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Review Article

Jewish Medical Ethics and End-of-Life Care

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ABSTRACT

While Judaism espouses the infinite value of human life, Judaism recognizes that all life is finite and, as such, its teachings are compatible with the principles of palliative medicine and end-of-life care as they are currently practiced. Jewish medical ethics as derived from Jewish law, has definitions for the four cardinal values of secular medical ethics: autonomy, beneficence, nonmaleficence, and justice, with the major difference between Jewish law and secular medical ethics being that orthodox or traditional Jews are perceived to limit their autonomy by choosing, with the assistance and advice of their rabbis, to follow God's law as defined by the Bible and post-Biblical sources. With an understanding of Jewish medical ethics as defined by Jewish law, various issues pertaining to the care of Jewish patients who are near the end-of-life can be better understood. Jewish tradition contains within its textual sources the concept of terminal illness. The shortening of life through suicide, assisted suicide, or euthanasia is categorically forbidden. For patients who are terminally ill, treatments that are not potentially curative may be refused, especially when harm may result. Under certain circumstances, treatments may be withheld, but active treatment already started may not usually be withdrawn. While patients should generally not be lied to regarding their conditions, withholding information or even providing false information may be appropriate when it is felt that the truth will cause significant harm. Pain and suffering must be treated aggressively, even if there is an indirect risk of unintentionally shortening life. Finally, patients may execute advance directives, providing that the patient's rabbi is involved in the process.

> To everything there is a season and time to every purpose under heaven, a time to be born and a time to die. . . . "[a]

THESE FAMOUS WORDS, found in the Biblical book of Ecclesiastes (3:1–2), generally attributed to the authorship of King Solomon, suggests that Judaism understands that for everyone, death is an inevitable outcome. Yet, based on the Biblical verse " . . . I have placed life and death before you, blessing and curse; and you shall choose life, so that you will live. . . ." (Deuteronomy 30:19), Judaism espouses the infinite value of life, and it is taught that preservation of life, even for a moment, is important enough to violate the Holy Sabbath (Babylonian Talmud Yoma 83a).[b] From this, one might surmise that, despite recognizing the inevitability of death, Judaism

[a]This and all subsequent Biblical translations are taken from The *Tanach*. Art Scroll Series, the Stone edition. Brooklyn, Mesorah Publications, 1996.

[b]The fourth of the Ten Commandments mandates that Jews "Remember the Sabbath day to keep it holy," which includes prohibiting Jews from many different types of work-related and weekday-related activities. Without getting into the technical nature of how these activities are identified and derived, among the activities that are prohibited include cooking, actively using electricity, driving an automobile, and writing. All this changes when someone's life is at stake, a situation known in Hebrew as *pikuach nefesh*. Under the laws of *pikuach nefesh*, one is permitted, and in fact mandated, to violate the Sabbath in order to save a life. This is true even in a case where it is possible but uncertain that a life is a risk, and even if the life will only be saved for a short period of time, which would apply to patients near the end of life, the subject of this paper (Babylonian Talmud Yoma 85a-b, Rabbi Joseph Karo, Shulchan Aruch Yoreh Deah 328:2 and commentaries).

would support using all means possible to maintain life as long as possible irrespective of the patient's prognosis and level of pain and suffering, which is incompatible with the modern definitions of palliative care at the end-of-life. However, as will be demonstrated throughout this paper, Jewish law is compatible with the principles of palliative medicine and end-of-life care as they are currently practiced.

That this is so is, perhaps, best demonstrated, as most issues in Judaism are, by looking at the Bible and its many commentaries. How did man die in Biblical times? From the time of creation until the death of Jacob at the end of the book of Genesis, the Bible is nondescript about death. From the death of Adam to the death of Abraham's father Terach, the Bible simply provides the person's age, states that he had offspring, and that he died. The deaths of Abraham and his sons Isaac and Ishamel are only covered in slightly more detail, with the Bible stating that each one "died and was gathered to his people (Genesis 25:8, 25:17, 35:29)." According to an ancient commentary known as Pirkei DeRebbi Eliezar (Chapter 52) there was no illness before death. When one's time came to die, one sneezed, and the soul would exit through the nostrils.[c]

The Biblical account of Jacob's death, unlike that of his forefathers, occupies more than four chapters at the end of the book of Genesis. Jacob becomes ill, Joseph is summoned and brings his two sons so they can receive blessings from their grandfather. As Jacob's illness worsens, all his son's are summoned to his bedside, where he blesses and instructs them, and then asks to be buried in the Cave of Machpelah in Hebron alongside his parents (Isaac and Rebecca), his grandparents (Abraham and Sarah), and his wife Leah (Genesis 47:28–49:32). "When Jacob finished instructing his sons, he drew his feet onto the bed; he expired and was gathered to his people" (Genesis 49:33). According to several texts, Jacob had asked God to create illness before death so that one's children could be at the bedside prior to one's final moments, and so that one could bless and instruct one's children before passing on (Babylonian Talmud Bava Metzia 87a, Sanhedrin 107b, Midrash Rabbah Genesis 65:9, Pirkei D'Rebbi Eliezer 52).

In essence, what Jacob experienced was the first "hospice" death in recorded history. When he became terminally ill, there were no unnecessary medical interventions. Jacob was surrounded by his loved ones, had the opportunity for blessing and instructing his children, following which he died peacefully.

There was one challenge regarding Jacob's request for illness prior to death: no one ever recovered from such an illness, at least not until the time of King Hezekiah of the Kingdom of Judah.[d] King Hezekiah became "deathly ill" (Kings 2, 20:1) and the prophet Isaiah was sent by God to inform King Hezekiah that he would die. Hezekiah prayed to God, and God sent Isaiah back to Hezekiah to inform him that he was adding 15 years to his life (Kings 2 20:1–6). When Hezekiah prayed to God, he asked Him to change the nature of illness from always signifying that death was imminent, to allowing for the possibility of recovery. Hezekiah reasoned that if one had the hope of recovery, one would "fully repent" (Midrash Rabbah Genesis 65:9, Pirkei D'Rebbi Eliezer 52).

What King Hezekiah had done was add to Jacob's earlier request by introducing hope into the equation of illness. Moreover, it is this combination, hope in the face of terminal illness, which is central to the Jewish concept of care near the end of life. Likewise, these same principles lie at the core of hospice and palliative medicine as it is practiced today in the United States and throughout the world.

PRINCIPLES OF JEWISH MEDICAL ETHICS

Prior to delving into how Jewish medical ethics addresses various issues pertaining to end-of-life care, it is important to under how the basic principles of Jewish Medical Ethics are derived. Judaism is a religion based on God's law, referred to in Hebrew as *halacha*. The foundations of *halacha* are based on the 613 *mitzvot*, translated for this purpose as commandments or precepts, that are delineated in the Torah (which are also known as the five Books of Moses or *Chumash* in Hebrew, and constitute the first 5 books of the Jewish Bible

[c]According to Pirkei DeRebbi Eliezar, when a person heard someone sneeze, he would responds "life." This is the origin of the custom to say "God bless you" or a similar phrase when someone sneezes.

[d]According to the accounts in the Babylonian Talmud Bava Metzia 87a and Sanhedrin 107b, the change in the nature of illness occurred during the time of the prophet Elisha.

and the Christian Old Testament). Further understanding of how the *mitzvot*, 248 of which are positive (things that a Jewish person should or must do) and 365 of which are negative (things that a Jewish person should or must not do), are to be practiced have been derived over time in small part from the remaining 24 books of the Jewish Bible and to a much larger degree from the "Oral Law," believed to have been given to Moses by God along with the written *Torah* and then passed down from generation to generation, until being recorded in the second century of the Common Era in the form of the *Mishnah* and, about two centuries later, in its major commentary, the *Talmud*. Over the centuries, rabbis have utilized these major texts as well as the myriad of commentaries written on them to address various questions and problems related to the practice of Judaism and the *halacha*. They have done so by the analytic method of casuistry, in which case examples from the biblical, Mishnaic, and/or Talmudic texts, as well as the commentaries to those texts, are compared to the circumstances surrounding the question or problem at hand.

It is through this method that one can derive *halachic* equivalents for the four cardinal values of secular medical ethics, to which the term Jewish medical ethics may be applied: autonomy, beneficence, nonmaleficence, and justice.[1,2] The definitions of each of the values from a secular and Jewish viewpoint are contrasted in Table 1, and from the *halachic*, or Jewish legal, point of view, are discussed below.

Autonomy

Jewish law recognizes freedom of choice, as it says in the book *Ethics of the Fathers*: "Everything is foreseen, but the freedom of choice is given" (3:19). However, while God has granted Jewish people with freedom of choice, "(o)bservant Jews abdicate their personal and individual wishes and . . . conduct themselves according to what is right or wrong in Jewish legal-moral terms."[2] In other words, while Jews recognize and espouse autonomy as an ethical principle, they voluntary limit their autonomy by using their freedom of choice to make decisions that are consistent with God's law.

Table 1. Jewish Medical Ethics: Definitions

Value	*Secular Medical Ethics*	*Jewish Medical Ethics*
Autonomy	The patient's right to choose among available alternatives.	Autonomy is voluntary limited to being consistent with Jewish law.
	Autonomy in health care today is determinative and the dominant ethical value.	Traditional Jews will look to their rabbi to ensure that their decision-making is consistent with Jewish law.
Beneficence	Physicians provide care that is of benefit to the patient.	Physicians are obligated to heal and benefit patients.
		Patients are obligated to seek beneficial treatment.
Nonmaleficence	Physicians avoid providing care that is harmful.	Physicians avoid providing care that is harmful.
	This principle is considered secondary to beneficence and not always adhered to since many beneficial treatments may also cause harm.	Individuals also have a specific obligation to care properly for their bodies and avoid exposing themselves to bodily harm.
Justice	Providing care that is good for the society as a whole, as opposed to focusing on a specific individual.	Societal good is defined by Jewish law.
	Fair allocation of limited health care resources.	Patient priority is on a first-come, first-served basis.
		In case of conflict, priority is based on defined hierarchy related to social worth.
		Limiting of health care based on available resources is permissible.

This clearly separates autonomy under the Jewish ethical system from that in secular ethics. For while secular Medical Ethics espouses the principle that each individual has the right to choose for him or herself, under Jewish law patients choose to make decisions not based solely on what they might want, think, or feel. Instead, they include God and His law as an active partner, and make their decisions accordingly. Therefore, when faced with questions pertaining to end-of-life care, traditional Jewish patients and families will look to God's law and the rabbi,[e] who is the expert in God's law, for advice and counsel prior to making choices regarding appropriate end-of-life care.

Beneficence

"To benefit a fellow man is considered to be one of the most important positive precepts in Jewish law,"[2] derived from several biblical passages including, "Love they neighbour as thyself" (Leviticus 19:18) and "And thou shalt do that which is right and good in the sight of the Lord" (Deuteronomy 6:18). Regarding the specific obligation of physicians to benefit patients, the repetition of the word "heal" in the passage in the book of Exodus "and heal, he shall heal" (Exodus 21:19) is interpreted as an authorization granted by God to physicians to heal patients.[3]

Patients also have an obligation to seek beneficial treatment and to be healed. This can be derived from the biblical passage, "Take ye therefore good heed unto yourselves" (Deuteronomy 4:15), which is interpreted to mean that man is obligated to care for his health and life. This obligation is based upon the idea that "man's body and his life are not his to give away (and that) the proprietor of all human life is none other than God himself."[4]

Nonmaleficence

Judaism, much like secular ethics, supports the avoidance of harm. Additionally, just as in secular ethics, the avoidance of harm must always be weighed against the potential benefits of the treatment or intervention being recommended. While there are specific rules as to how medical decisions related to issues of beneficence and nonmaleficence should be made, these rules may be overruled or waived under specific circumstances, some of which will become apparent later in this paper.

In addition to the avoidance of harm in respect to treatment by a physician of a patient, Judaism also commands that one protects one's own body from harm and danger. Again, this command has its origin in the Bible. The rabbis have interpreted the verse, "Duly take heed to yourself and keep your soul diligently" (Deuteronomy 4:9) and other similar verses as conferring upon Jews the obligation to avoid bodily harm.[f]

Justice

Justice is the lynchpin of the Jewish legal and ethical system, as it states in the Bible: "Justice, justice you shall pursue" (Deuteronomy 16:20). From the health care perspective, justice under Jewish law primarily concerns itself with triage and resource issues. Patient priority is generally defined on a first come, first served basis. In other words, one is obligated to focus one's attention on the patient currently under care. An issue with patient priority may arise when resources are scarce. For example, if there is only one critical care bed remaining in a hospital and there is a patient who needs the bed, one cannot be concerned that a patient may come later who might need the bed more, as according to Jewish law the patient currently under care has priority. When two patients present at the same time, the one with more serious medical problem is given precedence. However, if the medical needs of both patients are equal, priority is given based on a social hierarchy (i.e. rabbi, par-

[e]The need to consult a rabbi and follow his advice is fundamental to the principles of what is today termed "Orthodox Judaism." As there are areas within Jewish law in which even Orthodox rabbis will disagree, including issues related to end-of-life care, having a specific rabbi one can rely on to answer *halachic* questions provides an Orthodox Jew with a consistent viewpoint on Jewish legal issues. While an Orthodox Jew who is knowledgeable about specific issues may not feel compelled to consult his or her rabbi, if one does choose to ask the rabbi a specific question, one is then obligated to follow the rabbis advice in that matter. In other branches of Judaism, such as the Conservative and Reform movements, while the rabbi is available to give religious advice, congregants are not and do not feel compelled to necessarily follow that advice, as do Orthodox Jews.

[f]This was stated by Maimonides in his Mishnah Torah (Laws Concerning Murder and the Preservation of Life, 11:4,5) and by Joseph Karo in the Shulchan Aruch (the Table of Jewish Law): "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."

ent, teacher, priest, etc.) as defined by the *Talmud* and other texts.[2,5,7]

The availability of resources is also addressed, with Jewish law recognizing that resources are not unlimited. Based on laws related to the ransoming of captives, which forbid paying more than their value,[g] it has been determined that health care may be rationed under certain conditions.[5]

JEWISH MEDICAL ETHICS AND END-OF-LIFE CARE

With the understanding that Judaism's principles for care at the end-of-life share the same basic principles as does the modern hospice and palliative medicine movement, and with a basic understanding of how Jewish law provides definitions to the cardinal ethical principles, one is ready to examine the various issues related to end-of-life care from the perspective of Jewish medical ethics (Table 2).

As we examine the various issues, several caveats need to be remembered. First, the issues being discussed pertain only to patients who are terminally ill (which will be defined below from the Jewish point of view). The various laws regarding patients who are not terminally ill may substantially differ, and are beyond the subject matter of this article.

This paper is being written from a traditional, or Orthodox, Jewish viewpoint. It is recognized that there may be significant differences of opinion on some of these issues among adherents of Conservative, Reform, and other non-orthodox denominations. (Table 3 highlights some of the basic principles of each of the major Jewish denominations practicing in the United States today. However, a more extensive review is beyond the scope of this article.) Generally speaking, where there are differences of opinion, the non-Orthodox branches tend to be more in keeping with the secular point of view.

The reader must also be cautioned that the information presented is primarily intended for guidance, as even among the Orthodox, differences in opinion regarding end-of-life issues may exist. Therefore, it is highly recommended that whenever end-of-life care decisions are required for care involving traditional Jewish patients and/or families, a rabbi who is knowledgeable in this area should be consulted as part of the decision making process.

[g]In the Babylonian Talmud, Tractate Gittin 45a, the Mishnah states: "One may not ransom captives for more than their value, for the benefit of society."

JEWISH DEFINITIONS OF TERMINAL ILLNESS

Jewish law does indeed recognize terminal illness.[6] There are two recognized stages. The first is called *treifah* (defects), which is defined by a prognosis of about one year or less and the second is termed a *goses* (dying), which is what health care providers working in end-of-life care would describe as "actively dying."

Treifah

In the Babylonian Talmud Chullin 42a, the Mishnah defines 18 specific defects that would make an animal that was properly slaughtered and otherwise permitted to be eaten under Jewish dietary laws forbidden as food. The reason why the animal would be rejected is because the presence of any of these defects would indicate that the animal would have died naturally within a finite period of time, most often viewed as approximately 12 months. This is the definition of a *treifah* as it applies to animals. 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 the animal may now be cured of the defect. Conversely, a defect not described in the *Talmud* that is now believed to fatal to the animal would not disqualify that animal as a *treifah*.[7]

As applied to man, a *treifah* is likewise defined by the presence of an illness or pathology that "the physicians say . . . does not have any remedy for humans, and it will surely cause his death" (Maimonides, Mishnah Torah, Laws Concerning Murder . . . 2:8). Unlike an animal, however, where the specific fatal defects are defined and not subject to change based on advances in veterinary science, specific illnesses or pathologies that may have defined a human as a *treifah* may no longer do so, if advances to medical science have given physicians the ability to cure what previously was an incurable illness. Hence, many infectious and malignant diseases that in the past would have rendered one a *treifah* no longer do so today.[7]

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

Table 2. End-of-Life Care Issues and Jewish Law

Issue	*Jewish law*
Terminal illness in jewish law	*Treifah*: Incurable illness resulting in a limited life expectancy, typically 1 year or less. *Goses*: actively dying, typically last 3 days of life
Suicide, assisted suicide and euthanasia	Forbidden
Refusal of medical treatment	Treatment may be refused if ineffective, futile, or may cause suffering or significant complications.
Withholding and withdrawing treatment	Withholding: Permitted if treatment will only delay dying process and/or will not provide relief of pain and suffering. Withdrawing: It is forbidden to withdraw life support and other direct life prolonging interventions. Removing "impediments to death" are permitted.
Informed consent and truth-telling	Informed consent must be provided in a sensitive and thoughtful manner. Truth may be withheld from patients if it is believed that the knowledge will be harmful to the patient.
Pain and suffering	It is an obligation to treat physical pain as well as emotional pain and suffering. In the face of intractable pain and suffering, other treatments may be withheld and impediments to death may be removed.
Cardiopulmonary resuscitation (CPR)	CPR may be withheld.
Artificial nutritional support and hydration	Generally must be provided as food and fluids are considered basic care. This should be done in a way that benefits the patient and avoids harm.
Antibiotics	Generally should be provided as infection is considered a separate illness. May be refused or withheld if they only delay the dying process and/or do not provide relief of pain and suffering.
Surgery, chemotherapy, radiation therapy	May be refused or withheld if they only delay the dying process and/or do not provide relief of pain and suffering.
Mechanical ventilator	May be withheld, but once initiated may not be actively discontinued.
Advance directives	Durable power of attorney and/or living will may be used. The patient's rabbi should be included as a decision maker to ensure that decisions are compatible with Jewish law.

treifah is murdered, the killer may not be executed.[h] If a *treifah* commits murder, he can only be liable to execution if he commits the crime in front of a Jewish court. If not, even if there are the requisite witnesses, the *treifah* murderer is not liable to execution.[i]

Goses

As already stated, a *goses* is a patient who would be described by people working in end-of-life care today as "actively dying." This state has been defined in Jewish texts as existing during the last 3 or so days of a person's life and is recognizable by the heavy, labored, erratic breathing that a patient experiences when death

[h]The murderer, however, is liable to punishment by the "Heavenly Court" (Babylonian Talmud Sanhedrin 78a, Maimonides, Mishnah Torah, Laws Concerning Murder . . . 2:8), which generally indicates that the individual's punishment will be left in the hands of God.

[i]The reason why the *treifah* murderer is not subject to execution in this situation is beyond the subject of this paper. The interested reader is referred to the Babylonian Talmud Sanhedrin 78a and Maimonides, Mishnah Torah, Laws Concerning Murder . . . 2:9 for further discussion.

is considered imminent and/or patient's inability to clear secretions from their upper airway, compatible with what is described as "death rattle."[6,7] A *goses* differs from a *treifah* in that a *goses* is not considered to have a specific illness or pathology, but is considered "an individual whose time has come."[7] In other words, while a *goses* may have been a *treifah*, and may now be actively dying of specific illness, such as cancer, a *goses* may not have been a *treifah*, but may 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 a *treifah*, and one is, therefore, liable to capital punishment for shortening the life of a *goses*. Because of the weakened state of the *goses* and in order to avoid any risk that an individual caring for a *goses* would inadvertently shorten his or her life and be liable to capital punishment, the Sages prohibited one from even touching a *goses*. This is best illustrated in the Babylonian Talmud Tractate Shabbos 151b where the Mishnah states, "Whoever closes the eyes (of a *goses*) at the moment of death is a murder," to which the eleventh century commentator Rabbi Solomon Isaac (Rashi) states, "in such a state, even the slightest movement can hasten his death." The twentieth century *posek*,[j] 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."[7]

As can be seen, the establishment of a Jewish patient as a *goses*, or "actively dying," has clear

[j]A *posek* is a highly respected rabbi who makes Jewish legal rulings based on Jewish law.

Table 3. Comparison of Various Jewish Sects

Sect	*Characteristics*
Orthodox	Observant of Jewish law and tradition
	Accepts rabbi as religious authority and interpreter of Jewish law
	Men and women have different religious roles and obligations
Conservative	Wide variation in level of observance of Jewish law and tradition
	Jewish law is reinterpreted to fit modern society
	Rabbi is advisor but is not as authoritative
	Egalitarianism: ritual equality between men and women
Reform	Jewish law is only a guide and is nonbinding
	Different definition of Jewish identity
	Less observance of tradition
	Rabbi not authoritative
Reconstructionist	Liberal offshoot of Conservative movement
	Varying traditions
	Universalistic approach to God
Unaffiliated	Majority of American Jews
	Minimal observance of traditions
	No connection or identification with any Jewish "movement"
	May identify with Israel or community charitable organizations

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 that "(t)he 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."[6] Therefore, a competent and knowledgeable rabbi should be consulted when attempting to determine whether a Jewish patient has the status of a *goses*.

SUICIDE, ASSISTED SUICIDE, AND EUTHANASIA

As already discussed, Judaism believes in the infinite value of human life and the idea that "man's body and his life are not his to give away (and that) the proprietor of all human life is none other than God himself."[4] These two ideas clearly indicate that Jewish law forbids one from intentionally shortening one's own life. In other words, suicide is categorically forbidden.[k,l]

Unlike suicide, which is the act of an individual, assisted suicide and euthanasia include the active participation of a physician. As such, the question must be raised as to whether the physician's involvement has any bearing on the prohibition against shortening a person's life, especially if the physician determines that this may be in that individual's best interests. Based on the passage "Heal, he shall heal" (Exodus 21:19) Jewish law gives the physician the responsibility of providing beneficial care to patients. However, this responsibility does not extend beyond healing, so that in a situation where "healing" of an illness is no longer possible, physicians must recognize the limits of their obligations and not provide any interventions that intentionally and actively determine the time of a patient's death.[9] Therefore, under no circumstances[m] does Jewish law permit assisted suicide or euthanasia and deliberate hastening of death, even if the patient is terminally ill and/or a *goses*, and is considered an act of murder according to Jewish law.[10]

REFUSAL OF MEDICAL TREATMENT

Jewish patients have the obligation to take proper care of their health and lives, and are required to seek beneficial treatment and cure when possible. However, what about when cure is no longer possible? Must Jews still accept treatment, or do they have the option of refusing treatment? Jewish law allows patients who are near the end of life, comatose, 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.[2,11] 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 in nature, providing the patient is able to make his or her own decision and has been fully informed of the benefit-risk profile of the proposed treatment.[6] (Specific treatments that are often issues at the end of life, including cardiopulmonary resuscitation and the provision of nutrition and hydration will be discussed below.)

It must be remembered that, while Jewish patients have the option to refuse certain interventions near the end of life, the conditions under which a patient may refuse such interventions can vary considerably from individual to individual. A treatment that is ineffective, futile, or causes suffering for one patient, may be effective and not cause suffering for another. Therefore, decisions to withhold various interventions must be individualized and made in consultation with

[k]It should be noted that while suicide is forbidden, "martyrdom" which is defined as the taking of one's own life or allowing oneself to be killed in order to sanctify the name of God, is permitted, specifically when one is being compelled to commit idolatry, adultery, or murder. In all other circumstances, even martyrdom as a form of suicide is forbidden.[8]

[l]The Babylonian Talmud, Tractate Avodah Zarah 18a, tells the story of the execution by the Romans of the sage Rabbi Chanina ben Tradyon. He was to be burned at the stake, and to prolong his agony, tufts of wet wool were placed around to retard the flames. Despite his agony and the admonitions of his students to open his mouth in order to hasten his death, he refused because the active commission of suicide under any circumstances is forbidden. (For more on this story see footnote "o" below.)

[m]Even if a dying patient is suffering from terrible pain and asks someone to kill him, the patient may not be touched (although his pain must be appropriately treated, as will be discussed below). Additionally, a patient who is dying and asks to be moved to another place so he can die there, may not be moved (Sefer Hasidim 723).

the patient's physician(s) and a rabbi knowledgeable in this area.

WITHDRAWAL AND WITHHOLDING OF TREATMENT

While in secular medical ethics, withdrawal and withholding of treatment are considered basically the same, Jewish Medical Ethics clearly differentiates the two. Therapy may 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 only delays the dying process,[n] and/or does not provide relief of pain and suffering being experienced by the patient.[11,12]

On the other hand, withdrawal of life support and other interventions is generally not permissible according to Jewish law. However, as will be discussed, there may be certain exceptions to this, specifically in circumstances where the life support or other interventions are only serving as impediments to the dying process,[o,p] rather than serving to prolong the patient's life.[q] [11]

TRUTH-TELLING AND INFORMED CONSENT

Clearly, based on passages in the Pentateuch such as: "Keep thee far from a false matter" (Exodus 23:7) and "neither shall ye deal falsely or lie to one another" (Leviticus 19:11), not telling the truth is prohibited. However, in regards to telling people who are ill the truth regarding the expected outcome of their illness, the Bible is less clear, as we see in two stories from the second book of Kings.

During the time of Elisha, the prophet, we learn that when Hazael inquires of the prophet Elisha whether Ben-hadad, king of Aram, would recover from his illness, Elisha says: "Go say unto him: 'You should indeed recover; but in fact the Lord has shown me that he will indeed die'" (Kings 2, 8:7–10). Years later, Isaiah comes to King Hezekiah and tells him: "Thus said the Lord: Instruct your household, for you shall die and not live." Hezekiah prays to the Lord, and Isaiah is instructed to return to the king and inform him that God has granted him another 15 years of life (Kings 2, 20: 1–6).

These stories seem to be contradictory, for while Elisha tells Hazael to lie to Ben-hadad about the nature of his illness, Isaiah is instructed to tell Hezekiah the truth. Yet, in reality, it is the synthesis of these stories that best illustrates Jewish law regarding informing patients about the terminal nature of their illnesses.

As we learn from the story of Hezekiah, Jewish law certainly permits patients to be told the truth, providing that it is what they want to hear, and that they are told it in a way that is not harmful to them. It is well recognized that the better-informed patients are, the easier it is for them to cope with reality. Patients who want information about their conditions will ask questions which should be answered honestly. Concerns about maintaining hope can be addressed by focusing patients on hope for improvement in symptoms when there is no cure for their illnesses, and, as learned from Hezekiah's story, even when no medical cure is available, patients can always maintain the hope that God will intervene.[13]

From the story of Elisha and Hazael, it may be learned that Judaism also permits patients not to be told the truth about the nature of their illnesses or have the truth withheld. This is especially important when patients, the physicians who treat them, and/or loved ones who care for them be-

[n] "One may not put salt on a dying person's tongue in order to keep them alive a little longer" (Rabbi Moses Isserles, Shulchan Aruch Yoreh Deah 339:1).

[o] Returning to the story of the death of the sage Rabbi Chanina ben Tradyon, while he refused to open his mouth to hasten his death (see footnote "l" above), he permitted the Roman executioner to remove the wet tufts of wool that were placed around him to prolong his dying. The removal of the wool was permitted since the wool represented an impediment to death. In fact, not only was removing the wool permissible, it was considered meritorious in its own right, as the Roman executioner, who jumped into the fire and died with Rabbi Chanina, was given a place of reward in the afterlife (Babylonian Talmud, Tractate Avodah Zarah 18a).

[p] Another important story that demonstrates the permissibility of removing impediments to death concerns the death Rabbi Judah the Prince, also known as "Rebbe," who was the redactor of the *Mishnah*. The Talmud tells us that as Rebbe was dying of a severe illness his students constantly prayed at his bedside in order to keep him alive. His pious maidservant, concerned about Rebbe's suffering and recognizing that the students' prayers were keeping Rebbe alive, went outside and dropped an urn from the roof of the house. The resultant noise caused the students to stop praying, allowing Rebbe to die (Babylonian Talmud, Tractate Kesubos, 104a).

[q] If a *goses* is being kept alive by the noise made a woodchopper chopping wood, one is permitted to ask the woodchopper to stop and allow the patient to die (Rabbi Moses Isserles, Shulchan Aruch Yoreh Deah 339:1).

lieve that imparting such information will be harmful to the patients' conditions and, perhaps, shorten their lives. Jewish law also respects the concept of denial, recognizing that patients who do not want to know information will not ask questions, and therefore, just as patients who want to be told the truth should be, information should not forced on patients who prefer not to be told about their illnesses.[13,14]

Finally, while informed consent must be provided to Jewish patients in the United States as it represents the law of the land,[r] the degree to which information is provided to satisfy the legal requirements of informed consent may be guided by the dictates of Jewish law as described above. Patients who wish to be fully informed certainly must be, while those patients who choose to be less informed or have information withheld from them should not have the facts forced upon them, for they are being informed to the extent that they deem necessary to make appropriate health care decisions. In all situations, by deciding what to tell Jewish patients based on the guidance of Jewish law, by providing them with as much or as little information as they desire in a way that allows them to make reasonable choices without taking away their hope, both secular and Jewish law in this area may be satisfied.

PAIN AND SUFFERING

Judaism is extremely concerned about pain and suffering. Therefore, although one may not hasten a patient's death even if he or she is suffering from intractable pain, "one may withhold any additional pharmacologic or technological interventions so as to permit the natural ebbing of the life forces."[15] Additionally, as noted above, one is permitted to remove impediments to death in the circumstance where the patient is suffering from intractable pain and there is no hope for recovery.[s] This does not only apply to physical pain, but to intractable mental anguish as well, which is recognized as being of equal importance to physical suffering in Jewish legal thought.[15]

While one is permitted to withhold interventions that will not benefit the patient, one has an obligation to utilize appropriate interventions, including opioid analgesics and other necessary medication in an attempt to relieve a patient's pain and suffering.[9,15] As Jewish law forbids actively hastening the end of a terminally ill patient's life, many caregivers are concerned that using opioid analgesics may hasten death. It must be emphasized that the medical literature has demonstrated that patients receiving chronic opioid therapy for the relief of pain develop tolerance to the respiratory depressant effects of these medications within a few days of initiating therapy.[16] Furthermore, studies demonstrate that when patients are on chronic opioid analgesics for pain, dosage increases of 50% or more are needed to treat breathlessness, another common symptom near the end of life. Additionally, such patients, when given opioids to treat their breathlessness, have improvement in symptoms and do not experience respiratory compromise or arrest.[17–19] Finally, it has been shown that increasing the dose of morphine in the last week of life because of increased pain does not shorten patient survival.[20] Therefore, there is no evidence that treating patients with the necessary therapeutic doses of opioid analgesic to relieve pain results in the hastening of death, and Jewish law fully supports appropriate treatment for the relief of pain without concern for the unlikely possibility of respiratory compromise.[11]

In addition to intervening to manage a patient's physical distress, psychosocial interventions designed to reduce mental anguish and suffering, such as those provided by hospice programs, are part and parcel of what Judaism requires be provided to terminally ill patients to reduce their pain and suffering and enhance their quality of life.[15]

CARDIOPULMONARY RESUSCITATION

As has been discussed, treatments that do not result in cure or remission of an illness, but only delay the dying process, and/or do not provide relief of pain and suffering being experienced by the patient, may be withheld from or refused by terminally ill patients. While many people have

[r]Jewish law states "the law of the kingdom is the law." This principle applies as long the law does not contradict what is mandated by Torah. (Talmud Bavli, Bava Kamma 113a.)

[s]It is stated by R. Moses Isserles in his commentary on the Shulchan Aruch Yoreh Deah 339:1 that if someone is dying and there is something that is delaying his death, such as a woodchopper making noise while chopping wood, or salt on his tongue, "one can remove them, for this does not involve an action at all, but rather the removal of a preventive agent.[9]

an inflated perception regarding the success of cardiopulmonary resuscitation (CPR),[21,22] the medical literature suggests that, in general, CPR as a procedure is not very successful. It is reported that only about 15% of all patients who receive CPR survive to hospital discharge, with the rate of survival varying by location, from a high of 39% for a selected group of cardiac patients who have a witnessed arrest in a monitored setting, to a survival rate of less than 1% for patients who have an out-of-hospital and/or unwitnessed arrest.[23,24] Because chronically ill elderly patients who require CPR have a less than 5% chance of surviving to hospital discharge, one can infer an even lower success in terminally ill patients, many of whom are in more advanced stages of the same chronic illnesses.

Not only is CPR not beneficial in the terminally ill, the procedure may be harmful, increasing pain and suffering in the few terminally ill patients who might survive the procedure. Autopsy studies have demonstrated significant traumatic injury following CPR, including rib and sternal fractures, mediastinal hematomas, aspiration pneumonia, epicardial hemorrhage, and other injuries to various cardiac and respiratory structures in the chest. Patients who survive CPR often are left with severe and irreversible neurologic deficits as well.[24] Additionally, the mental anguish and suffering that the family (and the patient if s/he remain somewhat neurologically intact) experiences knowing that death has only been delayed a short time may be intolerable.[25]

Putting all the evidence together, CPR is not beneficial for patients who are near the end-of-life, it may be harmful, it only serves to delay death in this population, and may contribute to increased pain and suffering.[25] Given these facts, it is clear that CPR may be withheld from or refused by Jewish patients who are terminally ill.[26]

ARTIFICIAL NUTRITION AND HYDRATION

Unlike other interventions at the end of life, that, as have already been discussed, may be withheld from or refused by patients when they only delay the dying process, and/or do not provide relief of pain and suffering being experienced by the patient, hydration and nutritional support are considered by most rabbis to be basic care rather then medical interventions.[t] 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."[6] These considerations stem from the fact that food and fluids are considered to be beneficial and do not cause patients harm or discomfort.[6,12,27,28] However, if one reviews the state of the art regarding hydration and nutritional support for patients near the end of life, significant medical questions are raised as to whether or not these forms of care are beneficial and whether or not there is risk of harm.

Regarding nutritional support at the end of life, review of the medical literature examining the benefits of artificial nutritional support by feeding tube (either via a nasogastric tube or a gastrostomy tube) in patients with advanced dementia (who may or may not be terminally ill) has shown:

1. No reduction in risk of aspiration pneumonia.
2. No improvement in clinical markers of nutrition.
3. No improvement in patient survival.
4. No improvement in or prevention of decubitus ulcers.
5. No reduction in infection risk.
6. No improvement in functional status or slowing of decline.
7. No improvement in patient comfort.[29,30]

Studies examining potential benefits of parenteral and oral nutritional support in patients with advanced cancer have demonstrated no improvement in patient survival, primarily because of metabolic abnormalities that prevent patients from properly processing nutrients.[31–34]

What about the potential for harm? Although feeding tubes are often placed to reduce the risk

[t]This is the generally accepted opinion of the majority of rabbis who are expert in this area. However, a small number of rabbis have recently given the opinion that artificial nutritional support via an operative gastrostomy or percutaneous endoscopic gastrostomy (PEG) tube is a medical intervention. As such, they would generally rule that such forms of artificial nutritional support could be withheld from or refused by terminally patients as other medical procedures that only delay the dying process or do not provide relief of pain and suffering.[6]

of the patient developing aspiration pneumonia, the risk of aspiration with tube feeding may be as high as it is in patients before the tube is placed. If a gastrostomy tube is placed, about 15% of patients will develop a local infection in the site, and about 30% will have the tube occlude, sometimes requiring another procedure to replace the tube. When a nasogastric tube is placed, approximately two thirds of patients will need the tube replaced on one or more occasions. Perhaps most sobering, however, is information which shows that about 25%–30% of patients who have gastrostomy tubes placed will die within month of the procedure (some from complications of the tube placement procedure, others from the complications of their primary medical problems). Approximately 50% of patients who have tubes placed for feedings will die within 1 year of having the tube placed.[29,34]

The track record of hydration is similar, with the literature suggesting that symptoms of dehydration are not usually uncomfortable for terminally patients and that dehydration may actually be beneficial by reducing the sensation of pain and discomfort. Furthermore, with physiologic changes near the end of life preventing the body from properly utilizing fluids, artificial hydration can cause the patient to retain fluid, resulting in, among other complications, swelling of the legs and abdomen and lung congestion.[35]

Returning now to the consideration of the rabbis that food and fluid must be provided based on the fact that it is beneficial and is not harmful, one can see that questions can be raised regarding these assumptions as they pertain to terminally ill patients, based on the medical information available to us today. What this means on a practical level is that, while Jewish patients who are terminally ill should be provided food and fluid, the physician and other care givers have a responsibility to make sure that the food and fluid provided (or the method by which they are provided) do not cause the patient harm and/or discomfort. If a competent Jewish patient refuses nutrition or hydration after attempts have been made to convince him or her to accept the supportive care, the patient's wishes must be respected. In situations where the physician and/or other caregivers believe that the food or fluid 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, because there may be situations where even the provision of artificial nutritional support and hydration can be avoided. The initiation of artificial hydration and nutrition should also be avoided if it is determined (by a competent physician and a competent and knowledgeable rabbi) that the patient is a *goses*.[27]

ANTIBIOTICS

The question of whether antibiotics should be provided to patients who are near the end of life is an interesting one, as it relates to how one views the nature of the infection. Is the infection an illness unto itself or is the infection a complication of the terminal illness as result of the debilitation and immunosuppression caused by the primary illness?

It would appear that Jewish law views an infection, such as pneumonia, as an illness unto itself, and as such, it generally would be required to treat terminally ill patients with antibiotics in the face of infection. However, as with other treatments, the decision to treat patients with antibiotics for infection near the end of life is under "the assumption . . . that treatment of the pneumonia will in no way exacerbate the principal disease (and that the patient is not experiencing intractable pain."[35]

CHEMOTHERAPY, RADIATION THERAPY, AND SURGERY

Chemotherapy, radiation therapy, and surgery are playing an ever-increasing role in end-of-life care. Palliative surgical procedures, for example, may range from minor procedures such as abdominal paracenteses or biliary stent placement under radiologic guidance, to endoscopic procedures with laser photocoagulation or stent placement, to major surgical procedures such as pathologic fracture stabilization or diverting colostomy for bowel obstruction. Radiation therapy to bony lesions may provide symptomatic benefit, and in the case of spinal cord compression, contribute to keeping a patient ambulatory rather than bedbound in the last few weeks of life. More recently, selected chemotherapy agents have shown palliative benefit in selected patients with advanced cancer near the end of life.[36]

When these interventions are indicated and may potentially benefit Jewish patients, they cer-

tainly may choose to take these treatments, although they are not compelled to in all circumstances. As already stated, because Jewish law allows patients to forego therapy that is not curative (which none of these interventions are when patients are near the end-of-life), especially if the treatments only serve to prolong the dying process or cause increased pain and suffering, these treatments may be refused or withheld in the appropriate circumstances as well. (As a reminder, these decisions should be made by the patient and/or family in consultation with the patient's physician and a competent rabbi who understands Jewish law in this area.)

The more interesting question is whether or not terminally ill patients may choose to receive chemotherapy, radiation therapy, or surgery when the chance of success is exceedingly small and the risk of side effects, including the possibility of suffering an earlier death is high. This question is based on the notion that such treatments have little benefit and may cause a great deal of harm, and as discussed above, Jewish patients have an obligation to avoid things that are harmful to their bodies, and to not intentionally shorten their lives.

Jewish law permits patients to request treatments that are of high risk and low benefit, providing that the treatment has as its potential positive outcome the opportunity for cure or long-term survival, enough to remove such patients from the category of a *treifah* as discussed above.[6,35] "However, if the treatment will only prolong life for a few months, and not for a full year, while the patient may die immediately because of treatment toxicity . . . it is forbidden to undertake such a course of treatment."[35]

DISCONTINUATION OF VENTILATORS

While one is not compelled to place terminally ill Jewish patients on mechanical ventilators when they are dying, active withdrawal of such therapy is clearly against Jewish law as it may be the act of discontinuing the ventilator that is the actual cause of the patient's death.[u] Therefore, it is forbidden to remove a patient from a mechanical ventilator under most circumstances.[10]

There are many situations, however, where patients require mechanical ventilation and their prognosis is not clear. For example, a patient has just experienced a severe stroke, and it is not known whether the patient has a chance to recover. In order to give him the opportunity to recover, he must be placed on a ventilator, but medically, it is clear that if he does not improve within several days that he will not survive. If the ventilator cannot be removed under any circumstances, will the physician and family be less likely to use the intervention and allow the patient to die without giving him the opportunity to recover? Not providing mechanical ventilation would certainly not be compatible with Jewish law, as it could result in the premature death of a patient, who, if supported for several days, may yet recover.

While Jewish law does not permit the active removal of the ventilator, some rabbinic authorities permit the patient to be placed on a ventilator with an automatic time clock that will turn off the machine after a set time. When the machine shuts off, the physician would reassess the patient's condition. If the patient is showing signs of recovery, ventilation could be continued until the patient's condition is such that he can breathe independently. If it is determined that the patient is not going to improve, or if the patient's clinical condition has worsened, then, in conjunction with the family and proper rabbinical supervision and advice, a decision can be made as to whether or not the ventilator would be started (again).[10,26v] Of course, in order to be able to do this, one must have the forethought to initiate the time clock when the patient is first placed on the ventilator, and not add a timer after the fact. If no timer is placed, then Jewish law would not permit a patient to be removed from a ventilator, although a patient on a ventilator who was determined to be dying could be left on the ventilator and simply not provided any other interventions (such as vasopressors) then comfort, allowing the natural

[u]As the ventilator is directly assisting the body in breathing, and therefore, directly keeping the patient alive, it is considered an active intervention and not an impediment to death.[10]

[v]An alternative method to this would be to use oxygen tanks instead of wall oxygen to support the ventilator. When the tank's oxygen runs out, the physician would reassess the patient and determine whether a new tank should replace the old one.[10]

dying process to occur outside of the continued respiratory support.[w]

ADVANCE DIRECTIVES

As has already been discussed, Jewish patients have the ability to express autonomy about the health care they receive, as long as it is in keeping with Jewish law. Therefore, advance directives would be acceptable for Jewish patients provided that the instructions that were left on these documents were consistent with Jewish law as well.

There are two basic types of advance directive documents that patients may execute in preparation for a time when they will be unable to make health care decisions:

1. Living will: "This is a legal document, written and signed by an individual in the presence of witnesses, that conveys the instructions of that individual regarding health care interventions, desired or not desired, in the event of a terminal or irreversible illness and when the person is incapable of verbally communicating wishes regarding health care."[25] The living will delineates which treatments a patient desires or does not desire when s/he is in a terminal or irreversible state and can no longer express his/her wishes.
2. Durable medical power of attorney: This is "a legal document that allows an individual to appoint a responsible person or persons (usually called health care surrogates or proxies) who are empowered to make health care decisions in the event the individual becomes unable to make and communicate such decisions personally."[25]

The durable medical power attorney type of advance directive is very much in keeping with Jewish law and tradition. As has been discussed above, the rabbi is central to the process of decision making at the end of life. It is also clear that healthcare decision making for Jewish patients at the end of life is very individualized, and often depends on the circumstances of the specific situation. Therefore, using a durable medical power attorney type of advance directive, the patient would be able to designate a rabbi, knowledgeable in the area of medical decision making, as a health care proxy, along with whomever in his family she or he deems appropriate. Additionally, decision making, rather than being pre-determined (as would be the case in a living will), would be individualized, based on a discussion of the specific clinical circumstances by the patient's health care proxies (the rabbi and the designated family member) and the patient's physician.

The living will type of advance directive may also be acceptable according to Jewish law, although it is somewhat more controversial. Remembering that the living will delineates what treatments a patient may or may not desire when she or he is in a terminal or incapacitated state, although the rabbi could advise the patient on how to delineate which treatments would and would not be desired, there is no provision for rabbinic advice at the time the living will would actually be utilized. Therefore, treatment preferences indicated by the patient when the living will was executed may not be applicable to the patient's specific situation, and without the requirement for rabbinic input, there is a greater risk that the patient will be treated in a way that is not consistent with Jewish law.[13]

CONCLUSION

Judaism is a religion of law, a law that goes back 3500 years. The traditional, observant Jew incorporates that law into his or her everyday life, and all decisions that he or she makes are based on that law. Decisions regarding health care are no exception.

Just as importantly, Judaism is a religion of life. As has been discussed, even the laws of the Sabbath may be violated when a life is at stake, so that one may live by the law. However, Judaism also recognizes that life is finite, and just as one lives as a Jew, so does one die as a Jew, following the laws and precepts that have been passed

[w]As mentioned, not all Orthodox rabbinic authorities agree with the use of a timer to allow the ventilator to turn off automatically, allowing one to then withhold rather than withdraw care. The concept of utilizing a ventilator with a timer is currently being evaluated in Israel as well.

down from generation to generation since the time of Moses.

Regarding end-of-life care, Jewish law is specific and often appears exacting and inflexible. Yet, at the same, through rabbinic interpretations of Jewish law coupled with an ever improving understanding of the both the advances and limitations of modern medicine, the Jewish legal precepts that define Jewish medical ethics, when closely examined, are actually quite flexible regarding end-of-life care decision-making. Much like the principles of end-of-life care espoused by practitioners in hospice and palliative medicine, Jewish principles of end-of-life care are primarily focused on the patient and family, and involve shared decision-making based on the specific circumstances that the patient is in at the time, rather than on any absolutes. Certainly, there are limits to this, most notably that under no circumstances may life be intentionally shortened. However, under appropriate circumstances, every Jewish person who is terminally ill, can, under Jewish law, have the opportunity to have his or her life end as the life of Jacob, father of the Jewish nation, did; with dignity, surrounded by family, with the opportunity to provide blessing and instructions for his or her children, and to leave this world and enter the next in peace.

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REFERENCES

1. Kinzbrunner BM: Introduction. In: Kinzbrunner BM, Weinreb NJ, Policzer J (eds): *Twenty Common Problems in End-of-life Care*. New York: McGraw Hill, 2001, pp. xi–xiv.
2. Steinberg A: A Jewish perspective on the four principles. In: Gillon R (ed): *Principles of Healthcare Ethics*. John Wiley and Sons, Ltd., 1994, pp. 65–73.
3. Rosner F: The physician's license to heal. In: Rosner F: *Biomedical Ethics and Jewish Law*. Hoboken: Ktav Publishing House, 2001, pp. 5–11.
4. Bleich JD: Treatment of the terminally ill. Tradition 1996;30:51–87.
5. Rosner F: Managed care: The Jewish view. In: Rosner F: *Biomedical Ethics and Jewish Law*. Hoboken: Ktav Publishing House, 2001, pp. 513–530.
6. Schostak Z: Precedents for hospice and surrogate decision-making in Jewish law. Tradition 2000;34:40–57.
7. Feinstein, M: Iggeros Moshe, Choshen Mishpat II: 73. In: Tendler MD (ed): *Responsa of Rav Moshe Feinstein, Vol. 1, Care of the Critically Ill*. Hoboken: Ktav Publishing House, 1996, pp. 38–53.
8. Rosner F: Suicide. In: Rosner, F: *Biomedical Ethics and Jewish Law*. Hoboken: Ktav Publishing House, 2001, pp. 237–255.
9. Herring BF: Euthanasia. In: Herring BF: *Jewish Ethics and Halakha for our Time, Sources and Commentary*, Vol. 1. New York: Ktav Publishing House, 1984, pp. 67–90.
10. Rosner F: Euthanasia. In: Rosner F: *Biomedical Ethics and Jewish Law*. Hoboken: Ktav Publishing House, 2001, pp. 271–285.
11. Tendler MD, Rosner F: Quality and Sanctity of Life in the Talmud and Midrash. In: Tendler MD: *Responsa of Rav Moshe Feinstein, Vol. 1, Care of the Critically Ill*. Hoboken, NJ: Ktav Publishing House, 1996, pp. 135–148.
12. Feinstein M: Iggeros Moshe, Choshen Mishpat II: 74. In: Tendler MD: *Responsa of Rav Moshe Feinstein, Vol. 1, Care of the Critically Ill*. Hoboken, NJ: Ktav Publishing House, 1996, pp. 53–62.
13. Lamm M: *Caring for the Jewish Terminally Ill*. Palm Springs, CA: National Institute of Jewish Hospice, 1990.
14. Herring BF: Truth and the Dying Patient. In: Herring BF: *Jewish Ethics and Halakha for our Time, Sources and Commentary, Vol. 1*. New York: Ktav Publishing House, 1984, pp. 49–65.
15. Rosner F: Quality and sanctity of life. In: Rosner F: *Biomedical Ethics and Jewish Law*. Hoboken: Ktav Publishing House, 2001, pp. 223–235.
16. Hanks G, Chernys N: Opioid analgesic therapy. In: Doyle D, Hanks G, McDonald N (eds): *Oxford Textbook of Palliative Medicine*, 2nd ed. New York: Oxford University Press, 2001, pp. 331–355.
17. Weinreb NJ, Kinzbrunner BM, Clark M: Pain management. In: Kinzbrunner BM, Weinreb NJ, Policzer J (eds): *Twenty Common Problems in End-of-life Care*. New York: McGraw Hill, 2001, pp. 91–145.
18. Bruera E, MacEachern T, Ripamoni C, Hanson J: Subcutaneous morphine for dyspnea in cancer patients. Ann Intern Med 1993;119:906–907.
19. Bruera E, Macmillan K, Pither J, MacDonald RN: Effects of morphine on the dyspnea of terminally ill cancer patients. J Pain Symptom Manage 1990;5:341–344.
20. Thorns A, Sykes N: Opioid use in the last week of life and implications for end-of-life decision making. Lancet 2000;356:398–399.
21. Diem SJ, Lantos JD, Tulsky JA: Cardiopulmonary resuscitation on television. Miracles and misinformation. N Engl J Med 1996;344:1578–1582.
22. Von Gunten CF, Weissman DE: Discussing do-not-resuscitate orders in the hospital setting: Part 2. J Palliat Med 2002;5:417–418.

23. Bedell SE, Delbanco TL, Cook EF, Epstein FH: Survival after cardiopulmonary resuscitation in the hospital. N Engl J Med 1983;309:569–576.
24. Murphy DJ, Murray AM, Robinson BE, Campion EW: Outcomes of cardiopulmonary resuscitation in the elderly. Ann Intern Med 1989;111:199–205.
25. Gomez D: Advance directives and CPR. In: Kinzbrunner BM, Weinreb NJ, Policzer J (eds): *Twenty Common Problems in End-of-life Care*. New York: McGraw Hill, 2001, pp. 297–311.
26. Schostak Z: Ethical guidelines for the treatment of the dying elderly. J Halacha Contemp Soc Fall 1991;XII: 62–86.
27. Eisenberg D: Halachic issues regarding the futility of medical treatment: Applications to nutrition and hydration in the terminally ill patient. ⟨www.ijme.org/Content/Transcripts/Eisenbery/treatment2.htm⟩
28. Berman A: From the legacy of Rav Moshe Feinstein, z"l. J Halacha Contemp Soc S 1997;13:5–18.
29. Finucane TE, Christmas C, Travis K: Tube feedings in patients with dementia: A review of the evidence. JAMA 1999;282:1365–1370.
30. Gillick M: Sounding board: Rethinking the role of tube feeding in patients with advanced demential. N Engl J Med 2000;342:206–210.
31. Nelson KA, Walsh D, Sheehan FA: The cancer anorexia-cachexia syndrome. J Clin Oncol 1994;12: 213–225.
32. Klein S: Clinical efficacy of nutritional support in patients with cancer. Oncology 1993;7(Suppl):87–92.
33. Ovesen L, Allingstrup L, Hannibal J, Mortensen EL, Hansen DP: Effect of dietary counseling on food intake, body weight, response rate, survival, and quality of life in cancer patients undergoing chemotherapy: A prospective, randomized study. J Clin Oncol 1993;11:2043–2049.
34. Kinzbrunner BM: Nutritional support and parenteral hydration. In: Kinzbrunner BM, Weinreb NJ, Policzer J (eds): *Twenty Common Problems in End-of-life Care*. New York: McGraw Hill, 2001, pp. 313–327.
35. Feinstein, M: Iggeros Moshe, Choshen Mishpat II: 75. In: Tendler MD: *Responsa of Rav Moshe Feinstein, Vol. 1, Care of the Critically Ill*. Hoboken, NJ: Ktav Publishing House, 1996, pp. 62–67.
36. Weinreb NJ: Diagnostic Tests and Invasive Procedures. In: Kinzbrunner BM, Weinreb NJ, Policzer J (eds): *Twenty Common Problems in End-of-life Care*. New York: McGraw Hill, 2001, pp. 329–364.

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