ON THE BIOETHICS OF JEWISH LAW: THE CASE OF KAREN QUINLAN*

*By Alan J. Weisbard***

It has been widely remarked, in both the popular press and the scholarly literature, that rapid technological advances in the biomedical sciences may have outpaced society's ability to consider and cope with all their implications. In short, that technology is out of control. A particularly poignant example of the quandaries wrought by modern technology has been the plight of Karen Quinlan and her family. Pronounced by her doctors to be in a "persistent vegetative state", with permanent loss of all cognitive function, Karen was seemingly sustained only by her connection to a mechanical respirator. Following a lengthy vigil and with the blessing of their church, the Quinlan family requested that the respirator be disconnected. The doctors refused, stating that such an action would be contrary to accepted medical practice. The Quinlans responded with a legal action for declaratory and other relief, the practical effect of which would be the termination of use of the respirator. After failing in the lower court, *In the Matter of Karen Quinlan,* 137 N.J. Super. 227, 348 A.2d 801 (1975), the Quinlans were successful in the New Jersey Supreme Court, 70 N.J. 10, 355 A.2d 651 (1976). Shortly thereafter, the Quinlans directed that the respirator be removed; much to their surprise (and undoubtedly that of the Court), Karen proved able to breathe unassisted. With antibiotic treatment and intravenous feeding, but without the respirator, Karen has survived since June of 1976 in a New Jersey nursing home. There is no indication that she has regained cognitive function.

While widely perceived as concerning "the right to die with dignity", the Quinlan situation in fact raises a great many issues central to the interaction of law, morals, and modern technology and provides a convenient focus for discussion of these issues. In the *Quinlan* case, the Court invited the par-

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** A.B., Economics (Harvard); J.D. (Yale Law School, 1977); Member of the District of Columbia Bar.

ticipation of the New Jersey Catholic Conference as *amicus curiae* and carefully considered what it characterized as the "Catholic view".[1] The purpose of this essay is to consider some of these issues from the perspective of another religious tradition, Judaism. No claim is advanced that Jewish law and ethics have evolved any clear-cut and universal solution to the problems posed by modern medical technology. However, the investigation does reveal that some of the moral issues and pragmatic problems raised by the new technology are by no means so novel as is sometimes thought. Indeed, the arguments advanced in contemporary debate have precursors reaching back hundreds if not thousands of years. That no simple and satisfying answers are to be found is in a sense reassuring, for wrestling with the ethical problems posed by life and death may itself define a central aspect of our humanity. What is remarkable is the degree to which discussions in venerable Jewish sources display keen psychological and legal insights not always evident in more contemporary discussions of similar issues.

Apart from the normative guidance provided by Jewish law, perhaps the most striking finding to emerge from this investigation is the relevance to biomedical ethics of a dimension of justice, fundamental in the Jewish legal tradition, which is almost wholly absent from contemporary secular legal systems. Jewish law recognizes a category of crimes in which human courts have no part to play. While the proscribed behaviour is fully culpable, punishment is limited to the workings of divine justice, in which the community shares an implicit faith. This dimension of divine justice permits, at least within the context of a religious community, the working out of powerfully conflicting values in a relatively harmonious fashion. The conflicting values are precisely those at the heart of the problems posed by modern medicine.

While secular legal systems cannot replicate this resolution, they can learn from it. The lesson is primarily a procedural one, a counsel that courts of equity should exercise their discretionary power to refuse to entertain declaratory judgment actions where validation is sought for the taking of life. This counsel differs from suggestions that the substantive criminal law be changed to prohibit prosecutions of those in the position of the Quinlan family or the Quinlan doctors. Such criminal prosecutions, or the threat of them, may exact a harsh and sometimes arbitrary toll on individual defendants, both actual and potential.[2] But this toll is the price of allowing the courts, and the society at large, to evolve their positions more slowly and hopefully, more surely, in an area of exquisite moral sensitivity and large consequence for the society's sense of itself. The testimony of eons provides cogent evidence that no easy answers are forthcoming.

1 355 A.2d at 660.

2 See e.g., *Commonwealth* v. *Edelin* 359, N.E.2d 4 (Mass. 1976).

I. *Criteria for Determining Death*

For Jewish law as for the *Quinlan* court, the baseline for consideration of the appropriate treatment of a patient is a determination of what that patient's condition is. Such a determination may depend upon both medical facts and legal standards. A natural first question is whether the patient is alive or dead.

Given the medical facts of Karen Quinlan's case, this inquiry does not require elaborate consideration of Jewish criteria for determining death.[3] The relevant facts were set forth in the trial record by Dr. Fred Plum. Discussing his examination of Karen, Dr. Plum testified:

> I took her off the respirator... and beginning three minutes and forty-five seconds after that, she breathed without the respirator quite regularly, although she increased her rate... The sample of blood indicated that in fact she was, at least during that period of time, breathing physiologically normally.[4]
> ... [I]f she was able to maintain a perfectly normal level for four minutes, one has to be able to say that the function is potentially there.
> [Q. Function for what?]
> For spontaneous breathing, is potentially there.[5]

Other medical testimony offered at the trial was considerably less sanguine about Karen's ability to survive off the respirator for a prolonged period, but none of the doctors precluded the existence of limited potential for some spontaneous breathing. Dr. Javed, the pulmonary internist in charge of that aspect of Karen's care, testified that Karen's own breathing periodically triggered the respirator and that he had taken her off the respirator periodically for as much as thirty minutes.[6]

The traditional indications of life in Jewish law focus on the capacity for respiration. There is some disagreement as to whether the capacity must be for spontaneous (i.e., non-assisted) respiration. In either case, it is clear that Karen cannot be considered dead under traditional Jewish standards.

A recent attempt has been made to base a concept of brain death on traditional Jewish sources.[7] Whatever the merits of that approach, which has been rejected by the Chief Rabbinate of Israel,[8] it would not apply to

3 The most comprehensive English language treatment of this subject is J. David Bleich, "Establishing Criteria of Death" (1973) 13:3 Tradition 90 (hereinafter cited as Bleich).

4 *In the Matter of Karen Quinlan I* (Arlington, Va., University Publications of America, 1975) 480 (hereinafter cited as *Quinlan I*).

5 *Ibid.*, at 483.

6 *Ibid.*, at 276.

7 G. Rabinowitz and M. Konigsberg (1971) 32 *Hadarom* 59.

8 I. Jakobovits, *Jewish Medical Ethics* (New York, Bloch Publishing Co., 1975) 277 (hereinafter cited as Jakobovits).

the facts of Karen's case. Karen demonstrates measurable brain activity; she does not meet the criteria of "brain death" proposed by the Harvard Ad Hoc Committee[9] or by Professors Rabinowitz and Konigsberg.[10]

While not constituting death, Karen's condition offers little cause for hope. The doctors concurred that she had entered a "chronic persistent vegetative state", a condition characterized by "the capacity to maintain the vegetative parts of neurological function, but... no longer [with] any cognitive function".[11] The doctors testified that the brain damage suffered by Karen was irreparable; no one held out any medically significant prospect for meaningful improvement in Karen's condition or for survival beyond a year.

II. *The* Goses: *Status and Treatment of the Moribund in Jewish Law*

Given that Karen Quinlan cannot be regarded as dead by any relevant legal standard, has she, or any person in her condition, a special status that governs or guides our obligations to her? Is there a duty to take all steps to prolong her life? Is one approach mandatory, or are there other permissible approaches?

The New Jersey Supreme Court, in its decision of the *Quinlan* case, focused on the procedure recommended by the celebrated Ad Hoc Committee of Harvard Medical School,[12] which it quoted in its opinion:

> The patient's condition can be determined only by a physician. When the patient is hopelessly damaged as defined above [meeting the Committee's criteria for "brain death"], the family and all colleagues who have participated... should be so informed. Death is to be declared and *then* the respirator turned off. The decision to do this and the responsibility for it are to be taken by the physician-in-charge, in consultation with one or more physicians who have been directly involved in the case.[13]

While the Harvard Ad Hoc Committee does not address itself comprehensively to all questions of termination of treatment, it is explicit with respect to termination of mechanical respiration for patients with irreversible coma. Cessation of treatment comes after a determination of death, not prior to it.

Although Rabbi Bleich's definition of criteria of death differs from that suggested by the Harvard Ad Hoc Committee, his view of the time to cease treatment is remarkably similar. For Bleich, the position of Jewish law is straightforward:

9 Ad Hoc Committee of Harvard Medical School to Examine the Definition of Brain Death, "A Definition of Irreversible Coma" (1968) 205 J.A.M.A. 337.

10 See *supra* n. 7.

11 *Quinlan I, supra* n. 4, at 485.

12 See *supra* n. 9.

13 355 A.2d at 656. (Emphasis in original).

> [A]precise definition of death becomes of crucial importance because only the presence of the criteria of death which are recognized by *Halakhah* relieves the physician of his obligation to use all available means in order to prolong the life of the patient.[14]

On this reading, the Jewish response is clear: the question of life or death and the question of continuation or termination of treatment are flip sides of the same coin. Yet that hardly need be the case; both Christian theologians and secular observers have articulated rationales for termination of treatment prior to death.[15] Careful examination of the Jewish sources reveals that the Jewish position is less unequivocal and far more subtly textured than is suggested by Bleich. The key to disengaging the interlocked but distinct questions of life and treatment is the Jewish recognition of a special status for patients in a moribund condition. In fact, the Jewish tradition is not content with a single such status, but recognizes two.

The first such status, which will be of primary relevance to the next phase of this investigation, is that of the *goses*. The term is variously defined as applying to a person dying, moribund, or *in extremis*.[16] One enters the status of *goses* when death is thought to be imminent. Traditional tests include "when the rattle in the throat indicates that a person is at the point of death"[17] or when a patient can no longer swallow his saliva.[18] Dagi, a physician writing in 1975, notes that the latter test "is equivalent to brain-stem death in modern medical parlance, and destruction of the gag reflex".[19]

Some authorities consider the maximum duration of this state to be three days.[20] Others understand a *goses* in more metaphorical terms, as being "one moment" or "one qualitative level" from death, in the "penultimate state prior to death".[21] Under this understanding, a person being maintained at death's door by artificial means for an indefinite period might be considered *goses*. For Bleich, even if a patient cannot swallow his saliva, he is not *goses* if he can be kept alive for more than three days.[22]

14 Bleich, *supra* n. 3, at 93. Indeed, according to Bleich, there may be an obligation to resuscitate even a patient who is dead, according to Halakhic criteria, if such resuscitation is feasible. *Id.* at 108.

15 See e.g., Paul Ramsey, *The Patient as Person* (New Haven, Yale University Press, 1970); Robert Veatch, *Death, Dying and the Biological Revolution* (New Haven, Yale University Press, 1976) (hereinafter cited as Veatch).

16 Jakobovits, *supra* n. 8, at 121.

17 Rabbi J. Rabinowitz, Notes to the Soncino edition of Tractate *Semachoth*.

18 *Shulchan Aruch, Even haEzer* 121:7, cited in Dagi, "The Paradox of Euthanasia" (1975) 23 Judaism 157 at 164 (hereinafter cited as Dagi).

19 Dagi, (see preceding note) at 165.

20 Jakobovits, *supra* n. 8, at 121 n. 18, citing Joshua Falk (c. 1550–1614, Lvov), *Perishah, Yoreh Deah* 339:5; *cf. Yoreh Deah* 339:2.

21 Professor S. Leiman, personal communication.

22 Dagi, *supra* n. 18, at 164, citing a personal communication from Bleich.

While the general rule is that a *goses* is "still to be treated as a living person in all respects",[23] a number of legal disabilities attach to one in that status, and there is a sizable body of legal material specifically concerning the *goses*. Before moving to an analysis of that material, it should be noted that Jewish law also recognizes a status termed *trefah*, which is also rendered in English as "dying" or "moribund".[24] While a dying person may be both *goses* and *trefah*, the notion of moribundity explored in the present discussion is exclusively that of the *goses*.

The earliest rabbinic discussion of moribundity is found in the minor tractate *Semachoth* 1:1–4:4. In the translation by Rosner:

> One who is in a dying condition *(goses)* is regarded as a living person in all respects.
> One may not bind his jaws, nor stop up his openings, nor place a metallic vessel or any cooling object on his navel until such time that he dies as it is written (Ecclesiastes 12:6): "Before the silver cord (*Midrash* interprets this as the spinal cord) is snapped asunder".
> One may not move him nor may one place him on sand nor on salt until he dies.
> One may not close the eyes of the dying person. He who touches them or moves them is shedding blood because Rabbi Meir used to say: this can be compared to a flickering flame. As soon as a person touches it, it becomes extinguished.. So too, whosoever closes the eyes of the dying is considered to have taken his soul.[25]

The Talmud compares one who closes the eyes of a dying person while the soul is departing to "a lamp that is going out. If a man places his finger upon it, it is immediately extinguished".[26] The great commentator Rashi (Rabbi Solomon Yitzhaki, 1040–1105, France) explains that this small effort of closing the eyes may slightly hasten death.[27]

In his classic twelfth century Code,[28] Maimonides largely repeats these earlier formulations, adding only an explicit injunction against rubbing or washing the *goses*.

The sixteenth century *Shulchan Aruch*'s treatment of the *goses* is found largely in Chapter 339 of *Yoreh Deah*. Here the formulation follows that of the Tur (Rabbi Jacob ben Asher, c.1270–c.1343, Germany and Spain), embracing a more general proposition that "any act performed in relation to death should not be carried out until the soul has departed". Of special

23 Jakobovits, *supra* n. 8, at 121.

24 For a full description of that status and a discussion of the Jewish legal response to one who kills a *trefah*, see Section V *infra*.

25 F. Rosner, *Modern Medicine and Jewish Law* (New York, Yeshiva University Press, 1972) 117–18 (hereinafter cited as Rosner).

26 Tractate *Shabbath* 151b.

27 Cited in Rosner, *supra* n. 25, at 118.

28 Book of Judges, laws of mourning 4:5.

interest is an injunction forbidding the removal of a pillow from beneath the patient's head.

Commenting on this injunction, Rabbi Moses Isserles (c. 1525–1575, Poland), the authoritative Ashkenazi commentator on the *Shulchan Aruch* and a major figure in the development of Jewish medical ethics, states:

> It is forbidden to cause the dying to pass away quickly; for instance, if a person is in a dying condition for a long time and he cannot depart, it is prohibited to remove the pillow or the cushion from underneath him following the popular belief that feathers from some birds have this effect [i.e., to prevent the patient from dying easily].[29]

In the absence of the last portion of Isserles' explanation, the prohibition on removing the pillow would seem closely analogous to that against closing the eyes of a *goses;* both come within Rashi's injunction against movements of the body which might hasten death. In that sense, both actions would be akin to what is now termed active euthanasia, which is clearly proscribed in Jewish law. Isserles, however, added a new element, linking the proscription to a folk belief that certain feathers prolong the dying process. To the extent this justification provides an independent alternative ground for Isserles' ruling, it would seem to introduce a new element of considerable significance; namely, that conditions hindering the dying process may not be removed. (The principle does, however, stop short of requiring all actions that would hinder the dying process to be taken.) The applicability of such a principle to the removal of Karen Quinlan's respirator would seem straightforward.

But there is compelling evidence that such was not Isserles' true position. Isserles was clearly aware of the thirteenth century *Sefer Chasidim,* or *Book of the Pious,* authored by Judah the Pious (R. Judah ben Samuel, d. 1217, Germany). Two passages from this work are relevant:

> If a man is sick and in pain and dying and asks another man to kill him mercifully, this request must *not* be fulfilled, nor may the man take his own life. Still, you may not put salt on his tongue to keep him alive longer. (Nos. 315–318).[30]
>
> ... [I]f 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. (No. 723).[31]

Relying in part on these passages, Isserles made a major ruling:

> [I]f 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

29 Cited in Jakobovits, *supra* n. 8, at 121.

30 Cited in Solomon B. Freehof, *Reform Responsa* (New York, Ktav, 1973) 120 (hereinafter cited as Freehof, RR).

31 Cited in Rosner, *supra* n. 25, at 119.

> such as 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.[32]

This would seem to negate the "independent alternative" hypothesis posed above, and to suggest a distinction which has had continuing vitality in Jewish law. Active steps to shorten life are proscribed, while removal of impediments to the dying process are permissible and, perhaps (following Judah the Pious, no. 723 *supra*), mandatory under some conditions.

To state this distinction is to raise a host of problems whose resolution in the Jewish sources would seem no more satisfactory than in corresponding secular contexts. Removing a pillow, like closing the eyes, is deemed an act and proscribed; wiping salt from the tongue is "no act" and is permitted if not mandated.[33] One possible explanation of the distinction between the proscribed and the permitted might be the degree of movement of the patient's body necessitated by the two actions. But can it be maintained with any degree of conviction that wiping the tongue is so markedly less intrusive than closing the eyes? Two responses come to mind: first, that closing the eyes may not constitute removal of an impediment; second, that the prohibition on closing the eyes may be based on a different, and perhaps symbolic, rationale.[34] Still, as to the pillow and the particle of salt, the difference remains perplexing, more one of degree than of kind.

A possible reconciliation, not mentioned in the literature, might proceed from an assumption that Isserles disbelieved and disapproved the folk custom attributing magical powers to bird feathers. On this view, as the pillow was not in fact an impediment to death, no amount of movement would be permissible to remove it. Thus, Isserles' true principle would allow removal of all *bona fide* impediments, at least absent major jostling of the body and consequent direct threat to life.

A variant on this hypothesis might posit that Isserles was addressing different audiences in his two rulings. There is fragmentary evidence to the effect that salt was used by physicians as a therapeutic agent during Isserles' time. Isserles' second ruling, then, might constitute a directive to medical

32 Cited in Rosner, *supra* n. 25, at 119–20.

33 Freehof notes that the Taz (Rabbi David ben Samuel ha-Levi, 1586–1667, Poland) expressed doubt about the permission to wipe the patient's tongue, for that would shake and disturb the patient and would be an overt act. Solomon B. Freehof, *Modern Reform Responsa* (Cincinnati, Hebrew Union College Press, 1971) 201–202 (hereinafter cited as Freehof, MRR).

34 Rabinowitz, commenting on this verse in the Soncino Talmud, notes that the custom of closing the eyes of a corpse was widespread among ancient Greeks, Romans and Egyptians. At the moment of his death, man was believed to behold the Divine Presence; it was unfitting that after that vision his eyes should look at anything mundane.

professionals authorizing them to withhold or terminate treatment in a futile cause. Such a directive would call upon the physician to exercise his professional expertise and thus would run little risk of being misunderstood or of having unintended consequences. In contrast, the first ruling concerning folk beliefs about bird feathers might have been intended to discourage the general populace from practicing folk medicine, where the risks of active hastening of death (and the associated psychological consequences) might be considerably more grave.

Authorities subsequent to Isserles have employed his principles in their own decisions, but the pattern that has emerged is free neither from ambiguity nor from controversy. Rabbi Joshua Boaz Baruch, an adherent of the folk theory that pillow feathers do prevent the soul from departing, stated that such impediments to death should be removed and called for the abolition of the prohibition against removing the pillow, basing the argument in part on a decision attributed to Rabbi Nathan of Igra.[35] Rabbi Joshua drew the line at moving the dying person from one place to another, a practice whose propensity for hastening death was more readily evident. Rabbi Joshua's policy can be reconciled with the first hypothesis concerning Isserles, *supra,* on the assumption that Joshua considered the pillow a *bona fide* impediment while Isserles did not; neither authority would countenance active hastening of death while both would permit minor bodily intrusions for the purpose of removing *bona fide* impediments.

A Talmudic example illustrates the interplay of prohibited active hastening of death and permitted removal of impediments artificially prolonging the dying process. The passage is a dramatic one, relating the martyrdom of Rabbi Hanina b. Teradion. The Romans

> . . . wrapt him in the Scroll of the Law, placed bundles of branches round him and set them on fire. They then brought tufts of wool, which they had soaked in water, and placed them over his heart, so that he should not expire quickly.

Hanina's disciples called out to him to open his mouth, so that the fire could enter him and put an end to his agony. Hanina refused, responding:

> Let Him who gave me my soul take it away, but no one should injure oneself.

The Roman executioner, moved by this response, requested Hanina's permission to raise the flame and take away the tufts of wool. This Hanina would allow, and his soul departed speedily. Then the executioner jumped

35 Rabbi Solomon Eger is said to have quoted another rabbinic authority to the effect that "it is forbidden to hinder the departure of the soul by the use of medicine". The original context of this statement is not clear, however, and other authorities disagree. See Rosner, *supra* n. 25, at 120 citing *Beth Yaakov* no. 59, and *Shebuth Yaakov,* part 3:13.

into the flames. A heavenly voice proclaimed that both Hanina and the executioner were assigned to the world to come.[36]

The passage is significant in a number of respects, with important implications for the permissibility of suicide and the propriety of prayer for a speedy death. For present purposes, the passage is noteworthy for its contrast between Hanina's refusal to take an overt act, opening his mouth, which would accelerate his death, and his granting of permission for the removal of an impediment, the wet tufts, which artificially prolonged his agony.

Viewed in their own terms, these classical discussions provide several suggestive, if hardly compelling, analogies to issues posed by modern medical techniques. For example, while the sources generally proscribe removal of the feather pillow from underneath the dying patient, there is no clear statement on whether the pillow should or must be placed under the *goses* in the first place, as a quasi-medical impediment to death. This distinction presages the debate in contemporary bioethics on whether different standards should govern the decision to connect a respirator and the decision to remove it once it is connected and functioning. With respect to what those standards should be, a partial answer is furnished by the salt on the tongue example. At least insofar as the consequent movement of the *goses* is not significant, the salt, and with it the impediment to death, may be removed from the tongue of a dying patient. Perhaps analogously, the mechanical respirator, if it functions solely as an impediment to the dying process of the *goses,* may be disconnected or, more simply, unplugged. While disconnecting the respirator would clearly not constitute purely passive behaviour, there seems little apparent reason for it to be regarded as more an "overt act", and therefore prohibited, than the permitted wiping away of a particle of salt or the analogous removal of the wet tufts from over the heart of Rabbi Hanina. As to whether the respirator should be connected in the first place, it may be recalled that Judah the Pious (although not Isserles) explicitly forbids employing an impediment to prevent an easy death; if the sole function of the respirator is to impede an inevitable and imminent death, it should not, on this reasoning, be employed. Finally, the wood-chopping example provides an instance of a continuing action thought to impede death so long as it continues; in this case, cessation of the action, which constitutes removal of the impediment, is clearly permissible. This precedent provides at least a formalistic analogy to cessation of a continuing active treatment, as in the provision of antibiotics to combat infection or the replacement of exhausted supplies of nutriment or oxygen.

The modern reader may well find the aforementioned analogies rather wooden at best, and wonder whether they have anything to teach us about the control of modern medical technology. Yet the comparisons are worth

36 Tractate *Abodah Zarah* 18a.

setting forth, both for their inherent interest and, more pointedly, because the development of a contemporary Jewish response to medical technology is likely to be articulated, or at least justified, in the vocabulary of such homely analogies.

An approach more congenial to contemporary analytic tastes would surely look beyond such mechanical comparisons to the values underlying the decisions of the rabbis and seek to assess how those values may be effectuated in the context of the problems posed by modern medical technology. Unfortunately, much of the material already discussed is rather opaque with respect to underlying value premises. A possible source for further guidance concerning issues of life and death is the Jewish attitude toward prayers for the dying, to which the discussion now turns .

III. *Prayer: Limits on the Duty to Save Life*

The principle of *pikuach nefesh,* the duty to save life, is fundamental in Jewish law. The principle cuts across and supersedes virtually all other commandments. The warrant is Scriptual. "Ye shall therefore keep my statutes and mine ordinances: which if a man do he shall live in them" (Levit. 18:5). "See I set before thee this day life and good, and death and evil;... choose life that thou mayest live, thou and thy seed; to love Jehovah thy God, to obey his voice and to cleave unto him" (Deut. 30:15, 19–20). *Mishnah Yoma* 8:6–7 provides that a case of risk of loss of life supersedes even the Sabbath law. If débris of a collapsing building falls in the vicinity of a person, searchers must probe the heap to determine if the victim is alive, even on the Sabbath, to rescue him. Once it is determined with certainty that the victim is dead, no further violation of the Sabbath law is permissible, and the body must be left until after the Sabbath.

The injunction to save life is not, however, absolute. Even if threatened with death, one may not commit murder, idolatry, or adultery/incest.[37] Nor, in most instances, may one count lives, sacrificing one innocent life for the preservation of many.[38]

The obligation to save life also has limits in the context of the *goses,* the "moribund" person whose death is imminent. The classic illustrations of these limits are premised on the Jewish belief in the therapeutic efficacy of prayer for the sick.

Prevention and healing of disease are linked to the divine from the earliest period of Jewish history. In the first moments of the Exodus, prior even to the provision of manna, the Lord proclaimed (Exod. 15:26):

> If thou wilt diligently hearken to the voice of Jehovah thy God, and wilt do that which is right in his eyes and wilt give ear to his command-

37 *Cf.* Tractate *Sanhedrin* 74a.

38 See D. Daube, *Collaboration with Tyranny in Rabbinic Law* (London, Oxford University Press, 1965), and Tractate *Ketuboth* 19a.

> ments and keep all his statutes, I will put none of the diseases upon thee, which I have put upon the Egyptians: for I am Jehovah that healeth thee.

The motif of divine healing has been everpresent in Jewish life. The Karaite sect took this quite literally, totally rejecting the permissibility of human healing and relying entirely on prayer for their healing:

> Man must ever pray not to become ill for if he becomes so, it is demanded of him to show merit in order to be healed.[39]

Normative, or Rabbinic Judaism rejected this exclusive reliance on divine healing, finding Scriptural warrant for human physicians. Within the Rabbinic tradition, recourse to divine healing and to human physicians provide complementary and roughly parallel paths to healing. For many commentators, the preferred path is the divine, with human physicians in a clearly subsidiary role. The interplay is expressed in a Talmudic passage, *Berachoth* 60a, which prescribes the appropriate prayer for one about to undergo an operation:

> May it be Thy will, O Lord my God, that this operation may be a cure for me and mayest Thou heal me for Thou art a faithful healing God and Thy healing is sure since men have no power to heal but this is a habit with them.

Rosner notes that it is required for the patient to recognize "that the physician is acting as an agent for the Divine healer" and states Rashi's interpretation of the above prayer

> . . . to mean that the afflicted person should have prayed for Heavenly intervention rather than human healing and perhaps the bloodletting might not have been necessary.[40]

As is evident from the above passages, the channel of communication for requests for divine healing is prayer. Needless to say, this is hardly the occasion for a comprehensive discussion of the efficacy of prayer. But it should be apparent that Jews do regard prayer as an efficacious therapeutic agent. A *Midrash* to Deuteronomy is illustrative.[41] The *Midrash* begins with the statement that "Great is prayer in the sight of God", then goes on to discuss the story of Cain and Abel. After slaying his brother, Cain confessed before God, thus averting half of the punishment (the fugitive status) in the decree against him, "a fugitive and wanderer shalt thou be in the earth" (Gen. 4:12). This is cited for the proposition that prayer, "if it does not achieve the whole of its object, . . . achieves at least half of it".

The *Midrash* continues with a discussion of chap. 38 of Isaiah, concerning

39 Tractate *Shabbath* 32a.

40 Rosner, *supra* n. 25, at 20.

41 *Midrash Rabbah* to Deuteronomy, Soncino edition, chap. VIII, *Nitzabim* 147–48.

the illness of King Hezekiah. When God said to Hezekiah, "set thy house in order, for thou shalt die", Hezekiah "turned his face to the wall" and prayed. Whereupon God said to him, "I have heard thy prayer... I will add unto thy days fifteen years". The *Midrash* concludes:

> For so Scripture says, He will fulfil the desire of them that fear Him; He also will hear their cry, and will save them.

Depending on the circumstances, prayer may be more or less efficacious than resort to human physicians (a balance that perhaps has changed as physicians have gained in skill and knowledge, to be sure). Nevertheless, it is within this context that the forthcoming analogies between prayer and medical treatment must be evaluated in elucidating Judaism's attitude toward the dying. The discussion will proceed via a series of incidents illustrating rabbinic attitudes toward prayers for the dying, with analysis to follow.

The most famous incident, related in *Ketuboth* 104a, concerns the dying day of Rabbi Judah the Prince, the redactor of the *Mishnah*. The Rabbi lay dying in great suffering.

> We are told that the rabbis gathered in ceaseless prayer to keep him alive, but his servant-maid (who... was honoured as a learned woman in the Talmud), seeing how hopeless was his case and how much he suffered, prayed that he be given the privilege of death. When the rabbis insisted on praying that he be kept alive a little longer, she threw down from the roof a huge earthen jar in order to disturb them and stop their prayers so that Rabbi Judah might peacefully die.
> And so it happened: for a moment the rabbis ceased their prayers and the soul of the great Rabbi departed to its eternal rest.

The Talmud quotes this action of the maid-servant with evident approval.[42]

A second case, described in *Yalkut Shimoni* to Proverbs (no. 943), concerns an old woman living a life of ugliness and despair. Wanting to die, she came to Rabbi Yossi ben Chalafta, who, seeing that her wish was justified, asked by what merit she had lived so long. Learning that she prayed daily, the rabbi advised her to absent herself from the synagogue for three days. She did so, and died.[43]

A similar instance concerns the Jewish precursor to Rip Van Winkle, Honi the Circle Drawer, whose return to the world after a seventy-year

42 Following Freehof, RR, *supra* n. 30, at 119. The incident is also illustrative, of course, of the power attributed to the prayers of the rabbis.

43 Seymour Siegel, "Updating the Criteria of Death" (1976) 30 Conservative Judaism 23, at 29–30; compare Freehof, RR, *supra* n. 30, at 120. Jakobovits renders the story somewhat differently, *supra* n. 8, at 124 n. 48: the woman's wish would be granted if she would not absent herself from the synagogue for three days.

sleep met with ridicule and disbelief. Honi "therefore prayed to God (that he should die), and he died".[44]

Rabbi Nissim Gerondi (early thirteenth century, Spain), commenting on a Talmudic passage (*Nedarim* 40a) discussing the duty of visiting the sick and praying for their recovery, stated that there are times when a man should ask God's mercy for a sick person that he may die, as, for example, when the sick person is in agony and it is impossible for him to recover. The roughly contemporaneous *Sefer Chasidim* of Judah the Pious discussed the same issue in light of Ecclesiastes 3:2: "a time to be born and a time to die":

> If a man is dying, do not pray too hard that his soul return; that is, that he revive from coma. He can at best live only a few days, and in these days he will endure great suffering. So "there is a time to die".[45]

A more recent consideration of the subject is contained in a responsum by Chaim Palaggi, dating to 1800.[46] He was asked the following question:

> A woman with a painful disease was dying. She pleaded with her husband and sons to pray that God be merciful and let her die. The husband and sons did everything material that they could do to ease her suffering, but they did not have the heart to comply with her request to pray for her death. Instead, they prayed, and asked others to pray, for continued life. Did they do right?

Chaim Palaggi answered:

> ... that it is right for them to pray that she die, but since there is some slight possibility of selfishness in their prayer, in that they might wish to be disencumbered of the burden, therefore let them not pray for her death, but let others do so.

Suffering for its own sake is not a value in Judaism; this is particularly true of the pangs of death. Even for those condemned to capital punishment, with whom the society might be thought out of sympathy, the execution should be carried out swiftly "as an act of mercy"[47] and the condemned should be given a drug to deaden the pain. A similar lesson is conveyed by several of the stories related *supra,* some of the most dramatic in Rabbinic literature. In each case the subject is suffering in agony, and in most is irrecoverably dying, without hope of cure. In such cases, there is no obligation to use prayer to prolong life, or, perhaps more aptly, to prolong the

44 *Ta'anit* 23a.
45 Following Freehof, RR, *supra* n. 30, at 119–20.
46 Following Freehof, RR, *supra* n. 30, at 120–21.
47 Simon Federbush, "The Problem of Euthanasia in Jewish Tradition" (1952) 1 Judaism 64.

dying process. Indeed, there is explicit approval of a variety of steps designed to terminate a life of agony. In the different cases, these steps include not praying too hard for recovery, withholding prayer altogether, praying directly for death, and praying directly for death in conjunction with taking steps to frustrate the prayers of others for continued life. As noted by Jakobovits:

> The significance of these concessions can only be appreciated if one considers the often unfailing efficacy commonly attributed to the power of prayer and mystic prescriptions.[48]

It is reasonably clear from these materials that Jewish teachers were not out of sympathy with efforts to deliver incurables from their agony. The obligation of *pikuah nefesh* is here superseded by other values; a potentally efficacious measure (in the sense of forestalling death) may be withheld, at least within the context of prayer. The question naturally arises whether a similar lesson applies to medicine. The case is put by Freehof:

> From the point of view of the Jewish legal tradition, both medicine and prayer are efficacious modes of healing. A physician is considered an authorized emissary of God and prayer is also an effective therapeutic agent.[49]

Freehof reasons that in the absence of direct and positive guidance to the physician as to treatment of the incurably dying, Jewish law and its implied ethics provide "a strongly *implied* guidance in the attitude toward prayers for the dying". Thus, the physician is not "in duty bound . . . to keep a miserable and dying patient alive".[50]

The validity of this reasoning, with its easy assimilation of medicine to prayer, is subject to some question. More detailed examination suggests that prayer may have unique characteristics rendering such simple analogies highly problematic.

The first issue concerns the difficult situation of those confronted by the necessity of prayer for the dying. For both the dying person and, even more so, for the family, attitudes toward an impending death may be deeply ambivalent. One element is likely to be the wish for the patient's recovery and return to health, whether or not such a prospect is considered medically realistic. When the dying process is prolonged and accompanied by suffering, there may also be a wish that the process be speeded up and done with. This may be particularly true where the costs, both financial and emotional, weigh heavily on those who will remain. But it is unlikely to be entirely absent in even the "best" of such situations.

The rabbis seem to have recognized that these ambivalent feelings could creep into the prayers of the relatives, raising the possibility that even a

48 Jakobovits, *supra* n. 8, at 124.
49 Freehof, RR, *supra* n. 30, at 118–19.
50 Freehof, RR, *supra* n. 30, at 119.

consciously "well-intended" prayer might include an unworthy and selfish request for the patient's death. If that result should eventuate, a believer might well be tempted to link cause and effect, with a lasting residuum of personal guilt. The responsum of Chaim Palaggi, *supra,* is clearly responsive to the conflicting loyalties inherent in such a situation. While the rabbi was no doubt innocent of such concepts as regression and infantile omnipotence, his advice seems fully consistent with the insights of modern psychology.

The case of the aged woman may also reflect an interesting psychological dimension. The woman's daily prayers were doubtlessly more than tinged with ambivalence, perhaps creating an inner tension which prevented her "relaxing unto death"—a situation reminiscent of the concentration of attention which forestalled death in the salt and wood chopping paradigms of Rabbi Isserles. Rabbi Yossi's advice, permitting her to refrain from prayer and its accompanying tension, may have facilitated the necessary "letting go".

The conflicting signals sent out by the aged woman also draw attention to a second special characteristic of prayer: the mechanism linking request and result. Prayer achieves its desired effect through the invocation of divine intervention. Not only is there a mediating agency between the request of the person offering prayer and the consequence of that prayer; the mediator is the Supreme Power in the universe. And His ways are mysterious, indeed. For instance, we are told in a portion of Talmud[51] concerning King Hezekiah that:

> If a man makes his petition depend on his own merit, heaven makes it depend on the merit of others; and if he makes it depend on the merit of others, heaven makes it depend on his own merit.

The same passage suggests that Hezekiah's fate (and his succession) will be determined "through your merit and mine combined", referring to the prophet Isaiah.[52] Thus, the divine response to prayer may depend on several

51 Tractate *Berachoth* 10b, and see text *supra* at n. 41.

52 The Hezekiah story is also instructive with respect to the rabbis' attitude toward informing patients of their prognosis. The great prophet Isaiah is rebuked for telling a man that his situation is hopeless, and in fact the decree is averted through prayer. The traditional literature demonstrates a keen sensitivity to the psychological effect on the patient of what is said and done around him. A dying man cannot be informed of the death of a close relative, lest his mind grow distraught. While the family may be informed, this should not be done in the presence of the ignorant, the young, or of women, "lest they weep and terrify his heart". *Semachoth:* 1:3. Some commentators hold that should a patient inquire of his condition, it may be permitted to deceive him. Eliezer Minz, *Shaare Deah,* cited in Freehof, RR, *supra* n. 30, at 123–24. When the time comes to call the patient to confession (the *viddui* prayer), this must be done in such a way as not to terrify him.

factors in addition to the substantive content of the prayer. The obscurity of this connection, and its opaqueness to analysis, may well differentiate prayer from other contexts where the causal chain at least appears to be more direct and unidimensional. In particular the performance of physical acts which accelerate death may well be more likely to be accompanied by feelings of guilt than are fleeting thoughts or wishes in the course of prayer. While the thinking of bad thoughts is not to be encouraged, acting out those thoughts poses far greater danger, both to the individual and to the society. Thus, regulatory techniques appropriate to the prayer context may not be readily transferable to medical technology.

In addition to these special characteristics of prayer, a further nuance of interpretation arises in the cases of the aged woman and of Honi. In contrast to the other instances discussed, although both the woman and Honi, are suffering, neither is described as moribund, and neither can be regarded as *goses.* Yet their prayers for death are approved and answered, suggesting that the rabbis' solicitude, at least with respect to prayer, is not limited to those who are *goses,* and that what is otherwise forbidden may be permitted in the special case of prayer. An instructive comparison is the case of R. Hanina b. Teradion, whose martyrdom at the hands of the Romans is described *supra.* Rabbi Hanina refused to open his mouth so that the fire could enter him and put an end to his agony. Yet, he prayed "Let Him who gave me my soul take it away". The passage thus differentiates an impermissible action from a permissible prayer for a speedy end, again suggesting that lessons drawn from prayer should not be applied too readily to other contexts.

Only a limited conclusion can be drawn from these materials on prayer. Clearly the rabbis were sympathetic to efforts to deliver incurables from their agony. They looked favourably upon and authorized behaviour inconsistent with a maximal effort to prolong life. Yet, in each instance, the process was mediated by and, presumably, consistent with, the divine will. Thus, to the extent prayer's nexus with the divine will is unique, lessons drawn from Jewish attitudes toward prayer for the dying provide only uncertain guidance with respect to medical interventions.

IV. *Normative Treatment of the Moribund in Jewish Law*

With the assistance of these rather equivocal lessons drawn from prayer, we may return to the consideration of impediments to death, both medieval and modern. What are we to make of all the discussion in the sources of feather pillows and grains of salt?

Understanding may be enhanced through recognition of the mode of Jewish legal development. Grand generalizations and overarching principles, while perhaps implicit in the working out of concrete problems, play a subsidiary role. Rather, Jewish law has developed in a richly contextual vein, highly dependent on examination of particular cases and hypotheticals.

While the focus on pillows and grains of salt may appear particularistic to the point of eccentricity, such examples illustrate the working out of broader principles in practical contexts. Our task is a retranslation from these particulars to some more general observations.

The pillow/salt distinction may represent the rabbis' line-drawing exercise between what are now termed active and passive euthanasia. Generations of law students have cut their teeth trying to enunciate and defend their intellectual rationalizations of the active/passive dichotomy that seems emotionally so clear and compelling. It cannot be assumed that the rabbis—no strangers to intellectual dialectic—were unaware of these difficulties. Rather, the bald statement that wiping salt from the tongue is "no act" must be seen as defining the rabbis' dichotomization of the active/passive spectrum.

Despite the intellectual difficulties in defending them, this and similar dichotomies have thrived in discussions of medical ethics. In his recent work on bioethics and dying,[53] Robert Veatch devotes a lengthy chapter to cataloguing such dichotomies: killing v. allowing to die, ordinary v. extraordinary means, actions v. omissions. Little of Veatch's material would be truly foreign to the rabbis, and it is far from clear that this contemporary discussion has improved on the rabbis' formulation or resolution of the issues.

In evaluating these formulations from a social viewpoint, the logical and intellectual foundations of the attempted distinction are less crucial than how the distinction will work in practice. The consequences of acting on the distinction for individual participants and for the moral tone of the society must be considered in an inquiry that is less logical than psychological. The formulation proposed by the rabbis—allowing removal of impediments to the dying process while forbidding any active hastening of death—may largely restate the question, but in the restatement the focus is on precisely the relevant values. Within the Jewish tradition,

> ... man lacks the right to assess the quality of any human life and to determine that it is beneficial for that life to be terminated.[54]

What is perceived as active hastening of death, the taking of life—not only at an intellectual level but emotionally and psychologically, with all its resonances for the actor and for society—is proscribed. What is permitted is something we perceive quite differently, with responsibility clearly attributed to a force outside ourselves:

> ... [I]f a person is conscious, obviously he is alive ... and therefore there is no licit way I can see to shorten his life, even if he consents to it. You can do something whose consequence may be to shorten life, but you cannot directly shorten life. The reasoning is that you can

53 Veatch, *supra* n. 14.

54 Bleich, *supra* n. 3, at 109. Of course, this statement must be qualified by recognition of capital punishment, for which there is explicit Scriptural warrant.

> let nature take its course—and nature is identified with Providence from a religious point of view.[55]

It is unlikely that "allowing nature to take its course" is without its own psychological ramifications: the combination of a fulfilled death wish with "failure to take every step" to prolong life cannot be without its costs. Yet the potential for attribution of responsibility to an outside cause is also part of this psychic equation. It is quite another matter when the actor directly fulfils his death wish—is himself the instrument of death. Judaism has often been characterized as a religion concerned with acts rather than intentions. While this implicit theory of human psychology is doubtless oversimplified, it has its elements of truth. And that truth may be particularly pertinent to matters of life and death.

While this exposition has focused on the psychology of the individual, the consequences for society are not too different. When society approves the taking of life in any context, the slippery slope cannot be too distant. Thus, Jewish allowance of letting nature take its course is hedged with safeguards. The patient must be *goses,* already in the process of dying, and what is removed may only be an impediment, not an instrument with potential for cure. Even then, removal may not proceed if it would necessitate severe jostling of the body which might itself actively hasten death, or be perceived as having done so.[56]

Within this context, the determination of whether a particular medical intervention in a particular case is an "impediment" requires a functional analysis. Only if the patient is *goses,* if the medical intervention functions purely to maintain the patient in that state, impeding the natural dying process without prospect of healing, and if removing the intervention is not perceived as the real cause of death, does the intervention constitute an impediment which may be removed.[57]

55 Siegel, *supra,* n. 43, at 35. In this respect, a statement attributed to Joseph Quinlan, Karen's father, is highly instructive. During his ordeal, statements appeared in the press to the effect that Mr. Quinlan wanted to kill his daughter. Mr. Quinlan responded: "There's no attempt being made to really kill her... [S]omewhere there's a loving God, a loving Father, just waiting for her. And there's a special place for her. And I want to get her back in her natural state and leave it up to Him to decide if He's going to take her now or later". Quoted in B.D. Colen, *Karen Ann Quinlan: Dying in the Age of Eternal Life* (Plainview, N.Y., Nash Publishing, 1976) 43.

56 Such perceptions will often depend on conditions of time and place. What the determinants of these perceptions are, and how they are modified over time in a given society, are underlying themes of Section V of this essay.

57 A further question not fully explored here is whether an impediment prolonging the dying process should or may be removed if the patient is not suffering. All of the instances discussed in the sources, in both the impediment and prayer contexts, concern persons undergoing considerable suffering, and this fact may

Consideration of three types of intervention potentially relevant to Karen Quinlan can proceed in this framework. The simplest case is that of the mechanical respirator. On the basis of trial testimony, that device impeded the cessation of Karen's respiration and her consequent death in the absence of any realistic prospect for therapy, recovery, or cure. Removal could be accomplished without life-endangering movement of Karen's body. While medical practice and societal attitudes toward the respirator are in flux, the respirator's use in a case like Karen's is perceived as extraordinary, preventing the death that would otherwise come naturally. Thus, under Jewish law (and assuming Karen is *goses*), removal of the respirator would probably be permissible.

Termination of antibiotics and nasal-gastric feeding are more difficult to conceptualize in this fashion. Both are essential for the prevention or control of potential causes of death (infection or starvation) to some degree independent of the primary illness; both offer instances where purely passive behaviour (refraining from provision) would result in the patient's death. Absent the primary illness, the physician's obligation to heal would clearly require provision of antibiotics and sustenance; in that case, provision would be therapeutic both as to the potential death threats and as to the patient. In the Quinlan case, what would be therapeutic as to certain threats need not, in a larger sense, be therapeutic for the patient, who would remain *goses*. Analogies to pillow or salt in this context may seem somewhat forced; the question appears, rather, to be whether the obligation to heal pertains to the patient or to the disease. Where healing the disease would not rescue the patient from a moribund state, the action might be conceptualized as prolonging the dying process rather than healing, and thus outside the obligation of the physician.

Rabbi Jakobovits has recently examined this question in a related context:

> ... [I]n the case of a diabetic who cannot survive without insulin shots every day, and afterwards there is added to him the illness of cancer, which causes him terrible pain and agony, which keep increasing and for which there is no hope of cessation, it seems to be that we should not prevent him from removing that which prevents his death even when he is not literally expiring ... since the recourse to medical means which cannot possibly lead to recovery is not an obligation, but an option open to the patient.[58]

be critical to their rationale. In the *Quinlan* case, although the Court's perception was suggested by its statement that "no externally compelling interest of the State could compel Karen to endure the unendurable", 355 A.2d at 663, the Court recognized that "the quality of her feeling impulses is unknown". *Id.* at 655. Medical testimony left unanswered the question whether Karen, in her comatose state, experienced pain or had the capacity for suffering, physical or otherwise.

58 *Hapardes*, cited by Siegel, *supra* n. 43, at 32.

A further distinction might be drawn between provision of antibiotics and provision of food. There may be an independent obligation for all persons, not just physicians, to provide sustenance to persons under their control. If so, termination of antibiotics may prevent fewer problems than termination of food. And within the category of sustenance, a distinction is possible between relatively ordinary means (e.g., sugar water, which would result in eventual wasting away and death) and more sophisticated, ultra high calorie nutrients, which may sustain the body indefinitely. One could argue that in the Quinlan situation, there is no obligation for the doctors, either in their capacity as physicians or in the capacity of controlling persons, to provide special means of sustenance.

Contemporary authorities are divided on issues of this type; unfortunately, several recent responsa[59] were not accessible for this investigation. Jakobovits sums up the situation this way:

> Analgesics may be administered, even at the risk of possibly shortening the patient's life, so long as they are given solely for the purpose of rendering him insensitive to acute pain. Some authorities also sanction the removal from a dying patient of medications or machines which only serve to prolong his agony, so long as no natural means of subsistence (such as food, blood, and oxygen) are withdrawn. Another view goes even further, holding that there is no obligation to maintain the life of a patient in a permanent coma, and with no prospect of recovery, by medical treatment or the provision of food.
> But others will not tolerate any relaxation of efforts, however artificial and ultimately hopeless, to prolong life.[60]

Several qualifications should be expressed prior to concluding this part of the discussion. First, it should again be stressed that the traditional Jewish sources here considered all relate to a patient in the state of a *goses*. Extension of that concept from the traditional three day period to a metaphoric understanding which would encompass the almost indefinite maintenance of a patient "one moment from death" (made possible by modern medical technology) is far from universally accepted; definitive rejection of that extension would take cases like that of Karen Quinlan outside the legitimate scope of reasoning based on authentic Jewish precedent. Yet the values underlying the traditional sources seem equally relevant to the modern context—particularly as those values were elucidated in the context of prayer—and creative use of *Halakhah* would certainly seem consistent with its spirit in these applications.

A second qualification, raised by Rosner, is that the impediments spoken of in Jewish law "do not constitute any part of the therapeutic armamentarium employed in the medical management of this patient". Rosner suggests

59 Cited by Jakobovits, *supra* n. 8, at 276.

60 Jakobovits, *supra* n. 8, at 276 (notes omitted).

that it is for this reason that the impediments might be removed, whereas "discontinuation of instrumentation and machinery which is specifically designed and utilized in the treatment of incurably ill patients" might present a different case, "permissible [only] if one is certain that in doing so one is shortening the act of dying and not interrupting life".[61] Rosner, a physician, is dubious about practical application of that "fine distinction". Yet one must ask, in the case of each patient, precisely what function is truly being performed by "specifically designed instrumentation". Where the technology offers a meaningful hope of cure, partial recovery, or even a temporary remission (as where medical progress is on the doorstep of a potential cure), the patient falls outside the definition of *goses* and the objection is not truly applicable to him. But for those cases where the patient is truly *goses*—where there is no real hope for improvement—how does the technology function differently from the grain of salt? Is it not merely an impediment, whose result may be a painful, lingering death rather an easier one? And if so, does Rosner's distinction make a difference?

V. *The* Trefah: *On What Can Be Expected of Man*

The discussion thus far has focused on normative aspects of Jewish law and ethics, on what man should do in responding to the problems posed by modern medicine. But the inquiry should not stop there, for it is painfully clear that in matters touching life and death, man cannot be expected always to live up to the normative ideal. This need not result in the abandonment of the ideal, but it does require that the society and its legal system find a way to cope with failures to attain the ideal.

The dilemma is an eternal one in the law, classically posed in the Anglo-American legal tradition by the twin overcrowded lifeboat cases, *United States* v. *Holmes*[62] and *Regina* v. *Dudley and Stephens*.[63] Lord Coleridge stated the response of this tradition in *Dudley and Stephens:*

> It must not be supposed that in refusing to admit temptation to be an excuse for crime it is forgotten how terrible the temptation was: how awful the suffering . . . We are often compelled to set up standards we cannot reach ourselves and to lay down rules which we could not ourselves satisfy . . .
>
> There is no safe path for judges to tread but to ascertain the law to the best of their ability . . . and if in any case the law appears to be too severe on individuals, to leave it to the Sovereign to exercise that prerogative of mercy which the Constitution has entrusted to the hands fittest to dispense it.

Lord Coleridge went on to pass a sentence of death upon the defendants,

61 Rosner, *supra* n. 25, at 121.
62 26 Fed. Cas. 360 (No. 15383) (C.C.E.D. Pa. 1842).
63 14 Q.B. 273 (1884).

who, shipwrecked and without food for many days, had killed a near-dead young boy and survived by eating his flesh. This sentence was afterward commuted by the Crown to six months' imprisonment.[64]

Jewish law responds to the universal dilemma through an entirely different institutional pattern and through a variety of legal doctrines. Most significant for present purposes, Jewish law recognizes a category of crimes over which human courts simply have no jurisdiction: enforcement is relegated solely to the workings of divine justice. For example, certain actions taken under duress, while not validated or condoned as a matter of law, are nevertheless not punishable in this world by human institutions. This, indeed, would be the response of Jewish law to actions taken in the lifeboat situations of *Holmes* and *Dudley and Stephens*. Of course, the resolution owes its viability to the peculiar institutional framework within which Jewish law operates. In the absence of a community which shares an abiding faith in divine judgment and justice, failure to prosecute and punish the perpetrator would severely undercut the legal norm. The concept of non-punishable culpability adds a dimension to Jewish law which permits simultaneous affirmation of a legal ideal, through shared belief in the inevitability of divine justice, and compassionate treatment for those who fail to achieve the ideal. This dimension is lacking in secular law systems, although as suggested by Lord Coleridge, it may be approximated in some respects by executive clemency.

The notion of actions prohibited by law but not punishable by human institutions has direct relevance to treatment of the dying. For these purposes, the relevant legal-medical status in Jewish law is not the *goses* but the *trefah*.

A. The term *trefah* is defined principally as an "animal torn by a beast of prey".[65] In ritual law, *trefah* refers to "an animal with a fatal organic disease, the discovery of which, after slaughtering, makes it forbidden".[66] The *Mishnah* defines it this way:

> This is the rule: If an animal with a similar defect could not continue to live [for twelve months], it is *trefah*.[67]

By analogy, the term is extended to encompass a person having a fatal organic disease.

There is extensive discussion in the Talmud and later authorities as to what physical impairments render an animal *trefah*.[68] What is considerably

64 See J. Goldstein, A. Dershowitz, and R. Schwartz, *Criminal Law: Theory and Practice* (New York, Free Press, 1974), 1030–31.

65 *Midrash Tehillim* to Ps. 7:2.

66 M. Jastrow, *Dictionary of the Targumim* (New York, Jastrow, 1967).

67 Tractate *Hullin* 42a.

68 Tractate *Hullin* 43a; Maimonides, *Hil. Shechitah* 10:9.

less clear is whether, and to what degree, the conclusions reached as to animals are applicable to man.

Freehof summarizes the conclusions on this question as follows:

> In general, [the rabbis] may disagree about certain animal ailments or injuries, whether they are a mark of moribundity when found in man, but by and large they accept the standards set down for animals, namely, that if a person ... cannot be expected to live more than twelve months, such a person is considered to be in dying condition ... [and] when similar injuries are fatal in others, these injuries, whenever they occur, are deemed fatal.[69]

The distinction in status between a *goses* and a *trefah* is not without its difficulties, a problem illustrated by the fact that the common English rendering of both terms is "moribund" or "in a dying condition". Despite this, both the operational criteria and the legal status attaching to the two conditions are different in significant respects. As stated by Dov Zlotnick,[70] *trefah* describes the status of one

> ... who cannot possibly survive because of a fatal injury to a vital organ. Since the imminent death of the [*trefah*] is certain, he is called *gabra ketila*, "a man slain", and if one kills him, he cannot be tried, for in the eyes of the Sages he has killed a man already dead.

In contrast,

> Although the Sages accept the rule that "most *[gosesim]* die", i.e., succumb to their illness, yet up to the moment of death the [*goses*] is legally alive, the rule itself conceding that some may live.

At the risk of some oversimplification, the *trefah* is one with an irreparable organic disease who "will die"; the *goses* is anyone who "is dying". The death of a *trefah* is regarded as ultimately more certain, although perhaps less imminent, than that of the *goses*. As the *goses*, unlike the *trefah*, is regarded as having at least the theoretical potential to return to health, the *goses*, unlike the *trefah*, is not regarded as "a man slain". Thus, while the murderer of a *trefah* is not answerable to a human court, those courts will bring to account the murderer of a *goses*. Needless to say, in both cases the murderer is culpable and answerable to God; no authority would give permission in advance for the murder of either a *goses* or a *trefah*. The difference is limited solely to the ability of a human court to prosecute and to punish the offender.[71]

69 Freehof, MRR, *supra* n. 33, at 190–91, citing the commentary of Yom Tov Lipmann Heller (1573–1654, Prague) to *Yev.* 16:4.

70 Introduction to Tractate *Semachoth*, Yale Judaica Series, at 9.

71 This paragraph represents the author's personal conclusions drawn from consideration of the sources and from a discussion with Professor S. Leiman, who should not be held responsible for the author's errors of restatement or interpretation. It should be noted that some authorities limit the concept of *trefah*

For all its ambiguity, the status of *trefah* would seem virtually perfectly matched to the picture of Karen Quinlan drawn at the *Quinlan* trial, whether or not Karen is also regarded as *goses*. The physicians were virtually unanimous in their prognosis for Karen: her brain was irreparably damaged, and even with the full benefit of continued mechanical respirators, high calorie nasal-gastric feeding, and antibiotic treatment to ward off infection, Karen had no more than a year to live. There was also testimony that, with some allowance for the unknown etiology of Karen's disease, there were no known cases similar to Karen's in which the results were other than fatal.[72] Thus, insofar as the testimony is reliable, the standards relevant to a determination of *trefah* are precisely met. It follows that under Jewish law, termination of treatment impeding Karen's death, or for that matter more active steps themselves resulting in Karen's death, would not constitute homicide punishable by human courts.

B. The *Quinlan* case and its attendant publicity have resulted in considerable discussion of the proper role of courts and the legal system in re-

in its application to humans to persons *in extremis* as a result of wounds inflicted by the hand of man. On this reading, if a victim is in a moribund state as a result of natural causes, his murderer is fully liable and may be prosecuted and punished for homicide. Jakobovits, *supra* n. 8, at 124 n. 44. In this respect, it is not clear whether brain damage attributed to the combined effects of drugs and alcohol, the suspected cause of Karen Quinlan's affliction, should be regarded as resulting from natural causes or the hand of man.

72 The passage of time has demonstrated these prognostications to be incorrect, highlighting the difficulties of reliance on even the best medical testimony. In fact, questions have arisen regarding the validity, or at least the completeness, of the material in the *Quinlan* trial record with respect to comparable cases. A crucial passage is from the testimony by Dr. Plum: "Extensive studies on several hundred such subjects . . . up to the present time record no patient who has recovered sapient behavior after being in this kind of physiologically unresponsive condition for a period of six months". *Quinlan I*, at 476. Later in his testimony, Dr. Plum adverted to certain ambiguities in this statement, but this reference was not followed up at trial with requests for further elaboration. It has subsequently been suggested that many of the subjects of the studies referred to by Dr. Plum died fairly soon after entering their "physiologically unresponsive state", not as a direct consequence of the underlying disorder, but rather from infections following decisions by the doctors to terminate antibiotic treatment. One doctor has observed: "Had the doctors quietly acceded to the family's wishes, medical reality would have taken over. It is rare for a vegetative patient to be kept indefinitely on a respirator". Michael Halberstam, "Other Karen Quinlan Cases Have Never Reached Court", *New York Times* (2 November 1975), E9. Thus, evidence on long-term prognosis for patients in Karen's condition is in reality quite sparse. Karen herself is now providing evidence on the subject; she has already confounded the predictions of all the physicians save Dr. Plum in her successful weaning from the respirator.

gulating treatment decisions concerning terminal patients. Many have argued that physicians and others should be given immunity from liability for their decisions in these matters. Such a result could most plausibly be accomplished by legislation removing criminal penalties from acts involving termination of treatment. The response of Jewish law to the murder of a *trefah* might seem to support that approach. However, such a reading of the Jewish sources fails to take into consideration the different institutional settings of Jewish and secular legal systems. Once these institutional factors are taken into account, it becomes clear that Jewish law does not support explicit legal validation of a broad category of medical interventions which accelerate the death of a terminal patient.

The secular legal and institutional framework can be examined fruitfully in the context of the New Jersey Supreme Court's decision in the *Quinlan* case. It should be recalled that the case did not arise as a criminal prosecution, but as an action for declaratory judgment brought by Karen's parents seeking, *inter alia,* explicit authorization from the Court for termination of Karen's life-supporting apparatus.[73] A critical matter before the court, legally prior to the substantive issues relating to Karen's case, was "the scope of judicial responsibility, as to the appropriate response of an equity court of justice to the extraordinary prayer for relief of the plaintiff".[74]

The New Jersey Supreme Court explicitly recognized, in the first paragraph of its precedent-setting opinion, that the *Quinlan* litigation touched on the responsibilities, rights and duties not only of Karen, her family and guardian, the doctors, and the hospital, but also of "the State through its law enforcement authorities, and finally the courts of justice".[75] With respect to the appropriate role of the courts, the trial judge, who denied relief, had expressed strong reservations:

> The nature, extent and duration of care by societal standards is the responsibility of a physician. The morality and conscience of our society places this responsibility in the hands of the physician. What justification is there to remove it from the control of the medical profession and place it in the hands of the courts?[76]

After quoting this passage, the New Jersey Supreme Court held that such notions as to the distribution of responsibility, while previously generally entertained, should

> ... neither impede this Court in deciding matters clearly justiciable nor preclude a re-examination by the Court as to underlying human values and rights. Determinations as to these must, in the ultimate, be responsive not only to the concepts of medicine but also to the com-

73 355 A.2d at 660.
74 *Id.* at 652.
75 *Id.* at 651.
76 137 N.J. Super. at 259, 348 A.2d at 818, quoted at 355 A.2d at 665.

> mon moral judgment of the community at large. In the latter respect the Court has a nondelegable judicial responsibility.
> Put in another way, the law, equity and justice must not themselves quail and be helpless in the face of modern technological marvels presenting questions hitherto unthought of. Where a Karen Quinlan, or a parent, or a doctor, or a hospital, or a State seeks the process and response of a court, it must answer with its most informed conception of justice in the previously unexplored circumstances presented to it. That is its obligation and we are here fulfilling it, for the actors and those having an interest in the matter should not go without remedy.[77]

This determination of its own obligations made, the Court went on to consider the substantive issues raised by the case. The Court found the constitutional "right to privacy", as elucidated in *Griswold* v. *Connecticut*[78] and *Roe* v. *Wade*,[79] "broad enough to encompass a patient's decision to decline medical treatment under certain circumstances"[80] and further determined that Karen's right of privacy may be "asserted in her behalf . . . by her guardian and family under the particular circumstances presented by this record".[81] The Court observed that the family's prospective decision on Karen's behalf to terminate treatment "should be accepted by a society the overwhelming majority of whose members would, we think, in similar circumstances, exercise such a choice in the same way for themselves or for those closest to them".[82]

While "aware that such termination of treatment would accelerate Karen's death",[83] the Court next concluded that this would not constitute criminal homicide:

> We believe, first, that the ensuing death would not be homicide but rather expiration from existing natural causes. Secondly, even if it were to be regarded as homicide, it would not be unlawful.[84]

The Court finally proceeded to fashion what it deemed appropriate relief. Interestingly, the New Jersey Supreme Court, like the trial court, declined to grant specific authorization for termination of the life-supporting apparatus. Instead, acting unanimously, the Court stated as follows:

> Since [Karen's] present treating physicians may give reconsideration to her present posture in the light of this opinion, and since we are transferring to the plaintiff as guardian the choice of the attending physician

77 355 A.2d at 665–66.
78 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965).
79 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973).
80 355 A.2d at 663.
81 *Id.* at 664.
82 *Id.*
83 *Id.* at 669.
84 *Id.* at 669–70.

> and therefore other physicians may be in charge of the case who may take a different view from that of the present attending physicians, we herewith declare the following affirmative relief on behalf of the plaintiff. Upon 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 that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital "Ethics Committee" or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital or others. We herewith specifically so hold.[85]

Thus, the Court, while not phrasing its relief as a grant of affirmative authorization for termination of treatment, in practical effect removed the legal impediments to that course of action. In explicitly releasing the participants from civil or criminal liability for their actions, the Court resolved what many commentators considered the crux of the matter, what the Court itself referred to as the "brooding presence" of potential liability.[86] One perceptive social observer who is also a medical doctor, Michael Halberstam, has written that the *Quinlan* case "never would have gone to court were it not for phantom fears and medical paranoia". According to Halberstam, decisions to prolong or not to prolong life, however difficult or agonizing, are typically made in hospital corridors and waiting rooms in a subtle transaction, often unspoken or deliberately ambiguous, between physicians and family. The *Quinlan* case, and the fact that the case went into the public domain for resolution, represents a failure of this usual procedure. Once the permission by the family to end Karen's life became explicit—and public—"the doctors were fair game for any crusading prosecutor who might hear of the case and decide to make a test case—and possibly a reputation—out of Karen Quinlan".[87]

The decision of the New Jersey Supreme Court calmed this concern over potential liability, but not without costs. In declaring that certain actions recognized to accelerate death were, as a matter of law, outside the scope of criminal or civil liability, the Court necessarily undercut the presumption in favour of life which is a foundation stone for Anglo-American jurisprudence. While the Court was careful to state that it "did not intend to be understood as implying that a proceeding for judicial declaratory relief is

85 *Id.* at 671 (note omitted).

86 *Id.* at 666.

87 See *supra* n. 72.

necessarily required for the implementation of comparable decisions in the field of medical practice",[88] the Court's determination to adjudicate the *Quinlan* matter and its express statement of the active role of equity courts necessarily invited further declaratory proceedings challenging the presumption in favour of life in other medical and legal contexts.

C. Lord Coleridge recognized in *Dudley and Stephens, supra,* that law and morality are not the same, but warned that "the absolute divorce of law from morality would be of fatal consequence..." Professor Robert Burt, building on this insight in a sophisticated and provocative discussion of treatment options for anomalous newborns,[89] has observed that in granting explicit legal sanction to decisions to withhold life-supportive treatment, "we are pushing along in barely perceptible steps the internal psychological processes which permit us one day rationally, coolly, bloodlessly, to consider what today seems wildly beyond possibility".[90]

Burt argues that "explicit and generalized community validation of the physician's death-dispensing role should be withheld and that the shadow of possible criminal liability for both parents and physicians should fall starkly across the path toward decision for withholding treatment..."[91] While not encouraging a multiplicity of such prosecutions, Burt contends that the very threat of prosecution will impose a potent discipline on life-denying decisions by physicians and families while allowing time for the society to consider the moral and legal ramifications of new technology. Burt therefore counsels against proposals for legislative or judicial action granting explicit legitimacy to life-denying withholding of treatment.

It is here that Jewish law concerning the *trefah* offers an instructive parallel. In a secular legal system, removing the threat of prosecution and criminal liability in this context necessarily threatens the society's commitment to life. But were the *Quinlan* court somehow in the position of applying Jewish law to the situation before it, the court's options might look rather different.

If the court determined that Karen were not *goses,* perhaps on the basis of rigid application of the three day criterion, or determined that termination of treatment would constitute an active hastening of death, there would be no Jewish warrant for the court to authorize such termination;[92] indeed,

88 355 A.2d at 672.

89 Robert A. Burt, "Authorizing Death for Anomalous Newborns" in A. Milunsky and G.J. Annas, *Genetics and the Law* (New York, Plenum Press, 1975) 435–470.

90 *Id.* at 440.

91 *Id.* at 437.

92 If the court determined that Karen were *goses* and that termination of treatment would constitute only the removal of an impediment, rather than an active hastening of death, there would be a basis in Jewish law for authorizing termination of treatment.

termination in such circumstances would be legally prohibited. But that would not end the story. While the court would be precluded from authorizing termination of treatment, it would similarly be precluded, assuming Karen were *trefah,* from imposing criminal punishment for homicide were the participants nevertheless to terminate treatment resulting in Karen's death. The participants' guilt before God would be a matter for their consciences and for consequences not of this world. Shared communal belief in the working of divine justice would prevent, or at least limit, the absence of humanly-imposed punishment from undercutting the legal norm in favour of life. Thus, the community, through its legal and institutional structure, could simultaneously preserve the legal norm while humanely accommodating departures from it. Further, the legal norms in their particularistic applications could be allowed to evolve slowly as the community assimilates the new questions posed by changing technology.

This possibility of mitigating the harshness of particular applications of the legal norm exists solely by virtue of the institutional structure of Jewish law. It is the inability of secular law systems to reproduce this institutional structure—in particular, the inability of a secular society to depend on divine justice to provide redress for violations of communal norms—that renders faulty the argument that Jewish law supports non-prosecution of those who speed the death of terminal patients. While Jewish law retains the norm favouring life, legislative action in a secular society to eliminate the possibility of criminal prosecutions would necessarily abandon or redefine that norm. Declaratory judgments authorizing termination of treatment in particular cases have much the same effect.

Furthermore, by putting the court in the position of granting society's express approval for a decision to take life, the declaratory judgment procedure allows responsibility for that fateful decision to be diffused among the entire society rather than concentrated on the immediate participants, easing the decision to take life. After the fact, one may well ask who made the ultimate decision. Each participant can point to someone else; meanwhile, the deed has been accomplished. Milgram has strikingly demonstrated the dangers of diffusion of responsibility, particularly in the presence of figures of authority.[93] While any comparison to the Nazi death machine may be overdrawn, the parallel is instructive nevertheless. In contrast, under Jewish law, responsibility before God for the murder of a *trefah* is focused ineluctably on the immediate participants.

The courts involved in the *Quinlan* case were sensitive to the dangers of granting secular sanction to a decision to take innocent life. At the trial level, Judge Muir rebelled at the thought of it. The New Jersey Supreme Court, bound on a different result, instinctively grasped for a mediating device to avoid the appearance of explicit societal sanction. It found two,

93 Stanley Milgram, *Obedience to Authority* (New York, Harper and Row, 1974).

invoking the right to privacy, and committing the final decision to a faceless bureaucracy, a hospital "God squad". One question raised by this essay is whether this is the best we can do.

The investigation has suggested that, on a plausible reading of the sources, the rabbis have evolved over the centuries a set of principles and practices which take their content from both psychological insights into the nature of man and from the perceptions and realities of different times and places. While creating a series of presumptions in favour of life, these practices permit deviations, subject to safeguards, when actions will be perceived as removing impediments to death. The rules can adjust to changing perceptions more or less quickly; flexibility is provided by the practice of not punishing those who fail to live up to the ideals of a given time. It is true that the actor must contemplate the possibility of divine punishment, but this says little more than that he must take moral responsibility for his actions.

Secular legal systems cannot replicate the principles of the rabbis. But they can learn from them. We should tread cautiously in attempting any definitive resolution of the problems posed by medical technology, recognizing that a venerable and highly self-conscious legal system has found wisdom in refraining from definitive resolutions.

> Only the passage of time, and debate by many people in many forums with many differing perspectives will ultimately move us toward resolution or, perhaps, toward accepting continued irresolution.[94]

The Talmud, and indeed all of Jewish law, constitutes precisely such a conversation across the centuries.

Secular legal systems also cannot refrain from imposing punishment, in reliance on a shared communal belief in divine punishment. But they can adopt procedures which would not result in the premature crystallization of inflexible rules of law. These procedures promote the evolution of more organic developments in the common law, linking the moral sentiments of the community with highly fact-sensitive adjudications, allowing values to evolve gradually, "looking backward to what we have been, as often as we look forward to imagine what we will become".[95] The presumption, as in the development of Jewish law, should be in favour of life, and every attempt should be made not to test that presumption, or our commitment to its underlying value, except where it cannot be avoided.

A variety of procedural postures can be envisaged which would advance these goals. Within the existing framework of criminal law, society's commitment to the preservation of life is tested by prosecutions for homicide. The hardships imposed on defendants by such prosecutions (and on potential defendants by the threat of prosecution) should not be minimized. However, such prosecutions are likely to be limited in number in the medical technology

94 Burt, *supra* n. 89, at 448.

context; the exercise of prosecutorial discretion is likely to screen out cases in which the termination of life-prolonging treatment does not outrage the sensibilities of the participants or of the community. In the few difficult cases in which prosecutions are brought, the defendant could avoid conviction by enlisting the sympathy of a single juror. The record of prosecutions for active euthanasia suggests that convictions will be few and far between.[96] Yet the threat of prosecution imposes a potent discipline. When prosecutions do take place, they are likely to present the full range of factual development necessary for the sensitive application of legal norms. Perhaps most important —at least in the United States—the decision would be made by a jury, the chosen instrument of American jurisprudence for applying community values in the course of finding facts. Through its power of nullification, the jury allows the law to set its ideal standard while simultaneously providing the result required by existing community standards, all without the need for an articulated rationale that would undercut the ideal. Another advantage of the jury is its one-time, ad hoc character. In contrast to the hospital review committees favoured by some, including the *Quinlan* court, jurors are less likely to become hardened by the "routine" of life-death decisions and are more likely, by remaining unspecialized, to represent the moral values of society. The changing composition of juries, and the variety of fact patterns presented to them, may also have a tendency to keep the area in some confusion, which may have a normative utility where the danger is one of premature formulation of substantive rules.

There is one procedure which seems precisely the opposite of what is called for. The declaratory judgment route, travelled in the *Quinlan* case, requires important values to be challenged and difficult decisions to be taken when the need for such decisions remains speculative and the factual development inadequate for sound decision. Because less is at stake for the parties —they can still draw back from a provisional decision—declaratory judgments encourage going to court earlier and more often, and reduce and segment the sense of responsibility for the decision by all participants. Finally, the declaratory judgment action requires a principled opinion by the judge rather than an unexplained verdict by a jury, vastly accelerating the process by which legal rules are crystallized. Rather than promoting a dialogue of values over the centuries, a rapid succession of *Quinlan* decisions will wrest from us an instrument which facilitates this testing of values. Recognizing the burden that uncertainties will place on the medical community and on grieving families, courts of equity should nevertheless exercise their discretionary power to refuse to entertain declaratory judgment actions seeking validation of the termination of life-supporting treatment.

95 Burt, *supra* n. 89, at 446.

96 Veatch, *supra* n. 14, at 79–80. See also Halberstam, *supra* n. 72.