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NEONATAL EUTHANASIA

Jewish Views of a Contemporary Dilemma¹

I

Whereas in bygone days nature's course would, perforce, go essentially unchallenged, today's burgeoning medical technology has enabled physicians to ameliorate many disorders and often, even, to prolong life itself. Accepting that physicians must always do that which is in their patients' best interests, how do we define "best interests"? In fact, decisions regarding the initiation, continuation, and withdrawal of therapy are generally based upon three different widely held approaches. Some² want to base the decision on *what* will happen, that is, upon outcome. Others³ want to designate a particular person *who* will make the decision. A third thesis⁴ holds that *how* the decision is made of paramount importance.

As the senior member of the Judaeo-Christian tradition, and having pioneered the moral order, Judaism still elaborates teachings of a universal dimension which can be applied even in the most technologically advanced circumstances. In addressing the *who*, *what* and *how* facets of the contemporary "Baby Doe" debate regarding the management of defective newborns, these timeless teachings have timely significance.

II

Good ethics begins with good facts. Parents making treatment decisions for a severely afflicted child—each year approximately 30,000 such children are born in the United States alone⁵—and physicians giving medical counsel to such a family ought to have as

complete and accurate a view as possible about the diagnosis, prognosis and treatment options available. Yet, in the case of spina bifida, for example, both the parental decision and the medical counsel are particularly vulnerable to error or conflict because this medical condition is so poorly understood. Further, a rapidly advancing technology is continuously changing the prognosis for these children.

Baby Doe—the popular name adopted from the legal jargon—comprises a heterogeneous group of infants. Before relating the tale of the Baby Doe which the lay press has catapulted into the national headlines, a brief synopsis of the main categories of newborn conditions in which decisions not to treat are being—or may be—made today is in order.⁶

Meningomyelocele with hydrocephalus—the accurate terminology for spina bifida—results when the spinal column fails to fuse properly during fetal development. The meninges (membranes that cover the spinal cord) protrude in a sac through an open lesion; if the spinal cord itself protrudes, the condition is called myelomeningocele. This congenital affliction is not uncommon; it occurs in approximately one out of every thousand live births.

Cases can vary from very mild to very severe. In the very mild cases, there is a hole in the sacrum at the base of the spine, which can be easily repaired surgically, with very little risk. If treated, these children will be essentially normal, though a number of them will have some foot deformities, or some difficulty with bowel and bladder control that can be effectively treated. Without an operation, however, these children will usually develop meningitis in the first few days of life with associated high risk of subsequent retardation.

At the other end of the spectrum are the most severe cases in which there is a large opening over the spine—not at the base but higher up—sometimes involving the spine and its coverings in the lower chest area. On extremely rare occasions the entire spine is involved, not only the skin, muscle, and overlying bone of the spinal column but even the spinal cord itself. All these children will be paraplegic, unable to control their bowel or bladder voluntarily and will have no sensation in their lower extremities.

Surgical repair of such a lesion carries some risk; perhaps one infant in twenty will not survive the first month of life. In addition, a number of children will develop severe scoliosis, resulting in a hunchbacked state. They will require bracing and, very likely, further extensive surgical correction to permit them to sit in a wheelchair and breathe adequately.

Essentially all children with severe meningomyelocele also have a condition called hydrocephalus (“water on the brain”). In hydro-

cephalus, the cerebro-spinal fluid accumulates within the brain and slowly squeezes it. The result is a markedly enlarged head and, if not treated, usually significant degrees of mental impairment. However, except in the most severe cases, the hydrocephalus can be treated by inserting a shunt, a small device placed under the skin that drains the fluid from the brain into the abdominal cavity where it is absorbed. Children with hydrocephalus who are treated reasonably early and who do not develop meningitis have a better than 50 percent chance of being intellectually normal.

The association of mental retardation with spina bifida is one particularly troublesome aspect of the prognosis. About 30 percent of all cases of spina bifida are accompanied by some degree of retardation (compared to 10 percent of all births in this country). Some retardation is preventable, by surgical treatment to prevent the risk of meningitis and by shunts to treat hydrocephalus; some is not. However, even severe hydrocephalus is not a definite predictor of retardation.

Spina bifida is only one of several congenital defects which pose dilemmas regarding treatment. Another condition, Down's Syndrome, is due to an abnormality of the twenty-first chromosome (trisomy 21) which results in varying degrees of mental handicap associated with fairly typical Mongoloid facial features. It too occurs at an overall rate of 1:1000; the specific rate is largely related to maternal age. These children can often be expected to achieve an I.Q. ratio of up to 60 with appropriate care and stimulation. In itself, Down's Syndrome does not provoke decisions of whether to treat or not to treat unless it is accompanied by serious heart and bowel defects that mandate urgent surgical correction if neonatal death is to be avoided. If surgical measures are undertaken such infants have life expectancies only slightly shorter than normal (40-60 years).

Another chromosomal abnormality, trisomy 18 or Edward's Syndrome, occurs in 1 of 4500 live births. Affected neonates usually have serious cardiac and intestinal defects, blindness, deafness, severe mental retardation and limb abnormalities. These babies may need respirators, pacemakers and urinary catheters in addition to intravenous feeding. Death usually occurs within three months; if surgical intervention is offered life remains precarious and is limited by mental retardation, blindness and deafness.

Partial or total absence of the brain, anencephaly, also occurs at a rate of 1:1000 live births. Medical intervention could conceivably sustain life but cognitive function, if present at all, would be minimal. While reliable data are not available, it appears that neonates with this condition are rarely treated; indeed they are often not even fed so that death can ensue more quickly.^{7,8}

Finally, extreme prematurity or severe perinatal trauma at or near birth, that results in anoxic cerebral damage, may occur. Measures to preserve life are necessarily undertaken when the prognosis is entirely unknown, without the benefit of even the admittedly crude predictive statistics available for the previously discussed categories.

III

The question whether to save defective babies is a question that has existed as long as there have been birth defects, but has been widely perceived to be a serious problem only in the last few decades with the advent of modern, technologically advanced medicine.⁹ Although there are several interesting reports in Jewish sources dating already from the 12th century¹⁰ requiring care for defective neonates, such care was custodial at best and clearly not definitive. In spite of the development of today's medical techniques, pediatric euthanasia has continued on a relatively large scale without much public notice or concern because it was typically a "low visibility" physician's decision. Physicians withheld therapy in "good faith" judgments. On occasion, even parents were not involved in the decision and may have had no knowledge of it. Physicians, when questioned anonymously, have confirmed that passive euthanasia is not uncommon. In 1961 a poll of 250 Chicago-area doctors revealed that 61 percent admitted knowing of, or participating in, adult or pediatric euthanasia.⁵ Ten years later a similar poll of physicians found that 80 percent had actually used passive euthanasia while 87 percent said they favored it;¹¹ 90 percent of first-year medical students would also favor it.¹² In a 1976 survey⁸ 83 percent of 259 pediatric surgeons and 81 percent of 188 pediatricians felt that some newborns, at any rate, should not be offered sophisticated medical interventions. Incidentally, the physicians' religious affiliation bore no relationship to their likely stance on this issue as assessed by this study of physicians' attitudes.

Cases involving selective non-treatment of congenitally defective children have been discussed in the medical literature for years,^{13,14} as well as in many biomedical ethical contributions.^{15,16,17} Beginning in the 1970's, primarily due to probing by the lay press, neonatal medical issues became popularly recognized and debated. Indeed, because of the propensity of the media to highlight individual cases, some of these hitherto private tragedies have developed into national *causes célèbres*. With its characteristic penchant for catch-phrases, the public focused on the "Baby Doe" issue in fora throughout the

country. The principal ingredients in the contemporary controversy stem from several cases taken together.

Early in 1982, in Indiana, the “original” Baby Doe was born, afflicted with Down’s Syndrome complicated by esophageal atresia and a tracheo-esophageal fistula, conditions necessitating urgent interventional surgery. Though a lower court had upheld the parents’ resistance to heroic measures, the case was brought by public prosecutors for judgment by the Supreme Court. Alas the child expired prior to a ruling.¹⁸

In direct response to this case—and doubtlessly in indirect response to many others—the Department of Health and Human Services (DHHS) reiterated Section 504 of the 1973 Rehabilitation Act which “forbids recipients of federal funds from withholding from handicapped citizens, simply because they are handicapped, any benefit or service that would ordinarily be provided to persons without handicaps.”¹⁹ The nation’s 6,800 federally-funded hospitals were warned that they risked losing such funds if they withheld treatment or nourishment from handicapped children. Signs, of prescribed dimensions, were to be placed at strategic locations within these institutions which read: “Discriminatory failure to feed and care for handicapped infants may also violate the criminal and civil laws of your State.”²⁰

As a result of the medical communities’ immediate and widespread dissatisfaction the directives were eventually modified, emphasizing instead that Section 504 was designed to protect only such infants who are able to benefit from treatment, exempting the terminally ill and other infants for whom treatment expectations would be nil.

A subsequent case in New York State prompted the federal authorities to demand the actual medical records in order to press for life-prolonging surgery in the courts. In defending this unprecedented action the Surgeon General argued that the government is “fighting for the principle of this country that every life is individually and uniquely sacred.” Lawyers for the parents, who wished that nature be allowed to take its course, unimpeded by medical intervention, promoted a more limited interpretation of the Rehabilitation Act, arguing that its intention was to encourage facilities to ensure safety and accessibility for the handicapped.

The reaction of the medical fraternity, in particular, was predictably critical. An editorial in the prestigious *New England Journal of Medicine*²¹ assumed that the right of a competent adult to refuse treatment is “well established” and goes on to ask whether “we have the right to inflict a life of suffering on a helpless newborn just

because we have the technology to do so and despite the fact that we ourselves would have the legal right to reject such a life?"

In response to these and similar arguments the Department of Health and Human Services revised its guidelines, acknowledging the power of the medical community while virtually ignoring, in any overt manner at least, the role of ethics. The present directives encourage the establishment by hospitals of Infant Care Review Committees which would have at least three distinct functions. They would be charged with setting hospital policy with respect to a range of anticipated cases, giving advice regarding specific cases brought before it, and reviewing cases retrospectively in which non-treatment was chosen. General acceptance of these committees will be slow because of the widespread perception by physicians that they represent yet another erosion of the previously unchallenged autonomy and paternalism ascribed to the profession.²² On the other hand, the need to establish legal buffers to help diminish the growing effects of malpractice settlements might well convince many skeptics to establish committees as kind of shock absorbers between physicians on the one hand and legal or governmental officials on the other.²³

Strikingly, ethics is missing—in word and in substance—in the DHHS formulation. The word is used only once, and that is in the title of the President's Commission. And although the hospital committee described in the guidelines is closely modeled on the one suggested by the American Academy of Pediatrics,²⁴ its name has been changed from Infant *Bioethical* Review Committee to Infant *Care* Review Committee—substituting a medical for a moral term. One category of committee member which the Academy recommended for inclusion is absent from the DHHS version altogether—the ethicist or clergyman!

IV

From an ethical point of view several fundamental issues may be raised: Does anyone, in fact, have a moral right to reject life in any circumstance? Only if this can be answered affirmatively can a second question be asked: in the absence of the person's own competence, as with neonatal, mentally defective, or moribund patients, is there any "natural" guardian who could make such decisions on that person's behalf? Such "power of attorney" has been variously ascribed in legal circles to a medical board,^{25,26} legislators,^{27,28} and court-appointed guardians, among others.²⁹ Popularly, parents—or next of kin—are given pride of place. Traditionally, of course, physicians have been

the *de facto* witnesses, jurors, judges, and executioners. The “living will” whereby the person himself declares his own decision prior to becoming incompetent has, of course, no application in neonatal situations.

In searching for Jewish values with which to evaluate some of the perplexities raised by the Baby Doe cases it is imperative to identify several specific questions. Without intending to exclude any others, these should include three cardinal considerations:

1. What value does human life have? Is this value in any way contingent on the “quality” of that life?
2. As the title of a recent production put it, “Whose life is it anyway?” Who, if anyone, may make life and death decisions on the patient’s behalf?
3. Are there any circumstances in which human life may, with halakhic sanction, be allowed to expire without “putting up a fight”?

1. The principle that human life is of supreme and infinite worth is not recorded in these terms in Jewish sources. It is, however, the invariable assumption in all of our literature. The validity of all laws, in fact, is predicated on the proviso “that man may live by them.”³⁰ Hence, any precept, whether ethical or ritual in nature, is automatically suspended if it conflicts with the interests of human life,³¹ the only exceptions being the three cardinal offences, idolatry (against God), murder (against fellow man), and adultery or incest (against oneself), as expressly stipulated in the Bible itself.³² Furthermore, mathematical logic dictates that since any part of infinity remains infinite, any part of life—even only one hour or one second—is of precisely the same worth as seventy years of it. This tenet is not unique to Jewish law. Indeed, in one case, the South Carolina Supreme Court stated with eloquence:

... though a human body must be alive in order that it may be the subject of homicide ... the quantity of vitality which it retains at the moment the fatal blow is given, and the length of time life would otherwise have continued, are immaterial considerations. If any life at all is left in the human body, even the least spark, the extinguishment of it is as much homicide as the killing of the most vital being.³³

Actually, nine centuries earlier Maimonides, based on still earlier Talmudic sources, ruled that to kill a patient even at death’s brink constitutes exactly the same crime of murder as to kill a young, healthy person who may have decades yet to anticipate.³⁴ The opposite corollary is also true: one life is worth as much as a thousand lives because infinity is not increased by multiplying it.

Hence the unconditional Jewish opposition to deliberate euthanasia as well as the surrender of one hostage to save any number of others, even if the whole group is otherwise threatened with death.³⁵

In the title to life and its infinite value, there can be no distinction whatever between one person and another, whether healthy, crippled, demented, or terminally ill. Mentally defective patients can even sue for injuries received, though they cannot be sued because of legal incompetence.³⁶ The saving of physically or mentally defective persons sets aside all laws in precisely the same way as does the saving of normal people.³⁷

The ultimate reason for Judaism's position that human life remains infinite in value in all circumstances is because of the law's Divine origins.³⁸ A secondary, but still overwhelmingly convincing argument may be made for its adoption. Failure to define all life as inviolate would be the thin end of the wedge and all lives would consequently assume but a relative value. If it were morally defensible to smother the life of a grotesquely handicapped individual, then one less severely afflicted, who might not be so expendable, would have a greater value. If a person with an IQ ratio of 10 were not entitled to an infinite claim to life, then what about one with an IQ of 30, 50, or 80? Where shall the line be drawn? Furthermore, if the degree of handicaps (number of limbs or level of intelligence, for example) were admissible criteria, would it not follow that a person of education and intelligence would have precedence to limited medical resources over someone with lesser capacities? Likewise, if life expectancy were to determine the value of life would it not follow that a person with 50 years to look forward to has a greater value than someone older with less actuarial expectancies? Taken to its logical conclusion, once any life is not considered infinitely valuable, all of us would have a merely relative value—dependent on our age, health, intelligence, quality of life, or even usefulness to society. Clearly, such discrimination would be wholly unacceptable and it would grate on our moral conscience.

2. Having established that life's value is truly infinite and that its worth bears no relationship to that life's quality, the next axiom is that every person is duty-bound to protect and preserve that life. Anyone refusing to come to the rescue of a person in danger of losing life, limb, or even property, is guilty of the Biblical injunction "you shall not stand upon the blood of your neighbor."³⁹ Hence, a doctor's refusal to extend medical aid when required is deemed tantamount to bloodshed.⁴⁰ Although physicians are in a privileged position because of special training and qualifications, the law with respect to the preservation of life is addressed to everyone. Not only is it incumbent on the physician; it is equally binding—within the limits

of ability—on the rest of society, the next of kin, and even on the patient himself. The jurisdiction over life is not man's (except where such a right is conferred by the Creator, as will be discussed in the next section), and killing oneself by suicide, or allowing oneself to be killed by unauthorized martyrdom is a mortal offence.⁴¹

Furthermore, not only can suicide not be sanctioned, but Judaism regards the body itself as Divine property. Therefore it is an offence to make any unwarranted incision or to inflict any injuries, whether on another's body or on one's own. While this principle is enunciated several times in the Talmud⁴² and subsequent codes,⁴³ the first to specify a reason is R. Shneur Zalman of Ladi (1746–1812), the founder of *Habad*, in his *Shulkhan Arukh*.⁴⁴ In recording the ruling forbidding striking someone else even if the victim gives his permission, he adds: "because a person has no ownership rights over his body whatsoever."

While clearly consistent with previously established teachings, the precise source for R. Shneur Zalman's position is unclear. A fascinating discussion about this and related aspects of authorization for self-mutilation is presented by the late R. Shlomo Y. Zevin.⁴⁵ He examines, in his own unique style, the halakhic ramifications of the pledge extracted by Shakespeare's⁴⁶ Shylock from Antonio to provide a pound of his own flesh as collateral for a loan. In establishing the *a priori* illegality of such a commitment, the author demonstrates that Judaism regards a person's flesh as belonging to God and that therefore it is not man's to barter. The author presents a comprehensive and more detailed discussion of all the relevant sources in a later contribution elsewhere.⁴⁷

The clearest explicit early statement regarding God's exclusive title to the human body in a legal setting is by Maimonides⁴⁸ who rules that a murder victim's next of kin cannot opt to refrain from prosecution, because "the victim's life is not that of the next of kin; it is the property of God." Likewise, an earlier authority⁴⁹ rules that "the Torah does not permit one to injure oneself, and there is no difference if one injures oneself or someone else. Hence, a person cannot incriminate himself with respect to physically punishable transgressions, whereas he can do so in purely civil cases." Man can own his belongings, but not his person. A liturgical reference to this notion is recalled in the High Holyday services: "The soul is Yours and the body is Yours. . . ."⁵⁰

The prohibition of self-mutilation extends even to causing oneself needless distress. Thus the Talmud⁵¹ states that a *nazir* brings a sin-offering upon the conclusion of his period of self-imposed abstentions because he caused himself unnecessary suffering. Fur-

ther, the Talmud extrapolates from here that, generally, denial of permitted enjoyments is frowned upon.

The abhorrence with which Judaism views the ultimate form of self-mutilation—suicide—is repeatedly expressed in numerous references. As a consequence, the usual laws of mourning by the next of kin are suspended.⁵² Although burial some distance from other graves has been customary,⁵³ the Kaddish prayer is said out of regard for the survivors.⁵⁴ One source,⁵⁵ of questionable authenticity,^{56,57} states that taking one's own life because of overwhelming circumstances would not be regarded as suicide in Jewish law. Likewise, if someone seeks death for fear of committing a crime (other than the three cardinal crimes for which death rather than transgression is mandated), it is not judged as suicide.⁵⁸ Some even regard this as laudable.⁵⁹ Others,⁶⁰ however, emphatically reject suicide as an option under any circumstances, including instances of severe physical agony,⁶¹ perhaps reflecting David's words of praise, "the Lord has afflicted me but has not put me unto death."⁶²

A commonly quoted adage declares that "he who commits suicide has no share in the world to come." The earliest extant reference to this is in the novellae of the 16th-century R. Joseph Trani,⁶³ although a later authority⁶⁴ reports that the Talmud⁶⁵ itself already states this. We do not, however, find this assertion in our editions of the Talmud, but the expression has circulated widely.

3. Having established that Jewish law regards life as infinite and inviolable in value, and that neither life nor health are commodities which can be deliberately forfeited, our final consideration turns to whether within the framework of the law there exist circumstances under which life can be allowed to expire without intervention. Given that life belongs to God it could only be by His sanction that life may occasionally be forfeited. That in principle this is so is evident in that some offences are capital in nature, under which the law may mandate the ultimate penalty. The concept which has characterized the whole of Jewish history, of dying *al kiddush ha-Shem*—in sanctification of God's name—is another example of occasionally legalized voluntary martyrdom. But though having occurred all too often, these are exceptional cases and clearly apply only under duress.

In view of the general ban on the voluntary surrender of life, the patient's consent is not required in Jewish law for any life-saving operation or treatment. His lay opinion that the operation is unnecessary, or his declared desire to risk death rather than undergo the operation, has no bearing on the issue.⁶⁶ Indeed, the obligation to preserve life and health is ineluctable and devolves on the patient himself as much as on the physician. The conscientious physician

may even have to expose himself to the risk of malpractice claims in the performance of this superior duty.⁶⁷

On the other hand, Jewish law specifically permits the application of possibly hazardous procedures or medications if safer methods are unavailable. In the case of an experimental treatment protocol any prospect that it may prove helpful—even if the chances are less than 50 percent that it will succeed—is sufficient to warrant its use provided that the majority of medical consultants concur.⁶⁸ In the terminal phases of life, drugs, such as narcotics, may be given in an effort to insure the patient's comfort, even if there is a risk that by so doing circulatory or respiratory depression could precipitate an earlier demise.⁶⁹

V

Active physical euthanasia, then, could never be sanctioned; deliberately depriving someone of even a moment of life, regardless of the age or quality of that life, is regarded as murder.⁷⁰ Nevertheless, the sources are replete with references to prayers having been offered on behalf of persons who wished to die. This is all the more striking when one remembers that prayer had a very real and immediate meaning to the savants who recorded these views. For example, the Talmud⁷¹ relates that prayers, which were answered, were offered for the demise of R. Judah the Prince out of consideration for the travails of his intestinal afflictions. Likewise, the Rabbis themselves prayed for the death of R. Yohanan after the expiration of his closest colleague, R. Shimon ben Lakish, left him profoundly bereaved.⁷² A curious example of this "euthanasia by prayer" is recorded in the following early passage:⁷³

Once there was an aged woman who came to R. Yosi (ha-Gelili) saying, "I have lived longer than necessary. My life has become unbearable; I can no longer taste food nor drink. I wish to be free of this world." R. Yosi inquired: "How have you managed to live so long?" Answering, the woman said: "I have learnt to set aside even enjoyable pursuits in order to attend daily synagogue services." "In that case," replied R. Yosi, "withhold yourself from the synagogue for three consecutive days." She complied, and on the third day she fell ill and died.

Only one decisor, R. Nissim of Gerondi,⁷⁴ states explicitly that occasionally, when a terminally ill patient is suffering greatly, it is appropriate to pray for mercy and ask for his death. Curiously, none of the later classical codes make any reference to this ruling.

More germane to our discussion, however, would be the several references to withholding actual treatment in certain situations.

Perhaps the most striking Talmudic reference is related in the story of the martyrdom of R. Hanina ben Teradyon.⁷⁵ Having been wrapped in a Torah scroll, water-soaked wads of cotton were placed on the sage's chest to retard the flames of the stake onto which he was bound in order to prolong his dying agony. R. Hanina resisted his onlooking students' suggestion that he inhale the fiery fumes in order to hasten his end, for, he said, "better that He who gave life take it, than that one should injure oneself." Apparently, doing so would have constituted a form of suicide. Nevertheless, the Talmud continues, R. Hanina did sanction the removal of the water-soaked cotton thereby allowing death to supervene more quickly, even rewarding the non-Jewish guard who offered this final act of mercy with an assurance to him of a place in the world to come. This source has been marshalled to establish the acceptability of passive euthanasia in terminal circumstances, although there are alternative interpretations limiting its application.⁷⁶

While reconfirming that nothing may be done to hasten death, R. Moses Isserles⁷⁷ records the view that "if there is something which inhibits the soul's departure, such as a near-by noise caused by a wood-chopper, or such as salt on the patient's tongue, and these prevent the soul's departure, then it is permitted to remove these (the wood-chopper or the salt) because this constitutes no action, but only the removal of an impediment (to death)." Actually, the indicated source⁷⁸ for this position even records a view⁷⁹ which holds that it is permissible to remove a pillow from under the patient's head, though R. Isserles himself specifically prohibits such action for fear that even the slightest movement of a dying person may hasten death, albeit by moments. R. Yehuda he-Hasid (c. 1200, Regensburg) also states⁸⁰ that it is proper, as opposed to being merely permitted, to remove an impediment to death, such as the disturbance caused by the wood-chopper. Accordingly, the *Arukh ha-Shulhan's* author considers it a *mitsva* to remove an incidental impediment to death in order to spare the patient any unnecessary prolongation of the death agony.⁸¹

Elsewhere,⁸² R. Yehuda he-Hasid writes that one should not cry out at the time a person dies "in order that the soul shall not return, for this could involve severe pain." While some later authorities⁸³ adopt the view that medicines which artificially prolong life should not be used in the final stages of life, others⁸⁴ disagree and require the use of such medications if life can be prolonged, even for a short while.

Recently, several contemporary authorities have re-addressed the issue of passive euthanasia in the modern era in the light of Jewish teachings. Bearing in mind the previously stated position that neither life expectancy nor the wishes of parents or other next of kin

nor the quality of life, in themselves, have any bearing on the issue, many of the directives with regard to euthanasia at the end of a long life are equally relevant to euthanasia at the end of a short life. The dilemmas of Baby Doe are similar in substance, if not emotion, to those of Grandparent Doe!

With regard to passive euthanasia, R. Moshe Feinstein, zt'l, this generation's premier halakhic decisor, specifically allows—nay, encourages—it in situations where, a) the disease is so advanced as to render the patient irreversibly and terminally ill, and where b) he as a consequence suffers greatly, and if c) he does not expressly wish to prolong the ordeal. Furthermore, he writes,⁸⁵ when a patient is comatose this is in itself tantamount to extreme suffering “in spite of what physicians may tell you to the contrary.” Thus, if a pain-ridden or unresponsive patient who is irreversibly ill is on a respirator (having been placed when the prognosis was unknown) the resuscitation efforts may be discontinued.⁸⁶ In practice, patients who are on respirators must be taken off the machine for a short while every two or three hours in order to suction out the accumulation of pulmonary secretions. Since, in these circumstances, the law does not mandate *active* intervention, but rather, it sanctions *passively* allowing death to supervene, the patient may be left unattached to the respirator at this point. It would be incorrect to prolong such a patient's life even in effort to preserve his kidneys, for example, for potential transplant to someone else.⁸⁵ The manipulation of one patient's life—even in extending his life—solely in the interests of another would be an unacceptable interference with each person's individual and fully autonomous human rights.

Artificial methods for the prolongation of life falling under these restrictions clearly include such dramatic procedures as major surgery, mechanical respirators, or renal dialysis. Likewise, more subtle forms of intervention, such as supra-physiological fluids or antibiotic administration, would also be proscribed.⁸⁷ On the other hand, it should be emphasized,^{88,89} that the provision of nutrition, oxygen, and blood, being the essential natural needs of everyone—patient and healthy person alike—should never be withheld, and denial of these would literally fall within the rubric of “you shall not stand upon the blood of your neighbor.”³⁹ Interestingly, the basic distinction between natural and artificial needs has also been recognized by the civil courts⁹⁰ as well as by the Church authorities.⁹¹ In a recently published survey of physicians' attitudes, 73 percent of 103 would provide adequate intravenous fluids to terminally ill, moribund patients.⁹²

Of particular pertinence to the Baby Doe debates is a responsum by R. Eliezer Waldenberg, the senior *dayyan* of the Jerusalem Beth

Din (religious court) and longtime rabbinic adviser to that city's Shaare Zedek Hospital. In considering⁹³ the appropriateness of interventional surgery in infants with meningomyelocele as well as children with Down's Syndrome, complicated by intestinal atresia, he concludes that if surgery will provide these unfortunate neonates with "permanent" (i.e., enduring) life, that is to say, where the expectation is the provision of independent life and not merely the staving off of impending death, then such procedures must be undertaken with the same determination as one would have for otherwise normal children so afflicted. On the other hand, if death is inevitably anticipated in spite of the proposed intervention then nature should be allowed to take its natural course provided, of course, that minimal support including nutrition, oxygen, and blood are not withheld.

VI

In sum, the following principles would appear to govern the Jewish attitudes to these hard, heart-rending problems:

1. All human life is infinitely and equally valuable, irrespective of actual or potential impairments of intelligence, health, comfort, life expectancy, quality of life, or usefulness to society.

2. As such, all life is sacred in the sense that it may never be willfully forfeited by any active means, other than by prayer, and this would constitute murder.

3. This restriction on the forfeiture of life devolves equally on the physician, hospital administrators, the courts, government, and next of kin, as well as on the patient himself.

4. A terminally ill patient, again irrespective of age, may be given narcotic analgesics for the sole purpose of reducing his pain even if some risk is thereby incurred.

5. Notwithstanding our second principle, one would not be required—or may even be advised not—to extend the life of a terminally ill patient who is in distress by artificial means, unless the patient specifically declares his wish that this be done.

6. Nutrition, oxygen, and blood may never be withheld, even in cases falling into the previous category.

7. Thus, if Baby Doe had Down's Syndrome he or she would be entitled to any and all interventions. On the other hand, if Baby Doe were anencephalic and no amount of intervention could be expected to provide more than a tenuous "temporary" life, such procedures would not be mandated, and would probably be discouraged.

8. Each of these highly complex medical, halakhic and emotional decisions should involve participation by competent religious

authorities. This will assure the compassionate and ethical application of the previously cited principles in the interface between medicine and morals.

NOTES

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31. *Yoma* 85b.
32. Deuteronomy 6:5 and 22:26; see also *Pesahim* 25a and b, and *Shulhan Arukh, Yoreh De'ah* 157:1 and 195:3.
33. *State v. Francis* 152, S.C. 17, 60, 149, S.E. 348, 364 (1929) quoting 21 *A. & E. Encyl of Law*, 92 (2nd ed).
34. Rambam, *Hilkhot Rotse'ah*, 2:6.
35. *Shulhan Arukh, loc cit.* A fuller discussion can be found in Jakobovits, I., *Jewish Medical Ethics*, p. 45 ff. (1962) and in his "Medical Experimentation on Humans in Jewish Law," in *Proc. Assoc. Orth. Jew. Sci.*, 1, 1-8, 1966.
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37. *Shulhan Arukh, Orach Hayyim*, 329:4; see also *Mishnah Berura* and *Be'ur Halakhah, ad loc.*
38. Inherent in the verse: "*Ha-Shem natan va-ha-Shem lakakh*," Job 1:21.
39. Leviticus 18:15, Rashi *ad loc*; Rambam, *Hilkhot Rotse'ah*, 1:14.
40. *Shulhan Arukh, Yoreh De'ah*, 336:1.
41. Based on Genesis 9:5, and commentaries. Also Rambam, *loc cit.*, 2:5.
42. *Bava Kamma* 90b and 91b.
43. Rambam, *Hilkhot Hovel u-Mazik* 5:1; *Shulhan Arukh, Hoshen Mishpat* 420:31.
44. *Shulhan Arukh ha-Rav*, V, *Hilkhot Nizkei Guf va-Nefesh*, 4.
45. *Le-Or ha-Halakhah*, 2nd ed., p. 310, 5717.
46. Shakespeare, William, *The Merchant of Venice*, Act I, Scene III.
47. Cf. Zevin, S.Y., "May One Person Grant Permission to Another to Injure Him?" in Hershler, M., (Ed), *Halakhah and Medicine*, II, pp. 93-100, 5741.
48. Rambam, *Hilkhot Rotse'ah*, 1:4.
49. *Ibn Migash, R. Yosef Halevi, rRi Migash*, no. 186.
50. Attributed to Rav Amram Gaon and rearranged by Rashi. From the *Selihot* service.
51. *Nedarim* 10a, and elsewhere.
52. *Shulhan Arukh, Yoreh De'ah* 345.
53. *Gilyon Maharsha, loc cit.*; *Tur, Yoreh De'ah* 362:5.
54. *rHatam Sofer, Yoreh De'ah*, no. 326.
55. *rBesamim Rosh*, no. 345, attributed to R. Asher b. Jehiel.
56. Chajes, Z. H., *Imrei Binah*, ch. 6, notes; *Kol Bo al Avelut*, ch. 4, 3:50. See also Zevin, S.Y., *Hamo'adim ba-Halakhah*, p. 257, and *rTashbatz*, no. 416.
57. Yosef, O., *rYabia Omer*, II, *Yoreh De'ah*, no. 24 provides a characteristically encyclopedic review of the authenticity of *rBesamim Rosh*.
58. *Kiddushin* 40a. Cf. *Beit Yosef, Yoreh De'ah* 157 and gloss R. Akiva Eiger, *loc cit.*
59. *Tosafot, Gittin* 57b, *Avoda Zarah* 18a.
60. *Yam Shel Shelomo, Bava Kamma*, ch. 8, 59. Of interest also is *Da'at Zekenim mi-Ba'alei ha-Tosafot* on Genesis 9:5, quoted in *Beit Yosef, Bedek ha-Bayit, Yoreh De'ah* 157, recording an episode in which a certain rabbi slaughtered (sanctioned the slaughter of?) many children during times of religious persecution lest they be forcibly converted. Another Rabbi's condemnation of this as murder was eventually vindicated when the persecutions ceased and it turned out that the children might thus have been spared.
61. Kransner, S., *Nahalat Shimon*, I Samuel, 31:4, quoting *Sefer Hasidim*, ed. Parma, no. 315, that even extreme agony would not be sufficient reason to sanction suicide. See also *rHatam Sofer, Yoreh De'ah* no. 326, who argues that R. Hanina ben Teradyon's martyrdom proves that suicide is condemned even under the harshest circumstances.
62. *Psalms* 118:18.
63. *Hiddushei MaHarit, Ketubbot* 103a. Cf. *Yad Hamelekh, Hilkhot Avelut*, ch. 1, who deduces a similar position from *Gittin* 75b. Also *rTeshuvah me-Ahavah*, III, 409 and *Yabia Omer*, VI, *Yoreh De'ah*, no. 36.

64. Tukzinsky, Y.M., *Gesher ha-Hayyim*, vol. I., ch. 25, quoting Emden, Y., *Sefer Lehem Shamayim*.
65. Tract. *Semahot* (*Tosefta*). Not apparently found in our editions however. See *rYabia Omer*, *ibid*.
66. Y. Emden, *Mor u-Ketsi'ah*, *Orah Hayyim*, 228; Jakobovits, I., *Journal of a Rabbi*, p. 185, 1966.
67. See note 35 above.
68. *She'vut Ya'akov*, III, no. 75.
69. *Tsits Eliezer*, XIII, no. 83.
70. *Shulhan Arukh*, *Yoreh De'ah* 339:1.
71. *Ketubbot* 104a.
72. *Bava Metsia* 84a.
73. *Yalkut Shimoni*, Proverbs, no. 943.
74. *Ran*, *Nedarim* 40a, s.v. *ein mevakkesh*. See also bottom of *Nedarim* 22a where Ulla, accompanied by two (Jewish) bandits, one of whom struck the other a fatal blow, encouraged the murderer to complete his crime and "cut his throat clear across." *Ran* and *Rosh*, s.v. *u-fara leh beit shehitah*, both explain that Ulla's concern was "so that he die more quickly." *Tiferet Yisrael's* explanation of this apparent euthanasia (in *Boaz* on *Yoma* ch. 8, sec. 3) is that Ulla feared for his own *hayyei olam* lest the murderer strike him too, and that when set against the victim's *hayyei sha'ah*, Ulla's life took precedence. *Rosh's* comment however, clearly implies that "so that he die more quickly" is reason in itself, independent of Ulla's fear lest he anger the murderer. Noteworthy is that neither *Ran* on *Nedarim* 40a nor this passage in *Nedarim* 22a are codified in the classic codes.
75. *Avodah Zarah* 18a.
76. *rIggerot Moshe*, *Yoreh De'ah* II, no. 174:3 suggests that although there may be alternative interpretations, it appears that R. Hanina ben Teradyon's dispensation hastening his own death would have been granted only to a non-Jew.
77. *Shulkhan Arukh*, *Yoreh De'ah* 339:1; see also *rMinhat Yitshak* V, No:7:7 who states that this is applied only to a *goses*.
78. *Shiltei ha-Gibborim* on Alfasi, *Mo'ed Katan* ch. 3.
79. In the name of his teachers and of R. Natan *ish Igra*.
80. *Beit Lehem Yehudah*, *Yoreh De'ah* 339, quoting *Sefer Hasidim*, no. 723.
81. *Arukh ha-Shulhan*, *Yoreh De'ah* 339:4.
82. *Sefer Hasidim* no. 234.
83. *rBeit Ya'akov* no. 59.
84. *rShevut Ya'akov* III, no. 13 quoted by *Gilyon Maharsha*, *Yoreh De'ah* 339:1 together with *rBeit Ya'akov*, *loc cit*.
85. *rIggerot Moshe*, *Yoreh De'ah* II, no. 174:3; cf. *rLev Aryeh*, II, no. 33 and *rMinhat Yitshak* V, 7:7.
86. *rIggerot Moshe*, *Yoreh De'ah* III, no:132. In a personal communication of 16 Iyyar, R. Feinstein writes:

כיון שלא יהא ניכר אם ימות צריך להניחו באקסידשען קימעא שיהיה כל פעם לשעה אחת או שתיים וכשיכלה האקסידשען יראו אם חי הוא עדיין יתנו עוד אקסידשען לשעה אחת או שתיים וכן כל הזמן אם כשיראו אחר שכלה האקסידשען איך שהוא מת ובאופן זה לא יהיה שום מכשול לחשש איבוד נפשות ולא להתרשלות ברפאותו אפילו לחיי שעה הקצרה ביותר.

... since continuing artificial respiration may obscure the onset of death, it is appropriate to observe the patient every hour or two off the respirator to determine whether he remains alive.

The context of this reply suggests that the reference is to a non-comatose patient.
87. Personal communication, 1980. "In hopelessly ill patients for whom no relief from terminal suffering can be expected by medical treatment, life-prolonging medicine should be withheld; rather nature should be allowed to take its course unimpeded." This, and the previous reference, has since been published in *rIggerot Moshe*, *Hoshen Mishpat*, III, no. 73.
88. Auerbach, R. S.Z., "Treatment of the Dying," in Hershler, M. (ed.) *Halakha and Medicine*, vol. II, 1981, p. 131, argues that "it is logical to suppose that nutrition and oxygen would have to be provided in spite of (prolonging) severe agony, even against the patient's wishes. However, if the patient demands it, it would be permitted to withhold

treatments which cause the patient more suffering. Nevertheless, one is always obliged to try to convince the patient that 'one moment of repentance in this world is worth more than all the life of the world-to-come.'"

89. See AMA "Statement on Euthanasia" (Dec. 4, 1973) reviewed by Horan, D.J., "Euthanasia, Medical Treatment and the Mongoloid Child: Death as a Treatment Choice," 27 *Baylor Law Rev.*, 76, 78 (1976); in re. *Storar*, 52, N.Y. 2d 363, 438 N.Y.S. 2d 266 (1981) the court overrode a mother's decision to halt treatment and it authorized blood transfusions for a 52-year old profoundly retarded man suffering from terminal, metastasized bladder cancer. In this case, although the cancer threat to the patient's life was deemed untreatable, the bleeding was deemed treatable. The court analogised the treatment—blood transfusion—to food rather than to major surgery or respirators. This case should be viewed against the background of numerous judgments where the courts have overridden refusal by patients or their next-of-kin to have blood transfusions, for various reasons including religious objections.
90. "MDs Charged with Murder," *Am. Med. News*, 25, 9.3.1982, p. 22.
91. Pius XII, "The Prolongation of Life," *The Pope Speaks*, 4:393-8, 1958.
92. Micetich, K.C., Steinecker, P.H., and Thomasarn, D.C., "Are Intravenous Fluids Morally Required for a Dying Patient?" *Arch. Int. Med.*, 143:975-8, 1983.
93. *rTsits Eliezer*, XIII, no. 88.