MORASHA KEHILLAT YAAKOV

Essays in Honour of
Chief Rabbi Lord Jonathan Sacks

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Section 1
World Jewry

An Approach to Dangerous and Terminal Illness

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It is my privilege to offer this contribution in honour of Rabbi Lord Jonathan Sacks. I would particularly like to acknowledge the personal welcome given to me by Rabbi Sacks when I arrived to work in this community some fifteen years ago.

The following is adapted from my book *Dangerous Disease and Dangerous Therapy in Jewish Medical Ethics – Principles and Practice* (Targum Press, 2010). The subject is timely because we find ourselves in a social and cultural ethos in which the value of life is too often not appreciated in accordance with halakhic standards. Further detail and clinical cases illustrating the principles described here may be found in my book.

The obligation to save life – *pikuaḥ nefesh* – stands close to the pinnacle of the halakhic hierarchy of obligation; it supersedes virtually all other duties. A dangerously ill patient must be aggressively treated, desecrating the Sabbath and transgressing almost all other prohibitions if necessary. Even where there is no known definitive therapy, whatever can be done for the patient must be done both to prolong life and improve its quality; and even where it is clear that no medical therapy will help, the patient must not be abandoned.[1]

1. Even if only in order not to cause the despairing realization that the situation is hopeless – anguish, despair, and pain are halakhically regarded as real dangers to a very ill patient (*Iggerot Moshe*,

From a halakhic perspective, there are two categories of terminal illness: *ḥayei sha'a* and *goses*. Loosely translated, *ḥayei sha'a* refers to a terminal situation, where death is very likely in the near future; *goses* refers to an agonal situation, where death is almost certainly immediately imminent. These must be clearly distinguished as the *halakhot* (laws) pertaining to patients in these two categories differ markedly.

ḤAYEI SHA'A

Terminal illness, *hayei sha'a*, is generally defined in halakha as a medical condition that is clearly expected to be fatal[2] within one year[3] (as opposed to *ḥayei olam*, life that is under no such short-term threat).[4] The derivation of this twelve-month period is not explicit in original sources; the suggestion that it derives from the period of survival associated with the category of *trefa* should be seen as setting up a general parallel more than a strict derivation.[5] Consequently it has been suggested that this period should not be seen as an absolute cut-off and that a more basic element of the definition of *ḥayei sha'a* is the presence of a lethal process

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Ḥoshen Mishpat 2:75). Even where a patient *must* be informed of a grim diagnosis (for example where consent and cooperation will be needed for treatment) the information must be conveyed gently and with a very clear message of hope.

2. A lethally dangerous but curable or definitively treatable condition does not render a patient *ḥayei sha'a* where the appropriate treatment is being given – an insulin-dependent diabetic on appropriate insulin therapy is not in the *ḥayei sha'a* category (and of course such patients must be aggressively treated).
3. *Iggerot Moshe, Ḥoshen Mishpat* 2:75 and *Yoreh De'a* 3:36; R. Shlomo Kluger, *Sefer HaḤayim, Haggahot. Ḥokhmat Shlomo* (155: 1) gives a rationale for the period of twelve months; also quoted by *Darkhe Teshuva, Yoreh De'a* 155:1:6.
4. Some secular jurisdictions adopt six months as the relevant period for a definition of terminal illness. A period of six months was chosen for current Israeli law with regard to possible withdrawal of treatment, after deliberations that included rabbinic advisors; it was decided to regard survival of more than six months as outside the terminal category to allow a margin of safety for diagnostic and prognostic uncertainty (Professor A. Steinberg).
5. Rabbi Feinstein (*Iggerot Moshe, Ḥoshen Mishpat* 2: 75) indicates that since a survival of less than twelve months is relevant (although not definitive) in the category of *trefa* (one who is suffering from any of a set of pathologies that will generally not allow survival of twelve months) it can be applied to the category of *ḥayei sha'a* as the period that indicates loss of the normal assumption of life (*ḥezkat ḥayim*). Rabbi Feinstein emphatically states that where the medical consensus is that the patient will not live for *two* years, such a patient has no less claim to treatment than any other, not even where triage decisions must be made. In other words, patients who are expected to live for more than a year must not be regarded as "terminal" in any way that would deprive them of therapy or appropriate treatment priority.

or pathology that is presently inexorably threatening life in the relatively short term; the exact duration of that short term is not necessarily fundamental to the definition. However, expected survival of less than a year has become the generally accepted criterion of *ḥayei sha'a*.

In certain situations of terminal illness, treatment may be withheld (subject to stringent conditions, see below). There is an important distinction, however, between withholding and withdrawing therapy: while withholding therapy may be appropriate (and even obligatory) under certain specific conditions, withdrawing life-sustaining therapy that is already being administered is generally forbidden. More accurately, because 'withholding' and 'withdrawing' do not correspond exactly to the relevant halakhic categories, while withholding therapy may be proper in certain situations, actively shortening life is not allowed. (This is in clear opposition to a number of secular sources which make no distinction.[6] A strict utilitarian approach holds that the only issue of significance in such situations is the outcome: if the outcome is that the patient will not survive there is no real meaning to the distinction between acting to bring about that death or failing to act in such a way that death is allowed to occur. Some go further and assert that there is no moral difference between murder and failure to save;[7] in Judaism there is certainly a difference between these two forms of moral failure, with very different consequences.)

Three categories must be distinguished:

(a) Withholding: not starting a therapy that is not currently being administered. Examples would be withholding chemotherapy (where such therapy has not yet begun) from a patient with widespread metastatic disease, or the decision not to operate on a patient who is a poor surgical risk.

(b) Withdrawing: stopping a current therapy in such a manner that death is a direct consequence. Examples would be withdrawing ventilation from a patient who is currently totally dependent on ventilation, or stopping an infusion of pressor agents that are currently being continuously infused to maintain adequate circulation.

6. See R. Gillon, *Philosophical Medical Ethics* (John Wiley, 1986), esp. ch. 20: "Acts and omissions, killing and letting die", and M. Hauser, *Moral Minds* (Little, Brown, 2006); see e.g. the case on p. xvi of the prologue and the discussion there. Beauchamp and Childress argue against distinguishing between the language of "killing" and "letting die".
7. See Hauser, *Moral Minds*, for exactly this assertion.

(c) Withdrawing a therapy that is being administered intermittently by withdrawing it during an interval between administrations (stopping a therapy by not starting it after a regular break in its use); this may be seen in some sense as 'intermediate' between (a) and (b). Examples would be:

- the decision, implemented between dialysis sessions, to stop intermittent dialysis;
- stopping the long-term administration of a drug that is being given as a once-daily or weekly dose, or as a series of cycles such as chemotherapy;
- withdrawing demand cycle ventilation while the ventilator is inactive but attached ready to ventilate if respiratory function deteriorates below a set standard;
- inactivating cardiac pacing or defibrillation (by an implanted automatic device) during the inactive standby phase.

In general, category (a) is the most lenient of these categories in halakha; there are cases where such withholding may be allowed and even obligatory. Category (b) is forbidden in the context of dangerous illness; stopping a continuously needed life-sustaining therapy amounts to active euthanasia and is forbidden.[8] (Distinctions between 'withholding' and 'withdrawing', or 'active' and 'passive' conduct may not cover all cases unequivocally; mature halakhic judgment is needed.) Each case in category (c) raises the question of whether that particular treatment modality is seen as continuous or intermittent in halakha. Is a course of treatment comprising intermittent administrations deemed to be continuous in essence from a halakhic perspective? That question must be answered specifically in each case independently. The distinction is important because directly stopping a continuous life-sustaining therapy may well constitute a homicidal act; the perpetrator is terminating the patient's life by stopping a needed therapy, directly bringing about death – that is utterly forbidden in halakha. Distinct from that, however, is the withholding of a therapy that has not yet begun: in that case death results from the underlying pathology and the failure to prevent it – and there are situations in halakha where that may be permitted.[9]

8. A life-sustaining therapy such as ventilation may not be stopped on a terminal patient even to save another patient who could be saved for the long term; the general rule is that one person may not be killed to save another.
9. Other relevant distinctions can be drawn here too: is actively *removing* a device that will be needed soon while it is presently inactive worse than passively *failing to give* such a therapy when

Withholding Treatment in *Ḥayei Sha'a* Situations

A number of sources indicate that certain categories of therapy may (and sometimes should) be withheld in some terminal situations. Although healing is a mitzva (commandment), there are conditions under which it does not apply. In certain situations, treatment that is extremely painful or that prolongs severe suffering falls into this category.[10]

Throughout this section, it should be borne in mind that this discussion concerns the parameters governing withholding treatment, as in category (a) above, not actively hastening death, which is never allowed. It must also be specified that withholding therapy does not include withholding staples such as adequate fluids, nutrition, oxygenation, and other basic needs. Therapy that may be withheld in appropriate circumstances includes surgery, chemotherapy and other medical treatments and interventions that will increase or prolong suffering or add risk; basic and staple needs must always be provided. Perhaps more accurately, all modalities[11] must be provided except those that will add significant danger or pain.

When all of the following conditions are satisfied, treatment may be withheld and indeed may be *forbidden*:[12]

(1) The patient is in the category of *ḥayei sha'a*, terminally ill. In such cases, *ḥayei sha'a* means that the consensus of duly qualified opinion is that the patient will not survive a year. This judgment must be made

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it falls due? Removing an implanted defibrillator may well be more problematic halakhically than not implanting one in the first place (in situations of equal clinical need), or not giving the next dose of chemotherapy when it is due. The latter cases may be discretionary in halakha, the former may not.

10. *Kraina DeIgerta* 190 states that one should not prolong the suffering of a *goses* and probably not that of any terminal patient. *Iggerot Moshe*, *Ḥoshen Mishpat* 2:75 adds that one should ask the patient: if he prefers to live despite his suffering, one should certainly attempt to prolong his life. R. Eliashiv points out that life is of such inestimable value that one should ideally choose to live despite great suffering; unfortunately this is not universally recognized and that choice cannot be forced on an individual who does not want it. The *Ḥazon Ish* too (quoted by R. Farbstein) stated that one is not required to prolong terminal suffering.

11. The distinction between 'ordinary' and 'extraordinary' or 'natural' and 'artificial' has limited application in halakha; for detailed discussion of this point see R. J. D. Bleich, *Bioethical Dilemmas*, i. 72–4.

12. *Iggerot Moshe*, *Ḥoshen Mishpat* 2:75 (also in R. M. Hershler, *Halakha and Medicine*, iv. 102); based on Ketubbot 104 and Ran, Nedarim 40: when therapy can neither cure the underlying disease nor prevent extreme suffering in terminal situations but will only prolong that state of suffering, it is appropriate to withhold such therapy. Where this is clearly the case, although one may do nothing actively to shorten life, it may be appropriate to pray for the patient's demise. See also *Tiferet Yisrael* (Yoma 8: 7, 'Boaz' 3) on this.

by fully competent expert opinion based on the best medical information available in terms of the relevant particular disease process and its clinical stage, applied to the particular patient at hand. If it is doubtful whether the patient has *ḥayei sha'a* or *ḥayei olam*, the stringent view must be adopted – that is, the patient is regarded as having *ḥayei olam* until the doubt is resolved. The general principle in *pikuaḥ nefesh* (lifesaving) is that the default approach must be to regard life as potentially salvageable; the burden of proof always falls on the less optimistic opinion.

(2) The patient is either suffering uncontrollably, or is unconscious with no hope of ever recovering consciousness even for a moment. Uncontrollable suffering may be physical or psychological.[13] Suffering should not be regarded as uncontrollable until all appropriate expert therapeutic options have been exhausted. Pain that has been inadequately treated cannot be used as a rationale for justifying the withholding of lifesaving therapy. Psychological suffering, including depression secondary to somatic pain, indicates failure to treat the pain. All possible treatment must be administered competently before intractable psychological suffering is diagnosed. Psychological and psychiatric problems that are not secondary to physical pain need treatment in their own right no less aggressively than somatic problems. The treatment of psychological issues such as depression and the sense of being a burden on family must be dealt with appropriately: treatment should not be limited to drug therapy – if practical arrangements are necessary to relieve suffering those must be made. Again, failure to relieve psychosocial, practical, or financial issues that can be alleviated cannot be used as justification for withholding lifesaving therapy.

Despite the fact that the patient is not obviously suffering,[14] permanent unconciousness, such as an irreversible coma in a terminally

13. Psychological suffering is no less real than physical suffering in the eyes of halakha – see *Tosafot*, Shabbat 50b.

14. This point is the subject of dissension between Rabbi S. Z. Auerbach and Rabbi Y. S. Eliashiv regarding resuscitation (Prof A. Abraham). Rabbi Eliashiv's view is that coma does not represent a state of suffering; Rabbi Auerbach's view is that it may (that is, perhaps a deeply comatose patient suffers but is merely unable to demonstrate that due to inability to respond appropriately – absence of clinical signs in this situation may not represent absence of pain but only absence of the ability to respond to pain in a clinically recognizable way). Rabbi Auerbach held that if the

ill patient, may justify withholding treatment where the patient has clearly indicated such a wish.[15]

(3) Finally, the patient must have expressed the wish not to continue treatment.[16] Such a wish to allow a lethal condition to take its natural course is relevant only when:

- No safe curative therapy exists (that is, therapy that could prolong survival beyond *ḥayei sha'a*). Where safe and painless curative therapy exists it should be administered.[17] Where the effectiveness or safety of a therapy is subject to dispute among experts, the patient is not obliged to undertake it.[18]
- Therapy exists but is risky in its own right and the patient refuses such therapy on account of that risk.
- Therapy exists but is painful or mutilating and the patient refuses it on that account; in some such cases coercion may not be allowed.[19]

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patient was in pain before becoming comatose it should be assumed that he may continue to suffer while comatose. According to this view, there is no reason to change a decision to withhold resuscitation that was appropriately taken while the patient was conscious; the reason for withholding resuscitation then was to avoid prolonging suffering, and it is no different now. However, according to the view that coma does not involve suffering, perhaps that previous decision should be amended – now that the patient is no longer suffering, that reason for withholding resuscitation no longer applies. (Their respective rulings were made in the context of DNR decisions; presumably their views would apply to treatment decisions as well.) In practice, modern halakhic authorities do not require changing treatment or resuscitation decisions for terminal patients who become comatose.

15. A common error here is to confuse a family's suffering with that of the patient. The family of a comatose patient with no hope of recovery may indeed be suffering greatly, but that is not what is meant by intractable suffering justifying consideration of the withholding of lifesaving treatment; it is the patient's suffering that is relevant here, not the family's.
16. R. Moshe Feinstein states that if a terminally ill patient in extreme suffering requests continued treatment due solely to a conviction that his religious duty requires him to do so, treatment should be withheld – there is no religious duty to prolong terminal life artificially at the cost of extreme suffering. If, however, the patient genuinely wants to continue therapy in the face of severe suffering, that wish should certainly be honoured.
17. Where a more expert physician is expected, treatment should be continued (despite suffering) until that expert has seen the patient. This applies also to a physician who is not necessarily more expert but who may have a helpful opinion (*Iggerot Moshe, Ḥoshen Mishpat* 2:75.)
18. See *Mor uKetzia*, *Oraḥ Ḥayim* 328 for other limits to obliging acceptance of therapy.
19. The patient is, however, acting incorrectly in refusing safe lifesaving therapy and should be strongly encouraged to consent.

- The patient is a fully informed mentally competent adult.[20]
- The patient is not refusing therapy due to inadequately treated pain, depression, or other ameliorable suffering or any external coercive pressure.

In cases where the patient is unconscious and cannot express the wish to cease therapy, such a patient must have previously unequivocally expressed the personal desire for cessation of therapy in such circumstances and there is no reason to think that that opinion may have subsequently changed. In such cases that opinion would remain valid and may be applied as if given explicitly now.[21] However, where the patient is not known to have expressed a clear personal opinion, the family, knowing the patient well, can testify that the patient would have wished for cessation of therapy. Such testimony can constitute valid proxy. More generally, even if the family does not know what the patient would have wanted they are entitled to decide on his behalf – most people rely on their close family to act in their best interests and this trust tacitly empowers family members as de facto proxies.[22] Of course, this can be accepted only where there is no reason to suspect that the family may be acting from inappropriate motives.

When *all three* of the above conditions are met, treatment should be withheld. However, the details qualifying each of these criteria are critical.

Minors and mentally incompetent patients

Where the patient is a minor[23] or is mentally incompetent, the parents' opinion can substitute for the patient's in such cases. Parents are the usual *apotropos* (guardians) here,[24] and again, this applies only where their motives are not questionable. In general, where it is not possible to ascertain a patient's wishes, it may be assumed that the patient would not want suffering prolonged when that suffering is so great that a clear majority of people would respond thus.[25]

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20. See below for patients who are unable to express a preference: unconscious, incompetent, or minor patients.
21. This should be established with the family.
22. *Iggerot Moshe*, *Ḥoshen Mishpat* 2:74.
23. That is, under bar mitzva age: 12 years for a girl and 13 for a boy.
24. Rabbi Y. Zilberstein (*Iggerot Moshe*, *Ḥoshen Mishpat* 2:74) includes close family (not necessarily only parents) when decisions must be made in a patient's best interest (since most people would rely on family in such situations). Where there is no family, the local *beit din* (halakhic authority) should assume responsibility for such decisions.
25. Professor A. Avraham quoting Rabbi S. Z. Auerbach; *Iggerot Moshe*, *Ḥoshen Mishpat* 2:73.

Babies with short life expectancies (for example, a baby with Werdnig Hoffman disease) constitute a separate category. Even where there is only a small chance that the child will survive, for example where there is a 5 per cent chance of surviving beyond 18 months, the child must be treated;[26] there is no reason to withhold lifesaving treatment because the patient is a baby. The child who is a *ḥayei sha'a* must receive all the treatment that an adult would receive.[27] The baby must be ventilated if necessary.

If it is clear that the child will not survive and the ventilation or other therapy will be very painful, it should not be administered; oxygen should be given to ease respiratory difficulty. One is not obliged to cause serious suffering to prolong a terminal disease.[28] However, therapy to relieve suffering must be given,[29] even where this may prolong the terminal state.[30]

In cases where ventilation or other lifesaving treatment modalities are limited and there is another child who can be salvaged in the long term who also needs the treatment, that child takes precedence.[31]

When the child is a *goses* do not initiate ventilation; provide oxygen.[32]

The above factors apply regardless of the opinions of the guardians of the child; no guardian is empowered to deprive a child of appropriate therapy. Where relevant decisions must be made, however, it is usually the parents who must make those decisions; but where the parents have abandoned the child and foster parents have stepped in, the foster parents are the proxies; that is, those who have taken upon themselves the mitzva of caring for the child, not those who have abandoned him.[33]

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26. In general, if the child will survive for at least one year, all treatment should be given (Rabbi Y. Zilberstein). Where survival will be for a few months only and involve suffering, it may be more difficult to decide about therapy such as major surgery. Major surgery with little chance of success which will impose much suffering with no appreciable chance of survival should be withheld.
27. Mishna Yoma 8:6 and Bartenura there; Maimonides, *Hilkhot Shabat* 2:18; *Shulḥan Arukh, Oraḥ Ḥayim* 329:4. See also *Meiri*, Yoma 84b for a rationale behind this ruling where the patient is a conscious adult, and Rabbi Eliyahu Baal Shem Tov, *Sefer HaMitzvot*, where the patient is not conscious. See also *Iggerot Moshe, Ḥoshen Mishpat* 2:71.
28. *Iggerot Moshe, Ḥoshen Mishpat* 2:73.
29. *Iggerot Moshe, Ḥoshen Mishpat* 2:73 discusses the obligation to give therapy to relieve suffering safely.
30. *Tiferet Yisrael*, Mishna Yoma 8:6, 'Boaz' 3, demonstrates that it is preferable to lessen suffering in terminal situations even where such action will prolong the terminal state rather than allow a more rapid demise where that would be more painful.
31. *Iggerot Moshe, Ḥoshen Mishpat* 2:73:2.
32. *Iggerot Moshe, Ḥoshen Mishpat* 2:73:3.
33. Rabbi Y. Zilberstein, based on Maharam Shick and on *Zekher Shlomo, Parashat Lekh Lekha*, regarding a child's obligation to honour parents who abandon the child.

All of the above applies to patients who are mentally incompetent as well as to children.

Analgesia in dangerously or terminally ill patients

In modern medicine, uncontrolled pain should be extremely rare – the modern medical and surgical armamentarium includes modalities capable of relieving even the most severe pain. Traditionally, pain relief was poorly taught and practised (there have been major improvements in this field and pain relief is now a recognized area of specialization and expertise); it has been suggested that one reason for this failure was the fear that liberal administration of narcotics may depress respiration and hasten patients' demise. To be sure, some of the analgesic and palliative modalities that may be needed to relieve severe pain carry significant risk; but such risk is acceptable in the treatment of severe pain in dangerously and terminally ill patients, and in fact such risk *must* be taken, subject to certain principles of care, as detailed below. In life-threatening circumstances risky analgesic interventions may be permitted even if they carry a risk that is more than moderate. This requires explanation: why is an intervention that poses a risk to life acceptable when it is directed at symptoms and not cure? Surely life should not be seriously endangered to deal with symptoms? High-risk interventions are acceptable when they are undertaken in the attempt to cure potentially lethal conditions, but why in situations where the gain will be only symptomatic? Ordinarily, high risk can be undertaken only when life is at stake.

The halakhic rationale is this: unavoidable significant risk accompanying analgesia is acceptable in life-threatening circumstances because in such situations *the pain is not innocuous* – it is an assumption of halakha that severe pain may be a real factor adding to the danger of an underlying primary pathology.[34] In situations of dangerous illness severe pain itself constitutes a real additive risk;[35] it is a burden that increases the present risk to life.[36] A patient's will to live and

34. *Iggerot Moshe*, *Ḥoshen Mishpat* 2:73. See also "Palliation of Pain" in Rabbi J. D. Bleich, *Bioethical Dilemmas*, vol. ii.

35. Experienced physicians know that adequately addressing severe pain, anguish, despair, loneliness, and depression may be critically important for healing and survival.

36. In life-threatening situations halakha ascribes significance to factors that may be considered minor in other settings. One may desecrate the Sabbath for a critically ill patient to provide for the patient's needs, including needs that may not appear to be directly lifesaving. Where satisfying such needs will help the patient emotionally (though physiologically unnecessary) they are mandated in halakha (*yishuvei daatei*). Such needs are material enough to be considered lifesaving.

battle illness is a real factor in that patient's healing and survival,[37] and relieving severe pain (and alleviating anguish, despair, and depression) is therefore *not only humane but also therapeutic*.

Rabbi Feinstein reasons that since pain (and depression, hopelessness, and mental anguish) are tangible additive lethal elements, a measure of risk is acceptable in the course of treating the pain just as it would be in treating the disease itself. A common clinical application of this principle would be in the case of a terminally ill patient suffering severe pain due to a widespread malignancy. In such circumstances the physician may naturally hesitate to prescribe high doses of narcotic analgesics for fear of suppressing respiration in a very ill patient; however, according to Rabbi Feinstein such medication would be permitted and even obligatory because the patient's pain is part of the clinical problem no less than the underlying pathology.[38]

A number of important limitations apply here, however. For instance, the analgesic must be administered only with the intention of relieving pain, and not to terminate life or compromise it at all. Narcotics must be titrated carefully and expertly against the pain to provide adequate analgesia with minimum danger; any dangerous unwanted effects due to the therapy must be treated appropriately. In addition, only the most qualified and experienced physician available may administer the therapy; this is a general principle in medical halakha, but is particularly relevant in situations of known danger involving very ill patients where therapeutic skill is likely to be critical. Of course, it is the patient's pain that must form the indication for analgesia, not the family's suffering.[39]

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37. A seriously ill patient must not be given bad news. *Shulḥan Arukh, Yoreh De'a* 337; *Nishmat Avraham* ii. 294; *Iggerot Moshe, Ḥoshen Mishpat* 2:73.

38. Rabbi Feinstein rules that an ordinarily prohibited procedure may be performed for palliation even where there is no registered survival benefit: he allows orchidectomy for palliation of metastatic prostate carcinoma even where research may not have shown a statistically significant survival advantage. Rabbi Feinstein reasons that even if a survival difference is not recognized in terms of statistical significance, since it is known that severe pain may shorten survival in serious illness it stands to reason that alleviation of pain is likely to prolong survival *at least slightly* – and that is enough to allow it (*Iggerot Moshe, Ḥoshen Mishpat* 2:73; also in Rabbi M. Hershler, *Halacha and Medicine*, iv. 114).

39. This error is not unknown. An experienced internist reports: "A terminally ill patient was coherent, lucid and not in pain. His family asked to have him on morphine as they could not deal with relating to him. I refused. During my leave, he was given morphine. On my return I found him heavily sedated. I gave him Narcan, his sedation was reversed and he sat up and hugged his wife (to her distress). Ongoing sedation was requested. There was a standoff and I was removed from his care."

Withholding fluids, nutrition, and other basic needs

Even where therapy may be withheld, basic staple needs must always be provided.[40] A patient may never be starved or dehydrated to death, no matter what the clinical situation. Basics that must be given include adequate fluid and attention to electrolyte balance, adequate nutrition, oxygenation, and anything else that the patient would have ordinarily needed: if the patient is taking insulin, it must be continued. The same applies to thyroid hormone replacement or any other therapy that is a staple ongoing need for that patient. Whatever has been necessary over the long term may not be stopped when the patient becomes terminally ill; those needs are staple and ordinary for that patient, and there is no reason to stop them now. Withholding food or any life-sustaining need for long enough will certainly kill, regardless of the acute clinical situation, and that is never allowed.

In the modern context, in hospices and other settings, it is becoming common practice to withhold food and fluids from terminally ill patients. The undoubted result is that in many such patients the specific cause of death is starvation or dehydration rather than the underlying pathology. This is absolutely unacceptable in Judaism; such action amounts to homicide.[41]

Maintaining fluid and electrolyte balance can be a serious clinical challenge in extremely ill patients; this must be skilfully managed. It is important to understand that the problem here is clinical, not ethical—whatever must be done to maintain fluid balance is obligatory; how that is handled medically may well be a clinical challenge, but that does not in any way allow less than full attention to this basic medical need. This includes intravenous fluid and electrolyte administration if oral intake is inadequate.[42]

Feeding extremely ill patients is recognized as an area of clinical difficulty. Desperately ill and cachectic patients may absorb very poorly no matter what route is chosen for the administration of nutrition. But again, this is a clinical

40. *Nishmat Avraham*, ii. 319–25; *Iggerot Moshe*, *Ḥoshen Mishpat* 2:74. Rabbi Feinstein points out that food, unlike medications, is a constant and universal need for all living creatures; patients must be fed (see there for specific exceptions).

41. For the question of whether causing death by depriving the victim of a life-sustaining need is actionable in Jewish law, see Maimonides, *Hilkhot Rotzeaḥ*.

42. Clinical expertise and experience may be needed. Proper hydration of a clinically unstable patient takes skill; on occasion complications of inadvertent excessive fluid administration such as pulmonary edema can be prevented by the use of a pediatric intravenous administration set – medical and nursing personnel must be adequately expert in all aspects of care when treating terminal patients.

problem; appropriate medical expertise must be applied to the challenge. Despite the fact that it may appear almost impossible to nourish an extremely ill patient adequately, and indeed some forms of nutrition may entail risk and potential harm, withholding all food for long enough will certainly kill the patient.

In an imminently terminal situation where a patient will clearly die from the underlying disease process *sooner* than a lack of nutrition would cause any harm, food may be withheld.[43] Since food is not ordinarily needed from minute to minute or even hourly, where death is inevitable within a very short time there may be no benefit in attempting to feed a patient who is not absorbing and who indeed may be harmed by such efforts. (This is not the case with liquids where fluid balance may be unstable in the very short term.) For the management of a *goses* in general, see below.

Where oral feeding is impossible or dangerous, feeding by nasogastric or other route must be instituted. Where gastrostomy or jejunostomy would be the best clinical solution they must be performed. Where a patient is deemed too ill for such a procedure, some method of feeding must be found (except for situations of imminent demise as outlined in the previous paragraph), no matter how clinically difficult; guaranteeing death by starvation is not a Jewish option.

Breathing is perhaps the most basic of needs, and adequate oxygenation must be provided. Where nasal cannula or facemask administration is inadequate to prevent respiratory failure, mechanical ventilation must be used. Where mechanical ventilation has not been started, the patient is terminal, and is *not suffering from the inability to breathe*, it need not be started (where all the conditions for withholding therapy as discussed above have been satisfied) – not every dying patient needs mechanical ventilation. Where the patient is suffering from acute air hunger that suffering must be relieved;[44] if mechanical ventilation proves necessary for this it must be administered.

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43. *Nishmat Avraham*, ii. 324 concerning a *goses* who does not want staples, where death will occur sooner than their lack will cause, writes in the name of Rabbi S. Z. Auerbach that these may be withheld.

44. *Iggerot Moshe, Ḥoshen Mishpat* 2:73. Rabbi Feinstein points out that this is a particularly severe form of suffering; it must certainly be treated. Morphine or sedatives must not be used to stop the struggle to breathe; that amounts to active euthanasia and is forbidden. (Where carefully titrated doses of appropriate drugs will allow the patient to relax and breathe more efficiently, however, thus avoiding the need for mechanical ventilation, that may be appropriate; but only where extreme care is exercised to ensure that the patient improves physiologically and remains stable. The goal must be to help the patient breathe; not to facilitate peaceful asphyxia.)

Where mechanical ventilation has been started it may not be stopped while the patient is dependent on it.

Antibiotics, other drugs and blood products must, as a general rule, be given (also as a general rule, intercurrent infection in terminal patients must be treated). This rule applies to blood products and other drugs or agents that would be used if the patient were not terminal. Where a drug or other therapy will itself add a significant new danger, its use may be discretionary. Drugs (such as pressors) need not be given to a patient in the final stages of the dying process where there is no hope of recovery and the drug will not change the overall clinical picture (though a continuous infusion that is already running and that is maintaining life may not be actively stopped).[45]

All standard nursing care must be given to terminal patients including careful attention to movement for the prevention of pressure sores and all related therapy.

Withholding and withdrawing ventilation, dialysis, cardiac pacing

Subject to all the conditions outlined above (terminal illness, intractable suffering, the patient does not want this treatment) ventilation, dialysis, and cardiac pacing may be withheld if they have not been started but may not be stopped if they have.

- Ventilation: see the discussion of oxygenation above.
- Dialysis: a patient in renal failure must be dialysed. A terminal patient who is dying from other (untreatable) causes and whose renal function deteriorates as part of the overall terminal process need not be dialysed (subject to all the provisos governing withholding therapy from terminal patients discussed above). Where renal failure is the specific clinical problem and is reversible it must be treated.
- Cardiac pacing that is sustaining life may not be stopped, whether the pacing is continuous or set to pace only on demand. In the latter case it is protecting life and that protection may not be withdrawn. An implanted defibrillator may not be inactivated; once implanted it is part of the patient's life-protecting functions and may therefore not be withdrawn.[46]

45. *Nishmat Avraham*, ii. 327 quoting Rabbi S. Z. Auerbach.

46. Unless the patient is so distressed by its presence that the distress constitutes more of a threat than the absence of the device.

Risky Treatment in *Ḥayei Sha'a* Situations

Not uncommonly, therapy may be available for the treatment of a *ḥayei sha'a* condition, but only at the risk of worsening that *ḥayei sha'a* situation if it fails. Indeed, such therapy may be curative if successful and lethal if it fails. An example of this type of problem would be a hematological malignancy threatening to terminate life within a year, where long-term remission may be achieved by marrow ablation and rescue grafting, but only with a significant risk of mortality from the procedure. Here, a procedure is available that will result in cure if successful but will foreshorten the patient's *ḥayei sha'a* if not. If successful, the weeks or months of survival that would be expected if the condition were untreated will be extended to years; but if unsuccessful those weeks or months will be sacrificed – the patient will die *sooner* than the natural *ḥayei sha'a* would have lasted. A surgical example would be an enlarging aortic aneurysm that is expected to prove lethal within a year in a patient who is unfit for surgery. Surgery may be curative if successful but on the other hand may result in immediate death during the procedure.

What is the halakha in these situations? Is it preferable to preserve limited *ḥayei sha'a* or to choose a risky attempt to gain *ḥayei olam*? The key source for this area of halakha is Avoda Zara 27b. The discussion there concerns the question of seeking medical attention that may itself prove lethal in a situation of grave danger to life, and offers as a biblical source the case of four lepers who found themselves facing starvation outside the Jewish encampment during an enemy siege.[47] Their options were certain starvation, or entering the enemy camp where they might either be saved or summarily executed. They chose to risk entering the enemy camp (where, as it happened, they survived). This incident suggests that in the equivalent medical dilemma it would be proper to risk immediate death for the chance of long-term survival.

The commentaries engage in extensive analysis of this source, variously construing its constituent parameters particularly with respect to the degree of the risks involved, and a range of halakhic precedents is based on its various understandings. Rabbi Feinstein raises a question that leads him to a principle in this area:[48] these lepers were clearly spiritually negative individuals; why do we base halakhic precedent on them? He concludes that this source demonstrates not necessarily a spiritually correct conduct so much as a logical and acceptable human choice; he therefore rules that in such situations the patient must choose

47. II Kings 7.
48. *Iggerot Moshe, Yoreh De'a* 3:36.

between the immediate risk for long-term survival and the alternative short-term certain demise.[49]

It is thus clear that risk is permissible in these situations,[50] and even high risk according to many authorities.[51] *Shevut Yaakov* deals with a case in which a patient was faced with a disease that, untreated, would prove fatal within days, but had the option of taking a drug which might either cure or kill immediately; he allows taking the drug.[52]

Rabbi Chaim Ozer Grodzensky was presented with the case of a patient in Koenigsberg who was expected to survive for no more than six months without therapy.[53] An operation was however possible that would prove curative if successful but fatal if not (the operation in this particular case had a greater than even chance of proving fatal). Rabbi Grodzensky allows the operation. He goes on to state that this applies even if the operation has only a "distant" chance of success since the language of the Talmud is *leḥayei sha'a lo ḥayshinan* – we are "not concerned" about temporary life in this type of situation and the Talmud makes no distinction between degrees of likelihood of success. In this he explicitly disagrees with *Mishnat Ḥakhamim*, who requires at least an equal chance of success to allow the surgery. (See below for discussion on the permissible limits of this

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49. The discretionary nature of this acceptance of risk appears to be agreed by the halakhic authorities who deal with this question. Certainly where the risk of losing *ḥayei sha'a* is greater than 50 per cent, those who allow such risk do so subject to the patient's choice.

50. Other sources besides Avoda Zara 27b corroborate the precedence of *ḥayei olam* over *ḥayei sha'a* in allowing such choices. Bava Metzia 62a discusses the case of two stranded individuals one of whom possesses a flask of water sufficient to ensure the survival of only one. Two positions are presented: Ben Petura holds that the water should be shared allowing both to survive temporarily; Rabbi Akiva holds that the owner of the water should drink it and survive. Rabbi Akiva's opinion is halakhically definitive here; *ḥayei olam* takes precedence over *ḥayei sha'a* – at least, one's own *ḥayei olam* takes precedence over another's *ḥayei sha'a*. The *Ḥazon Ish* (*Hilkhot Avodat Kokhavim* 69) states that if a *third party* were the source of the water, that third party would similarly be obliged to give it entirely to one, thereby saving one life in the long term rather than two in the short term (one *ḥayei olam* is preferable to two *ḥayei sha'a*). The *Ḥazon Ish* thus holds that *ḥayei olam* should take precedence over *ḥayei sha'a* quite apart from the obligation to save one's own life first.

51. But not all; see *Meiri* (Avoda Zara 27a–28b), who mentions opinions that would not risk shortening temporary life; presumably this means only that high risk is unacceptable (since the Gemara says explicitly that risks may be taken here). See also *Tosefot Rid* (Mahadura Kama Avoda Zara 28a, para. 10) who distinguishes between expert and non-expert practitioners in this context – his concern appears to be the relative levels of risk that these two confer.

52. *Shevut Yaakov* 3:75 (quoted in *Gilyon Maharsha*, *Shulḥan Arukh*, *Yoreh De'a* 155:1).

53. *Aḥi'ezer*, pt. 2, *Yoreh De'a*, 16:6, based on Avoda Zara 27b and referring to *Shevut Yaakov* 75 brought in *Pitḥei Teshuva*, *Yoreh De'a* 339, *Gilyon HaRashba* 336, *Binyan Tzion* 200, *Tiferet Yisrael* in Yoma (presumably 'Boaz' 3 in Mishna 8:6) and *Mishnat Ḥakhamim* 108.

risk.) He mentions the requirement to have approval of the local halakhic authority in each case and states that the physicians involved must be the most expert.[54]

Rabbi Moshe Feinstein rules similarly that such a risky procedure is allowed,[55] and that when a patient is faced with these options of *ḥayei sha'a* or risky therapy, the patient should be given the choice (as noted above); he agrees that the risky option is allowed even when the chances of its success are less than 50 per cent. Where success is more likely than failure, the patient should choose the therapy (that choice would be halakhically correct and preferable although the patient cannot be coerced);[56] where it is less likely (that is, where the mortality of the therapy is greater than 50 per cent[57]) it is discretionary.[58]

Rabbi Feinstein states that in this context the period to be considered the limit of *ḥayei sha'a* is twelve months[59] – he states that the *Aḥi'ezer* quoted above mentions six months only because that happened to be the period that was relevant in the case at hand; the general rule to be applied should be based on a period of twelve months. Where expected survival is longer than this, one should not undertake such risks; Rabbi Feinstein writes that if a patient has a condition that may allow survival for years although it could prove suddenly fatal at any time, it would be difficult to permit a dangerous procedure to attempt cure.

What choice should be made for a patient who cannot choose (a patient who is unconscious, incompetent, or a minor)? This must be decided in each case by appropriate halakhic consultation. The decision may depend on the degree of risk; if the risk is reasonable, the appropriate choice would be to

54. *Shevut Yaakov* stipulates that the doctor must deliberate with particular caution, that he obtain other expert medical opinions, and that they come to a clear majority decision (that is, a proportion of at least 2:1, according to *Melammed LeHo'il*'s understanding of *Shevut Yaakov* here) and in addition that the decision be approved by the local rabbinic authority.

55. *Iggerot Moshe, Yoreh De'a* 3:36.

56. Rabbi Feinstein does not quote a textual source for this obligation; he states that it is "logical" or "reasonable."

57. A risky therapy that has a greater than 50 per cent chance of success is permissible even in *ḥayei olam* situations.

58. Rabbi Feinstein (*Iggerot Moshe, Yoreh De'a* 3:36) allows risky therapy in *ḥayei sha'a* situations only where the therapy will remove the threat to life *completely* if successful; *ḥayei sha'a* should not be risked for longer-term life that is constantly under threat of death. The risky therapy must be *curative* with respect to the threat to life (it may be used where the long-term life gained will be of lower quality than previously, but not where the original pathology will linger, subjecting the patient to ongoing risk of death that could occur at any time).

59. *Iggerot Moshe, Ḥoshen Mishpat* 2:75 and *Yoreh De'a* 3:36; Rabbi Shlomo Kluger in *Sefer HaḤayim*.

attempt cure despite the risk. Some authorities hold that even where the chance of success is under 50 per cent that chance should be taken where the alternative is certain death.[60] Where the mortality is less than 50 per cent (that is, there is a majority chance of saving life for the long term) most would agree with Rabbi Feinstein that the choice to be preferred is the active attempt to save long-term life.[61]

Does halakha empower or indeed oblige parents to choose for a child in this situation? Some authorities hold that only the patient can choose to actively undertake high risk; caregivers cannot impose high risk on incompetent wards. Rabbi Feinstein holds that parents can make this choice for a child.[62]

Limits of risk

In these *ḥayei sha'a* situations, how small must the chance of cure be to render the procedure forbidden? There is a range of opinion on this point: *Mishnat Ḥakhamim* quoted by *Aḥi'ezer* requires a success rate of at least 50 per cent to allow the attempt.[63] *Aḥi'ezer* does not give a figure but holds that even a "distant" chance of success in an otherwise hopeless situation is enough.[64]

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60. Rabbi M. Sternbuch.

61. Rabbi Feinstein holds that this amounts to an obligation; presumably he would require it for an incompetent or minor patient.

62. *Iggerot Moshe*, *Ḥoshen Mishpat* 2:74. This is the generally accepted view. See however *Melamed LeHo'il* (104; p. 115) who states that where there is a clear majority of medical opinion (at least 2:1) in favour of a risky operation on a child where the alternative is certain death, parents have no right to refuse and that indeed parents never have a right to endanger their children.

63. The logic behind this figure appears to be that a therapy that has a success rate of over 50 per cent is properly considered a therapy; a procedure with a *mortality* of over 50 per cent cannot be deemed to be "therapy" (Rabbi Moshe Shapira). *Tzitz Eliezer* (10:25) similarly requires a 50 per cent chance of success.

64. The logic behind this opinion (and the others that find a chance of less than 50 per cent acceptable) would seem to be that as long as the therapy is successful in a *significant minority* of cases it is worth attempting in otherwise hopeless circumstances; the Talmud states that the temporary life being risked is "of no concern" here. (The debate among these opinions is on the question of how small a minority should be considered significant in this particular context.) *Tosafot* and others ask how the Talmud can hold that temporary life is "of no concern" when elsewhere (Yoma 85a) it mandates desecrating the Sabbath to excavate a person who is buried under rubble no matter how temporary the life gained will be; the saving of even moments of life obliges this. The answer is that in both cases we act for the patient's good: in the case of excavating a victim, if nothing is done he will certainly die, and in the case of lethal illness too, if nothing is done the patient will die. In both cases we choose the lifesaving attempt (*Tosafot*). Put another way: in the case of excavation where the victim faces certain death or only temporary life, we act to save that temporary life. In the case of lethal illness where the patient faces certain death

Rabbi Feinstein similarly holds that even a distant chance of success is adequate to make the risk permissible.[65] Rabbi Eliashiv requires a chance of success of at least 30 per cent.[66] Others hold[67] that even one in a thousand may be adequate.[68] The *Ḥatam Sofer* would not sanction a "remote" chance but does not stipulate a specific probability.[69]

The range of opinion is thus wide;[70] this is an area for judgment by competent halakhic authority.

Terminal life, therapy safe but efficacy doubtful

Where *ḥayei sha'a* can be treated with a therapy that is safe but of doubtful efficacy (that is, where the therapy may or may not succeed in prolonging *ḥayei sha'a* into *ḥayei olam* but will certainly not shorten the *ḥayei sha'a*) it should be attempted.[71]

Risking terminal life to prolong terminal life

There is a general obligation to prolong temporary life (except in the specific circumstances discussed above). This is so even when the extended period will remain in the temporary category, since any period of life, no matter how short, is of inestimable value,[72] and the patient should be counselled thus. Is there such an obligation in the face of significant risk? If there is no obligation, is it permissible to risk terminal life for its temporary extension?

Where a risky therapy exists that will extend terminal life (but not long enough to constitute long-term life) if successful, but will shorten it if unsuccessful,

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or the chance of cure, we risk temporary life for that chance of cure (Ritva; *Tosefot R. Elḥanan*). Temporary life is "of no concern" *only* when long-term life is the possible alternative.

65. *Iggerot Moshe, Yoreh De'a* 2:58.

66. R. Y. Zilberstein.

67. Rabbi Y. Zilberstein would be unwilling to allow surgery for a neonate with congenital heart disease where the chances of surviving surgery are given as no more than 5–10 per cent. Even where the prognosis without surgery is dismal (less than one year survival), such surgery is too risky to allow (based on R. Eliashiv; see above).

68. *Beit David* 2:340.

69. *Ḥatam Sofer*, Yoreh De'a 76.

70. It appears that there are two broad issues here: firstly, there is a debate over whether more than 50 per cent chance of success is required; as suggested (nn. 74–5 above) the point at issue here may be whether a therapy that has a mortality of over 50 per cent can properly be regarded as "therapy" or not. Secondly, among those who allow less than 50 per cent chance of success there is a debate over how small the chance must be in order to be reckoned insignificant.

71. *Iggerot Moshe, Ḥoshen Mishpat* 2:74.

72. Rabbi I. Jacobovitz, *Jewish Medical Ethics*, 152.

the therapy should ordinarily not be given;[73] however, some authorities would allow a patient that choice, at least where the risk is low enough.[74] What is the limit to the risk that may be accepted in this circumstance? It seems that less than 50 per cent risk may be acceptable, and that 50 per cent risk or more would make the therapy prohibited.[75] Where patient choice is not an issue, the proper course of action is to avoid adding any significant degree of risk of precipitating death for the possible benefit of prolonging temporary life.[76]

Intercurrent and Secondary Problems in Terminal Illness

Intercurrent or secondary problems (such as an intercurrent pneumonia) in a terminally ill patient must be treated (where treatment will not add risk or suffering, as outlined above).[77]

Acute Intermittent Threats to Life

What is the halakhic status of a patient who has a chronic threat to life due to acute events, or exacerbations of his chronic disease? Where patients typically survive for more than a year but there is an incidence of acute events that may

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73. *Iggerot Moshe, Ḥoshen Mishpat* 2:75. Rabbi Feinstein does not offer a primary source for this ruling but states that logic suggests it. In summary: where the dangerous therapy has only a 50 per cent chance of prolonging life beyond 12 months, it is doubtful whether it should be given (but the patient may choose to take it); where the chance is over 50 per cent it is certainly permitted (and should be chosen); where there is no chance of prolonging life beyond twelve months but only extending it somewhat at the cost of risk, this should not be done. Where it is clear that the therapy will extend temporary life with no risk, or at least will do no harm if unsuccessful, it should certainly be given (unless it will add or prolong unbearable suffering and the patient declines for that reason).

74. Rabbi Y. Zilberstein. Rabbi Feinstein appears to disagree; see next note.

75. R. Feinstein states that high risk is acceptable in *ḥayei sha'a* situations only where a successful outcome will remove the threat to life *completely*; that is, where the *ḥayei olam* gained will not be under constant threat of death due to ongoing pathology (see n. 69 above). Thus it follows that Rabbi Feinstein would not allow high risk where the *ḥayei sha'a* status will not be removed at all. In fact, in *Iggerot Moshe, Ḥoshen Mishpat* 2:75 he states clearly that risk is not permissible to prolong *ḥayei sha'a*; there he appears to include any significant level of risk, and he makes no mention of allowing a choice (although it is possible that he does not mean to prohibit such a choice).

76. An example of this type of situation would be a terminally ill cancer patient who develops massive gastro-intestinal bleeding and becomes severely unstable hemodynamically; if transfer to hospital for fluid resuscitation and transfusion is likely to involve significant risk of precipitating death because the patient is too ill to survive the transfer, it should not be attempted (see previous note). A risk of 10–20 per cent is probably sufficient to be considered significant here.

77. *Iggerot Moshe, Ḥoshen Mishpat* 2:75 states that there is no reason to think otherwise.

be life-threatening occurring at any time, is such a patient in the *ḥayei sha'a* or the *ḥayei olam* category?

There are two broad groups of clinical conditions that raise this question. The fist includes chronic conditions with acute exacerbations such as chronic obstructive pulmonary disease, where the patient has an ongoing illness that may worsen gradually over time but tends to be punctuated by acute exacerbations that may be life-threatening. The second group includes conditions in which the patient is typically well but is subject to unpredictable acute events such as cardiac arrhythmias, as in intermittent atrial fibrillation without structural cardiac disease, or the Wolff-Parkinson-White syndrome.

Other conditions may be intermediate between these groups: for example, chronic conditions that smoulder in a low-grade or quiescent manner for long periods but may become active – some hematological malignancies that tend to be indolent but may become acute, such as chronic lymphomas that may undergo unpredictable blastic transformation.

In these categories, statistical survival figures are much less meaningful for the individual patient than in a gradually and uniformly progressive disorder. Actuarial survival for the group may be measured in years, but some individual patients will experience an acute threat to life in any given year, and it may be impossible to predict which individuals will experience such a threat sooner and which will experience it later or never.

Where the group survival is more than a year, these types of conditions are not considered *ḥayei sha'a*. Therefore, despite the fact that the individual with such a condition is under a certain degree of constant threat, it is difficult to allow a high-risk procedure or therapy in an attempt to lessen the risk of an acute episode.[78]

These same general considerations probably apply to patients who have life-threatening allergies triggered by particular antigens (such as foods or insect stings). Here, a statistic is even less meaningful – the danger depends on whether the patient is exposed to the particular trigger or not. Again, where the risk of exposure is low it would be difficult to allow a therapy that carries high risk.

Extreme Old Age

Age has no bearing on the obligation to treat. Even in extreme old age all available therapy must be given. Where an old patient requests no therapy in a dangerous

78. *Iggerot Moshe*, *Yoreh De'a* 3:36. Rabbi Feinstein states that if a patient can live for years but could die at any moment, it is hard to permit a dangerous procedure.

situation claiming old age as a reason to be allowed to die, that is not a halakhically acceptable reason to abandon the patient. Old age should not be invoked as a reason to give a patient lower priority even in triage decisions.[79]

Risking long-term life for longer-term life
May one risk long-term life for longer term life (risking *ḥayei olam* for longer *ḥayei olam*)? Where the risk is low enough, this may be considered.

Prolonging long-term life with severe suffering
As discussed above, where terminal life can be prolonged only for the short term and at the cost of great suffering, there is no general obligation to do so. However, where a patient's life can be prolonged indefinitely (*ḥayei olam*) but only at the cost of severe permanent pain and suffering, it is more difficult to decide whether an obligation exists. In practice, Rabbi Feinstein rules that the decision should be left to the patient, or the patient's family in the case of a child.[80]

GOSES

It is important to distinguish *ḥayei sha'a* from the situation of a *goses*: a *goses* is agonal, that is, in the throes of death.[81] Understanding the distinction is vital because the halakhot pertaining to a *goses* differ radically from those pertaining to a *ḥayei sha'a* who is not a *goses*.

A *goses* manifests certain signs, among them a characteristic gasping respiratory pattern or inability to clear respiratory secretions; the Talmud states that most *gosesim* do not survive for seventy-two hours (although this is not part of the definition of *goses*; a small majority do survive longer than this).[82]

A patient may become a *goses* in the final stages of disease, or due to injury.[83] At least one authority holds that brain stem death represents a possible *goses* status.[84] A *goses* may not be moved. The reason for this is that the *goses*'s hold

79. *Iggerot Moshe, Ḥoshen Mishpat* 2:75.
80. *Iggerot Moshe, Ḥoshen Mishpat* 2:74.
81. Shabbat 151b; *Shakh, Yoreh De'a* 339:5; Semaḥot 1:4; Maimonides, *Hilkhot Avelut* 4:5.
82. Rabbi M. Feinstein suggests that although it is claimed that expertise in diagnosing the state of *gesisa* is rare nowadays, doctors can become familiar with the signs characterizing this condition by observing patients *in extremis* in the clinical setting (in Rabbi M. Hershler, *Halacha and Medicine*, iv. 106).
83. It is clear that Rabbi M. Feinstein (*Ḥoshen Mishpat* 2:73; also in Rabbi M. Hershler, *Halacha and Medicine*, vol. iv) regards an individual in the throes of death due to injury as a *goses* – Rabbi Feinstein is discussing the case of Rabbi Ḥanina ben Tradyon, who was being burned to death.
84. Rabbi S. Z. Auerbach; see brain stem death, pp. 135-8.

on life is so tenuous that any movement may snuff it out – a *goses* is likened to a candle flame at its last ebb; the slightest movement may extinguish it, and to do that would constitute taking life.[85]

Whether injecting fluids or drugs intravenously (into an existing intravenous line – that is, without moving the patient) is considered "movement" that is forbidden for fear of extinguishing life is debatable. There are authorities who hold that it is;[86] such injections should therefore be limited to fluids and drugs that are already being continuously infused, or material injected in an attempt to cure.

Although one may do nothing to shorten the life of a *goses* directly, one may remove an external impediment to the dying process[87] in order to avoid unduly prolonging the last moments of separation of body and soul.[88] If an external stimulus is responsible for maintaining the flickering *gesisa* status (such as a repeated loud noise that stimulates the patient to continue gasping respiration when respiration would otherwise cease), one may remove that stimulus (in this case, stop the noise).

Similarly, medical modalities that merely prolong the state of *gesisa* may be withheld – for example where repeated bolus doses of pressors are being infused to maintain blood pressure in an inevitably terminal *goses* situation these need not be continued indefinitely.[89]

A *goses* is considered alive in all respects. If there is a chance that treatment may reverse the *gesisa* situation and bring about recovery it must be given. Where there is a chance of curing a *goses* but only at the risk of precipitating death, the halakha is no different than for any *ḥayei sha'a*; the treatment may be given (for that purpose the *goses* may be moved – the risk of precipitating death is acceptable where there is a real chance of cure).[90]

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85. *Avel Rabba*; Semaḥot 1:4; Shabbat 151b; Maimonides, *Hilkhot Avelut* 4:5.
86. Rabbi S. Z. Auerbach was of the opinion that intravenous injection may in fact cause a more significant perturbation than external movement and is therefore more dangerous and hence certainly forbidden (*Nishmat Avraham*, ii. 32).
87. *Sefer Ḥasidim* 723; Rema in *Shulḥan Arukh, Yoreh De'a* 339:1 and also in *Darkhei Moshe* on *Tur, Yoreh De'a* 339:1. From these sources it is clear that only an extrinsic impediment to the dying process may be removed; no action may be done to the *goses* himself, not even mere movement, that may extinguish life. The distinction is this: one may not actively shorten life – that is homicide and utterly forbidden (regardless of the state of health of the victim); however, where a stimulus entirely external to the *goses* is preventing death, thus prolonging his suffering (see next note), one may stop it.
88. This is understood to be a spiritually painful state (*Iggerot Moshe, Ḥoshen Mishpat* 2:74).
89. See *Nishmat Avraham*, ii. 327, in the name of Rabbi S. Z. Auerbach.
90. *Beit Meir, Yoreh De'a* 339; see there for details. See also *Tzitz Eliezer* 17:10.

A *goses* may be moved indirectly – that is, the bed on which he lies may be moved carefully for an essential need, for example, to save another endangered patient.[91] Routine observations such as temperature and blood pressure measurement should generally not be performed where they require directly moving the patient and will not alter what is being done for the patient.[92]

91. See *Nishmat Avraham* ii. 318–19 for details and related extensive discussion regarding *goses*.
92. See exceptions in *ibid.*, ii. 318–19.