 266, 276 n.2, (ed. Rosner & Bleich 1979) [hereinafter Jewish Perspective].

51. See "Jewish Perspective," *supra* note 50, at 273 (citing Me'iri at *Yoma* 85a) "although the moribund patient may be incapable of any physical exertion he may be privileged to experience contrition and utilize the precious final moments of life for the achievement of true

Finally, because all these issues are on a spectrum, it is argued that permitting 'A' will lead to permitting ethically reprehensible action 'B'. Thus, some ethicists fear early termination will result in Darwin-like applicability or God-like decision making.<sup>52</sup> Moreover, the mentally and physically disabled fear society will soon render value judgments regarding the quality of their lives.<sup>53</sup> However, one writer responds that many arguments may similarly fall victim to this broad "slippery slope" argument, for virtually all worthwhile issues involve the attempt to draw a legitimate black line on a continuum. Thus, he argues, we should not disqualify a position which allows for the termination of life-sustaining treatment merely because it is not based upon a clear black line.<sup>54</sup> To ensure that a patient's wishes are carried out in accordance with his/her religion, some religious groups have formulated

repentance." *Id.*)

52. Bleich asserts, "if the comatose may be caused to 'die with dignity,' what of the mentally deranged and the feeble minded incapable of 'meaningful' human activity? Withdrawal of treatment leads directly to overt acts of euthanasia; from there it may be but a short step to selective elimination of those whose life is deemed a burden upon society at large." "Criteria for Death," *supra* note 7, at 291.

53. Lewin, "Despite Daughter's Death, Parents Pursue Right-to-Die Case," *New York Times*, July 28, 1991, p. 14, col.2 (discussing the case of a disabled child who, brain-damaged since birth, was rendered unconscious after a fall in 1987. After an Indiana Superior Court ruled that the child's parents had the authority to order the removal of their daughter's feeding tube, the National Legal Center for the Medically Dependent and Disabled intervened declaring the court's ruling "as a form of unacceptable discrimination against the handicapped." *Id.* at col. 4. An attorney for the Right to Life Committee explains, "[y]ou wouldn't let them starve a child who wasn't disabled, so it is simply discrimination against the disabled to let them do it here." *Id.* at col. 5).

54. President's Commission *supra* note 8, at 29 n. 52.

their own proxies.<sup>55</sup>

### Religious Response to Advance Directive Legislation

Within Orthodox Judaism,<sup>56</sup> two versions of advance directives have evolved.<sup>57</sup> While the Rabbinical Council of America [RCA] expounds a very specific position and advises its followers to make a living will following its mandates, Adukat Israel merely gives general guidelines as to what one should do and reserves ultimate decision-making to the individual's pre-selected rabbi. Other differences between the two reflect the difference of opinion regarding the actual time death occurs. According to both Agudat Israel and the RCA, the cessation of respiratory activity is required before life-sustaining treatment can be removed. However, Agudat Israel also requires cessation of cardiac activity before a patient is

55. Some religious denominations, such as Reform Jews, are satisfied with personal decision-making regarding life-sustaining treatment. See the comments of Rabbi Dayle A. Friedman, Cong. Rec., Oct. 17, 1989 (asserting "[w]e Reform Jews champion the right of individuals to make choices regarding their conduct . . . . We reject imposition of specific choices from external authorities, either contemporary or historical." *Id.*). Both Jewish and Christian organizations have produced their own versions of living wills. These living wills differ from the more generic ones advocated by the state, insofar as they reflect the religious concern for the sanctity of life. In doing so, the circumstances permitting life-sustaining treatment are limited.

56. As of the date of this article there has been no formal response from the Conservative movement.

57. Agudat Israel revealed its *Halachic Living Will* in late 1990, which was followed by the Rabbinic Council of America's *Health Care Proxy* in mid-1991. The *Halachic Living Will* is reprinted in Zweibel, "The Halachic Health Care Proxy: An Insurance Policy With Unique Benefits," *Jewish Observer*, at 20-21 (Sept. 1990) [hereinafter Zweibel].

pronounced "halachically" dead.<sup>58</sup> Because the brain stem controls respiratory functions, the RCA asserts that the presence of cardio-pulmonary activity is not dispositive. Therefore, the RCA has devised a health care proxy, which permits a patient in a comatose or persistent vegetative state, or a brain-damaged patient, the choice to refuse life-sustaining treatment, even if that patient is not terminally ill. The one exception exists when there remains "small likelihood of recovering fully, a slightly larger likelihood of surviving with permanent brain damage, and a much larger likelihood of dying . . . ."<sup>59</sup>

### Halachic Considerations

As a result of federal legislation, requiring that patients be informed of their rights to make health care decisions; state legislation, in favor of patient autonomy; and judicial decisions, favoring the right to privacy as above and beyond any state interest, many halachic complexities arise. Indeed, many of these have been discussed at length by Jewish scholars; hence, I will attempt to highlight the most problematic of these complexities and the various approaches of these scholars. Furthermore, other issues which have yet to receive full attention will be discussed in detail.

### Violating the Will of the Patient

Physicians and hospitals will continue to face dilemmas concerning a patient's advance directive. This is especially true when a patient directs to terminate or withhold treatment which will certainly save that patient's life. While some states refuse to prosecute a physician for violating a patient's

58. See generally, *Criteria for Death*, *supra* note 7; Soloveichik: *supra* note 7.

59. RCA Health Care Proxy-B (Detailed Directive).

advance directive, especially when the patient has asked to remove naso-gastric feeding, there is a popular lobby calling for criminal prosecutions.<sup>60</sup> This is troubling halachically since most authorities assert that "*lo ta'amod*" (Do not stand by idly), (Deut. 19:16) and "*lifnei iver*" (do not put a stumbling block) (Lev. 19:14) obligate a physician to force feed or force treat a patient when that patient refuses to be fed or treated.<sup>61</sup>

While halachic authorities assert that there is little, if any, room for right to privacy concerns in determining health care decisions,<sup>62</sup> the parameters of "Do not stand idly by" are not always so broad as to require a doctor to risk his life or livelihood to fulfill its requirements. For example, the Ramo in *Yoreh De'ah* 336:3 asserts that a doctor can charge money to heal a patient, even though healing the sick is an obligation, because the obligation to heal is on the public at large. To be sure, the Vilna Gaon in his commentary to the Ramo makes it clear that a doctor can choose whether or not to heal a patient even if that doctor is the only person in the area who can save that patient.<sup>63</sup>

Similarly, according to Rabbi Moshe Hirschler in his *Halacha Urefua*,<sup>64</sup> the obligation to heal is composed of both private and public elements. Rabbi Hirschler cites the

60. See Note, "The California Natural Death Act: An Empirical Study of Physicians' Practices," 31 *Stanford L. Rev.* 913, 945 (May 1979) [hereinafter Note].

61. The *Tzitz Eliezer* asserts that even one who screams, "go away, I do not want to be treated", must be ignored. IX, no. 47, sec. 5.

62. R. Moshe Feinstein, for example, asserts that a physician can treat a patient even if the patient refuses the advice of that physician and asks to be transferred elsewhere for treatment. *Iggerot Moshe*, C.M. II, no. 74.5.

63. For this proposition the Vilna Gaon cites a passage in *Kiddushin* 8b.

64. Hirschler, *Halacha Urefua*, Vol. 3, no.3, at 45 (Jerusalem:1988).

responsum of a 16th century rabbi, Moshe ben Joseph di Trani, asserting that when the people of Pisa were faced with meeting a heavy ransom,<sup>65</sup> it was not obligatory for the community to choose members who would meet that ransom.

Thus, the public has the obligation to heal everyone; the private individual should heal one who will most certainly die without his or her help, but does not have to incur financial loss to do so. Thus, while the doctor is often chosen because of his proximity to the patient, his duty to heal should never be self-detrimental. Indeed, at that point the doctor's obligation of *Lo Ta'amod* might be limited to voicing his protest. The obligation to heal that patient then "reverts" to the public from which it originated. It is up to the public at that point to violate judicial decision or, in the alternative, protest such decision.

However, the potential financial and professional cost to the doctor which may offset his obligation to heal, the threat of which exists in some state statutes, has never been enforced.<sup>66</sup> In fact, studies indicate that doctors in some states such as California<sup>67</sup> and New York have systematically refused to

65. *Ibid.*, at 49.

66. Although the court in *Bartling* submitted a final order instructing the hospital to release the patient, the patient had, by that time, already died. *Bartling* illustrates that while some courts do assert that doctors are obligated to assist patients, against any moral convictions, they have not yet taken any action against disobedient doctors. The final order submitted in *Bartling* read:

ORDERED AND ADJUDGED that William Francis Bartling, in the exercise of his right to privacy, may remain in defendant hospital or leave said hospital free of the mechanical respirator now attached to his body and all defendants and their staff are restrained from interfering with Mr. Bartling's decision.

67. The California study revealed the following information; % of Doctors Who Would Administer Treatment in Violation of The Patient's Wishes

enforce ethically suspect advance directives. As a result, doctors,<sup>68</sup> ethicists,<sup>69</sup> and courts are split over the issue

Patient Has No Family	Wishes of Patient's Family	
	Family Acquiesces in Patient's Request	Family Wants Everything Done to Save Patient
Form of # 73.6	26.8	20.8
Patient's Request * 36.3	16.7	11.5

#= Patient requests orally that treatment be withheld

\*= Patient executes a binding directive.

Note, *supra* note 61, at 936 n. 100 (table 6).

68. See e.g. Wanzer et. al., "The Physician's Responsibility Toward Hopelessly Ill Patients," 310 *New England Jour. of Medicine* 955 (April 1984) [hereinafter Wanzer]. All agree that the patient's right to make decisions regarding his or her personal care is paramount. However, many questions arise when a patient's decision making capacity becomes diminished or when a patient refuses treatment capable of saving that patient's life. In the former case, doctors are generally advised to "rely on the presumed or pre-stated wishes of the patient." *Id.* But, because it often happens that patients are rendered incompetent prior to having informed anyone of their wishes regarding life-sustaining treatment, doctors are often forced to consult with and often to seek judicial decision regarding the withdrawing or withholding of life-sustaining treatment. In order to avoid the complexities of litigation, doctors are advised to take the initiative while the patient is competent enough to make such a decision. *Id.* at 956. See also, Task Force, *supra* note 4, at 9-12. Whether or not it is possible for a competent person to appreciate the gravity of his or her decision, is outside the scope of this article.

Wanzer asserts that a physician often fails to respect a patient's wishes because "[p]hysician's are strongly influenced by their personal values and unconscious motivations." He suggests that, "they should guard against ...[the] tendency to equate a patient's death with professional failure, or unrealistic expectations." Wanzer, *supra*. Perhaps more troubling in Wanzer's assertion that although the patient's welfare always remains paramount, a doctor should not ignore the high cost of patient care. "Financial ruin of the patient's family, as

regarding the disobedient doctor.

The court in *Bartling v. Glendale Adventist Medical Center*<sup>70</sup> and *Bouvia v. Superior Court of Los Angeles County*<sup>71</sup> ordered a hospital to forego its moral and religious beliefs and favor a patient's health care decision holding that "the right [to die] . . . include[s] the ability to enlist assistance from others, including the medical profession."<sup>72</sup> However, both New York and New Jersey have enacted legislation dissenting from this view and have adopted a standard similar to that announced in *Brophy v. New England Sinai Hospital, Inc.*, asserting:

"There is nothing . . . [which] would justify compelling

well as the drain on resources for treatment of other patients who are not hopelessly ill, should be weighed in the decision making process . . ." *Id.* at 957. As a result, some advocates of patient autonomy argue that legislation calling for criminal prosecution is necessary to force a doctor to comply with a patient's desire to withhold or withdraw treatment. Note, *supra*, 61, at 945; see also, Steinberg, "California Natural Death Act ( A Failure to Provide for Adequate Patient Safeguards and Individual Autonomy," 9 *Conn. L. Rev.* 203, 216 n. 18 (1977).

69. See generally, Annas, "Transferring the Ethical Hot Potato," 17 *Hastings Cent. Rept.* 20 (Feb. 1987)

70. 184 Cal. App. 3d 961, 229 Cal. Rptr. 360 (1986). For information regarding tort claims arising out of a physician's failure to remove life-support systems, see 58 A.L.R. 4th 222.

71. 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); See also, *N.Y. Times*, May 23, 1986, A, at 18, col. 5.

72. 179 Cal. App. 3d at 1147, 225 Cal. Rptr. at 307 (Compton, J., concurring). Similarly, the *Bartling* court declared, "if the right of the patient to self-determination as to his own medical treatment is to have any meaning at all, it must be paramount to the interests of the patient's hospital and doctors." 163 Cal. App. 3d 186, 194, 209 Cal. Rptr. 220, 225 (1984). A recent New York case cited a similar opinion, see, *Elbaum By Elbaum v. Grace Plaza of Great Neck*, 544 N.Y.S. 2d 940, 847 (2d Dept. 1989).

medical professionals . . . to take active measures which are contrary to their view of their ethical duty toward their patients. There is substantial disagreement in the medical community over the appropriate medical action. It would be particularly inappropriate to force the hospital, . . . to take affirmative steps to end the provision of nutrition and hydration . . . A patient's right to refuse medical treatment does not warrant such an unnecessary intrusion upon the hospital's ethical integrity . . .<sup>73</sup>

This suggests that at this point there does not exist an imminent fear of criminal prosecution which would outweigh the obligation of "Do not stand idly by" and, therefore, a doctor remains obligated to save a patient's life even if in doing so the doctor violates the patient's will.

### Transferring Patients

It has been recently made very clear that an individual's right to privacy may outweigh a hospital's, physician's or state's interest in maintaining the ethical integrity of the medical profession.<sup>74</sup> Therefore, not only have physicians in some states been required to make full accommodations for a patient who desires to withhold or withdraw life-sustaining treatment, but some courts have read state statutes to require, under certain circumstances, the assistance of the physician or hospital even when such assistance violates religious and ethical beliefs.<sup>75</sup> While a physician in New York is afforded the opportunity to transfer a patient who desires a given treatment withheld or withdrawn, courts in other states have refused to allow for the transfer of such a patient asserting

73. 398 Mass. 417, 441, 497 N.E. 2d 626, 639 (1986) (citations omitted).

74. 76. See *supra* notes 71-73.

75. *Id.*

that such a transfer may cause severe emotional and psychological distress.<sup>76</sup> However, because transferring the patient to another hospital or physician will certainly result in that patient's death prematurely, since the latter will surely honor the patient's directive, thus violating halacha, the halacha-abiding doctor, in doing so, may violate the *issur* of *Lo Ta'amod* and perhaps also the violation of *Lifnei Iver*.

Simply, the doctor and hospital could avoid the bulk of halachic problems by informing the patient beforehand that under certain circumstances that patient's directive will not be honored. For example, if the patient requests upon admission to the hospital that should it become necessary to be fed through a naso-gastric tube, he would rather forego such feeding, the physician or hospital administrator could state hospital policy to the contrary. Indeed, refusal to treat the patient on these grounds can be likened to refusal to treat the patient who refuses to pay for the physician's services, which halacha clearly permits.<sup>77</sup> Thus, if the hospital or doctor were to inform the patient ahead of time, halachic problems could be avoided. Moreover, legislation in New York and New Jersey, and judicial decisions in other states, suggest that early explanation of hospital or doctor policy will help prevent prosecution for failure to enforce the patient's advance directive.

However, in the event that the doctor did not have the opportunity to inform the patient of hospital or personal policy, a different problem arises. While it is certain that the doctor in charge of enforcing hospital policy could never halachically be permitted to withhold nutrition and/or hydration,<sup>78</sup> whether the doctor may invite another doctor to perform the

76. See, *In the Matter of Reguena*, 213 N.J. Super. 475, 482, 517 A 2d 886, 893 (1986).

77. See *supra* notes 63-66.

78. According to all authorities this would constitute *rezicha* (murder).

removal may raise halachic concerns, but in effect raises the same issues involved in violating the patient's will. Simply, a doctor acting as an administrator of hospital policy does not have to risk criminal prosecution or financial loss by refusing to transfer the patient to another hospital even though that patient's life will be terminated prematurely.

### Timing of Death

Indeed, the distinction between the RCA and the Agudat Israel's position rests upon differing views of when death actually occurs. Obviously the actual time death occurs has enormous repercussions.<sup>79</sup> For example, if one asserts that death does not occur until the cessation of respiratory and cardiac activity, then pulling the plug on a patient who is merely brain dead but whose heart continues to beat is murder.<sup>80</sup>

While there are few discussions in the Talmud on the timing of death, modern halachic scholarship on the topic is abundant.<sup>81</sup> Indeed, virtually all discussions have evolved from various understandings of *Yoma* 85a and the Mishnah in *Oholot* 1:6.

*Yoma* 85a involves the limits regarding the removal of fallen debris on the Sabbath from an individual who may or may not be alive. *Oholot* 1:6 asserts that an animal whose head has been cut off is unclean. Further, *Oholot* asserts that

79. For a full examination of the halachic opinions on this crucial topic, see *Journal of Halacha and Contemporary Society*, Vol. 17, Spring 1989, pp. 7-69, wherein a number of articles addressed the problem from a wide variety of positions

80. For a criticism of the RCA Health Care Proxy on this point, see Zweibel, "A Matter of Life and Death: Organ Transplants and the New RCA 'Health Care Proxy,'" *Jewish Observer* (Summer 1991) [hereinafter *Life and Death*].

81. See note 80, above for a discussion of halachic sources and interpretations.

any movements or convulsions following that decapitation are not to be considered as evidence of life.

In light of these texts varied opinions emerge. The majority interpret *Yoma* 85a as an appropriate standard for defining death. In doing so, they assert that death occurs shortly after the cessation of both cardiac and respiratory activity. Others add that cessation of brain activity is also required.<sup>82</sup>

Conversely, the minority asserts that *Yoma* 85a focuses only on the circumstances which warrant desecrating the Sabbath to save a life.<sup>83</sup> The minority, therefore, rely heavily upon *Oholot* 1:6 for the halachic determination of death. In doing so, they liken decapitation to the termination of brain stem activity and compare human cardiac and muscle activity following brain death to that of the animal convulsions. For as Maimonides asserts, an organism should no longer be considered to be alive when "the power of locomotion that is spread throughout the limbs does not originate in one center, but is independently spread throughout the body."<sup>84</sup>

Whether or not such convulsive movements are similar to those movements of one who is decapitated or not is an issue of medical<sup>85</sup> and religious debate. Certainly, some argue, one

82. See Soloveichik, *supra*, note 7, at 300.

83. Rabbi Tendler and Dr. Rosner, for example, assert, "[i]n the case of the Talmud [*Yoma* 85a] . . . the interest focuses on any sign of residual life to warrant desecrating the Sabbath to dig [the one entrapped] out. It has no relevance to a patient lying in an [ICU] whose every function is monitored and whose status is open to full evaluation. In such a case, the issue is truly one of definition, not confirmation." Tendler & Rosner, *Practical Medical Halachah*, at 64 (3rd ed. 1990) [hereinafter *Tendler & Rosner*].

84. Commentary on *Oholot* 1:6.

85. See Winkler & Weisbard, "Appropriate Confusion Over Brain Death," 261 *J.A.M.A.* 2246 (1989); see also, Tendler & Rosner, "Brain Death" 262 *J.A.M.A.* 2834 (Nov. 1989); see also, Oro, *id.* at 2835.

may distinguish between one who is decapitated from one who is brain-dead.<sup>86</sup> For example, two physicians recently responded to the analogy, asserting, "unlike decapitated bodies, [patients who are brain dead are in intensive care units and] maintain integrated function of their vital organ systems for days and even weeks."<sup>87</sup>

Rabbi Tendler retorts that brain death can be thought of as a physiological decapitation.<sup>88</sup> He asserts, "[t]here is not a more accurate definition of death today . . . Brain death objectively affirms death better than any other standard. If the circulation of the brain has ceased totally, the brain is divorced from the rest of the body no differently than if it were by the action of a guillotine."

The minority proposition also claims to find support in an alternative reading of a *teshuva* by Rabbi Moshe Feinstein in his *Iggerot Moshe*.<sup>89</sup> In Responsa III *Yoreh De'ah*, no. 132, Rabbi

86. Rabbi Bleich asserts, "[r]ejection of 'brain death' as an acceptable criterion of death is entirely compatible with recognition that decapitation does serve as incontrovertible indication of death even if spasmodic muscular movements persist after the head is severed. . . . Cessation of circulation to the brain cannot, in itself, be equated with total cellular destruction of the brain." Bleich, *Judaism & Healing: Halakhic Perspectives*, at 155 (1981) [hereinafter *Judaism & Healing*].

87. Winkler & Weisbard, 262 J.A.M.A. 2835 (Nov. 1989) (replying to the criticism of Drs. Tendler and Rosner regarding an earlier editorial).

88. Tendler & Rosner, *supra* note 84, at 64-5.

89. Notably, despite speculation to the contrary, very few halachic authorities have previously sanctioned brain death as an acceptable halachic definition of death. But see, Rabinowitz & Koenigsberg, *Ha Darom*, Vol. 32, at 59, 1971 (equating brain death with decapitation). Further, the reliance upon Rabbi Moshe Feinstein is grounded more in Rabbi Moshe Tendler's personal exchanges with Rabbi Feinstein than it is upon Rabbi Feinstein's actual writings. Notwithstanding,

Feinstein recognizes that because the brain stem controls respiratory activity, it is necessary that it too cease to function before death can be halachically pronounced. Further, Rabbi Feinstein asserts that when one is decapitated he should be declared dead, subsequent convulsions and spasms notwithstanding. In both statements Rabbi Feinstein omits the cessation of cardiac activity as a criterion, thereby, suggesting that brain death alone constitutes a halachic criteria of death.

However, the addition of brain death in the first example may also be explained as an added stringency to the halachic definition of death. The second example is a case of a non-person (for one who is decapitated loses his status as a person), therefore, it is less persuasive as proof of halachic acceptance of the brain death criterion by Rabbi Feinstein. Finally, such a reading cannot be reconciled with various other *teshuvot* by Rabbi Feinstein. For example, in *II Yoreh De'ah* 179.5, Rabbi Feinstein asserts that one who has removed the heart of a brain-dead patient is a murderer.

Rabbi Tendler responds to the above inconsistencies by providing documentation of a letter to the Chairman of the New York State Assembly's Committee on Health, sent by Rabbi Feinstein asserting that "[t]he sole criterion of death is the total cessation of spontaneous respiration."<sup>90</sup> Second, Rabbi Tendler understands Rabbi Feinstein's rejection of heart transplants in *Y.D.* 179.5, as limited to those situations when the patient is only partially brain dead, and may therefore remain breathing spontaneously. Therefore, Rabbi Tendler asserts that R. Feinstein's writings should not be interpreted as rejecting the whole brain death position. It needs to be

Rabbi Feinstein's various other *teshuvot* on the subject which declare brain death as unacceptable, are problematic and suggest that his *teshuvot* do not reflect his acceptance of brain death as an acceptable criterion of death.

90. Tendler & Rosner, *supra* note 84, at 63.

repeated that this interpretation of talmudic and rabbinic sources is a minority opinion and does not conform in certain crucial aspects with the majority of rabbinic rulings.

## Organ Transplants

Organ transplants are most viable while the patient's heart continues to beat.<sup>91</sup> Thus an organ transplant is viable under the brain death definition, because cardiac activity need not be arrested in order for death to be pronounced. The halachic validity of many organ transplants is moot under the Agudat Israel position, for death requires cessation of cardiac activity, at which time organs are not as viable for transplant.

Generally, once a patient is dead, several halachic interests arise which, at first glance, seem to conflict with sanctioning an organ transplant; first, the dead must be buried without delay;<sup>92</sup> second, one may not generally derive benefit from a

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91. "Vital organs are . . . candidates for harvest only during that period when brain stem function has irreversibly ceased yet the heart continues to beat." "Life and Death," *supra* note 81, at 11. The Halachic Living Will asserts that "[w]hether there exist exceptional circumstances that would permit an exception to the general prohibition under Jewish law against the performance of an autopsy or dissection of my body" is to be determined in accordance with strict orthodox interpretation and tradition (emphasis added). The RCA asserts that the commandment of "Do not stand idly by" is strong enough to outweigh that general prohibition and thereby permits transplants. The source for the RCA's position is disputed. While the RCA maintains that R. Moshe Feinstein, z"l, stated his high regard for organ transplants in his *Iggerot Moshe*, advocates of Agudat Israel disagree. Zweibel asserts, "Rabbi Feinstein employs extraordinary strong language to condemn heart transplants as . . . the murder of both the recipient and the donor," "Life and Death," *supra* note 81, at 12 (citing *Iggerot Moshe*, Y.D. II 179).

92. Deut. 21:22-23; San. 47a; BB 154a.

dead body.<sup>93</sup> Therefore, unless there exists a countervailing halachic interest such as *pikuach nefesh*, one cannot interfere with the corpse.<sup>94</sup>

In his famous response on this subject, Rabbi Ezekel Landau stated the guidelines for post-mortem procedures.<sup>95</sup> Accordingly, it is not sufficient that the organ be removed merely for future use, nor is it permitted that a non-essential organ be removed even for immediate use. Rather, what is permitted is the removal of essential organs, such as the heart, liver, kidney and some assert the corneas as well,<sup>96</sup> which will be utilized immediately for (a *choleh lefaneinu*) transplant.

While organ transplants are permitted under limited circumstances, they are still not yet favored by all members of the halachic community. Many fear that because organs may only be harvested immediately after cessation of cardiac activity, physicians or their assistants may become overzealous in preparing the patient for transplant and serve to hasten that patient's death before his or her time. In addition, because the probability of success is slim, some believe that such a procedure is not strong enough to outweigh the prohibition of benefiting from a corpse (*met assur behanah*). Still others assert that by not making provisions for halachically permitted organ transplants one may transgress *lo ta'amod*.<sup>97</sup>

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93. AZ 29b; Ned. 48a; see, Rabbi Jacob Emden, *Responsa She'elat Yavetz*, sec. 1, no. 41 (1734).

94. For a fuller discussion of the halachic permissibility of organ transplants, see the article by Reuven Fink in *Journal of Halacha and Contemporary Society*, Vol. 5, 45.

95. *Noda BeYehuda, Mahadura Tanina*, Y.D. no. 210 (1947); see also, Rosner, "Autopsy in Jewish Law & The Israeli Autopsy Controversy," *Tradition* (Spring 1971).

96. *Judaism & Healing*, *supra* note 86, at 129-132, and 133, n.8 (citing R. Unterman, *Shevet me-Yehudah*, I, 313).

97. See generally, Tendler & Rosner, *supra* note 83.

## Conclusion

Living will legislation has been enacted in over forty states, while the remainder of the states have legislation pending. But there are problems which require attention. Studies in both California and New York reveal that doctors are either not familiar with the legislation or may for personal reasons fail to honor a patient's living will. While this may not be a concern for many religious Jews who desire to be kept alive at virtually any cost, it may prove to be a problem should doctors choose to dismiss religious views which favor life-sustaining treatment at any cost as "outdated." Indeed, a recent story of a doctor who assisted a patient in her quest to commit suicide, as well as the success of suicide self-help techniques, indicates society may be heading that way.<sup>98</sup>

Finally, different definitions in different states create different presumptions concerning terminating life-sustaining treatment of a patient without an advance directive. While New York has a presumption encouraging the doctor in doubt to err on the side of life, other states do not. Thus, while authorities debate how and when treatment may be terminated, one thing that appears advisable is for an individual to have a living will or a health-care proxy based on sound halachic principles and supervised by an accepted halachic authority.

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98. Altman, "Jury Declines to Indict a Doctor Who Said He Aided in a Suicide," *New York Times*, July 27, 1991, # A, at 1, col. 2.