

# ASSISTED SUICIDE

**Rabbi Elliot N. Dorff**

*This paper was approved by the CJLS on March 11, 1997, by a vote of twenty-one in favor, two opposing and one abstaining (21-2-1). Voting in favor: Rabbis Kassel Abelson, Ben Zion Bergman, Elliot N. Dorff, Jerome M. Epstein, Samuel Frint, Baruch Frydman-Kohl, Nechama D. Goldberg, Arnold M. Goodman, Susan Grossman, Judah Kogen, Vernon H. Kurtz, Alan B. Lucas, Aaron L. Mackler, Lionel E. Moses, Paul Plotkin, Mayer Rabinowitz, Avram Israel Reisner, James Rosen, Joel Roth, Elie Kaplan Spitz, and Gerald Zelizer. Voting against: Rabbis Myron S. Geller and Gordon Tucker. Abstaining: Rabbi Shoshana Gelfand.*

*The Committee on Jewish Law and Standards of the Rabbinical Assembly provides guidance in matters of halakhah for the Conservative movement. The individual rabbi, however, is the authority for the interpretation and application of all matters of halakhah.*

## שאלה

May Jews assist others in committing suicide or request that others assist them in their own suicides?

## תשובה

### The Medical and Legal Contexts for This Question

Killing oneself and murdering others have always been technically possible but forbidden in Jewish law. In our time, though, the matter has taken on new dimensions. On the one hand, while people in the past had no choice but to endure the pain of dying, with minimal medication available to ease their suffering, now we have sophisticated ways to diagnose levels of pain and to calibrate pain medication to need. We also have developed hospice care, where the patient is supported physically, psychologically, and socially by a whole team of people, including family and friends. These factors should diminish the number of people who seek to take their lives.

On the other hand, though, we can now sustain bodily functions almost indefinitely, and so dying people may live through a long period of disability. Moreover, the drive to save money in health care has limited medical services for the dying, and in the future even less money will be spent on the care of each dying person as more and more of the baby boomers call upon whatever resources exist and as the need to contain health care costs becomes even more critical. This is especially problematic in our age of protracted life spans, where people generally die of chronic rather than acute illnesses.

Moreover, we can now predict the course of a disease with greater accuracy, and so people have less room for unrealistic hope. We now also have the means to bring about a quick, virtually painless death. These latter factors have prompted some people faced with an incurable disease to take their own lives, sometimes asking others to assist them.

Those who commit suicide and those who aid others in doing so act out of a plethora of motives. Some of them are less than noble, involving, for example, children's desires for Mom or Dad to die with dispatch so as not to squander their inheritance on "futile" health care, or the desire of insurance companies to spend as little money as possible on the terminally ill.<sup>1</sup> The morally hard cases, though, are those where the primary intention is the benign desire to stop the pain of a dying patient. Indeed, some have claimed that mercy killing is the only moral path, that keeping a person alive under excruciating and/or hopeless circumstances is itself immoral.

The Ninth Circuit Court of Appeals and the Second Circuit Court of Appeals have both recently affirmed that under the Fourteenth Amendment it is an American's right to commit suicide and to request others to assist in that process. The Ninth Circuit based its argument on the Amendment's clause that forbids states from depriving liberty to any person without due process of law. The Second Circuit, noting that people with terminal illnesses can legally request to be disconnected from life support systems but other people are denied aid in dying, based its argument on the Amendment's clause forbidding states from denying any person the equal protection of the laws.<sup>2</sup> As of this writing, the United States Supreme Court has taken both of those cases on appeal. [NOTE: The U.S. Supreme Court subsequently rejected these Constitutional grounds for permitting assisted suicide, returning the matter to the discretion of each state. *Washington v. Glucksberg* 117 S.Ct. 2258 (1997); *Quill v. Vacco* 117 S.Ct. 2293 (1997).]

These new medical and legal realities, then, require us to reexamine and reevaluate Judaism's stance on suicide and assisted suicide so that contemporary North American Jews will know their tradition's views of these issues and the reasons for those views.

## Jewish Theological and Legal Grounds for Opposing Suicide and Assisted Suicide

### A. Suicide

Judaism's stance on suicide and assisted suicide is rooted in its understanding of the body as God's possession. God, in fact, created and owns everything in the universe.<sup>3</sup> God has granted us the normal use of our bodies during our lifetimes, and that inevitably

<sup>1</sup> As we shall discuss below, though, the economic realities behind these arguments are real, but they argue not for assisted suicide, but for much greater utilization of hospice care.

<sup>2</sup> *Compassion in Dying v. State of Washington* 79 F.3d 790 (9th Cir. 1996); *Quill v. Vacco* 80 F.3d 716 (2d Cir. 1996). (A subsequent petition for the Ninth Circuit to rehear the case *en banc* was denied: 85 F.3d 1440 [9th Cir. 1996].) The Ninth Circuit also invoked the Supreme Court's past decisions on abortion in interpreting the Fourteenth Amendment's liberty clause to protect a person's right to make his or her own health care decisions. Thus Judge Stephen Reinhardt, writing for an 8-3 majority, stated that, "By permitting the individual to exercise the right to choose, we are following the constitutional mandate to take such decisions out of the hands of government, both state and federal, and to put them where they rightly belong, in the hands of the people."

<sup>3</sup> See, for example, Exod. 19:5; Deut. 10:14; Ps. 24:1. See also Gen. 14:19, 22 (where the Hebrew word for "Creator," *קנה*, also means "Possessor," and where "heaven and earth" is a merism for those and everything in between) and Ps. 104:24, where the same word is used with the same meaning. The following verses have the same theme, although not quite as explicitly or as expansively: Exod. 20:11; Lev. 25:23, 42, 55; Deut. 4:35, 39; 32:6.

involves some dangers and risks; but God, as Owner, imposes specific requirements and prohibitions intended to preserve our life and health as much as possible.<sup>4</sup>

One such provision relevant to our topic is that Jews may not even injure themselves, let alone kill themselves.<sup>5</sup> To do either one of those things would be to harm or destroy what belongs to God. Since we do not own our bodies, we do not have the right to expose ourselves to injury or death beyond the requirements of normal living and must instead seek to preserve our lives and health. The only three times, in fact, when a Jew is supposed to prefer death to violating the law – namely, where the choice is death or being forced to commit murder, idolatry, or adultery/incest<sup>6</sup> – are all choices of death for the sake of God, not for oneself.

When the Romans burned Rabbi Hananyah ben Teradiyon at the stake for teaching Torah, he refused to inhale the flames to bring about his death more quickly, saying “Better that God who gave life should take it; a person may not injure himself or herself.” The Romans, though, had attached tufts of wool soaked with water to his chest to make his dying slower and more painful, and Rabbi Hananyah allowed his students to bribe the executioner to detach them. From this and other sources, later Jewish authorities deduced that one may remove impediments to the natural process of dying but not actively cause one’s own death, much less someone else’s.<sup>7</sup> Indeed, based on the biblical story of Ahitofel’s suicide, medieval sources maintain that “he who commits suicide while of sound mind has no share in the World to Come” and is to be buried outside the Jewish cemetery or at its edge.<sup>8</sup>

Saul’s suicide (1 Sam. 31:3-5), though, is recorded in the Bible without objection, and the Talmud, apparently approvingly, records the case of children who take their lives to avoid being sexually violated.<sup>9</sup> These cases undoubtedly served as the backdrop for Jewish law’s justification of suicide when done as an act of martyrdom in

<sup>4</sup> Bathing, for example, is a commandment according to Hillel: *Leviticus Rabbah* 34:3. Maimonides summarizes and codifies the rules requiring proper care of the body in *M.T. Laws of Ethics* (De’ot), chs. 3-5. He spells out there in remarkable clarity that the purpose of these positive duties to maintain health is not to feel good and live a long life, but rather to have a healthy body so that one can then serve God.

<sup>5</sup> The prohibition against injuring oneself is stated in *M. Bava Kamma* 8:6 (90b); cf. *M.T. Laws of Injury and Damage* 5:1. Tannaitic sources recorded in the Talmud (*B. Bava Kamma* 91b) state divided opinions as to whether individuals may inflict non-fatal wounds on themselves. The later sources generally agree that people are not allowed to injure themselves, although some restrict the prohibition against self-injury to cases where wounds are produced (*Hemdut Yisrael*, commandment 310), and some think that the prohibition is not a violation of *Gen. 9:5* or *Deut. 4:9* (interpreted as a command to maintain one’s health) but is rather rabbinic (Lehem Mishneh on *M.T. Hilkhot De’ot* 3:1). In any case, people who injure themselves are not punished specifically for doing that, but they may be punished at the hands of Heaven (*Tosefta Bava Kamma* 9:11), and rabbinic courts may inflict disciplinary flogging (*מכת מרדות*) for injuring oneself (*M.T. Hilkhot Rotzeah* 11:5; *S.A. Hoshen Mishpat* 420:31; 427:10) – understandable, but more than a bit ironic! See “Hovel,” *Encyclopedia Talmudit* 12:681f. (Hebrew).

The prohibition against suicide is not recorded in the Talmud itself. The post-talmudic tractate, *Semahot* (Evel Rabbati) 2:1-5 serves as the basis for most of later Jewish law on suicide, together with *Genesis Rabbah* 34:13, which bases the prohibition on *Gen. 9:5*. Cf. *M.T. Hilkhot Rotzeah* 2:3; *Hilkhot Sanhedrin* 18:6; *S.A. Yoreh De’ah* 345:1ff. See “Suicide,” *Encyclopaedia Judaica* 15:489-491.

<sup>6</sup> *B. Sanhedrin* 74a.

<sup>7</sup> *B. Avodah Zarah* 18a; *S.A. Yoreh De’ah* 339:1 (with gloss).

<sup>8</sup> *2 Sam. 17:23*. See Irving J. Rosenbaum, *The Holocaust and Halakhah* (New York: Ktav, 1976), p. 36 and p. 162, n. 21, for a discussion of the origins of this maxim. Burying suicides outside the cemetery: *M.T. Hilkhot Aveilut* 1:11; *S.A. Yoreh De’ah* 345:1 – or at its edge: Responsum no. 763 of Rabbi Solomon ben Abraham Adret (the “Rashba,” c. 1235-c. 1310).

<sup>9</sup> *B. Gitin* 57b.

defense of Judaism<sup>10</sup> or as a way of avoiding the temptation to convert under torture.<sup>11</sup> Later Jewish law has taken this yet further: by narrowing the definition of a suicide to those who took their lives with competence of mind and freedom of will, modern authorities have maintained that those who suffered, or could be presumed to have suffered, from temporary insanity do not fall into the category of willfully committing suicide and are therefore permitted a normal Jewish burial.<sup>12</sup>

This distinction between the status of suicide itself and what one does with the body of a suicide *post facto* has important implications for assisted suicide. As our colleague on the Committee on Jewish Law and Standards, Mr. Frederick Lawrence, has pointed out, one must distinguish *justification* from *excuse*. If suicide is permissible, as it is in American law, a person who committed suicide would be justified in doing so, and an accomplice might or might not share in that justification. Hence the current debate over assisted suicide in the American courts and in state referenda.

In Jewish law, though, suicide is a criminal act except for the specific situations mentioned above. It is only in those exceptional cases that a justification for suicide exists; in all others the principal can at best have an excuse that does not render the act permissible but may mitigate punishment. The accomplice may suffer too. The aide's duress, however, is separate and apart from the principal's suffering, and so the aide's excuse to mitigate punishment must be judged independently. Indeed, while sometimes that excuse may be compelling, as in cases where the aide acted at the patient's express request to end his or her own suffering despite having the advantages of full medical and social support, in cases at the other end of the spectrum the aide may have acted to stop the medical bills and the need to care for the patient, perhaps even contrary to the desires of the patient. In no case, though, does the accomplice have a *justification* for assisting in the suicide. Even if the principal had a valid justification for committing suicide, the aide does not share in that justification and is therefore fully liable for the violations committed by assisting the suicide.

Suicide itself, then, remains forbidden by Jewish law except in the dire circumstances of martyrdom. Even then, a poignant ruling from the Holocaust indicates that suicide is to be avoided if at all possible. Rabbi Ephraim Oshry permitted a man who was to be tortured by the Nazis to force him to identify the whereabouts of other Jews to commit suicide lest he betray those other Jews, but Rabbi Oshry did not permit this ruling to be published for fear that it would undermine the commitment to life of the other Jews of the Kovno ghetto, and, other authors, both during and after the Holocaust, have taken pride in the small number of Eastern European Jews who committed suicide in the midst of the Nazi terror.<sup>13</sup> Moreover, Rabbi Oshry was ruling in a case where the person, were he not to commit suicide, faced the prospect of endanger-

<sup>10</sup> B. Sanhedrin 74a-74b. Cf. M.T. Hilkhot Yesodei Torah, ch. 5; S.A. Yoreh De'ah 157:1.

<sup>11</sup> E.g., Tosafot on B. Avodah Zarah 18a, s.v. וראל; Tosafot on B. Gittin 57b, s.v. קפצו.

<sup>12</sup> *Kol Bo 'al Aeilut*, p. 319, sec. 50; Yehiel M. Tuchinski, *Gesher HaHayyim* (Jerusalem: Solomon, 1960), 1:271-273; Isaac Klein, *A Guide to Jewish Religious Practice* (New York: Jewish Theological Seminary of America, 1979), pp. 282-283 (but note the mistake in citing the passage from *Gesher HaHayyim*: it should be 1:271-273, as noted above, not 1:71-73, as printed there). This may be based on an earlier source – namely, B'samim Rosh no. 345 – claiming to be the opinion of the much-respected Rabbenu Asher (the “Rosh,” c. 1250-1327), who there permits full Jewish burial of people who commit “suicide because of a multiplicity of troubles, worries, pain, or utter poverty.” That source, even if accepted as authentically the opinion of Rabbenu Asher, does *not* permit committing suicide in the first place, and neither do the later Jewish authorities cited above; they only permit normal Jewish burial after the fact.

<sup>13</sup> See Rosenbaum, *The Holocaust and Halakhah*, pp. 35-40.

ing the lives of others; those are not the circumstances in the vast majority of cases in which the contemporary question is being raised.<sup>14</sup>

In sum, then, the tradition prohibits suicide except as an act of martyrdom. Contemporary medical cases that raise the question anew clearly do not fit into that exception: the people involved ask to die in response to the excruciating pain of their illness, not in fear of being tortured by interrogators or forced to convert to another religion. Their suicide, then, would not be justified, even if people who violate this law would retroactively be permitted a traditional Jewish burial.

### *B. Assisted Suicide*

Since suicide itself is prohibited, aiding a suicide is also forbidden. The grounds for that prohibition depend upon how the assistance is administered.

Sometimes the aide provides the means for the patient to commit suicide but is not involved in any other way. In some typical cases, the assistant hands an overdose of pills to the patient or sets up a machine so that the patient can administer a lethal substance intravenously. Once supplied the means to commit suicide, the patient acts completely on his or her own.

In such cases, the helper minimally violates Lev. 19:14, “Do not put a stumbling block before the blind,” for the Rabbis interpreted that verse to prohibit moral stumbling blocks as well as physical ones.<sup>15</sup> The aide is guilty at least of misleading the patient to think that a forbidden act is permissible, of placing a stumbling block before a patient who is morally blinded by his or her medical condition to be able to see the authority and importance of the Jewish norm prohibiting suicide.<sup>16</sup>

Worse, the aide in such circumstances makes it possible for the patient to do what is forbidden. In talmudic terminology, the aide is “strengthening those who commit a sin” or “aiding those who commit a sin,” both of which are forbidden.<sup>17</sup> Such a person is even more culpable than the one who simply misleads a person into thinking that the

<sup>14</sup> While it is distinctly uncomfortable to second-guess a rabbi ruling in those dire circumstances, one must also note, as Rabbi Aaron Mackler has pointed out to me, that Rabbi Oshry’s decision is, in the end, one rabbi’s ruling, and since it extends permission to commit suicide to cases beyond the well-established exceptions of martyrdom, it may simply be an erroneous ruling. I would prefer to deny its relevance as a precedent on the basis of the important distinctions between his case and ours – namely, that the man in his case faced the prospect of endangering the lives of others through no fault of his own, while the cases we are discussing include no such factor.

<sup>15</sup> The prohibition of putting a stumbling block before the blind: Lev. 19:14. The rabbinic extension of that prohibition to apply not only to the physically blind, but to the morally blind as well: B. Pesahim 22b; B. Moed Katan 5a, 17a; B. Bava Mezia 75b; etc. (The principle is also applied to prohibit intentionally giving bad advice to people [see Sifra on this verse] and to those who are theologically blind in that they might be tempted to worship idols [B. Nedarim 42b].)

<sup>16</sup> If the aide additionally convinced the person to commit suicide, the aide may be considered an “inciter” (מסית). One who incites another person to worship idols is subject to death by stoning (Deut. 13:7; M. Sanhedrin 7:4, 10). In the case of other sins, though, the defendant can invoke the talmudic principle (B. Bava Kamma 56a), דברי הרב ודברי התלמיד מי שומעין? “When the words of the Master and the words of the student [conflict], to whom does one listen?” – the Master here being God and the student a human being. According to the Talmud (B. Sanhedrin 29a), however, those who incite other Jews to engage in idolatry cannot avail themselves of this defense because with regard to that offense the Torah (Deut. 13:9) specifically says, “Show him no pity or compassion, and do not shield him.” Thus while inducing someone to commit any other sin – like suicide – is certainly not laudable behavior, it is not culpable in law because each of us is responsible for knowing right from wrong and for resisting lures to do the wrong.

<sup>17</sup> “Strengthening one to commit a sin”: B. Nedarim 22a; B. Gitin 61a. “Helping one to commit a sin”: B. Avodah Zarah 55b. I would like to thank Rabbi Ben Zion Bergman for alerting me to this point.

act is permissible because the culprit in this case actively makes it possible for a person to commit the sin.

The aide in such cases might also be construed to be liable for injuring the patient indirectly (גרמה). One who does that is retroactively free of monetary liability for any harm done, but *ab initio* nobody may deliberately cause harm to another, even indirectly.<sup>18</sup>

Furthermore, one who harms another indirectly, while free of liability in human courts, is culpable in the judgments of Heaven. In fact, one specific case that the Talmud includes in this category concerns a person who placed deadly poison before the animal of a neighbor; if divine retribution is to meted out to a person who threatens the life of an animal in that way, God would undoubtedly be even more upset with someone who puts the life of a human being at risk in that way.<sup>19</sup>

If the assistant not only provides the patient with the means to kill himself or herself, but also participates in the process, the liability of the assistant depends upon how the help is given. If the aide directly causes the wound that eventuates in the patient's death, then she or he violates Jewish laws prohibiting the deliberate injury of another. Even if the victim asks to be injured, others may not do that, and they are fully liable for the injury.<sup>20</sup> This would be true even if the patient willingly took part in the act. So, for example, if a physician compromises the life of a patient by administering a given dose of medication or poison intravenously but leaves it to the patient to push a lever to insert the rest of the dose necessary to bring about death, the physician is liable both for misleading the patient morally and for injuring him or her.

Finally, some forms of assisted suicide amount to murder. So, for example, if the aide shoots the victim with a gun or knowingly administers a lethal dose of a medication or poison with the intent of bringing about the person's death, such acts clearly constitute murder, even though the motive was, by hypothesis, benign.

Note that these Jewish arguments against suicide and assisted suicide differ radically from the reasons invoked by many Christian opponents of euthanasia. Some Christians base their opposition on the redemptive character of suffering. Euthanasia is unwarranted, the argument goes, because pain is itself salvational, symbolized most graphically by the crucifixion of Jesus. Other Christian voices oppose any medical intervention, including those intended to reduce pain, as an improper human intrusion onto God's prerogatives of deciding when to inflict illness and when to bring healing.<sup>21</sup>

Judaism's opposition to euthanasia cannot be grounded in either of these lines of argument. For Judaism, the pain of disease is not in and of itself a good thing to be sustained for its own sake. *Retroactively*, when trying to explain how God could be just and yet innocent people suffer, the Rabbis suggested, among other approaches, that the pain of the innocent may be "afflictions of love" (יסוריין של אהבה) designed by God either to teach the person virtues of patience and faith or to punish the person in this life for his or her small number of sins so as to make his or her reward in the next life pure and all

<sup>18</sup> See B. Bava Batra 22a, and see Tosafot there.

<sup>19</sup> B. Bava Kamma 56a, which refers, among other such cases, to the one in B. Bava Kamma 47b concerning the person who places poison before a neighbor's animal.

<sup>20</sup> M. Bava Kamma 8:7 (92a); M.T. Laws of the Injury and Damage 5:11; S.A. Hoshen Mishpat 421:12.

<sup>21</sup> For a sampling of varying religious approaches to assisted death, including my own more extensive treatment of Jewish perspectives on this issue, see *Must We Suffer Our Way to Death? Cultural and Theological Perspectives on Death by Choice*, eds. Ronald P. Hamel and Edwin R. Dubose (Dallas: Southern Methodist University Press, 1996).

the greater,<sup>22</sup> but that doctrine was never used before the fact to justify withholding pain medication from the suffering. On the contrary, the Talmud records that Rabbi Hiyya bar Abba, Rabbi Yohanan, and Rabbi Eleazar all say that neither their sufferings nor the reward promised in the World to Come for enduring them are welcome – that is, they would rather live without both the suffering and the anticipated reward.<sup>23</sup> Moreover, from its earliest sources, Judaism has both permitted and required us to act as God’s agents in bringing healing or, failing that, in reducing pain.

I sympathize enormously with patients going through an agonizing process of dying, and in cases of irreversible, terminal illness, I have taken a very liberal stance on withholding or withdrawing life-support systems, including artificial nutrition and hydration, to enable nature to take its course. I would also permit the use of any amount of medication necessary to relieve pain, even if that is the same amount that will hasten a person’s death, as long as the intention is to alleviate pain.<sup>24</sup> The Committee on Jewish Law and Standards has validated that stance as well as that of Rabbi Avram Reisner, who permits withdrawing machines and medications from the patient but not withholding or withdrawing artificial nutrition and hydration, and who permits using large doses of morphine to relieve pain up to, but not including, the amount that poses a risk to the patient’s life.<sup>25</sup>

The Jewish tradition takes mental illness seriously as illness,<sup>26</sup> and so some might ask: What is the difference between administering a large dose of morphine for reducing physical pain and using that same dosage in response to a person saying, “I want to end this”? In other words, why is it the case that physical pain counts as sufficient ground to justify doses of morphine that may risk death while mental distress does not?

<sup>22</sup> M. Avot 2:16; B. Berakhot 4a; B. Eruvin 19a; B. Ta’anit 11a; B. Kiddushin 39b; Genesis Rabbah 33:1; Yalkut Shimoni to Ecclesiastes, 978. Among later Jewish philosophers, Saadia is the first to affirm this doctrine (*Book of Opinions and Beliefs*, books 4 and 5), while Maimonides rejects it (*Guide for the Perplexed*, pt. 3, chs. 16-23).

<sup>23</sup> B. Berakhot 5b. I would like to thank Rabbi Baruch Frydman-Kohl for suggesting the use of this source here.

<sup>24</sup> See Rabbi Elliot N. Dorff, “A Jewish Approach to End-Stage Medical Care,” *PCJLS 86-90*, pp. 65-126.

<sup>25</sup> Rabbi Avram Israel Reisner, “A Halakhic Ethic of Care for the Terminally Ill,” *PCJLS 86-90*, pp. 13-64; and, especially, Avram Israel Reisner, “Mai Beinaihu?” *PCJLS 86-90*, pp. 127-129.

In Rabbi Reisner’s view, I would imagine, if the physician knowingly administers enough morphine to kill a person, the physician would be liable for murder, even though his or her primary intent was to reduce pain. For me, in contrast, the primary intent of the physician to reduce pain makes such a case not one of injury at all, little less murder, but rather one of permissible benefit. Therefore the physician would not be liable for violating even the prohibition against indirect injury but would rather be carrying out his or her mandate to heal.

This case must be distinguished from acquiescing to a patient’s request to die, even when the death is requested for the express reason of relieving pain. To kill oneself, or to ask others to help in doing so, is forbidden in Jewish law, and so if that is the intent, it is illegitimate. In practice, this difference in motive may translate into the amount of medication administered. Specifically, in light of the fact that within a given range of dosages of morphine doctors never know whether a given patient will die or not, these cases never fall into the talmudic category of פסיק רישיה ואל ימות (“Can you cut off the chicken’s head and it will not die?” [B. Shabbat 75a; see Rashi on this principle on B. Sukkah 33b]), for within that range the result is never inevitable. Therefore doctors’ attempt to relieve pain is legitimate, in my view, even if they fear that the amount they need to use in the last stages of life may be crossing the line into a fatal dosage for a given patient, for they are still within the range where they do not know that for certain. On the other hand, to administer a dosage that beyond all reasonable doubt will kill the person is to commit murder, even when the stated intent of the physician is to relieve pain and even if the patient requests it. (I want to thank Rabbi Gordon Tucker for calling my attention to the need to make this distinction clearly.)

<sup>26</sup> See, for example, Moshe Halevi Spero, *Judaism and Psychology: Halakhic Perspectives* (New York: Ktav, 1980). I would like to thank Rabbi Mayer Rabinowitz for raising the question discussed in this paragraph.

The answer is that in these cases physical pain occurs against the will of the patient and the morphine is therefore a therapeutic response sanctioned by Jewish law and theology, while “I want to end this” is an expression of the individual’s will, a desire that it is illegitimate to fulfill according to Jewish law and theology. We do indeed need to respond to the patient’s mental distress, but our response must be in the form of supplying sufficient pain medication, treating clinical depression if that is present, and, most importantly, providing the personal and social support that patients in these circumstances direly need.

Even though Jewish law, then, goes quite far in permitting terminally ill patients to die with whatever palliative care they need and without any further medical interference, it does not permit suicide or assisted suicide. The tradition bids us instead to maintain a firm line separating permissible withholding and withdrawal of medical efforts, on the one hand, and illegitimately helping a person actively to take his or her own life, on the other. To fail to do that would be to violate Jewish law and to destroy creatures belonging to God.

### **The Contemporary Factors that Sully Arguments for Euthanasia**

We have expounded express Jewish law on the issues involved in assisted suicide. Sometimes contemporary circumstances or values argue for changing the stated law as it has come down to us, and we in the Conservative movement are open to considering such challenges. In this case, though, several aspects of the current situation instead present additional arguments for retaining the traditional position prohibiting assisted suicide. All of these factors invoke parts of Jewish law or the broader Jewish tradition. These, then, are not simply general concerns, but Jewish ones, and hence they are part of what should be our understanding and articulation of Jewish law on this issue:

#### *Theological*

First and foremost, as already indicated above, theological concerns underlie the Jewish legal position forbidding assisted suicide. The entire discussion of assisted suicide in American courts, in fact, calls into play two of the sharpest differences between American secular perspectives and Jewish views.

America’s ideology, as expressed in its economic system, its philosophy (especially the distinctly American school of pragmatism), in the media (where it is almost always the young and the able-bodied that are pictured), and even in contemporary reforms in American welfare legislation, would have us think of ourselves in utilitarian terms, where our worth is a function of what we can do for ourselves and others. American attitudes and laws thus permit suicide, especially when a person can no longer do anything useful for herself or himself or others. Judaism, in contrast, requires us to evaluate our lives in light of the ultimate value inherent in us because we were created in God’s image. Jewish ideology and law therefore strongly oppose committing suicide or assisting others in doing so, for life is sacred regardless of its quality or usefulness.

Second, in American law and ideology, as expressed in the Declaration of Independence and in American constitutional law and court rulings, we each own our own bodies and, short of harming someone else, we all inherit the liberty to do with our bodies what we will. This tenet, according to the interpretation of the Ninth Circuit Court of Appeals, has made it part of every American’s liberty to determine the course of his or her medical care, even to the point of committing suicide and asking others to



assist them in doing so. Suicide itself is a legal act in all fifty states.<sup>27</sup>

In sharp contrast, according to Judaism God created and therefore owns the entire universe,<sup>28</sup> including each person's body, and we therefore each have a fiduciary responsibility to God to preserve our life and health. We certainly do not have the right unnecessarily to destroy or damage God's property, including even God's vegetation and inanimate property.<sup>29</sup> This makes suicide an act of theft from God, a violation of God's prerogatives, and, indeed, a trespass of the proper boundaries between God and human beings.<sup>30</sup> Rabbi Yehiel M. Tuchinski, in his restatement of the laws of death and mourning entitled *Gesher HaHayyim (Bridge of Life)*, puts these points starkly:

The sin of one who murders himself is greater than that of one who murders someone else for several reasons: First, through this murder he has left no possibility for any remorse and repentance. Second, death (according to Talmud Bavli Yoma 86, etc.) is the greatest form of repentance, but he, on the contrary, has committed through his death the greatest sin, namely, murder. Third, through his act he has made clear his repudiation of his Creator's ownership of his life, his body, and his soul: he has denied the simple idea that he did not participate in his creation at all, but [thinks] rather [that] his entire identity is exclusively within his power to sustain, to reproduce his existence or to destroy it. He is like one who actively [and intentionally] burns a scroll of the Torah, for our Sages, may their memory be blessed, compared the creation of the soul to a scroll of the Torah that [now] has been burned and he must therefore face judgment in the future for this as well.

He is also among the unequivocal deniers of the continued existence of the soul and of the existence of the Creator, may His name be blessed, and of the future judgment after the departure of the soul [from the body].<sup>31</sup>

<sup>27</sup> As Rabbi Aaron L. Mackler has pointed out to me, the fact that American states do not criminalize suicide may be a function of the medicalization of suicide in our time rather than recognition of a legal right. That is, instead of putting those who attempt suicide in prison, we sedate them, treat them for depression, and restrain them if necessary. That does not mean, though, that suicide is a legal right, for if it were, we would not try to prevent people from taking their lives. The Ninth Circuit, though, has interpreted suicide, and therefore also assisting in suicide, as a legal privilege embedded in the Fourteenth Amendment's guarantee of liberty. Presumably, then, the only reason for trying to prevent people from committing suicide is that we doubt that they have the mental competence required by law to make that decision.

<sup>28</sup> See note 3 above.

<sup>29</sup> This includes even inanimate property that "belongs" to us, for God is the ultimate owner. This is the law of *בל תשחית*, the prohibition of destroying the world when human need does not require that. Cf. Deut. 20:19-20; B. Bava Kamma 8:6, 7; B. Bava Kamma 92a, 93a; M.T. Laws of Murder 1:4, where Maimonides specifically invokes this theological basis for the law against suicide; M.T. Laws of Injury and Damage 5:5; Sefer Ha-Hinnukh, Commandment 529; S.A. Hoshen Mishpat 420:1, 31. See Earl Schwartz and Barry D. Cytron, *When Life is in the Balance* (New York: United Synagogue, 1993).

<sup>30</sup> As Rabbi Myron Geller pointed out to me, one could conclude the exact opposite – namely, that since God inflicted the patient's illness, aiding the person in committing suicide would be just assisting God in bringing about what is presumably God's intended goal. While that is certainly logical, it is not the line of reasoning that the Jewish tradition has followed. On the contrary, Jewish law, as noted above, has consistently denied people the right to commit suicide or assist others in that path.

<sup>31</sup> Yehiel M. Tuchinski, *Gesher HaHayyim* (Jerusalem: Solomon, 1947, 1960), pp. 269-270 [Hebrew; this is my translation]. He adds there that the person who commits suicide "is like one who flees to a place where the

Contemporary Jews may not share all of Rabbi Tuchinsky's traditional beliefs about life after death enumerated here, but even a comparatively liberal view of Judaism must, in order to remain recognizably Jewish, begin with the tenet that the body belongs to God.<sup>32</sup>

The American and Jewish traditions, then, begin with radically disparate assumptions about the worth and ownership of our bodies. These variances sometimes lead the two traditions to different prescriptions for the care of the dying. Even when the two traditions agree on a given course of action, they often arrive at their respective positions using different arguments with different burdens of proof.

Specifically, since the American tradition of pragmatism and hedonism leads us, as Americans, to value life only if we can do things and enjoy life, a physically or mentally compromised life is not considered worth living. Moreover, each person has the right to determine the fate of his or her body. It is this perspective that undergirds requests for suicide in America, the legal grounding for those requests as expressions of autonomy and liberty, and the sense of compassion that those who assist in a suicide feel.

The Jewish tradition, in contrast, calls upon us to evaluate life from God's perspective. That means that the value of life does not depend on the level of one's abilities; it derives from the image of God embedded in us. The tradition thus strongly affirms the divine quality of the life of disabled people, even though everyone would undoubtedly prefer not to be disabled. Indeed, our tradition demands that, upon seeing a disabled person, we bless God for making people different, thus boldly reasserting the divine quality of such lives.<sup>33</sup> We certainly must do everything in our power to dissuade anyone thinking of committing suicide because of disability from doing so. Embedded in the arguments for assisted suicide, though, is an assumption frighteningly close to an assertion of the worthlessness of disabled people, for the terminally ill are also disabled. In line with its view of the disabled, then, the Jewish tradition requires that we recognize the divine quality of people in the last stages of life, regardless of the quality of their lives.

Moreover, even when life is not ideal and we question its divine dignity and its character as a gift, we lack the authority to destroy it because the body belongs to God, who alone has the right to terminate it. In other words, in the American setting arguments for permitting assisted suicide on the basis of autonomy have been taken very seriously, and in its worst forms these arguments are based on a culture of selfishness that diminishes human life by valuing only those who can be productive and enjoy it fully. The clear stance of Judaism, on the other hand, sets strict limits to the autonomy we have in this arena, given that we are God's creatures and agents, and it strongly affirms the value of human life regardless of its usefulness or quality. We might ask why a compassionate God would deny us the authority to take our lives when we can no longer function. Moreover, according to Maimonides, we must keep our bodies in good

---

hand of the government will catch him and can bring him back to this place with additional punishment also for his escape" – an understandable metaphor in his theology, but one that unfortunately makes life a prison sentence!

<sup>32</sup> I say this even though one Reform writer has maintained the contrary, claiming that contemporary Jews overwhelmingly believe that their body is their own and thus refuse to abide by medical directives based on God's ownership of our bodies. See Matthew (Menachem) Maibaum, "A 'Progressive' Jewish Medical Ethics: Notes for an Agenda," *Journal of Reform Judaism* 33:3 (summer 1986): 27-33.

<sup>33</sup> B. Berakhot 58b; M.T. Laws of Blessings 10:12. For an excellent account of these laws and the theology and practice surrounding them, see Carl Astor, "...Who Makes People Different?": *Jewish Perspectives on the Disabled* (New York: United Synagogue, 1985).

health so that we may serve God,<sup>34</sup> and if we cannot do that any longer, it would seem that God should allow us to curtail our lives. While we can certainly challenge God in either of these ways, the tradition is unanimous in asserting that God does not give us that authority, that even when people are incapacitated by, say, a stroke, God forbids us to commit suicide or to assist in one.<sup>35</sup>

In Judaism's perspective, then, it is not a compassionate act at all to assist a person in taking his or her own life because doing that would make both oneself and the person committing suicide violators of some of the most fundamental values and laws of Judaism, namely, those insisting that we not murder and that, on the contrary, we set aside virtually all of Jewish law in order to save lives.<sup>36</sup> We all sin, of course, but these are the most serious sorts of sin, ones that it is anything but compassionate to help someone do.

### *Social/Economic*

Several aspects of the current social and economic contexts make the prospect of permitting assisted suicide all the more troubling than it is inherently. One element lurking in the background of this discussion is the history of condoned assisted suicide in Holland, where there has been a wide range of rationales that have prompted physicians to help people end their lives. In the United States, Dr. Jack Kevorkian has similarly assisted people in all sorts of physical conditions to commit suicide, most recently in response to a person's chronic fatigue syndrome. He has admittedly sensationalized the whole subject, and it is not wise or fair to judge the issue on the basis of his actions alone. Moreover, I am not usually convinced by slippery slope arguments, for the essence of moral discernment is that we learn to distinguish cases.<sup>37</sup> Nevertheless, the experience in Holland and Dr. Kevorkian's cases have both clearly demonstrated just how slippery this particular slope is. Even though there are undoubtedly some situations where the case for assisting a suicide may seem compelling, we must prohibit assisted suicide altogether in order to prevent diminishing the value of life in the public eye and in public policy.

Another current factor that makes any opening to assisted suicide dangerous is the push to save money in health care. Motivated largely by how that economic agenda will

<sup>34</sup> M.T. Laws of Ethics (Hilkhot De'ot) 3:3; see also 4:1.

<sup>35</sup> The argument that assisting a suicide would be to further God's purpose in making the person sick in the first place is specifically rejected by Rashi and by Tosafot. Commenting on the Talmud's statement (B. Bava Kamma 85a) that Exod. 21:19 (ורפא ירפא) serves as permission for physicians to heal, Rashi (s.v., נתנה רשות לרפואה) says, "And we do *not* say that the Merciful One struck [the patient] and he [the physician illegitimately] heals." Tosafot there (s.v. שניתנה) points out that one can derive authorization for the physician to heal from just the first of the words in the phrase in Exod. 21:19, ורפא ירפא, and so why does the Torah state the verb "to heal" in two different forms? Because if it were only stated once, Tosafot suggests, one might think that the physician may heal only those maladies inflicted by human beings but not those inflicted by God; the double presence of the verb in the biblical verse indicates that the physician has permission to heal even illnesses inflicted by God.

<sup>36</sup> This is the law of פקוח נפש, saving a life, whether one's own or someone else's; see B. Sanhedrin 74a and B. Yoma 85b, and see notes 3-6 above and the text for those notes. In American law, by contrast, until recently when "Good Samaritan laws" were passed by many states, you could actually be sued if you tried to save a person in good faith and some injury resulted, and to this day no American law requires that you go out of your way to save a life. This is, in my view, American individualism at its worst.

Along the same lines, while aiding a suicide is against the law in most states, committing suicide itself is not a violation of the law, another manifestation of American individualism. (Most life insurance policies, though, become null and void if the insured commits suicide.)

<sup>37</sup> See my short essay, "Moral Distinctions," *Sh'ma: A Journal of Jewish Responsibility*, 21/401 (16 Nov. 1990): 6-8.

affect care at the end of life, the American Medical Association, in briefs to the Supreme Court, strongly opposed legalizing assisted suicide. They were justifiably worried about what such action would do to both the patient and the physician, for, especially under conditions of managed care, *permission* to take one's own life and to enlist the aid of others in doing so will quickly become all but an *obligation* to end the lives of those who have no reasonable hope for cure. Doctors, in the worst scenario, will be pressured by hospitals or health insurance companies to convince their patients that suicide is the best option, not only because it will end the patient's pain and thus serve the best interests of the patient, but also (and maybe primarily) because it will save the hospital or insurer money. The role of the physician as the patient's advocate thus becomes severely compromised.

The same considerations apply to the patient's family members. If assisted suicide becomes a guaranteed constitutional right in American law, patients will feel all the more pressed by their families to end their lives rather than drain the family's finances in keeping them alive. If Jewish law is also interpreted to permit assisted suicide, both the social and the religious setting in which American Jews will be making these decisions will argue for the legitimacy of such pressure, to the point that patients or family members who resist the suicide option will eventually feel that *they* are being unreasonably obstinate, that "normal" people would just end their lives once they cannot be cured. Indeed, in the context of such changed social expectations, even when family members do not want the patient to commit suicide and say that as clearly as they can, patients may feel that their families want them to end their life; my relatives, the patient may think, are just trying to be nice, but they really want me to end my own agony and theirs. Legitimizing assisted suicide thus dangerously shifts the burden of proof: currently those who want to take a life must justify that course of action, but if assisted suicide becomes legal, those who refuse it will need to show why.

The economic arguments in support of assisted suicide are not completely frivolous. In the United States people spend more on their health care in the last six months of life than they do throughout the rest of their lives. About 2.5 million Americans die each year, and more than fifty percent of those deaths occur in an acute care hospital.<sup>38</sup> Surely the money could be better spent, the argument goes, if people were given the choice and aid to die.

While the economic factor is real, assisted suicide is not the appropriate response. Hospice care is. In "hospice" care, all concerned recognize that the patient's disease is incurable, and the course of medical care is therefore not directed to aggressively and invasively trying to prolong life, but rather to the goal of providing comfort and pain relief. In hospice care, patients spend most of their last months of life at home, with some outpatient visits along the way. That form of care is not only more medically realistic and inexpensive, but more humane. Hospital care, after all, puts the patient in a strange, antiseptic setting where she or he is subjected to the hospital schedule, to repeated and possibly painful medical procedures, and to the loneliness of having the company of only occasional visitors. Hospice care, by contrast, puts the patient at home amidst family and friends, where pain medication can be administered when and how the patient feels most comfortable.

Hospice care should therefore be suggested to most people afflicted with terminal, irreversible illnesses. Moreover, contrary to current practice, patients need not first endure initial stays in intensive care units where improbably successful or knowingly futile aggres-

<sup>38</sup> See Terrence Monmaney, "How We Die May Be Behind Assisted Suicide Debate," *Los Angeles Times*, 8 Jan. 1997, pp. A1, A9.

sive care is attempted; they should rather be provided hospice care as soon as it becomes clear that the odds of curing the patient are slim to nil.

Along with hospice care for the patient, respite care can and should be provided for family caregivers. The bill for hospice and respite care combined will pale by comparison to what we are spending for people's last weeks and months now, and the patient will gain in dignity and comfort in the bargain.

### *Medical*

Possibly the most common and compelling ground suggested for justifying assisted suicide is to relieve a patient of racking pain. This would be both understandable and compassionate if there were no other alternative, but doctors today have ample means for controlling almost all physical pain. A very small number of patients (perhaps one in 10,000) need dosages of morphine that will make them unconscious, and in those cases patients may have to choose between some amount of pain with consciousness or losing consciousness as all pain is quelled. That is a legitimate choice that should be offered to patients.

American physicians, though, often do not offer or employ sufficient pain medication. Reasons for this vary. Sometimes doctors honestly do not know how much morphine to administer, for people differ in size and in their thresholds of pain. That is an understandable reason for failing to employ enough pain medication.

Some doctors, though, say they minimize pain medication for fear of inducing drug addiction. That is a proper concern in general, but a truly bizarre one in the case of terminally ill patients. Other doctors have a "John Wayne attitude" toward pain, claiming that good, morally worthy patients grin and bear their pain rather than complaining about it and requesting medication to quell it. Even worse, some of this is socio-economic: centers that treat primarily white patients provide pain relief more adequately than those treating minority patients, producing, on a percentage basis, many more requests for assisted suicide among the latter.

Perhaps the most pervasive root of this refusal to control pain is the American culture of medicine itself. American medicine, far more than medicine in other Western countries, is based on technological cures,<sup>39</sup> and when those do not work, doctors consciously or subconsciously avoid the patient who symbolizes the failure of their methods. They do not bother to administer pain relief either, for that is either not part of their goals in the first place (the "John Wayne attitude") or a secondary goal to be invoked only when they have failed to cure. Whatever the basis for this pattern of supplying insufficient pain medication, physicians should certainly seek to control pain rather than acquiesce to a request to die.<sup>40</sup>

Requests for aid in committing suicide stem from another medical phenomenon as well: far too many people with irreversible, terminal illnesses are subjected to futile, aggressive treatment. As indicated earlier, about 2.5 million Americans die each year, and fifty percent of those deaths occur in an acute care hospital. That high level of "hospitalized death," researchers say, suggests that too few terminally ill patients are taking advantage of hospice care.

---

<sup>39</sup> For a fascinating comparative study of how the same diseases are treated differently in the United States, Great Britain, France, and Germany as a reflection of their national cultures, see Lynn Payer, *Medicine and Culture* (New York: Henry Holt, 1988).

<sup>40</sup> On the other hand, in cases where patients are not seeking to die and choose to endure some pain in order to be able to remain conscious, that request must be honored. It is *permissible*, in my view, to use whatever amount of medication is necessary to alleviate pain, but it is *not required* to relieve pain at the cost of consciousness if the patient chooses instead to remain conscious with some degree of pain.

Moreover, as an editorial in the *Annals of Internal Medicine* maintained, far too many people are finding that their express desire for life support to be withheld or withdrawn, as stated in their living wills, is being ignored by “physicians who are so preoccupied with the preservation of life that they can no longer see the broader human context of their work.” Similarly, the largest study to address the human context of dying, known by the acronym SUPPORT, involves more than 10,000 seriously ill people at five medical centers in five cities. A chief finding of that study was that about half of all patients spent the end of life in what the researchers termed “an undesirable state,” including a week or so in an intensive care unit, having a physician who was unaware of wishes not to be resuscitated, or being in serious, insufficiently treated pain. “I believe the enthusiasm for physician-assisted suicide is driven, in part, by the fear that we will receive overly aggressive care at the end of life and that our suffering may be prolonged,” said Dr. William Knaus, an internal medicine specialist at the University of Virginia Medical School and a coordinator of SUPPORT.<sup>41</sup> Clearly, if that is what is prompting a request for assistance in suicide, the appropriate response is for physicians conscientiously to make themselves aware of their patients’ advance directives and then to adhere to a patient’s desire to remove impediments to the natural process of dying.

### *Psychological*

While some requests for assistance in dying are based on the patient’s excruciating pain, others are rooted in the hopelessness of the situation. We are, after all, mortal, and some diseases cannot be cured. When afflicted with such a disease, patients cannot realistically hope to return to the life they knew. They instead face the prospect of continued suffering and debilitation until death, and some would prefer to end things quickly to avoid the suffering and degradation of the last stages of their illness.

Such cases are precisely the ones that have produced the term “mercy killing” to describe active euthanasia, and, indeed, the hopelessness embedded in the medical situation of such people often makes their requests for assistance in dying emotionally compelling. Nevertheless, we should respond to such cases by doing things other than assisting people to commit suicide.

Physicians or others asked to assist in dying should recognize that people contemplating suicide are often alone, without anyone who takes an interest in their continued living. Rather than assist the patient in dying, the proper response to such circumstances is to provide the patient with a group of people who clearly and repeatedly reaffirm their interest in the patient’s continued life.

My mother once had a roommate in a nursing home who was literally visited by nobody. She had one son who lived on the other side of the country and who called from time to time, but she had no other family or friends. Worse, some clothes her son sent her as a birthday gift were stolen by the night staff. Under such conditions of abandonment (and, in this case, violation), one can understand why people would wonder why they should continue to fight to live – indeed, why they should get up in the morning at all.

Requests to die, then, must be evaluated in terms of the degree of social support the patient has, for such requests are often withdrawn as soon as someone shows an interest in the patient staying alive. In this age of individualism and broken and scattered families, and in the antiseptic environment of hospitals where dying people usually find themselves,

<sup>41</sup> This paragraph is based on the article, “How We Die May Be Behind Assisted Suicide Debate,” by Terrence Monmancy, *Los Angeles Times*, 8 Jan. 1997, pp. A1, A9.

the mitzvah of visiting the sick (ביקור חולים) becomes all the more crucial in sustaining the will to live, for, as the tradition recognized, visitors aid the person psychologically, physically, and religiously. Thus the Talmud says this:

Rabbi Abba son of Rabbi Hanina said: He who visits an invalid takes away a sixtieth of his pain [or, in another version, a sixtieth of his illness]. . . .

When Rabbi Dimi came [from Palestine], he said: He who visits the sick causes him to live, while he who does not causes him to die. How does he cause this? . . . He who visits the sick prays that he may live, . . . [while] he who does not visit the sick prays neither that he may live nor die.<sup>42</sup>

The Talmud here is asserting two aspects of the spiritual elements of coping with illness. On a social plane, those who visit the sick help to shift the patient's focus from the pain and degradation of the illness to the joy of the company of friends and family. They thus take away a sixtieth of the pain of the illness. Visitors also reassure the patient that family and friends are keenly interested in his or her recovery or, if that is impossible, in his or her comfort. They also remind the patient of life outside the sick room and thereby re-enforce the patient's determination to live on. Visitors are thus instrumental in motivating the patient to follow a medical regimen of healing or palliation, however tedious or painful it may be, and so, in the Talmud's alternate reading, they effectively take away a sixtieth of the patient's illness itself.

As discussed above, hospice care, endorsed by both Rabbi Reisner and me, recommends itself for economic and medical reasons. It is perhaps best, though, in responding to the psychological pressures of the dying process. Much of the loneliness inherent in being confined to a hospital is eliminated when the patient instead is cared for at home. Family members cannot be expected to shoulder all of this burden; ביקור חולים remains an important imperative for friends, even when the patient is living at home. The very familiarity of the home setting, though, together with the increased chances it offers of providing the companionship of family and friends, makes hospice care clearly preferable to hospitalization when doctors cannot realistically expect to cure.

Visitors can affect the physical quality of patients' lives not only by buoying up their will to live, but also by attending to their physical needs. Thus the Talmud tells the following story:

Rabbi Helbo fell ill. Rabbi Kahana then went [to the house of study] and proclaimed, "Rabbi Helbo is ill." Nobody, however, visited him. Rabbi Kahana rebuked them [the disciples], saying, "Did it ever happen that one of Rabbi Akiba's students fell ill, and the [rest of the] disciples did not visit him?" So Rabbi Akiba himself entered [Rabbi Helbo's house] to visit him, and because they swept and sprinkled the ground before him [that is, cleaned the house and put it in order], Rabbi Helbo recovered. Rabbi Akiba then went forth and lectured: He who does not visit the sick is like one who sheds blood.<sup>43</sup>

<sup>42</sup> B. Nedarim 39b-40a.

<sup>43</sup> Ibid.

Taking physical care of the sick can include not only cleaning house, but shopping for groceries, doing laundry, taking over carpool duties, and seeing to the other needs of the patient's children. Depending upon the circumstances, it can also include more direct physical interventions like taking the patient for a ride in a wheelchair (if medically permitted), feeding the patient (if necessary), and attending to the patient's other physical needs.

Visitors affect the patient on a more religious plane as well. By praying for and with the patient, and by indicating that prayers are being offered in the synagogue on his or her behalf, visitors invoke the aid of God, the ultimate Healer. Jewish prayer is traditionally done in community, in part because Jewish sources maintain that communal prayer convinces God to grant a request more effectively than private prayer does.<sup>44</sup> Praying with the patient at bedside and for the patient in the synagogue thus throws the weight of the entire community behind the patient's own plea to God for recovery or, failing that, for comfort.

The medical hopelessness of people with a terminal, irreversible illness remains, and it violates our duty to tell the truth to try to deceive patients into believing otherwise. While some sources in our tradition justify such behavior in the name of buoying up a patient's spirits,<sup>45</sup> deception is generally not the way to do that. Patients usually have a sense of their medical prognosis, and so they do not believe those who tell them otherwise anyway. Moreover, lies can only lead to distrust, anger, and feelings of disrespect and abandonment. The last thing one wants to do is to infantilize patients: they already feel diminished in stature by their illness, and deception makes them feel further diminished, as if they were being treated as children (who, by the way, should also not be misled). Family and friends should clearly not appear at bedside with sullen faces, dwelling on the terrible prognosis. At the same time, they should not pretend that the medical situation is other than what it is.

The patient's spirits can be lifted substantially and appropriately, though, if family and friends concentrate on what can make the remainder of the patient's life meaningful. Some topics that should be raised are practical in nature. Specifically, if patients have not previously filled out a will or a living will, they should be asked to specify their wishes about the distribution of their property and their preferred course of medical treatment, respectively. Even though Jewish law forbids morose talk of death around a seriously patient for fear of undermining the patient's hope for recovery, it permits and even requires that relatives or friends insure that the patient has written a will and even allows saying the final prayer of confession before death (צדוק הדיוק). One should also be sure that the patient has made funeral and burial arrangements. To preserve the patient's will to live and to fight the disease, Jewish law mandates that one tell the patient that writing a will, making plans for burial, and saying the confessional prayer are being done just in case the patient does not recover, but many people who have done these things have subsequently recovered.<sup>46</sup>

Beyond these practical topics, visitors will buoy the patients' spirits by treating them as adults, respecting them enough to engage in conversation about the same adult topics that previously interested them – and even some that they had not previously explored. One of the most enlightening experiences of my early rabbinic career was teaching a series of classes on Jewish theology to residents of a Jewish nursing home. The group consisted completely of college graduates. Even though none of them had ever studied Jewish theology before, they had specifically asked for these classes

<sup>44</sup> B. Berakhot 6a; 7b-8a; J. Berakhot 5:1; cf. M.T. Laws of Prayer 8:1.

<sup>45</sup> Basil F. Herring quotes and discusses those sources in his book, *Jewish Ethics and Halakhah for Our Time* (New York: Ktav, 1984), ch. 2, entitled "Truth and the Dying Patient" (pp. 47-66).

<sup>46</sup> S.A. Yoreh De'ah 335:7; 338:1.



because they were sick of playing Bingo. They had been intellectually active at earlier stages of their lives, and their physical illnesses now did not significantly change their intellectual interests or even their mental capacity – except that I had to speak just a little more slowly than I usually do. The students even read assignments in preparation for the class from specially prepared sheets with enlarged print. I wish my younger students were always as well prepared!

Visitors do not normally discuss Jewish theology, but this example will, I hope, indicate just how seriously I mean to make the point that conversations with patients should be challenging and should cover a wide variety of topics. The very normalcy of such discussions communicates that the illness has not diminished the visitor's respect for the patient's intelligence and humanity, and that the remainder of one's life can still be filled with meaningful conversation.

The Jewish tradition has also provided another mechanism to make the lives of terminal patients meaningful. That is the *ethical will*. In times past, ethical wills were written, but now they can be taped or even videotaped. Patients who know that they have a task to accomplish in leaving their children and (especially) their grandchildren a record of their experiences, values, thoughts, dreams, and hopes will redouble their efforts to live as long as they can so that they can complete this important project.<sup>47</sup>

Moreover, some families can heal troubling relationships that they were not able to resolve earlier in the last stages of the patient's life. The limited term of life remaining for the patient becomes patently clear in such a setting, and that often motivates all concerned to be more forthcoming in their relationships with family and friends than they were previously. Moreover, in positive relationships, the time spent together in a beloved's last days can be the last gift children give their parents or spouses give each other. Thus even though life at this stage may be physically painful, it may be emotionally some of the most significant days the person has lived.<sup>48</sup>

Indeed, the American courts that dealt with assisted suicide addressed what is, in many ways, the wrong question in the first place. We should not be asking whether one may aid another in dying; we should rather explore what prompts people to seek to die in the first place, and then we should remove those motivations through proper pain medication and through attentive care. Those are the most appropriate responses to requests for assisted death.

Medical hopelessness, then, need not and should not amount to psychological hopelessness. People asking for help in dying to overcome the loneliness and the futility of their lives should not be offered aid in dying, but rather assistance in making life meaningful.

### *Moral*

In refusing to allow people to “shuffle off this mortal coil”<sup>49</sup> when and how they wish, we are taking upon ourselves the moral responsibility of imposing our will on them, and why should a society based on individual liberty do that? This last concern, in fact, is precisely the basis of the Ninth Circuit's decision affirming the legality of assisted suicide.

<sup>47</sup> For some poignant examples of ethical wills, including many modern ones, see Jack Riemer and Nathaniel Stampfer, eds., *Ethical Wills: A Modern Jewish Treasury* (New York: Schocken, 1983). For some suggestions for preparing an ethical will, see Jack Riemer and Nathaniel Stampfer, eds., *So that your values live on – Ethical Wills and how to prepare them* [capitalized that way] (Woodstock, VT: Jewish Lights Publishing, 1991).

<sup>48</sup> See Elisabeth Kubler-Ross, *Death is of Vital Importance* (Barrytown, NY: Station Hill Press, 1995), for some striking examples of how meaningful and reconciling the last stages of life and death itself can be. I would like to thank my friend and colleague, Rabbi Elie Kaplan Spitz, for alerting me to this book.

<sup>49</sup> The poetic expression comes from Shakespeare, *Hamlet*, Act III, Scene I, line 67.

The liberty argument is not nearly as cogent in Jewish thought as it is in American ideology and law, for Jews are born with duties rather than rights. Even in the American context, though, the government must protect the most vulnerable populations, and the dying are surely among them. Similarly, the Torah's demand, "Do not stand idly by the blood of your brother," was interpreted by the Rabbis as a duty to come to the aid of those at risk.<sup>50</sup>

As indicated above, permitting assisted suicide may at first *look* like an affirmation of the patient's liberty, but it soon transforms into a duty to die. Protecting individuals' liberty, then, is more effectively achieved by making assisted suicide a socially unacceptable option so that individuals need not defend their desire to continue living. The current ban on assisted suicide inevitably infringes on the liberty to gain assistance in dying, but that is a reasonable price to pay in order to preserve the liberty of far more people to continue living without having to justify their choice.

Moreover, until now we have assumed the morally pure situation, where the patient is in pain or in increasing states of degradation (as in Alzheimer's patients), with prospects for only further deterioration, and where the aide is acting out of the sole motive of helping the patient fulfill his or her wishes (stated now or previously) to end life under such circumstances. Real situations, however, are almost never that simple. With regard to the patient, one must ask the hard questions of whether the request to die is a response to a lack of social support, as we have discussed, or a state of psychological depression that can be treated medically, or the patient's worry that further medical care will seriously deplete the estate to be left to the heirs. With regard to the aide, one must ask whether he or she stands to benefit from the end of the person's life, either monetarily or simply by the freedom from taking care of this person any longer. Assisted suicide, in other words, rarely occurs in the morally pure atmosphere usually assumed in arguments about its moral appropriateness, and as soon as one exposes the less noble motives often involved, it seems considerably less honorable.

Another moral issue arises in these cases. As the Ninth and Second Appellate Courts maintained, modern medical advances have made the line between active and passive euthanasia increasingly hard to define. That does not mean, however, that it has disappeared. The distinction between them constitutes the very real moral difference between helping someone live and die in a natural way, on the one hand, and homicide, on the other. Moral sensitivity is precisely the ability to make distinctions, including some hard ones.<sup>51</sup> We have, then, an important moral interest in discerning that line, however difficult it may be to see at times, because nothing less than our character as moral people is at stake.

These theological, social, economic, medical, psychological, and moral factors, then, reinforce the ban embedded in Jewish law on suicide and on assisting a suicide. They also demand that we take a much more active role in ensuring that the dying are not abandoned to physical pain or to social ostracism, that instead we make the mitzvah of **ביקור חולים** (visiting the sick) a critical part of our mission as Jews. This is especially important as Jews, along with other North Americans, become statistically older, for more and more of us in the time to come will need such care. In attending to the sick, we must assure that their physical needs are met and that their ending time in life is as

<sup>50</sup> Lev. 19:16; B. Sanhedrin 73a.

<sup>51</sup> Just as bad as recognizing no distinctions is creating sweeping, unexceptionable categories rather than discerning the fine lines that characterize real moral life. See my response to J. David Bleich in my article, "Moral Distinctions," *Sh'ma: A Journal of Jewish Responsibility*, 21/401 (16 Nov. 1990): 6-8.

psychologically, emotionally, and religiously meaningful as possible. Our compassion, in other words, must be expressed in these demanding ways rather than in acquiescing to a request for assistance in dying, for ultimately the Jewish tradition calls upon us to recognize God's rights of ownership of our bodies and God's exclusive right to take our lives in God's good time.

### ***Conclusion***

A Jew may not commit suicide, ask others to help in committing suicide, or assist in the suicide of someone else. Withholding or withdrawing machines or medications from a terminally ill patient, however, does not constitute suicide and is permitted. In my view, but not in Rabbi Reisner's, one may also withhold or withdraw artificial nutrition and hydration from such a patient, for that too falls outside the prohibitions of suicide and assisted suicide.