Jewish ethical guidelines for resuscitation and artificial nutrition and hydration of the dying elderly

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Author's abstract

The bioethical issues confronting the Jewish chaplain in a long-term care facility are critical, particularly as life-support systems become more sophisticated and advance directives become more commonplace. May an elderly competent patient refuse CPR in advance if it is perceived as a life-prolonging measure? May a physician withhold CPR or artificial nutrition and hydration (which some view as basic care and not as therapeutic intervention) from terminal patients with irreversible illnesses?

In this study of Jewish ethics relating to these issues, the author carefully examines the moral implications and legal precedents in the literature. Jewish ethics, affirming a 'sanctity of life' position, suggest that while an elderly person may direct in advance that CPR not be administered in most instances, in the absence of a DNR (Do Not Resuscitate) order, CPR must be performed. In reference to 'tube-feeding', while there is some debate about whether elderly patients may refuse the initiation of 'tube-feeding', there is a consensus that once initiated, it may not be withdrawn.

I: Jewish ethical perspectives

The age-old legal-ethical system known as halacha, governs virtually every aspect of Jewish life and offers much direction in the area of medical ethics and conduct. In medical decision-making, halacha would deem the sanctity of life, the preciousness of every moment, as the uppermost consideration. In fact, the imperative to preserve life supersedes, with few exceptions, concerns about the 'quality of life' in medical decision-making. Arguments for the 'quality of life' – limited medical resources for an ever-growing population, patient rights, and death with dignity – while superficially appealing are perceived as nothing more than man playing God, unduly intervening in the eternal processes of life and death. Quality-of-life concerns have, in fact, prompted a former Governor of Colorado to advocate eutha-

nasia for the elderly and a Michigan doctor to create and use the so-called 'death machine' (1). Jewish law vigorously asserts that life, even that of a terminal, demented, elderly patient is of infinite value; it must be preserved no less than the life of a young and alert child with a hopeful long-term prognosis (2).

This bold position is presented in a classic case (Yoma 83a) where the Mishnah directs that one must immediately remove debris that has fallen upon someone on *Shabbat*, even though the victim may only live for a short time. Jewish legal codes and responsa (3) elaborate that he or she must be saved even though his or her skull was crushed and he or she may live for only a few minutes. Though he may have been moribund, mentally incompetent, or a minor ... his life must be saved (4). This ruling is based on Judaism's attributing infinite value to human life. 'Infinity being indivisible, any fraction of life, however limited its expectancy or its health, remains equally infinite in value' (5). A more dramatic illustration of this principle is that of a triage decision in a facility which has only one respirator. The machine is connected to a deathly ill, disoriented 90-year-old. May this patient be removed from the respirator in favour of a young accident victim who has just arrived, who will surely die without it, but will probably recover with it? Here, too, halachic authorities rule that the dying elderly patient *already on the machine* may not be removed from the respirator (4). By removing the old man from the respirator in favour of the young one, we would be, in effect, declaring that the old man's life is less valuable than that of the young one. *De facto*, we play God when we pass judgement on the 'quality of life'. However, in such cases where neither of them has been placed on the respirator, priority is, of course, given to the young accident victim who has the better prognosis for long-term recovery (6).

Every life-saving measure – even extraordinary ones – must be utilized to prolong life, with few exceptions – the most common being severe, unremitting pain and suffering. The source of this concept is found in the Talmud, (*Ketubot* 104a) which describes the fatal illness of the great Rabbi Judah the Prince, known simply as 'Rebbe'. Rebbe's

Key words

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pious maidservant, upon seeing her master's suffering, prayed for his demise, and even interrupted his students from praying for his life. Since the Talmud does not criticize her conduct, Rabbenu Nissim, a major Talmudic commentator, concludes: 'There are times when one should pray for the sick to die, such as when one is suffering greatly from his malady and his condition is terminal ...' (7). Contemporary authorities have applied this passage to the treatment of the critically ill in extreme pain, by allowing them to refuse 'extraordinary' life-saving measures, and to receive intensive doses of pain-killers (2).

God entrusts us with our bodies which we must keep safe and healthy. He grants us the legal status of a bailee (8), who must make every effort to guard the article he is given, protecting it from loss and damage. Interestingly, this concept of guardianship is expressed clearly in the words of the Torah – 'Only guard yourself, surely guard your soul ...' (*Deut* 4:9), which Maimonides (9) and others say refers to protecting one's health. Another primary source for saving another's life is the verse: 'And you shall restore it [ie, the lost article] to him'. (*Deut* 22:2). The Talmud (*Sanhedrin* 73a) reasons that if one is obliged to return lost property to its rightful owner, then one must certainly restore that 'owner's' life and health (10), wherever possible. Once again the issue of refusal of medical treatment is raised: if the rightful owner chooses to abandon his property and not seek its return, why can't the seriously ill patient, under certain circumstances, forego the restoration of his health, too (11)? Others argue that the analogy between property rights and human life is flawed. While one may exercise proprietary rights over one's possessions, one does not 'own' one's body; it belongs to God (12).

Halachic precedents and guidelines for prudent decision-making have become increasingly important in our fast-paced, sophisticated world of medical technology. With recent legislation for advance directives expressed through a living will or a health-care proxy (13), we are now compelled to think about and articulate our views concerning the initiation or refusal of various medical treatments/therapies should we become incapacitated at a later date. Since the Cruzan case and advance-directives legislation have brought medical-ethics concerns to the forefront, it behoves us to review the issues involved.

II: Resuscitation/tube-feeding issues

In a geriatric-skilled nursing facility, the chaplain confronts vexing ethical issues on an almost daily basis. He is often asked to advise about resuscitation protocol in the absence of a DNR (Do Not Resuscitate) order. What are the doctor's moral-ethical obligations to revive a seriously ill, aged patient for whom 'Do Not Resuscitate' has not been

noted when the medical odds for survival are almost nil (4)? Is he permitted to perform CPR on this frail patient (a procedure so severe that brittle ribs are often broken) when, in fact, this patient may possibly be moribund, and, according to Jewish law, may not be touched (6)?

The chaplain is often called upon to recommend policy in another critical area: What should the facility's position be towards a patient who refuses to be 'fed' through a nasogastric tube or through a gastrostomy? Medically, both of these procedures are similar in that food and hydration are introduced into the patient's functioning gastrointestinal tract when he is unable to swallow or eat normally. The nasogastric tube is inserted into a patient's nostril and is guided through the oesophagus into the stomach. Though this is a relatively simple procedure, it can lead to serious side-effects, such as pneumonia, aspiration, and diarrhoea (14, 15). Moreover, it is not uncommon for patients who are irritated by larger tubes to pull them out (16). The more permanent procedure is a gastrostomy, where the feeding tube is surgically implanted directly through the abdominal wall into the stomach, which also presents some risk for seriously ill patients (14).

My colleagues and I have had to grapple with these issues as 'living wills' and health-care proxies have come into more common use. In this paper, I have attempted to formulate resuscitation and tube-feeding guidelines that are medically viable, halachically-sensitive, and compatible with state and federal law.

III: Resuscitation of the elderly

CPR, cardiopulmonary resuscitation, is a relatively recent development in medical science, having first become standard practice in the early 1960's (17). Then, almost every patient who had no pulse or respiration was routinely resuscitated. Later, in the mid-70s, there was serious concern that attempts to resuscitate certain hospital patients could be considered unduly invasive since their prognoses were not improved (18). Today, in addition to basic CPR, emergency medical technicians (EMTs) or paramedics are trained in the use of sophisticated electronic equipment and techniques: rhythm recognition, pharmacology, intubation, intravenous and intracardiac methods and defibrillation.

In a skilled nursing-home setting, where many residents are frail and suffer from irreversible illnesses, the resuscitation issue is particularly significant. Indeed, it really is not one single issue but a myriad of complex legal and halachic-ethical questions: If CPR is a life-prolonging measure, may a competent patient refuse it in advance? May a doctor withhold CPR from patients in cases of terminal irreversible illness where death is not unexpected (19)? In a nursing home, where the vast majority of residents who receive CPR will not

survive (and the few who do may suffer residual neurological, or other medical problems), the widespread practice of CPR has been challenged (20).

Some researchers declare that CPR is 'rarely effective for elderly patients' and that they and their families 'have a right to know the truth about the poor outcomes of cardiopulmonary resuscitation' (21). Others favour a more radical proposal: not to offer CPR to nursing home residents. Though they concede that this across-the-board policy 'might be unfair to the small number of residents who have a reasonable chance of survival ... it would protect the many residents who now undergo CPR without having genuinely consented' (22).

There are significant studies and clinical reports that differ markedly from the above and assert that 'elderly patients can benefit from attempted resuscitation from out-of-hospital cardiac arrest'. They cite earlier studies which show that between two per cent (in rural areas) and nine per cent (in urban centres) of patients aged 70 or older survive to hospital discharge after out-of-hospital cardiopulmonary arrest; their own research findings also confirm that 'rapid and efficient resuscitation from out-of-hospital cardiac arrest can extend the life of elderly patients, especially if ventricular fibrillation underlies the cardiac arrest' (23). Researchers at the Medical College of Wisconsin in Milwaukee compared elderly and younger patients and concluded that 'even though elderly patients are more likely than younger patients to die during hospitalization, the hospital stay of the elderly is not longer, (they) do not have more residual neurologic impairments, and survival after hospital discharge is similar to that in younger patients' (21, 24).

A small percentage of elderly CPR patients do survive!

Virtually all researchers would agree on one point: a small percentage of elderly CPR patients *do* survive! This would support a clear halachic position: attempts to resuscitate the elderly are mandated in the absence of a DNR order unless they are medically futile. As long as a percentage of elderly patients survive after CPR – however small – the doctor must attempt resuscitation (3); to withhold it, in effect, would deny the patient any possibility for survival (25).

In New York State, the law (26) is generally compatible with the halachic position. In the absence of a DNR order, New York State presumes that every patient admitted to a hospital consents to the administration of CPR in the event of cardiac or respiratory arrest. While an attending physician may issue a DNR order without the consent of a competent patient who 'would suffer immediate and severe injury from a discussion of cardiopulmonary resuscitation', he must first comply with a detailed

protocol (27). The attending physician can issue a DNR order if he determines (with the concurrence of another authorized physician) that: 'to a reasonable degree of medical certainty – "resuscitation would be *medically futile*"' (ie, CPR will be unsuccessful in restoring cardiac and respiratory function or the patient will experience repeated arrest in a short time period before death occurs.)

Halachically and ethically, may a doctor refrain from this potential life-saving action when he is reasonably certain that it is medically futile?

Underlying the ethical concern is the fundamental issue of whether CPR is regarded as an 'ordinary' or 'extraordinary' measure. There is no common law obligation to provide patients with extraordinary care and such treatment may be withheld (28). Though there is much debate in the literature about the definition of these terms, Kelly's formulation is quite precise:

'Ordinary means of preserving life are all medicines, treatments, and operations, which offer reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain, or other inconvenience ...

'Extraordinary means of preserving life ... mean all medicines, treatments, and operations, which cannot be obtained without excessive expense, pain or other inconvenience, or which, if used would not offer a reasonable hope of benefit' (29).

It would appear that attempts at CPR in a medically futile situation would be deemed 'extraordinary', according to this definition. Resuscitation would not offer a reasonable hope of benefit and much pain and inconvenience would likely accompany the procedure. Most legal authorities, in fact, consider CPR to be extraordinary care in the case of a terminally ill patient and beyond the scope of services that a physician is required to provide (30).

Halachic authorities rule that the patient may refuse to initiate extraordinary treatment when his condition is irreversible (ie, the proposed treatment promises only to extend his life somewhat but not to cure the illness), particularly if he objects because of the pain involved (31). Thus, a patient whose medical condition is futile, who stops breathing or experiences cardiac arrest, does not have to be resuscitated if this procedure will contribute to his pain (32).

Jewish law, in general, establishes another major criterion in determining the permissibility of a questionable act. It distinguishes between an act of commission (*kum v'aseh*), taking an active role in performing a questionable act, and an act of omission (*shev v'al taaseh*), refraining from any action whatsoever. In medical treatment, for example, halacha might not permit an act of commission, such as disconnecting a terminal patient from a respirator; however, it might permit not connecting him in

certain instances, ie, an act of omission. In the former, the physician actively engages in a possibly forbidden act, while, in the latter, he remains passive. This would explain why he may not be required to initiate CPR in a medically futile situation and why a terminal patient could refuse major surgery or painful treatments, which may prolong his life somewhat but only with much suffering. Conversely, a comatose patient on a respirator could only be detached from that machine if it was determined that he was halachically dead (33).

While the distinction between withholding and withdrawing treatment has significant implications in Jewish law, in secular ethics and law, it is, at best, irrelevant. In an opinion to a Jewish nursing home in the midwest the home's counsel addresses this point: Ethically, when 'the patient, or surrogate, in collaboration with the responsible health care professionals, decides that a treatment underway and the life it provides are more burdensome than beneficial, there is sufficient reason to stop. There is no ethical requirement that once treatment has been initiated, it must continue against the patient's wishes or when the surrogate determines that it is more burdensome than beneficial from the patient's perspective' (34).

Legally, as well, nothing makes stopping treatment a more serious legal issue than not starting treatment. In fact, it may be argued that not starting treatment that might be in a patient's interest is more likely to be held wrong in civil or criminal proceedings than stopping the same treatment when it has proved unavailing. The Supreme Court of New Jersey noted in *In re Conroy*, 98 NJ/321,486 A 2d 1209 (1985): 'It might well be unwise to forbid persons from discontinuing a treatment under circumstances in which the treatment could be permissibly withheld. Such a role could discourage families and doctors from even attempting certain types of care and could thereby force them into hasty and premature decisions to allow a patient to die' (35).

IV: Tube feeding in the elderly

Does the elderly patient's right to refuse treatment in a medically futile situation extend to food and water provided through a nasal or gastric tube? Is tube-feeding no different from oral feeding, that is 'ordinary' treatment which offers 'reasonable hope or benefit for the patient and ... can be obtained and used without excessive expense, pain or other inconvenience' (29)?

Or, should tube-feeding be regarded as a therapeutic procedure, where arguably it might be refused as one would other 'extraordinary' treatments; indeed, tube-feeding does present an increased degree of risk (14, 15) and inconvenience to the elderly (16).

Legally, New York courts have confirmed the rights of a competent adult to refuse medical

treatment (absent an overriding state interest), even when the treatment may be necessary to preserve that person's life (35). However, when the adult is no longer competent to make medical decisions, the state's highest court, the New York Court of Appeals, has applied the most rigorous standard, that of 'clear and convincing evidence', before life-sustaining treatment could be terminated or withheld (36). Under this standard, the trier of fact must be persuaded that the patient, when competent, held a firm and settled commitment to terminate life-support under circumstances like those which may have actually arisen. This would preclude common hearsay of the 'mamma told me so ...' variety.

New York courts have also ruled on two other critical concerns of the tube-feeding issue. First, the Appellate Division, Second Department, in *Delio v Westchester County Medical Centre* (37), viewed nutrition and hydration by artificial means as being the same as the use of a respirator or other life-support equipment; they are both *medical* procedures. Additionally, the court did not distinguish between *termination* of nutrition and hydration and *withholding* this treatment. Consequently, the court, citing the *Storar* precedent, ruled that there must be 'clear and convincing evidence' that the patient has expressed a desire to discontinue life-prolonging treatment such as artificial feeding under these circumstances. This 'clear and convincing' standard was validated again in the *Cruzan* case by the United States Supreme Court (38). While the court recognized that competent adults have a protected liberty interest in refusing life sustaining measures, *including artificial nutrition and hydration*, it held that the State of Missouri was not required to allow the Cruzan family to discontinue their daughter Nancy's treatment. Indeed, the court affirmed the authority of a state to require clear and convincing evidence of the patient's wishes.

While the courts have respected the rights of individuals to refuse artificial nutrition and hydration, they would not compel nursing homes to honour such directives where the homes have notified the resident (and/or his family) of their policy to provide artificial nutrition and hydration at all times, (unless medically contra-indicated) upon admission. This position is based on a recent case which received much local media attention *Elbaum v Grace Plaza* (39). In *Elbaum*, the husband of a resident in Grace Plaza wished to enjoin the facility permanently from providing artificial nutrition and hydration to his wife. The Appellate Division, Second Department, overturned a lower court decision and ruled that the wife had made a firm and settled decision while competent to decline the treatment under her present circumstances; she had, in fact, extracted promises from her husband and family members not to prolong her life if she were in a persistent vegetative state. The court held that the

wife's interests were not outweighed by those of Grace Plaza to preserve what it claimed to be the ethical integrity of the facility and the medical profession. *The nursing home had failed to make its policy against the withdrawal of the gastrointestinal tube known to the family until after the family requested the removal of the tube.* Thus, the family had every reason to believe that the wife's wishes would be honoured upon her admission to the home. The implications of this case are clear: where the nursing home provides notice of its treatment policies and ethical standards to the prospective resident (and/or family) upon admission, the interests of the home would supersede those of the entering resident. The resident would then have to consider another facility, or determine whether this nursing home would transfer him to another facility that would respect his wishes, in the event it became necessary to terminate his artificial feeding (39).

V: Ethical issues

The predominant legal view equating artificial nutrition (tube-feeding) with life-preserving medical treatment is shared by a wide range of physicians' groups and ethicists. They see no logical distinction between the removal of a respirator and the discontinuing of artificial nutrition. Just as a respirator may be required to maintain an oxygen flow to lungs which are not functioning, so tube-feeding may be necessary when the alimentary-digestive system is impaired due to disease, trauma, or bodily deterioration (40). An apparent consequence of this view is that the patient's right to refuse medical treatment applies with equal force to the refusal of artificial nutrition and hydration. Yet, in practice, this is not always the case. In about half of the forty states which have living will statutes, nutrition is either excluded or circumscribed from the forms of life-prolonging treatments which may be rejected (41). This would seem to reflect the opinion of legislators that withholding feeding from a terminal patient is more like active euthanasia than turning off a respirator. In fact, a leading constitutional scholar, Professor Yale Kamisar, has labelled court actions terminating artificial nutrition to stable, comatose patients as bringing America to 'the brink' of active euthanasia. Professor Kamisar proposes that the courts treat nourishment as being different from other forms of medical treatment, or distinguish between 'dying' patients who have clearly expressed a wish to forego nutrition and those who have not (42). Some ethicists suggest that providing nutrition and hydration to patients who have an irreversible disease is an act of caring which should be offered even when it may not prolong their lives. The dying patient still deserves palliative care for comfort's sake.

Perhaps, the most cogent argument of ethicists who oppose termination of artificial feeding to

stable, comatose patients is the 'slippery slope' theory. Simply put, in situations where the patient has not provided advance directives, any decision to terminate his or her medical therapy, including artificial feeding, would tend to be subjective. Who determines the quality of life of a patient in a persistent vegetative state, if, in fact, such a state can be accurately diagnosed (43)? More importantly, would a decision to terminate treatment in this case ultimately lead to decisions to terminate the treatment of mentally incompetent patients? Where do we draw the line? If one 'pulls the plug' on a comatose patient because he has become a vegetable with no human qualities, why not terminate life-sustaining treatment to a terminal, severely-retarded patient who has been no more than a vegetable since birth? If, however, one subscribes to the 'sanctity of life' position, the line is clear: man cannot properly assess the value or relative quality of life. Advocates of this position propose that the very existence of the mentally and physically-retarded suggests that the value of human life is determined by God. 'Quality of life' is a subjective determination which often leads to the dangers of the slippery slope. 'Sanctity of life', however, is the unequivocal position that all human life is valuable and that life-sustaining efforts can only be suspended under clearly defined guidelines. As we indicated at the outset, the danger of the quality-of-life, slippery-slope rationale is particularly acute in our society, where critical-care beds are at a premium, and cost factors may unduly influence triage decisions (44).

VI: Tube-feeding in Halacha

The late internationally renowned halachic authority, Rabbi Moshe Feinstein, in a series of responsa on medical issues, discusses the question of feeding a terminally ill patient intravenously. He maintains that providing proper nutrition is imperative, even in situations where intravenous feeding might only prolong a life of pain. The only exception to this rule would be where artificial nutrition would be medically contra-indicated. Rabbi Feinstein further declares that this procedure is so vital that it may be administered involuntarily. He distinguishes, however, between involuntary feeding, where the patient disagrees with the doctor's orders, but ultimately consents, and force-feeding, where he protests or must be physically restrained in order to be fed. In the latter, Rabbi Feinstein posits that the psychotrauma experienced by a dying patient whose wishes are thwarted might hasten his death. (See *Baba bathra* 147b) (45).

A major Israeli authority, Rabbi Shlomo Zalman Auerbach, considers artificial nutrition to be routine, 'ordinary' treatment which may not be refused or withdrawn, as one might 'extraordinary' treatment. Consequently, a dying patient, suffering from metastatic cancer, must receive oxygen and the

artificial nutrition and hydration which he requires – even if he is suffering and in great pain. Rabbi Auerbach compares these treatments to providing insulin, blood, transfusions and antibiotics, which may not be withdrawn, even in cases of terminal patients where withdrawal may be used to hasten their deaths (46).

Rabbi Hershel Schachter, a leading scholar at Yeshiva University and Rabbi Chaskel Horowitz (the Viener Rav) maintain that artificial nutrition and hydration are medical procedures which a terminal patient may refuse.

Rabbi Schachter bases his ruling on the opinion of Rabbi Yaakov Emden in the *Mor uketztyah* on *Schulchan aruch*, *Orach chaim* 328 that the obligation to save lives is comparable to the obligation to restore lost articles (*hashavat aveidah*). Just as one who is in extreme discomfort is not required to return a lost article, so may a suffering, terminal patient refuse medical treatment to restore his lost health. Rabbi Schachter also finds difficulty with Rabbi Auerbach's contention that one must provide a dying patient who is suffering with nutrition and hydration against his will, while simultaneously praying for his demise to spare him any further suffering (11).

Rabbi Horowitz, a noted authority in the Chassidic community, issued his decision on behalf of the Aishel Avraham Resident Health Facility in Williamsburg. He considers artificial nutrition and hydration to be a medical therapy on a par with other surgical procedures, which may be refused by critically ill, terminal patients (47).

VII Conclusions

1. Sanctity of life, the halachic imperative to preserve life, supersedes, with few exceptions, quality-of-life considerations in Jewish medical ethics. Indeed, quality-of-life decisions are perceived, in many cases, as nothing less than sanctioned euthanasia.

2. The imperative to preserve and prolong life, wherever possible, should be uppermost in medical decision-making. However, in cases of terminal illness where the decision to utilize certain treatments, surgery, or therapies would be likely to increase the patient's pain or be considered medically futile, the patient would be entitled to reject such treatment in advance.

3. CPR and other resuscitation procedures are generally considered to be 'extraordinary' means of reviving individuals who experience cardiac arrest. Nonetheless, halacha declares that, in the absence of a DNR (Do Not Resuscitate) order, medical staff are required to resuscitate an elderly patient. Halacha would, however, respect the decision of an elderly terminal patient to request a DNR order since CPR is, after all, a traumatic, extraordinary procedure with doubtful benefit.

4. The question of withholding and withdrawing artificial nutrition and hydration – tube-feeding –

is not clear-cut in halacha. In the elderly, for example, inserting or implanting feeding tubes may be perceived as extraordinary procedures with potentially serious complications for critically ill elderly patients. Some halachic authorities, however, equate tube-feeding with basic care and demand that patients be fed, even against their wishes. Others would maintain that tube-feeding is essentially a therapeutic procedure, which, like other medical treatments, may be refused by terminal patients in conditions of extreme pain or irreversible illness.

This writer suggests that, in geriatric patients, advance directives regarding artificial nutrition and hydration be limited to withholding nutrition – an act of omission – as opposed to withdrawing such nutrition after the fact, which is an outright act of commission – 'pulling the plug'. It should be noted that, medically speaking, tube-feeding (even the insertion of a nasal gastric tube) is considered a therapeutic procedure. It is also noteworthy that, both legally and ethically, there is no distinction between withholding or withdrawing medical treatment. In halacha, however, the difference between the two is extremely significant. Legally, it is of the utmost importance that the health-care facility communicate its philosophy, and policies *vis-à-vis* tube-feeding, DNR, and other treatments to all entering residents upon admission; a belated – after the fact – disclosure may subject the institution to legal liability.

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References and notes

- (1) Governor Richard D Lamm of Colorado, in March 1984, declared that elderly people who are terminally ill have the 'duty to die and get out of the way'. In June 1990, Janet Adkins, a victim of Alzheimer's disease, used a suicide device invented by Dr Jack Kevorkian.
- (2) *Halachah urefuah*, vol 2: 189, in an article entitled 'Treatment of a moribund patient and establishing the time of death, by Dr A S Abraham. Also, *Igrot Moshe Choshen mishpat*, vol 7; 73: 2.
- (3) *Shulchan aruch*, *Orach chaim* 329: 3–4. Also, *Tzitz Eliezer* 9: 17 and 10: 25.
- (4) *Biur halachah* on *Mishnah berurah*, *Shulchan aruch*, *Orach chaim* 329: 3–4. Also, *Tzitz Eliezer*, vol 8: 155 Ch 3.
- (5) Jakobovits I. *Jewish medical ethics*. New York: Bloch Publishing Company, 1975: 276.
- (6) See reference (2): *Igrot Moshe*, *Choshen mishpat*.

- (7) *Nedarim* 40a.
- (8) As heard from Rabbi Dr J D Bleich, interpreting the Ran to *Nedarim* 40a, at a lecture on the 19th of April 1990.
- (9) *Mishnah torah, rotzeach*, 11: 4.
- (10) Maimonide's *Commentary to the mishnah, Nedarim* 6: 8. Also, *Teshuvot atzei ha-levanon*, 61, who extends this passage to include restoring health in non-life-threatening situations. See also *Halacha urefuah*, vol 2: 133–134.
- (11) *Hakometz mincha* on *Minchat chinuch*, Mitzvah 237 and *Hochmat Shlomo* to *Choshen mishpat*, 426. See also article by Rabbi Hershel Schachter, appearing in the *Beit-Yitzchak* journal, 5746 issue.
- (12) *Igrot Moshe, Yoreh deah*, vol 2, 174: 3. *Mishnah torah, Sanhedrin*, 18: 6, and *Rotzeach* 1: 4; *Sefer chasidim* 723; *Shulchan aruch harav, Nizkei haguf v'nefesh*, 4; *Responsa of Rivash* 484 and *Chazon ish, Nezikin*, 19: 5.
- (13) Forty-two states already have living-will laws. Eighteen states, including New York, allow health-care proxies. In 1991, a new Federal law took effect, the Patient Self-determination Act. This measure states that patients entering a federally funded hospital or nursing home must receive written information about state laws and their rights under those laws to refuse treatment. They must also be notified of the institution's practices so that they can select one that will respect their wishes. In addition, every institution is required to record whether the patient has, in writing, rejected life-support.
- (14) Ciocon J O, Silverstone F A, Grauer L M, Foley C J. Tube feedings in elderly patients. *Archives of internal medicine* 1988; 148: 429–433. The authors conclude, on the basis of their research at a major metropolitan geriatric centre, that: 'tube alimentation in the elderly can be continued for long periods but is associated with a high frequency of complications'. Dresser R, Boisqubin E. Ethics, law and nutritional support. *Archives of internal medicine* 1985; 145: 122.
- (15) Pritchard V. Tube-feeding-related pneumonias. *Journal of gerontological nursing* 1988; 14: 32–36.
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- (17) Jude J, Koawenhaven W, Ing W, et al. Cardiac arrest: report of application of external cardiac massage on 118 patients. *Journal of the American Medical Association* 1961; 178: 1063: 1070.
- (18) Standards for cardiopulmonary resuscitation and emergency cardiac care: v medicolegal considerations and recommendations – orders not to resuscitate. *Journal of the American Medical Association* 1974; 227: 864–866.
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- (21) Tresch D D, Thakur R K, Hoffman R G, et al. Should the elderly be resuscitated following out-of-hospital cardiac arrest? *American journal of medicine* 1989; 86: 145–150.
- (22) See reference (20): Applebaum G E, King J E, Finucane T E.
- (23) Longstreth W T, Cobb L A, Fahrenbruch C E, Copass M K. Does age affect outcomes of out-of-hospital cardiopulmonary resuscitation? *Journal of the American Medical Association* 1990; 264: 2110.
- (24) Bellamy P E, Oye R K. Admitting elderly patients to the ICU: dilemmas and solutions. *Geriatrics* 1987; 42: 61–68; Galati R S, Blan G L, Horan M A. Cardiopulmonary resuscitation of old people. *Lancet* 1983; 2 (8344): 267–269. Both of these studies suggest that the severity of the illness or cardiac dysrhythmia are more accurate predictors of outcome than age *per se*.
- (25) Rosner F. [letter]. *Annals of internal medicine* 1989; 111: 687.
- (26) N Y Public Health Law: art 29-B.
- (27) See reference (26): Public Health Code Section 405.42: (C) General provision, 1–2 and (E) Decision-making by an adult with capacity, 3, therapeutic exception.
- (28) Ramsey R. On (only) caring for the dying. *The patient as a person*. Yale: Yale University Press, 1970: 113–164.
- (29) See reference (28): 122. Today, it can be argued that the 'ordinary-extraordinary' appellations are *passé*. In our fast-paced world of medical technology, what today may be an 'extraordinary' procedure will be 'ordinary' tomorrow. See Rosner F, *Modern medicine and Jewish ethics*, New York: Yeshiva University Press, 1986: 218.
- (30) LeBlang T R. Does your hospital have a policy for no-code orders? *Legal aspects of medical practice* 1981; 9: 1–5; 9: 5–8.
- (31) The opinion of Rabbi Shlomo Zalman Auerbach, cited by Dr A S Abraham in *Halachah urefuah*, 2: 189. See also *Igrot Moshe, Choshen mishpat*, vol 7, 74: 1. Rabbi Chaim Ozer Grodzinski, the leading halachic authority of pre-war Europe, determined that a patient who is critically ill may refuse surgery, according to Rabbi Yisrael Gustman, a member of Vilna's Rabbinical Court, as reported to Rabbi David Cohen.
- (32) *Igrot Moshe Yoreh deah*, 2: 174 and *Tzitz Eliezer*, 13: 89.
- (33) Rabbi Eliezer Waldenberg in *Tzitz Eliezer*, 13: 89.
- (34) In a 1st June 1989 communication to the Milwaukee Jewish Home from Robyn S Shapiro, esq of Quarles & Brady. Excerpted with permission.
- (35) *Matter of Westchester County Medical Center (O'Connor)* 72 NY 2d 517, 534 NYS. 2nd 886 (1988). *Fosmire v Nicoleau*, 75 NY, 2nd 218, 551 NYS, 2d 876 (1988); *Matter of Storar*, 52 NY, 2d 363, 438 NYS, 2d 266 (1981).
- (36) See reference (35): *Matter of O'Connor* and *Matter of Storar*.
- (37) 129 AD 2d 1, 516 NYS 2d 677 (1987). Most other states equate artificial nutrition and hydration with medical intervention. See *McConnell v Beverly Enters*, 209 Conn 692, 553 A 2d 596 (1989). *In re Gardnier*, 534 A 2d 947, 954 (Me, 1987) and authorities cited therein.

- (38) *Cruzan v Director, Missouri Department of Health*, 110 S Ct 2841 (1990).
- (39) 148 AD, 2d 244, 544 NYS, 2d 840 (1989).
- (40) From an 18th October 1990 communication to the Gurwin Jewish Geriatric Center from Andrew B Roth, esq of Nixon, Hargrave, Devans & Doyle. Excerpted with permission.
- (41) Condie C J. Comparisons of the Living Will statutes of the fifty states. *Journal of contemporary law* 1988; 105, 121: 123–129.
- (42) Kamisar Y. The right to die, or license to kill? *New Jersey law journal* 1989; 124: 1359.
- (43) Steinbock B. Recovery from persistent vegetative state?: The case of Carrie Coons. *Hastings Centre report* 1989; Jul–Aug: 14–15.
- (44) See references (1, 5).
- (45) *Igrot Moshe, Choshen mishpat*, vol 7, 74: 3 and 73: 5.
- (46) *Halachah urefuah*, volume 2: 131, 188–189.
- (47) In response to author's inquiry on 1 June 1991.

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may have been unnerved. Some (most) would have been readily reassured. The rest may have been more reluctant to reveal personal information. The doctor would have met his obligation. The patient would have been informed. The possible implications for medical practice would have been clear.

The new development represented by the department's booklet leaves no doubt. From the point of view of informed consent, a doctor would now appear to be under a clear duty to tell a patient that all personal health information could well come to be known by a wide range of people and that he (the doctor) is powerless to prevent this (indeed, according to the booklet, he is obliged to facilitate it). Such a warning would seem to be obligatory not least because the booklet contemplates that the patient may refuse permission for information to be passed on.

Of course, patients may well be surprised if doctors suddenly start telling them that they have a right to insist on what they have always thought was theirs anyway (the right to privacy), but at least this would see off the department's new assault on confidentiality. But would it? Even if patients were to be so informed, doctors would also have to advise them that keeping information from some others, for example, those involved in any further or future health care, may well be against their interests. As a consequence patients would not know how to stipulate whom to exclude and whom to include: a blanket 'not to be released to managers' would doubtless not do the trick. The patient may well

prefer to leave it all to the doctor, but as we have seen, the doctor cannot control what happens to personal health information.

Thus, informed consent in the form of advising the patient to refuse any release of information may not be the answer. The only other form which informed consent could take is to advise the patient that information will now only be 'confidential to the NHS'. Some patients will not care. Others faced by the implications of this, will decide not to confide certain matters to their doctors. They may not judge their doctors to be at fault but clearly trust will be an early casualty. So also will proper health care since the doctor will be treating the patient without knowing as much as the patient could tell him.

It is often a consequence of reforms of the NHS that good health care is the first casualty. The current assault on confidentiality (for managerial reasons) may be another example. Perhaps it is not too late for the booklet and the doubtful analysis underlying it to be abandoned. Or is confidentiality just not important enough?

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