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HALAKHIC PARAMETERS FOR REMOVING PATIENTS FROM A VENTILATOR

The recent establishment of a new 28-bed sub acute ventilator unit at the Gurwin Jewish Geriatric Center in Commack, N.Y., has provoked some serious halakhic-bioethical issues. Patients are admitted to this unit with severe, chronic respiratory illnesses, and many expect to be weaned from the ventilator and breathe on their own. Yet, tragically, some patients remain on ventilator life-support until the day they die. Unable to breathe spontaneously, they become dependent on this sophisticated piece of medical equipment. Indeed, one patient who was hospitalized on a ventilator with a severe bout of pneumonia instructed his family, prior to admission at Gurwin, "if my condition deteriorates to the point where I become ventilator-dependent, I wish to be weaned from it." Are we allowed to admit such a patient, knowing full well that he may become ventilator-dependent? Are there any circumstances under which halakha permits the removal of the patient from a ventilator?

In our ventilator unit, we treat and administer to several patients who suffer from a fatal neurological disease, Amyotrophic Lateral Sclerosis (ALS), better known as Lou Gehrig's Disease. When patients first develop the disease, their arms and legs grow weak until they have trouble walking and performing even simple tasks with their hands. They lose weight and gradually become paralyzed; eventually they are unable to move any limbs. In late stages, they are unable to speak, swallow, or even respond with facial expressions. Though they are fully alert and aware of everything that is going on around them, they can only respond "yes" or "no" with eye movements. They become, literally, prisoners in their own bodies. Ultimately, their chest muscles become paralyzed and they are unable to breathe on their own. To survive, they are connected to a ventilator, which might give them several years to

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live. There is no known cure for ALS and most patients die within two to five years from the onset of the illness, unless they are placed on a ventilator. According to halakha, may patients who suffer from ALS request that they not be placed on the ventilator? Are there circumstances under which halakha might permit removal of such patients from the ventilator? May they refuse to be treated with oral or intravenous antibiotics in the likely event that they contract pneumonia or other infections?

One of the great halakhic controversies of our time is when to pinpoint the time of death. Does one die only after the heart stops beating and the lungs stop breathing (cardiopulmonary death)? Does a person die when his total brain dies and is no longer able to regulate body functions (brain death)? While it is not within the scope of this article to explore the sources for these positions in depth, one must be aware of the halakhic implications and practical applications relating to ventilators.

The classical definition of death is "the irreversible cessation of respiration and circulation." Indeed, the Talmud[1] seems to describe a cardiopulmonary criterion. When debris falls upon an individual on the Sabbath, and we wish to determine whether he has died, the rabbis ask, "How far does one examine [to diagnose death if the (victim) appears to be dead so that he does not move his limbs][2]. . . ." The Talmud responds: "Until his nose [i.e., no respiration]. Some say: Until his heart."[3]

Physiologically, there is a direct connection between the brainstem, which regulates respiration, and the lungs. There is no such connection between the brain and the heart; in fact, under certain conditions, the heart functions independently after all brain and respiratory activity have ceased. Though the heart operates somewhat independently, it, like the other organs of the body, relies on the lungs to oxygenate it, and in most instances, the heart stops within a few minutes after the lungs stop breathing—unless the patient is connected to a ventilator. Hence, the halakhic query: May a physician disconnect a brain dead patient from a ventilator since he is no longer able to breathe spontaneously, or must the doctor wait until all cardiac activity has ceased?

At the outset, I must caution readers not to draw conclusions from this article in order to arrive at a halakhic decision about any specific case. Each case should be directed to a halakhic authority, who should be familiar with all the clinical considerations since there are often significant nuances which distinguish one case from another. We should be mindful that halakhic rulings relating to ventilators affect life-and-death decisions—*dinei nefashot*—which in Temple times could only be

referred to the Sanhedrin. Thus, the focus of this article is first to familiarize readers with how the ventilator is utilized in life-support, and second to study its halakhic implications and applications. Hopefully, readers will then be better prepared to pose questions about removing patients from a ventilator to a halakhic authority.

I. THE TECHNOLOGY

The ventilator or respirator breathes for the patient or assists the patient with breathing, specifically enabling him to inhale fresh or oxygenated air. The lungs work very much like a balloon. When we inhale, the lungs expand, as the diaphragm and the muscles of the chest wall contract. When we exhale, the lungs retract as the diaphragm and other muscles relax, expelling carbon dioxide and other gases into the atmosphere. The ventilator patient only requires assistance in filling his balloon-like lungs with fresh air; the lungs' natural elasticity enables him to exhale without assistance. Breathing is regulated by groups of nerve cells in the brain stem's respiratory center, which sends impulses to the muscles involved in respiration. These impulses control the rate and depth of breathing.

A respirator forces air into the lungs under pressure, and then cuts off the pressure once the lungs are filled, enabling their elasticity to expel the air. Respirators may function as assist ventilators, which are triggered by the patient's own breathing, or in a control mode, which fully regulates respiration for patients whose breathing muscles are paralyzed or severely impaired. As befits life-support equipment, respirators are equipped with battery backup systems to prevent any downtime caused by malfunction, which can be fatal; additionally, most units are plugged into an electrical source, which is protected by a backup generator. In the event the patient is accidentally disconnected from the respirator or there is a sudden change in his status, an alarm system alerts the medical team. Oxygen is supplied through a permanent high-pressure line, providing the patient with a virtually endless supply, unlike portable oxygen tanks, which have to be replaced periodically.

Only a few years ago, it was necessary to remove the patient from the ventilator for a very brief period in order to suction him. Suctioning is performed on patients who are unable to cough up normal secretions, leading to choking or aspiration pneumonia. This brief period of downtime provided a halakhic window of opportunity to reassess the

patient's ability to breathe spontaneously and to be weaned from the respirator. Halakhically, this window of opportunity is significant, since if the patient is unable to breathe on his own, then, under certain circumstances, he may refuse to be reconnected to the ventilator; refusal to initiate or restart treatment might then be viewed as withholding treatment, an act of omission (*shev ve-al ta'aseh*), which may be permissible. Today, however, with the advent of in-line suctioning (contained within the respirator's tubing), it is no longer necessary to disconnect the patient from the machine in order to suction him. Hence, disconnecting him from the ventilator could be construed as an act of commission (*kum va-aseh*), which evokes serious halakhic concerns.[4]

II. RESPONSA

Acutely Ill Patients

Among the earliest and most fascinating halakhic inquiries into the issues of the ventilator was a question posed to Rabbi Eliezer Waldenberg over 25 years ago.[5] After fully describing the technology to R. Waldenberg, Dr. David M. Mayer, Director General of the Shaare Zedek Medical Center in Jerusalem, posed the critical question:

> May a physician remove a patient from a ventilator, when his condition is medically futile and he is unable to breathe spontaneously?

To illustrate: A victim of a severe automobile accident is rushed to the emergency room. His skull is crushed, but the medical team, as part of its routine life-support protocol, connects him to a ventilator. After a while, the physicians wish to check the patient to determine whether he is alive or dead (in which case, he is maintained artificially on the ventilator). Among the tests physicians perform is one where the patient is disconnected from the ventilator for a few minutes to determine whether or not he is able to breathe spontaneously (apnea test): If he breathes on his own, he may be weaned from the ventilator; if not, he is reconnected to it.

Dr. Mayer questioned whether, under these futile conditions, a physician must continue treatment. If the patient is no longer breathing spontaneously, must the physician reconnect him to the ventilator?[6] In this instance, might not the ventilator be considered "an impediment to the dying process," which, according to the view of R. Moshe Isserles,

Rema, may be removed from the moribund patient to enable his soul to depart? Some physicians, Dr. Mayer observed, adamantly maintain patients on ventilators, though they are in deep comatose states, devoid of any signs of spontaneous respiration or neurological response. Does halakha obligate these physicians to do so?

Dr. Mayer then offered a novel proposal, which he hoped would extricate halakhically-sensitive physicians from this ethical dilemma. He suggested that ventilators in an emergency room be connected to time clocks, much like those used to regulate lights and appliances for Sabbath observers. After about 12 or 24 hours, these clocks are set to turn off the ventilator. During the period when the patient is on life-support, he can undergo a comprehensive battery of tests to assess whether he has even the slightest chance to survive. If he is able to breathe spontaneously, the ventilator is restarted. If, however, the patient's condition is medically futile, meaning that there is virtually no hope for recovery (e.g., the spinal cord is completely severed), the physician should be under no obligation to restart the ventilator once the time clock has shut it off. Not restarting the ventilator, at that point, could be considered in halakha as a *shev ve-al taaseh*—a permissible act of omission, akin to withholding treatment, rather than an act of commission or *kum va-aseh*, which would be tantamount to "pulling the plug."

R. Waldenberg devotes his response to an in-depth analysis of Rema's position in treating a moribund patient:

> And so it is forbidden to cause the hastening of death, such as [in the case of] one who has been moribund for a long time and is unable to depart from this world; it is forbidden to remove [feather] pillows or cushions from beneath him, based on what is reported that the feathers of some birds cause the extension of life. Similarly, he [the dying patient] should not be moved from his place [if that may hasten his death]. It is also forbidden to put the keys to the synagogue under his head if that will cause him to depart. However, if there is something which delays the departure of his soul, such as [in a case of a dying patient who resides] in a house adjacent to a wood chopper [where the noise of the chopping is prolonging his dying] or there is salt on his tongue which delays the soul's departure, it is permissible to remove it [i.e., the wood chopper or the salt], since there is no act of hastening death whatsoever, but rather [one is] removing the impediment.[7]

R. Waldenberg finds a number of inherent difficulties in the text which require clarification:

1. What is the medical status of the patient for whom we may not hasten death? Is he actively dying, but, clinically, still very much alive? Is he comatose, or, perhaps already dead, yet is being maintained artificially on a ventilator? What is the medical status of the patient from whom we may remove the "impediments" including the ventilator to enable death to occur naturally?

2. Is a ventilator an "impediment "to the dying process, as Dr. Mayer suggests? Does its removal entail an "act" of moving the moribund patient, which may be forbidden?

3. R. Waldenberg notes an apparent contradiction in the text. Initially, Rema writes that it is forbidden to remove the pillows from beneath the patient, even though the caregiver is not directly touching or moving the patient; yet, later, he declares it permissible to remove the salt directly from the patient's tongue. If moving a dying patient is categorically forbidden and comparable to "extinguishing a flickering flame," why is removing salt from a tongue "no act whatsoever, " yet removing the pillows from beneath the dying patient is considered an act which may hasten his death?

R. Waldenberg delves into the primary source for Rema's opinion, the commentary *Shiltei Gibborim*,[8] and into the works of later authorities.[9] As a result of his research, he reaches the following conclusions:

1. The only instance where Rema objects to moving a dying patient is where he is actively dying but clinically still very much alive. Though such a patient is close to death, his soul is not ready to depart, and so, even an indirect movement "may hasten his death." Just as we may not hasten his death, we may not prolong it either by such measures as placing salt on his tongue. This is the essence of the first case cited by Rema. In our scenario, where the patient is dying but clinically alive, R. Waldenberg rules that we should not introduce life- support measures, which would merely prolong his dying process.

2. Moving a dying patient's bedding is not prohibited categorically; indeed, the *Shiltei Gibborim* and all his teachers permit it—even though the caregiver is indirectly touching and moving the patient's body. Therefore, when a patient on a ventilator may already be dead, as confirmed by medical tests, his functions are being maintained artificially, and we may remove him from it. In

> this instance, removing this patient from a ventilator is tantamount to removing an impediment to his soul's departure. This is the essence of the latter case cited by Rema. R. Waldenberg reasons that removing the salt directly from the patient's tongue is "no act whatsoever" since it is not hastening a viable patient's death, but rather enabling an almost dead patient's soul to depart.

In conclusion, R. Waldenberg fully supports Dr. Mayer's proposal to connect time clocks to ventilators in an emergency room in order to provide medical staff with the time frame to determine whether the patient has even the slightest chance to survive. If tests determine that he has the capacity to breathe spontaneously after the time clock has turned off the ventilator, the ventilator should be restarted. This is essentially the first case of Rema, where the patient is terminal, but still very much alive, and we may not do anything to hasten his death. However, if the test indicates that the patient's condition is medically futile, and his death is imminent (e.g., the skull is crushed or the spinal cord severed), then a physician is not obligated to reconnect him to the ventilator; in fact, he is forbidden to do so! Reconnecting this patient to a ventilator may impede the departure of his soul and prolong his dying. Indeed, R. Waldenberg observes that when we have determined that a patient has no independent cardiopulmonary function,[10] we may remove him from the ventilator-even if this involves moving his body somewhat. In response to authorities who prohibit any movement of this patient and compare "removing salt from his tongue to closing his eyelids,"[11] R. Waldenberg proposes a straightforward solution: whenever it is impossible to extubate the patient without moving his body, we simply pull the plug or turn off the power switch.[12]

R. Hayyim David Halevi, the late Sephardic Chief Rabbi of Tel Aviv, in his responsa, *Aseh Lekha Rav,* addresses the very same issues which confronted R. Waldenberg: removal of patients, whose chances of survival are nil, from ventilators. Interestingly, though R. Halevi cites the very same sources as R. Waldenberg, he interprets Rema's glosses differently.

R. Halevi does not distinguish between two prototypes of dying patients: the patient who is actively dying, but clinically very much alive, and a nearly dead, comatose patient. Rather, R. Halevi interprets Rema and all the other sources to be discussing a dying patient who, though breathing spontaneously, is very close to death. He writes:

> . . . the patients that we are discussing in halakha are able to breathe spontaneously. Nevertheless, once we see that their souls wish to

> depart, but that a grain of salt impedes [death], we may remove it to enable them to die. How much more so is this true in our times where the patient is connected to the ventilator and is unable to breathe spontaneously and his very life is artificially sustained only by this machine . . . even if physicians wish to sustain such a patient on a ventilator, they are not permitted to do so...therefore, in my humble opinion, it appears that is permissible for you—once you have arrived at a clear, unequivocal determination that this patient has no chances of recovery—to disconnect him from the ventilator, and you may do so without any qualms of conscience.[13]

One of Israel's great authorities of the last century, R. Yaakov Yisrael Kaniefsky, addressed these most sensitive issues:

> Essentially, the principle that one is obliged to do everything in order to prolong the life of a patient (even 'hourly life') is one that I also heard in my youth, but I am not sure if it derives from an authoritative source. However, in my eyes, this matter requires great study, since in *Yoreh De'a* 339 it clearly states that it is permissible to remove an impediment from a dying patient, providing that such action does not directly affect the patient's body. Therefore, since [removal of the impediment] is an act of omission [in a situation where continued intervention would only prolong the suffering], I have found no prohibition to do so; quite the contrary, we may refrain [from maintaining impediments]. . . . This entire matter requires great study.[14]

There are halakhic authorities who state that if the ventilator is stopped in order to provide patient care, such as to suction excretions from the lungs, or in order to service the machine, there is no obligation to reattach the ventilator to the patient, as long as it is apparent that he will no longer be able to breathe spontaneously, and his medical condition (according to halakha) justifies discontinuing life-support.[15] Others declare that if the physicians determine that continued medical intervention to save this patient would be futile, and, moreover, he is suffering, it is permissible to decrease the ventilator's pressure or volume modality and lower the oxygen concentration level to 21 percent, which is the standard amount of oxygen in the air we all breathe naturally.[16]

The ventilator issues addressed by R. Waldenberg and R. Halevi were primarily aimed at an acute care facility—either an emergency room or intensive care unit where the patient's prognosis is one of imminent death and he did not express his wishes to refuse treatment in

an advance directive.[17] How, then, does halakha honor the request of a chronically ill ventilator-dependent patient to either withhold or withdraw a ventilator? Does halakha respect the wishes of the ALS patient not to be placed on a ventilator, when he might need to live for months or years on it? We should note that withholding ventilator therapy from chronically ill patients does not necessarily result in immediate death; however, refusing such life-sustaining treatment increases the likelihood that these patients will die sooner. May we remove the chronically-ill patient from the ventilator under any circumstances? May he refuse antibiotics if he contracts pneumonia or other infections?

ALS and Chronically Ill Patients

In a landmark 1990 court case in Israel, an ALS patient, Benjamin Ayal, brought some of these issues before Judge Goren of the Tel Aviv Regional Court.[18] Ayal petitioned for judicial relief to enable him to refuse ventilator support. In the United States, this case would not have been brought to court because every patient with capacity has the right to make his own medical decisions, including the ability to refuse treatment.[19] But in Israel, where medical paternalism of "the doctor knows best" variety is still in vogue, this case caused quite a stir. Interestingly, the Court, based on the "slippery slope" principle of medical ethics, utilized the "halakhic approach that clearly distinguishes between withholding painful treatment in a terminal patient, and active euthanasia."[20] In resolving this dilemma, the Court followed a position articulated by Professor Shlomo Shibolet: ". . . I did not find that there is any obligation to extend the suffering of the patient and connect him to the ventilator. I am obliged to treat the patient, and this obligation does not require [one] to extend a life of inestimable suffering through invasive measures, which are avoidable, providing that this accords with the wishes of the patient."[21] In October 1990, the Ayal case was presented to R. Israel Meir Lau, then Chief Rabbi of Tel Aviv-Jaffa.[22] R. Lau prefaced his decision with the following note of caution: ". . . it is forbidden, under any circumstance, to infer from my ruling a precedent to treat another patient . . . even if the cases appear to be as similar as two drops of water." R. Lau observes that halakha does not require, and at times forbids, administering extraordinary treatment which extends suffering without any chances of recovery. He rules that "when . . . the time comes, you will be permitted to respond to the requests of Mr. Ayal and his wife and not undertake the extraordinary treatment of connecting

him to artificial life-support equipment." R. Lau notes that, before reaching his decision, he consulted with the leading halakhic authorities of the generation, one of whom was R. Shlomo Zalman Auerbach.[23]

In 1989, Dr. Abraham S. Abraham posed a series of critical questions to R. Auerbach regarding the treatment of an ALS patient.[24] "Prior to the complete paralysis of the lungs and breathing, when the patient is [often] subject to repeated bouts of pneumonia, are we obliged to treat him with [intravenous] antibiotics which involve repeated piercing of the vein . . . in order to postpone the inevitable?" Dr. Abraham observes that the nerves and the bones of this ALS patient are very sensitive to pain, which may be aggravated by any movement or piercing pressure. He continues, "and, if we should say that we must still treat him, what happens when he stops breathing? Are we then obligated to connect him to a ventilator, so he will be able to continue living this way for, perhaps, a few more months, or do we apply the principle of *shev ve-al ta'aseh*, passively withholding treatment?"

In his responsum, R. Auerbach writes regarding a similar case: "Ultimately, the lives of those who are [totally] paralyzed are terrible and bitter; indeed some prefer death to life. Thus, in such a case, it is reasonable that we are not obligated to perform surgery in an active [*kum va-aseh*] manner particularly, since the patient's recovery is in doubt."[25] Dr. Abraham specifically questioned R. Auerbach about whether his ruling applied to refusal of ventilator treatment by an ALS patient. R. Auerbach responded that it did indeed apply to such a patient. However, in response to the inquiry regarding antibiotic therapy, R. Auerbach replied: "In my humble opinion, oral antibiotics should be given to him, however, piercing [his skin to administer treatment] and other things which pain him require [us] to consult with him; if he is able to answer 'yes' or 'no' appropriately [i.e., he has capacity], and if he wishes to withhold [treatment], it is possible that we should listen to him."

R. Hershel Schachter, Rosh Kollel of Yeshiva University, rules that a patient with capacity may withhold any treatment, even refusing being placed on a ventilator, because he may claim that this treatment is not beneficial for him (e.g., it would not reverse the outcome of his illness or alleviate his suffering). R. Schachter maintains that this patient's critical decision to refuse treatment must be made in close consultation with his physician and family. The family should not honor the patient's decision when it is unreasonable; for example, when the patient is young and there is a possibility for long-term survival, however slight. In this instance, R. Schachter states that we disregard his refusal because

"his intention is null and void when compared to the [reasonable] judgment of all other people." (*Berakhot* 35b). However, when a patient with capacity is already on a ventilator, and can no longer bear his quality of life, he may refuse antibiotics.[26]

Terminally Ill Patients

Is it permissible to remove a ventilator from a patient who is dying from a malignant brain tumor or lung cancer, whose life expectancy is very short (less than one year), and who feels that death is preferable to life? Halakha would regard this patient as a *terefa*, one who is suffering from an irreversible, fatal disease.[27] Would halakha treat removal of life-support, under these terrible circumstances, as a form of contributory homicide, since the immediate cause of this patient's death would likely be asphyxiation? Alternatively, would halakha propose that, because this patient's primary illness is terminal,[28] we cannot "heal" him by maintaining him on a ventilator, which, in the patient's mind, is only prolonging his death and suffering?

These critical issues lie at the core of scholarly dispute between two renowned Israeli authorities, R. Zalman Nehemia Goldberg and R. Levi Yitshak Halpern. In the fall of 1978, R. Goldberg published his opinion in *Moriah*, one of Israel's leading halakhic journals, and, three years later, R. Halpern responded in another noted publication, *Halakha u-Refu'a*.[29]

R. Goldberg maintains that, under specific guidelines, removing a ventilator from a patient who is a *terefa* would not constitute homicide. The obligation to "heal" or "save" this patient's life would not apply since the efforts would be futile, and, of critical importance, "we have no obligation to save one's life where he prefers death to life." R. Goldberg cites two sources to support his contention that we have no obligation to save this patient's life against his wishes. R. Hanina ben Teradyon, the great martyr (*Avoda Zara 18a)*, was wrapped in a Torah scroll and put to death by fire. His executioner placed tufts of wool soaked in water on his chest in order to prolong his suffering. Ultimately, R. Hanina permitted his executioner to raise the flame and remove the wool in order to hasten his death. Since R. Hanina acquiesced to the hastening of his death, R. Goldberg infers that there is no obligation to prolong a life of suffering in the face of impending death. Similarly, King Saul, in his final battle (*I Samuel* 31:3), fell on his sword after being pierced by enemy arrows that rendered him a *terefa*. Saul did not want to be "saved" and preferred suicide to falling into the hands of his

enemies.[30] R. Halpern counters that R. Hanina himself permitted the executioner to expedite his imminent death. However, we cannot presume that a physician has the authority, under similar circumstances, to remove a ventilator and hasten a dying patient's death. Moreover, R. Halpern cites a source demonstrating that we cannot terminate the life of a *terefa* patient, even where his death would save the lives of others.[31]

R. Goldberg advances a familiar source to support his position that we are under no obligation to "save" a dying patient's life against his wishes. Rema permits us to remove salt from the tongue of a dying patient or to restrain a woodchopper because the salt or the chopping noise impedes the departure of the patient's soul.[32] If our overriding concern would be to prolong the life of this patient, even where he would prefer death, then, R. Goldberg argues, we should, in fact, never remove the salt or stop the chopping. "Indeed, we would be duty-bound to introduce the salt and initiate chopping in order to prolong his life."[33] R. Goldberg, however, cautions us not to remove or wean a dying patient from a ventilator when doing so would mean his immediate death. In this instance, removal from a ventilator would be tantamount to an act of homicide. R. Goldberg distinguishes between direct acts of homicide, which are forbidden, and indirectly depriving the patient of life-sustaining resources, which would be permissible. For example, if a criminal forces his victim into a house and sets it on fire, or into a sealed, marble enclosure which asphyxiates him, he is liable for murder. However, if the perpetrator binds his starving victim and abandons him, so that he cannot access food, and, as a result, the victim dies, the perpetrator would not be so prosecuted.[34] Note that the murderer does not assault the victim's person directly in any of these crimes. In the former case, the victim died of asphyxiation resulting from the murderer directly creating the conditions that lead to death. In the latter, the perpetrator simply deprived an already starving individual of access to food. R. Goldberg maintains that depriving a dying patient access to resources such as food or oxygen does not constitute homicide, but is considered removing the means of "saving" or prolonging his life.[35] Hence, R. Goldberg would permit a dying or *terefa* patient to be removed from a ventilator, providing that it would not result in his immediate death.

In contrast, R. Halpern sees no distinction between a patient who dies immediately of asphyxiation after the ventilator is removed, and one who dies much later. In both instances, the act of removing the ventilator results in the patient's death. R. Halpern, therefore, defines

these cases as "*geram mita*," contributory or causative homicide. R. Halpern addresses the distinction R. Goldberg makes between a primary and direct cause of death such as asphyxiation, and food deprivation, which R. Goldberg regards as an indirect, secondary factor leading to death. R. Halpern cites Rava's statement in *Sanhedrin* 77a:

> If he bound him and he [the victim] dies of starvation, he [the perpetrator] is exempt. . . . If he bound him in the sun and he died, or in a place of intense cold and he died, he is liable; but, if the sun was yet to appear or the cold to make itself felt, he is not.

Tosafot explain that Rava's critical concern is where the cause of death is present, or, at least, imminent at the time the victim is bound: the intense heat or cold is indeed present, whereas starvation, "even if he was already starving before he was bound," is not imminent.[36]

Accordingly, R. Halpern compares removing a ventilator to the scenario of intense heat or cold, where the potential cause of death, oxygen deprivation, is present at the moment the equipment is removed—even if the patient survives much longer and begins to breathe spontaneously. R. Goldberg, however, would compare oxygen deprivation, in this case, to food deprivation, and allow the patient to be weaned from a ventilator, providing that he would not die immediately after the equipment is removed.

Brain-Dead Patients

A full treatment of the great controversy among contemporary halakhic authorities concerning the moment of death—cessation of brainstem or cardiopulmonary activity—is beyond the scope of this article. We have already observed that a patient's cardiopulmonary activity may be sustained artificially on "life support," even after neurologists have determined that his brainstem no longer functions. Thus, those who advocate for the brain-dead criterion would declare such a patient dead, though he could still be a viable organ transplant donor if his body is oxygenated. (Only after his organs are harvested would the ventilator be turned off.) According to the brain death criterion, in this instance, a physician would not be committing manslaughter by turning off a ventilator because his patient is already dead. Indeed, quite the contrary: by keeping the donor's organs viable, the physician enables the donor to perform the great *mitsva* of posthumously saving another's life. However, those who maintain that the patient is

not dead until after all cardiopulmonary activity has ceased would rule that the physician who turned off the ventilator based on a prior brain death diagnosis would technically be guilty of manslaughter.[37]

There are other relatively minor distinctions between the brain death and cardiopulmonary positions. According to the brain death adherents, the patient is already dead, so *kohanim* should not enter his room, funeral arrangements commence immediately, and the corpse is treated with the requisite dignity accorded the deceased. The cardiopulmonary advocates, however, would maintain that this patient, though moribund, is still very much alive, and should not even be moved! What evokes the greatest emotion in this controversy, however, is the primary distinction: Is the physician who turned off a ventilator of a brain-dead patient/organ donor regarded as a facilitator of *pikuah nefesh* (literally, "saving a soul") for the intended organ beneficiaries, or has he killed the donor?[38]

The focus of our current discussion is more limited: May one remove a brain-dead patient from a ventilator under any circumstances? Since the patient's heart is still beating, would the act of removing him be tantamount to manslaughter? Perhaps, though, the presence of cardiac activity does not define life—based on the fact that the heart of a decapitated human being still beats spontaneously after decapitation; thus, removing a ventilator from a brain-dead patient whose heart is still beating might be comparable to removing the impediment to death, which is halakhically permissible.

R. Yosef Shalom Elyashiv, a pre-eminent halakhic authority in Israel, offers a compelling source to demonstrate that rescuers must make every effort to save a victim whose brain is crushed in a building collapse on the Sabbath, even though they are sure that any victim will survive for only a very short time.[39] R. Elyashiv cites the following ruling of the *Shevut Ya'akov*:[40] "If they discovered that the victim is alive, though his brain is crushed, and he will only be able to live for a brief period [literally, 'hourly life'], we must remove the debris and afford him this brief time, as it says in Tractate *Semahot* [1: 4]: 'One who closes the eyes of the dying [*goses*], is reckoned as if he takes his life.' " R. Elyashiv questions the analogy between the accident victim and the dying patient. The first man's skull is crushed, and he is regarded as a *terefa*; hence, one who ends his life is exempt from prosecution for murder. The patient, however, is dying from a fatal illness ("inflicted from heaven"—*Sanhedrin* 78a), in which case one who kills him is prosecuted. The *Hafets Hayyim*, R. Yisrael Meir

Kagan, in his seminal super commentary *Bi'ur Halakha*,[41] declares that "one whose skull is crushed is also [classified as] a dying patient and is, in fact, worse, because he does not even have the minutest chance of survival. Nevertheless, we save his life, even for a brief period [' hourly life'], as we do for a dying patient." The *Hafets Hayyim* demonstrates that the obligation to remove debris on the Sabbath to facilitate even a few precious moments of life underscores life's intrinsic value. As proof, he cites our obligation to remove debris from an infant whose skull is crushed—even though his survival would not enable him to perform *mitsvot* or recite the confessional prayer.[42] R. Elyashiv thus concludes that the obligation to save a life by removing the debris on the Sabbath derives from the intrinsic value of life itself, and therefore even one who kills the accident victim, though formally exempt from prosecution, has deprived the victim of "hourly life."[43]

Most contemporary authorities who advocate the cardiopulmonary criterion cite a famous responsum of R. Moshe Sofer, published in his classic work, *Hatam Sofer*.[44] He writes: "When he [the victim of a building collapse] ceases to breathe, we no longer desecrate the Sabbath and, thus, this is the principle [to determine death] for all those who die, this is the accepted standard from the time God's congregation became a holy nation, and no winds in this world . . . will move us from the place of our holy Torah. . . ." R. Sofer bases his position on the Talmudic query of how we determine if a victim buried under a pile of debris on the Sabbath may still be alive. The normative ruling is that we must check "until his nose," namely, that his breathing has ceased. However, R. Sofer lists several other caveats. We must wait until the body rests "as silently as a stone, devoid of any beats/pulse [cardiac], and, if afterwards, there is no respiration [pulmonary], we only have our holy Torah [upon which to rely] that he is dead." Additionally, R. Sofer requires that we wait for a brief period of time after respiration has ceased before declaring the victim dead—"perhaps he has fainted."[45]

While many later authorities unequivocally accept the cardiopulmonary definition of death, there are two notable exceptions. R. Moshe Feinstein, in response to an inquiry from his son-in-law R. Moshe David Tendler, writes that

> nowadays there is a test . . . it is possible to determine, through intravenous injection of a solution, whether the brain is still connected to