The Terri Schiavo Case—from the Viewpoint of Jewish Law

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Presented at the Sixth Miami International Conference on Torah and Science, 13-15 December 2005

The Terry Schiavo case sparked tremendous controversy in the United States and abroad regarding how to best care for patients near the end of life. For Jewish patients in similar situations, *halakhah* (Jewish law) provides the guidance necessary to make appropriate decisions. I shall explore the issues raised by Terry Schiavo's case in this context: 1. Whether and under what circumstances medical interventions may be refused by, withheld from, or withdrawn from terminally ill Jewish patients—including artificial nutritional support; 2. The conditions under which Jewish patients may execute advance directives consistent with halakhah; 3. The halakhic definitions of terminal illness vis à vis the medical definition of a persistent vegetative state (PVS). I conclude that:

Withholding life-prolonging interventions in terminally ill patients is permitted under certain circumstances, while withdrawing is generally not. Artificial nutritional support is considered basic care by most rabbis and must be provided to the terminally ill patient in a way that is beneficial and not harmful. Advance directives are permissible as long as they are compatible with Jewish law. PVS is not a terminal condition under Jewish law. Therefore, according to halakhah, Terry Schiavo was not terminally ill. Halakhah would not have allowed her feeding tube to have been removed because withdrawal of treatment is generally forbidden and a feeding tube would not be considered an impediment to death. The removal of the feeding tube would be considered a direct cause of her death.

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During an eighteen-month period from about October 2003 through March 2005, one of the major captivating news stories was the tragic case of Terri Schiavo. This relatively young woman,

who suffered irreversible neurological damage following sudden cardiac arrest, was the focus of what remains an ongoing debate regarding the extent to which individuals in our society have the right to self-determination regarding matters of health care, medical treatment, and ultimately, life and death.

Summary of the Case

In 1990, twenty-six-year-old Terri Schiavo suddenly collapsed in her apartment and suffered a cardiac arrest. Despite being resuscitated successfully from the point of view of cardiopulmonary function, she suffered significant anoxic brain damage. Due to an inability to swallow, a percutaneous gastrostomy (PEG) feeding tube was placed. Lack of a neurological recovery led to a diagnosis of persistent vegetative state. As Mrs. Schiavo did not have an advance directive (either a living will or durable power of attorney) her husband was granted legal guardianship, without objection from her parents. Over the years, attempts at aggressive rehabilitation were unsuccessful and it became clear to the husband that his wife's condition was permanent and would not improve. He also believed that she would not have wanted to live in a persistent vegetative state. On that basis, Mr. Schiavo decided that he wanted his wife's feeding tube removed. Mr. and Mrs. Schindler, the parents of Terri Schiavo, disagreed with their son-in-law's decision. When consensus could not be reached, Mr. Schiavo petitioned the Florida courts to appoint a health care "proxy" in order to make an independent decision on his wife's medical condition—specifically whether or not it would be reasonable to discontinue feeding her through the PEG tube. The court proxy decided that the patient's condition was irreversible and that the husband demonstrated that his wife would not have wanted to be kept alive in this state. Therefore, the court proxy agreed with the husband's position that the feeding tube could be removed. The patient was admitted to an inpatient hospice for this purpose. However, the parents appealed this decision at every level within the Florida court system. The removal of the feeding tube was postponed numerous times so that the case could be adjudicated. In all

instances, the initial decision was upheld. This led, in 2003, to the removal of Terri Schiavo's feeding tube. The parents appealed to the Florida legislature, and a law was passed and signed by the state governor granting him the authority to order Terri's feeding tube replaced. This was successfully carried out. Over the next fifteen months, continued appeals and stays were granted at the state level, leading to the finding by the Florida Supreme Court that the law allowing the feeding tube to be replaced was unconstitutional. The parents attempted to appeal to the US Supreme Court, and special legislation was passed by the US Congress and signed by the President of the United States to allow the Supreme Court to hear the case. However, the Supreme Court refused to hear the case and the original court, standing by its prior decision, ordered the feeding tube removed on March 18, 2005. Terri Schiavo passed away on March 31, 2005.[1]

As the tragedy of the Terri Schiavo case rose to prominence in the public arena, everyone seemed to have an opinion on what should be done. More and more people, based on their individual beliefs and personal value systems, began to consider how they would react and what decision they would make if they found themselves in a situation similar to that of Mr. Schiavo or the Schindlers. People pondered over what instructions they should make in advance of possibly ending up in Terri's medical condition.

Jews throughout the United States and the world were no exception in asking themselves these questions. For traditional Jews, however, the answers to these questions would not be found by examining their individual beliefs and personal value systems, or going to the courts of their country. For traditional Jews, the answers come from the beliefs and values defined by *halakhah* (Jewish law) and the applications of halakhah that pertain to medical care—Jewish Medical Ethics.

Some of the key questions raised by the Terri Schiavo case will now be examined in the context of Jewish Medical Ethics. The questions under consideration are as follows:

1. May terminally ill patients refuse medical treatment?
2. May medical treatments be withheld or withdrawn from terminally ill patients?
3. May artificial nutrition or hydration be withheld or withdrawn from

terminally ill patients?
4. Does Jewish law allow individuals to execute advance directives?
5. Does Jewish law recognize terminal illness, and if so, how is it defined?
6. What is Persistent Vegetative State (PVS), and is PVS a terminal condition under Jewish law?

For purposes of discussion, it will be accepted that Terri's neurological diagnosis was Persistent Vegetative State—a diagnosis that was disputed in the public arena during the case but subsequently confirmed at autopsy.[1] In the discussion of at least the first four questions, the secular position that a PVS patient is considered on par with a terminally ill patient will be accepted.

May Terminally Ill Patients Refuse Medical Treatment?

The medical ethical principles of beneficence and non-maleficence prominent in the secular world apply as well in Jewish law. Based on the Torah precept "Watch yourselves very carefully" (Deuteronomy 4: 15), halakhah obligates Jewish patients to take proper care of their health and lives. We are required to seek beneficial treatment and cure when possible. A similar command a few verses before, "…take heed and watch yourself very carefully" (Deuteronomy 4:9) has been interpreted as obligating the Jewish patient to avoid bodily harm. This latter Torah precept is further codified in the *Shulkhan Arukh* (The Code of Jewish Law) at the end of *Hoshen Ha'Mishpat*:

> The sages prohibited many things because they involve danger to life…Whoever disregards these things and their like and says: "I will place myself in danger, what concern is this to others?" or "I am not particular about such things"—disciplinary flogging is inflicted upon him, but he who is careful about these matters will receive great blessing.[*Shulkhan Arukh, Hoshen Ha'Mishpat, siman* 427:6-19]

Based on these and similar passages, Jewish law allows patients who are near the end of life and/or suffering from intractable pain to refuse treatment if the treatment is not proven to be effective, is clearly futile, or entails great suffering or significant complications.[2, 3] In the face of terminal illness, the option to refuse therapy under certain circumstances may even extend to what can be described as "high benefit-low risk" therapy that is not curative and/or will not prolong life to a significant degree, pro-

viding the patient is able to make his or her own decision and has been fully informed of the benefit-risk of the proposed treatment.[4]

May Medical Treatments Be Withheld or Withdrawn from Terminally Ill Patients?

In secular medical ethics, withdrawal and withholding of treatment are currently considered to be ethically equivalent. Some medical ethicists, though, are now promoting the position that withdrawing may actually be ethically superior to withholding, since withdrawal of care comes with the knowledge that the treatment was ineffective for that particular patient.[5] Jewish Medical Ethics clearly differentiates between the two. Based on the prohibition in *Sefer Hasidim* 234 that "One may not put salt on a dying man's tongue to keep him alive a little longer" and similar statements, Jewish law allows medical therapy to be withheld when, in the judgment of the patient's physician, the treatment will not result in a cure or remission of the illness but will only delay the dying process and/or not provide relief of pain and suffering being experienced by the patient.[3, 6, 7]

Withdrawal of care, on the other hand, is halakhically much more challenging. Given that Jewish law does not allow the deliberate hastening of death even in the face of terminal illness,[8] withdrawal of medical interventions that maintain or extend life are not permissible. However, there is an exception to this. If the intervention is not serving to maintain or extend life, but is only serving to prolong the dying process, then the intervention may be withdrawn.

The descriptions in the Talmud of the deaths of two famous sages illustrate this point. When the Romans burned Rabbi Hanina ben Tradyon, they wrapped him in wet tufts of wool to prolong his suffering. He permitted the Roman executioner to remove the wool since it was only impeding death. Not only was removing the wool permissible; it was considered meritorious in its own right. After removing the wet tufts of wool, the executioner jumped into the fire and died with Rabbi Hanina. Talmud *Avodah Zarah* 18a says that the executioner was rewarded in the afterlife.

When Rabbi Judah the Prince, the redactor of the *Mishnah*, was dying

from a severe illness, his students constantly prayed at his bedside to keep him alive. His pious maidservant, concerned about his suffering and recognizing that the prayers were keeping him alive, climbed up to the roof and dropped an urn. The resultant noise caused the students to stop praying, allowing their revered teacher to die (Talmud, *Ketubbot* 104a).

This principle is further emphasized by Rabbi Moses Isserles (the Rama) in his commentary on the *Shulkhan Arukh Yoreh Dea* 339:1, where he states that if salt had been placed on a dying man's tongue (even though, as stated above, such a measure, meant only to prolong the dying, could be *withheld*)—the salt may be *withdrawn*.

Both *Sefer Hasidim* 234 and Rabbi Isserles (on *Shulkhan Arukh Yoreh Dea* 339:1) give the example of the noise of a woodchopper preventing a patient from dying. We are permitted to ask the woodchopper to stop chopping wood to allow the patient to die.

The above cases all illustrate the halakhic principle that an intervention may be withdrawn only when it has no beneficial value whatsoever and serves only to prolong dying.[3, 6, 7]

May Artificial Nutritional Support Be Withheld or Withdrawn from Terminally Ill Patients?

The loss of the desire or the ability to eat and loss of weight that accompanies it are common symptoms experienced by many patients with advanced or terminal illness. The importance to these patients and their families as well as the clinicians who care for them of attempting to reverse these trends by trying to restore appetite and weight, or, if all else fails, to provide artificial nutritional support cannot be underestimated.

The desire of clinicians to improve their patients' nutritional status and restore weight is supported by evidence that poor nutritional status and weight loss are associated with shorter survivals in patients suffering from advanced cancer or non-malignant advanced illnesses.[9, 10] For both patients and their families, strong cultural, ethnic, or religious beliefs in the vital role of food and its association with various festive and life-cycle events play a major role in the desire for nutritional support.

Additionally, the physical changes associated with anorexia and weight loss may create significant anxiety for parents and families. These physical changes serve as a constant reminder of the patient's deteriorating health, and—for some—an additional reminder of events experienced during the Holocaust.[11, 12]

These considerations have led to the opinion by most rabbis that the provision of nutritional support to patients near the end of life should be considered basic care rather than medical intervention. As such, it is generally held that, even for patients who are terminally ill, food and fluid must be provided, although if "…a terminally ill patient with capacity refuses food, despite our best efforts to convince him to eat, we must respect his wishes"[4] Food and fluids should not be withheld or withdrawn; they are beneficial and do not cause patients harm or discomfort.[4, 6, 13, 14]

Unfortunately, a review of the medical literature raises significant medical questions as to whether nutritional support can achieve the desired benefits of either the clinicians or the patients and families they care for to extend survival, improve well-being, or mollify some of the physical changes that occur as life draws to a close. Studies examining the potential benefits of either oral or parenteral nutritional support in patients with advanced cancer have demonstrated no improvement in patient survival, primarily due to metabolic abnormalities that prevent patients from properly processing nutrients.[15, 16, 17] For patients with advanced dementia receiving artificial nutritional support, the prospects of improvement are equally disappointing, with the medical literature providing no reduction in aspiration pneumonia risk, no improvement in clinical markers of nutrition, no improvement in patient survival, no improvement in or prevention of decubitus ulcers, no reduction in infection risk, no improvement in functional status or slowing of decline, and no improvement in patient comfort.[18,19]

Conversely, these same studies suggest that providing artificial support via a feeding tube may sometimes cause harm. Although these tubes are often placed to reduced the risk of the patient developing aspiration pneumonia, this risk may be as high as it is in patients before the tube is

placed. If a gastrostomy tube is placed, about 15 percent of patients will develop a local infection in the site, and about 30 percent will have the tube occlude, sometimes requiring another procedure to replace the tube. When a nasogastric tube is placed, about two-thirds of the patients will need the tube replaced on one or more occasions. Perhaps most sobering, however, is the statistic that 25-30 percent of patients who have gastrostomy tubes placed die within one month of the procedure. (Some of these fatalities are from complications of the tube placement procedure, others are from complications of their primary medical problems.) About 50 percent of patients who have feeding tubes placed die within one year.[11, 18]

Returning now to the consideration of the rabbis that nutritional support should be provided because it is beneficial and not harmful, we see that questions can be raised regarding these assumptions, especially if the nutritional support is provided artificially. While Jewish patients who are terminally ill should be provided with nutritional support, the physician and other caregivers have a responsibility to make sure that it is provided in a way that does not cause the patient harm and/or discomfort.

Moreover, many rabbis are of the opinion that if a competent patient refuses nutritional support, attempts should be made to convince him or her to accept the supportive care. If after such attempts have been made, the patient continues to decline, then his or her wishes must be respected.[4] In situations where the physician and/or other caregivers believe that the provision of nutritional support is of no benefit and/or harmful to a patient near the end of life, the specific circumstances of the patient should be discussed with a rabbi knowledgeable in this subject, as there may be specific situations where this may be avoided.

The evidence presented regarding the lack of benefit and potential harm associated with artificial nutritional support led a small number of rabbis to give the opinion that artificial nutritional support via an operative gastrostomy or percutaneous gastrostomy (PEG) tube is a medical intervention. As such, they might rule that under appropriate circumstances based on the specific conditions of an individual patient that artificial nutritional support could be withheld from or refused by terminally

ill patients. This same opinion applies to other medical procedures, when such interventions only serve to delay the dying process or do not provide relief of pain and suffering.[4]

The initiation of artificial hydration and nutrition may also be avoided if it is determined by a competent physician and a competent knowledgeable rabbi that the patient is actively dying. A patient in an active state of dying is called a *goses* in halakhah, and this will be discussed in detail below.[13] However, as nutritional support, even when administered artificially, would not be considered an impediment to death, it would generally be forbidden to withdraw nutritional support once it is instituted.

Does Jewish Law Allow Individuals to Execute Advance Directives?

A major aspect of the Terri Schiavo case was the fact that, perceiving herself as a relatively healthy individual, she never elected to create an advance directive, a document that would state who she wanted to make healthcare decisions for her or what those decisions should be if she became unable to express her own wishes. The lack of such an advance directive is what ultimately led to the controversy surrounding her situation. Such a document would have resolved issues of contention in her case, including whether her husband or parents should be making decisions for her, and, ultimately, whether or not she wanted to be fed artificially if she became neurologically incapacitated.

There are two types of advance directive documents that patients may execute in preparation for a time when they will be unable to make healthcare decisions. The first is called a "living will"—a legal document, written and signed by an individual in the presence of witnesses, that states what specific medical interventions s/he either does or does not desire in the event that he or she becomes terminally ill or neurologically incapacitated and unable to communicate these desires to those providing care.[20]

The second type of advance directive document is called the "durable medical power of attorney for healthcare." This is also a legal document, which—rather than delineating what care an individual wants or does not want—designates one or more persons (usually called healthcare

surrogates or proxies) to make healthcare decisions for the person in the event that s/he becomes unable to make and communicate such decisions personally.[20] In order to avoid ambiguity, some individuals choose to create advance directive documents that combine both forms. In other words, the advance directive would contain a "living will" portion that both lists those treatments that the person would or would not want, and designates one or more healthcare proxies through a "durable healthcare power of attorney" to ensure that those wishes are carried out.

According to Jewish law, patients do have the ability to exercise autonomy concerning the healthcare they receive. There is, however, a caveat to this autonomy. For while Jews recognize and espouse autonomy, they, in a sense, voluntarily limit their choices to those that are consistent with G-d's law.[2] This clearly distinguishes the Jewish from the secular ethics of autonomy. While secular medical ethics upholds that each individual has the right of individual choice, the halakhah-observing patient decides not only based on what s/he thinks or feels but on what the Torah allows. G-d thus is an active partner. When faced with questions pertaining to end-of-life care, traditional Jewish patients and families will consult with a rabbi for advice and counsel before making choices on end-of-life care. Needless to say, the rabbi sought out for such advice must be an expert in this particular area of Jewish law or willing to seek the advice of one who is.

From this vantage point, the durable medical power-of-attorney type of advance directive is very much in keeping with Jewish law and tradition. The patient would be able to designate a rabbi knowledgeable in the area of medical decision-making as a healthcare proxy along with a family member. Rather than being predetermined (as in the case of a living will), the decision-making would be individualized, based on a discussion between the physician and the healthcare proxies examining the specific clinical circumstances of the patient.

From the Jewish point of view, the living-will type of advance directive is more controversial. Although a rabbi could advise a patient how to delineate which treatments should be permitted by the living will when the document is drawn up, there is no provision for rabbinic advice at the

time the living will would actually be carried out. Therefore, treatment preferences indicated by the patient's living will might not be applicable later to the patient's specific situation. Without the requirement for rabbinic input, there is a greater risk that the patient will be treated in a way not consistent with Jewish law. A possible solution to this challenge would be for the Torah-observant patient who desires a living will to list the possible treatments that s/he would or would not want if terminally ill or irreversibly neurologically incapacitated, on the condition of approval by healthcare proxies including a competent rabbi.[21]

Does Jewish Law Recognize Terminal Illness, and How Is It Defined?

Jewish law indeed recognizes terminal illness. In fact, a number of different Jewish sources relate that it was the patriarch Jacob who asked G-d to create illness before death so that before passing on, one could bless and instruct one's children gathered around the bedside.[22]

According to halakhah, terminal illness has two recognized stages. The first is called *treifah* (defects), which is defined by a prognosis of about one year or less. The second is termed *goses*—the condition that end-of-life healthcare providers would describe as "actively dying."

Treifah

The Talmud defines eighteen specific defects that cause the meat of a properly slaughtered permitted animal to be forbidden as food.[23] The reason for disqualifying the slaughtered animal is that finding one of the eighteen defects indicates that the animal would have died naturally within a finite period of time, most often viewed as twelve months. It is important to note that despite advances in modern science and veterinary medicine, the defects that define a treifah remain in force, even though animals may now be cured of these defects.

Conversely, a defect not described in the Talmud that is now believed to be fatal to the animal would not disqualify it as treifah.[24]

As applied to humans, a treifah is likewise defined by the presence of an illness or pathology that "the physicians say…does not have any rem-

edy for humans and it will surely cause his death."[25] In the case of an animal, its specific fatal defects are defined and not subject to change based on advances in veterinary science. In the case of a human being, however, specific illnesses or pathologies that previously may have defined him or her as a treifah may no longer do so today—if physicians have the ability to cure what previously was an incurable illness. Hence, many infectious and malignant diseases that in the past would have rendered a patient a treifah no longer do so today, thanks to the advance of medical science.[26, 27]

From the standpoint of Jewish law, a human who is considered a treifah is treated differently with respect to the capital crime of murder. If a treifah is murdered, the killer may not be executed. The murderer, however, is liable to punishment by the "Heavenly Court," i.e., by G-d.[28] If a treifah commits murder, he can only be liable to execution if he commits the crime in front of a rabbinic court. If not, even if there are the requisite witnesses, the treifah murderer is not liable to execution.[29] From the medical point of view, treifah persons are considered alive in all respects and entitled to all appropriate medical care, although triage rules would give a non-treifah sick person priority over one who is treifah.[24, 26]

Goses

Jewish law defines the goses or state of active dying as the last three days or so of a person's life. The goses state is recognizable by heavy, labored, erratic breathing and the patient's inability to clear secretions from the upper airway (called the "death rattle" by healthcare workers).[4, 24] A goses differs from a treifah in that a goses is not considered to have a specific illness or pathology, but is consider "an individual whose time has come."[24] In other words, while a goses may have been a treifah, and may now be actively dying of a specific illness, such as cancer, s/he was not necessarily a treifah. S/he may simply be dying from "old age." (Adult-failure-to thrive or debility might be more familiar end-of-life descriptors for such patients.) As such, Jewish law does not consider a goses to be necessarily a treifah. Therefore, a person who shortens the life of a goses is liable to

capital punishment. Due to the weakened state of the goses and in order to avoid the risk of capital punishment for even inadvertently shortening his/her life, our sages prohibited us from even touching such a person. This is best illustrated in the Talmud *Shabbat* 151b. The Talmud quotes the Mishnah here that:

> Whoever closes the eyes [of a goses] at the moment of death is a murderer.

Rashi comments on this prohibition:

> …in such a state, even the slightest movement can hasten his death.

Rabbi Moshe Feinstein better defined the rules of the goses, stating:

> Touching does not refer to basic care needs such as cleansing and providing liquids by mouth to overcome dryness…Routine hospital procedures, such as drawing blood or even taking temperature, have no place in the final hours of a patient's life.[24]

As can be seen, the establishment of a Jewish patient as a goses, or "actively dying," has clear implications regarding the types of interventions, outside of comfort measures, that are deemed appropriate. However, as a final caveat on this subject, it must be pointed out that

> …recognition of the goses in modern medicine is somewhat controversial, since medication and suctioning can effectively clear secretions, and other interventions, if applied, can prolong or delay the dying process to a point where the patient's status as a "goses" could be considered in doubt.[4]

Thus, a competent rabbi should be consulted when attempting to determine whether a Jewish patient has the status of a goses.

What Is Persistent Vegetative State (PVS)?
Is PVS a Terminal Condition under Jewish Law?

Severe brain injury resulting in acute loss of consciousness can occur due to many causes, including acute trauma, non-traumatic injuries to the brain, degenerative and metabolic brain disorders, and severe congenital malformations of the central nervous system. Recovery from such injury may occur over time and is dependent on the degree of permanent central nervous system damage. Recovery may be partial or complete. For some patients, partial recovery may result in the development of a PVS.

The Persistent Vegetative State is a specific clinical condition defined by the complete lack of awareness of self or environment, the presence

of intact sleep-wake cycles, and the partial preservation of hypothalamic and autonomic brain-stem functions including, in many patients, spontaneous respirations. Individuals who are in a vegetative state also lack the ability to interact with others while awake; they cannot comprehend or express language or communicate their needs in any other fashion; they have no sustained or reproducible voluntary or purposeful responses to external stimuli; they are incontinent of bowel and bladder; and they have variably preserved cranial-nerve and spinal reflexes.[27]

PVS is defined as a vegetative state present for at least one month following either acute traumatic or non-traumatic brain injury, or lasting for at least a one-month period in a patient suffering from either a degenerative or a metabolic brain disorder, or having a congenital malformation. A patient with the diagnosis of PVS may be deemed to be in a permanent vegetative state if s/he is deemed unlikely to recover. The time period involved is approximately twelve months for posttrauma patients, about three months for patients with PVS due to non-traumatic brain injury, and several months for those with degenerative, metabolic, or congenital disorders.[27, 30]

PVS patients have an average life expectancy of slightly over three years (38.4 months). Studies in the medical literature have documented a 65 to 73 percent mortality rate three to five years post-diagnosis, with 90 percent of patients succumbing within ten years.[30]

Based on an average life expectancy of three years, and with at least 25 percent of patients surviving longer than five years, a patient with a diagnosis of Persistent Vegetative State without evidence of medical complications or clinical deterioration, and receiving appropriate supportive care, would not meet the definition of treifah, and certainly not that of goses. As such, PVS would not be considered a terminal diagnosis under Jewish law. Whether an individual suffering from PVS can be considered either a treifah or goses would depend on the individual clinical situation, including the presence of comorbid medical conditions, acute intercurrent infections, the presence of acute and/or chronic decubitus ulcers, or other complicating factors that would contribute to a significant shortening of

that specific individual's life expectancy.

Conclusions

While halakhah considers life to be so precious that it permits Sabbath violation in order to preserve and extend life even for one moment,[31] it accepts King Solomon's premise in Ecclesiastes 3:2 that "there is a time to die" and provides definitions in order to help us recognize the illness that precedes death. Individuals who meet either of these definitions may, under Jewish law, refuse or withhold treatments that are considered medically ineffective, futile, or that cause great pain or suffering. Once initiated, however, medical treatments generally may not be withdrawn. Halakhah considers the provision of nutritional support to be basic care. Therefore, under most circumstances, nutritional support should not be refused and may not be withheld or withdrawn. Halakhah permits patient self-determination and surrogate decision-making providing that the decisions made are consistent with Jewish law and in consultation with a rabbinic authority expert in Jewish medical ethics. The neurological condition known as Persistent Vegetative State does not fulfill the definition of terminal illness under Jewish law.

Applying these principles to the specific case under discussion, it is clear that Jewish law would not have considered Terri Schiavo terminally ill. Even though she was in a PVS for three years, such that one could argue that she had already surpassed the average life expectancy for PVS patients, there was no evidence that she was suffering from any life-threatening medical complications, such as frequent infections or decubitus ulcers. Hence, Jewish law would not have allowed the removal of her feeding tube. Even had halakhah considered Terri Schiavo terminally ill, it still would have forbidden withdrawal of the feeding tube. This is based on the established position of most rabbinic authorities that artificial nutritional support is considered basic care. Even for the minority of rabbis who might consider artificial nutritional support to be medical in nature,[4] withdrawal in this case could not have been justified because the feedings were clearly supporting her life and there was no evidence that the feed-

ings were causing harm.

In the Terri Schiavo case, the absence of an advance directive played a significant role in fostering the dispute between the patient's spouse and her parents. Such a dispute would have been mollified either by knowing what the patient would have wanted if she had a living will, or who she wanted to make decisions for her if she could not make them for herself.

Under Jewish law, while an advance directive document of either type would have been helpful, the decision that would have resulted would have been as described above. For whether there was an advance directive executed or not, any decision made by a traditional Jewish patient's family regarding the care that should be provided to a loved one unfortunately diagnosed with PVS would have to be consistent with Jewish law and made with the consultation of a rabbinic expert in this area. This approach, which has served Torah-observant Jews for centuries, allows the family to participate in decision-making while being secure in the knowledge that the decisions they are making are consistent with G-d's law.

Notes

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