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 halakka 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
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 Talmud¹ 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]….” 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 halakic concerns.4

II. RESPONSAA

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?

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. Waldenber 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. Waldenber delves into the primary source for Rema’s opinion, the commentary Shiltei Gibborim, and into the works of later authorities. 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. Waldenber 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 Kanefsky, 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’ah* 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. 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. 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. 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.” 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.” In October 1990, the Ayal case was presented to R. Israel Meir Lau, then Chief Rabbi of Tel Aviv-Jaffa. 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 Yitzhak 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 prolong a life of suffering in the face of impending death. 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. 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.

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. 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." 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. 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. 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 mitzva 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.\textsuperscript{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 \textit{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 \textit{pkva\n nefesh} (literally, “saving a soul”) for the intended organ beneficiaries, or has he killed the donor?\textsuperscript{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.\textsuperscript{39} R. Elyashiv cites the following ruling of the \textit{Shevut Ya\'akov}:\textsuperscript{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 \textit{Semahot} [1: 4]: ‘One who closes the eyes of the dying [\textit{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 \textit{teref\a}; hence, one who ends his life is exempt from prosecution for murder. The patient, however, is dying from a fatal illness (“inflicted from heaven”—\textit{Sanhedrin} 78a), in which case one who kills him is prosecuted. The \textit{Hafets Hayyim}, R. Yisrael Meir
Kagan, in his seminal super commentary *Bi’ur Halakha*, 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 *mitzvot* or recite the confessional prayer. 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.”

Most contemporary authorities who advocate the cardiopulmonary criterion cite a famous responsum of R. Moshe Sofer, published in his classic work, *Hatam Sofer*. 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.”

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
the entire body: If this solution does not go to the brain, it is clear that the brain has no further connection to the body, and also that the brain has deteriorated completely, as if the head were severed from the body. As a result, we should rule, strictly, that those who are unable to feel anything, even a needle prick, [i.e., they are unresponsive to neurological stimuli], even if they are unable to breathe without mechanical assistance, should not be declared dead until they undergo this test. If they [the physicians] see that there is a connection between the brain and the body, even if he [the patient] is not able to breathe [spontaneously], they should place the machine in his mouth, even for a prolonged period; however, if the tests reveal that there is no connection between the brain and the body, they may conclude that his inability to breathe constitutes death.46

Simply put, R. Feinstein subscribes to the respiration criterion for death; however, he maintains that if the brain stem’s respiratory center that regulates breathing no longer functions, as evidenced by the brain flow tests, the patient is both clinically and halakhically dead.

In 1986, a distinguished panel of prominent rabbis and physicians met to consider whether to permit heart transplants in Israel. After acknowledging the great progress in the success of heart transplant surgery over the past ten years, the panel ruled that, under strict guidelines, heart transplants were permissible. Indeed the primary halakhic sources for their decisions were the aforementioned responsa of R. Sofer and R. Feinstein.47

R. Shlomo Zalman Auerbach considers the halakhic status of brain death to be in doubt: the patient may either be moribund [goses], or dead. Consequently, one may not hasten the death of this patient by harvesting his organs for transplantation as long his heart is still beating, even though this transplant could benefit a recipient who might otherwise die. However, under certain conditions, R. Auerbach would permit this patient, who has been conclusively tested to be brain dead, to be disconnected from a ventilator, in keeping with the rule of “removing an impediment to the dying process.” Interestingly, R. Auerbach’s position derives from a scientific experiment designed to verify the application of a Talmudic principle. It is axiomatic that whenever a pregnant woman dies a natural death, her fetus predeceases her.48 Today, however, we are able to deliver a baby from a mother who is brain dead by maintaining her on life-support, which would suggest that either brain death is not death or modern medical advances have made it possible for even a brain dead mother to give
birth. R. Auerbach proposed that we prove that brain death is, indeed, an acceptable definition of death by conducting an experiment. If a pregnant lamb could give birth, despite having her head completely severed (literally, *hutaz rosho*), by being maintained on life-support, this would demonstrate that the Talmudic principle applies only in cases of natural death—but not in emergency/trauma scenarios, where patients might be placed on life-support. In fact, this experiment was conducted according to R. Auerbach’s instructions and the scientists were able to enable a brain dead (decapitated) lamb to give birth!49

III. APPLICATIONS

My purpose in writing this paper is to familiarize the reader with a wide spectrum of ventilator issues, the relevant halakhic source material and case precedents, in order to facilitate proper posing of questions to a halakhic authority, should the need arise. In order to apply these sources, the following factors should be considered.

*Patient’s Condition—Diagnosis and Prognosis*

Was the patient seriously injured in an automobile accident or a victim of a sudden heart attack, where, routinely, he would be rushed to an emergency room and, possibly, placed on a ventilator? In these instances, depending on both the seriousness of the event and the patient’s general condition, patients could expect to be weaned from the ventilator, and the protocol approved by R. Waldenberg might be considered. If, however, a ventilator patient was a victim of a building collapse or accident, where his skull was crushed, or he suffers from a chronic or end-stage terminal illness, the question arises: under what conditions, if any, may we remove him from the ventilator? May physicians remove a patient from a ventilator to determine whether he is able to breathe spontaneously, where such removal may lead to his imminent death? If we suspect brain death, can physicians test for it without moving the patient who may be moribund and, thus, should not be moved? Finally, do we honor the request of a chronically ill ALS patient not to be placed on a ventilator? Must we respect that patient’s wishes to withhold antibiotics in the event of an infection?
**Advanced Directives**

In the event of a serious accident or illness, we may question whether the patient is still able to make his own health-care decisions. Does he have the capacity to realize the consequences of his decisions to refuse life-support? If he lacks capacity, who is authorized to make decisions on his behalf? Does he have a health-care proxy who may represent him? Would halakha respect his or his proxy’s decision to withhold treatment, under any circumstances?\(^50\)

**A Final Thought**

R. Levi in the name of R. Hanina said: “For every breath that man breathes, he must praise the Creator. Why? ‘Let all souls praise God.’”\(^51\)

The Hebrew roots for the words “breath” and “soul” are virtually identical—nun, shin, mem. Breathing, respiration, is the essence of life: the life source of man’s being, his very soul. Man’s soul is no less than the breath of his Creator—“and He breathed into his nostrils the breath of life and the man became a living soul.”\(^52\) Man’s soul is of the essence of the Almighty, a reflection of His intellect and creativity. Indeed, a great Hasidic scholar, R. Abraham Bornstein, observed that God intervenes in man’s life through the medium of his intellect “which, in the tradition of our rabbis of blessed memory, is referred to as the soul. . . .”\(^53\) We might, therefore, conclude that just as, physiologically, man’s brain regulates his respiration, metaphysically, man’s intellect, emanating from the breath of his Creator, is his life source. We can only pray, as we seek guidance in response to these issues of life-and-death, that we appreciate the infinite preciousness of every moment of life, every breath, so that ultimately “every soul will praise God.”
This essay is dedicated in memory of my beloved and revered Rosh Yeshiva, Rabbi Aryeh Leib Bakst of Detroit—baren kapparat mishkavo.

The author is greatly indebted to Dr. Fred Rosner and to Rabbi Edward Reichman, M.D., for reviewing this article, and offering their insightful comments and warm support, as well as to Professor Abraham Steinberg for sharing the halakhic underpinnings for his commission’s proposed legislation to establish protocols for the terminally ill and dying in Israel. I am especially grateful to Rabbi Mordechai Halpern, M.D., Editor of Assia, for graciously releasing—during my research—the pre-publication galleys of the October 2002 issue (vol. 71-72, pp. 25-39), which features the halakhic sources for this new legislation. Special acknowledgements to Lucy Palmer M.D., and Mr. Robert Heidelberger, Department of Respiratory Therapy at the Gurwin Jewish Geriatric Center.

1. Yoma 85a.
2. Rashi, ad loc.
3. Those who subscribe to the halakhic brain-death criterion could interpret these criteria not as “causes” of death, but rather as “symptoms” of brain-stem death, manifestations that the brain stem is dead because the patient can no longer breathe spontaneously. Interestingly, though our version records the second opinion as “until the heart,” implying cessation of cardiac activity, the Jerusalem Talmud (8: 5) substitutes “until the navel” because that is “the core at which the embryo is formed and developed” (Korban ha-Eda); numerous early authorities—Rif, Ra’ah, Rosh, Rabbenu Hannanel, and others—share this version. Practically, though, respiration, not cardiac activity, is accepted as the normative halakhic criterion for death (Orah Hayyim 329:4): “if they cannot detect life at the nose, then he has certainly died.” The pulmonary criterion is especially significant for brain-death advocates since the brain stem is directly connected to the lungs and regulates respiration, and not to the heart!
4. If the patient were ventilator-dependent, removing him from such life support—without halakhic sanction—would be akin to physician-assisted suicide, since it would invariably lead to his imminent death. Under American law, however, which recognizes an individual’s right to both withhold and withdraw treatment, a patient may indeed request that ventilator support be terminated in a procedure known as a terminal wean. If the patient is dying, however, then a number of halakhic authorities, as we will see, consider maintaining him on a ventilator to be an impediment to the dying process, which, under certain circumstances, may be removed to allow nature to take its course.

The halakhic distinction between withholding or not initiating treatment and withdrawing or removing treatment already in place is not accepted in contemporary ethics or American jurisprudence. Ethicists argue that if physicians were not permitted to withdraw a treatment once begun—even though it later appears to be futile or burdensome, they might
later be reluctant to initiate promising treatment protocols, for fear they would be unable to withdraw them. See this author’s article, “Jewish Ethical Guidelines for Resuscitation and Artificial Nutrition and Hydration of the Dying Elderly,” *Journal of Medical Ethics* 20 (1994), p. 96 for a discussion of the distinctions between Jewish law and both secular bioethics and American jurisprudence. Nevertheless, a survey of physician’s practice regarding removal of ventilators from dying patients revealed that “twenty six percent of physicians believe there was a moral difference between withholding and withdrawing ventilators” and, furthermore, “fifteen percent of respondents almost never withdrew ventilators from dying patients forgoing life-sustaining treatment; 37 percent did so less than half the time.” See K.F. Langendoen, “The Clinical Management of Dying Patients Receiving Mechanical Ventilation,” *Chest* (1994), pp. 880-888.


6. Dr. Mayer raises similar questions regarding ventilators whose oxygen tank has become depleted or sustained electrical power failures. Must medical staff install a new tank or reconnect these medically futile patients to a generator? Today, with the advent of built-in oxygen supply systems and battery/generator back-up resources, these questions are, for the most part, academic.


8. See *Dapei ha-Rif, Mo’ed Katan*, 16b, number 4.

9. *Levush* and *Sheyyarei Kenesset Hagedolah* to *Toresh De’a* 339; *Derisha* and *Darkei Moshe* to *Tur* 339; *Beit Lehem Yehuda* 339:4; *Arukh ha-Shulhan* 339:4.

10. R. Waldenberg subscribes to the cardiopulmonary criterion of death and not brain death. Professor Abraham Steinberg in his *Encyclopedia of Jewish Medical Ethics*, Volume 4, p.407, f.n. 369, has difficulty in reconciling R. Waldenberg’s position with the timer solution: “According to his opinion, as long as the patient’s heart beats, he is considered to be alive in every respect . . . and as long as he is alive, every possible means to (sustain his life) must be done. Consequently, there is no basis for stopping the continuous operation of the ventilator as long as the heart is still beating, and testing for cardiological function is unrelated to the operation of the ventilator . . . .” We should note, however, that those who accept the brain death criterion would permit a ventilator to be removed from a brain-dead patient once testing has confirmed it. See *Emek Halakhah*, op. cit., pp. 66-69.

11. *Taz* 339:2; see also *Shakh* 339:7 and the latter’s *Nikudat ha-Kesef*.

12. Professor Abraham Steinberg chairs a public commission in Israel, which is devoted to establishing legislation for protocols concerning the terminally ill and the dying. His commission addressed the use of a timer for the ventilator. He wrote the author: “My committee on the legislation...accepted the principle of the timer. However, technically it is not a simple matter. We established a committee of intensive care physicians, respiratory technicians, respiratory machine engineers and representatives of ZOMET to try to make the suggestion a practical matter, with adequate safeguards and warning systems, with assurance that patients will not die unintended” (email, 8/9/02).

13. *Aseh Lekha Rav* 29, pp. 198-211. In addressing the inconsistencies of
Rema, R. Halevi offers a convincing explanation. Under no circumstances may one hasten the death of a dying patient. This patient is conscious and breathing spontaneously, and we may not introduce any metaphysical measures which might hasten his death. This would include not only placing the synagogue keys under his head, which has mystical properties to hasten death, but even moving the patient to another room where he believes he will be better able to die. R. Halevi questions why moving the patient isn’t categorically prohibited, regardless of the patient’s belief. In fact, the Bet Tosef begins this halakha by declaring that any movement of the dying patient is forbidden: “We may not administer any post-mortem care before he actually dies such as tying his jaws, sealing his apertures or placing his body on the sand.” Rema’s prohibitions to move the dying patient from his place now appear to be superfluous. Rather, R. Halevi concludes that the prohibition to move the dying patient from his place to any other room is based on its metaphysical qualities to facilitate death in the new location, not merely because any movement of a dying patient is forbidden. Hence, Rema lists it among those measures which involve metaphysical qualities to hasten death. However, where the patient is about to die, we may remove any impediments preventing his soul’s imminent departure.

16. The opinions of R. Shlomo Zalman Auerbach and R. Shmuel Wasner, as reviewed by Professor Abraham Steinberg in Asia 63-64 (5759), pp.18-19.
17. Advance directives, either in the form of a living will or health care proxy, as we know them in the United States, have not yet taken hold in Israel. Professor Abraham Steinberg is among the leading advocates for these directives in Israel, where medical paternalism is still in vogue.
18. File: 90/1141 Ayal vs. Lichtenstater Hospital, the Ministry of Health, and the State of Israel.
21. The Ayal Decision 90/1141: p. 75. Indeed, in the Netherlands, where physicians who perform euthanasia and assisted suicide in compliance with strict guidelines are not punished, a study revealed that one in five patients with ALS died as a result of euthanasia or physician-assisted suicide. (New England Journal of Medicine 346 (2002), pp. 1638-44.)
22. Ibid. See the section of this essay labeled “Brain Dead Patients,” beginning on page 54.
23. R. Lau does not cite the names of the authorities with whom he consulted; however, he evidently approached R. Auerbach, whose ruling on this matter predated the Ayal decision.
26. In discussions with R. Schachter. See his article in Bet Yitshak Journal, 5746. R. Schachter bases his ruling on the opinion of R. Yaakov Emden in
the Mor u-Ketsi’a (Orah Hayyim 328), that the obligation to save lives is comparable to the obligation to restore lost articles (hashavat aveda). 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. R. Schachter also shared with the author that he concurs with the opinion of the renowned Israeli authority, R. Zalman Nehemia Goldberg, who declares, “we have no obligation to save one’s life where he prefers death to life.” See the following section of this paper, “Terminally Ill Patients,” for a detailed explanation of R. Goldberg’s views and sources.


28. R. Avraham Yitshak Kook ruled that when the patient’s condition is so critical that his dying process has begun, inexorably leading to his death—whether imminent or not—halakha deems his status to be that of “hourly life.” Mishpat Kohen 144:3.

29. The complete exchange between Rabbis Goldberg and Halpern was published in Emek Halakha (Yeshiva University, 1989), Section IV, pp. 183-206. This version includes an abstract of their positions, as well as later addenda, in which each rabbi responds to objections raised by the other.

30. Ibid., pp. 183-184.


32. Toreh De’a 339:1.

33. R. Goldberg suggests that placing salt on the tongue of a dying patient as well as chopping wood in his presence are natural stimuli, which arouse “the individual not to slumber since a moribund [goses] patient who falls into a deep sleep becomes closer to death.” However, the author met with R. Goldberg (6/25/01), who described the scenario of goses as one of a dying patient who is unconscious or comatose (i.e., seemingly non-sentient and unresponsive to stimuli), in contrast to a victim buried under debris (Yoma 83a), who, though dying imminently, is still conscious and able to confess his sins and even authorize a divorce. Indeed, R. Goldberg proposed that, according to his distinction, a ventilator-dependent patient, who is conscious and has capacity, would be akin to the victim of a building collapse, and he would not be allowed to discontinue ventilator treatment, unless the patient met R. Goldberg’s criteria, e.g., was a tefufa, with life-expectancy of less than one year, and would not die immediately as a result of being weaned. R. Goldberg indicated that R. Halpern would make a different distinction between goses and the victim of the building collapse. In the latter case, the rescue team is obligated to undertake all natural, ordinary means of recovery for possible survivors, whereas removing an impediment from a goses—salt or chopping noise—is metaphysical in nature, akin to the extraordinary measure of prolonging the life of a patient on a ventilator. Consequently, R. Halpern, in the opinion of R. Goldberg, would be lenient in allowing this ventilator-dependent patient to discontinue ventilator treatment, where his extended life would no longer be beneficial to him.

34. Ibid., footnote 29, pp. 187-188. See Mishneh Torah, Rotseah 3:9-10, and Kesef Mishneh ad loc.
35. In the former case, where he dies of hunger, Rashi notes that “at the time he [the victim] is bound there is no deadly condition, [rather] the hunger comes on its own and gradually increases, and cannot be compared to where a perpetrator forces his victim into water and fire, where the deadly condition [literally, ‘the murderer’] already exists.”

36. Tosafot, s.v. Kafto.

37. Since the brain stem regulates respiration, hospitals have established clinical criteria to diagnose brain death, even without confirmatory tests. In fact, confirmatory tests such as brain blood flow scans or ultrasonography, are required only when clinical examinations are uncertain—for example, where the patient has severe facial trauma or has ingested toxic levels of certain drugs. Thus, for instance, the attending neurologist or intensive care unit physician should be able to reasonably predict whether the weaning of any particular patient will lead to imminent death. (Extracted from the Administrative Policy and Procedure Manual of a major New York City medical center.)

38. For a comprehensive review of the positions and sources, see Encyclopedia of Jewish Medical Ethics, Volume 4, pp. 401-402, and Volume 6, pp. 39-40.


42. Meiri in his commentary to Yoma 85a writes, “. . . if they discovered that he [the victim of the building collapse] is alive, we complete the rescue, even though it is clear that he will be unable to live for even an hour [i.e., a very short time], since, in that hour, he will be able to repent and confess his sins. . . .” Additionally, the Talmud, Shabbat 151b, records: “We desecrate the Sabbath to save the life of a one-day old infant, for the Torah says ‘desecrate one Sabbath so that he will be able to observe many. . . .’” However, since an infant whose skull is crushed will neither be able to confess nor survive to observe another Sabbath, the Bi’ur Halakha concludes that life has intrinsic value, since, tragically, he is not nor will ever be obliged to perform mitzvot. Additionally, R. Elyashiv cites Rash on Yoma 82, who quotes Ramban to the effect that we desecrate the Sabbath even where there is a danger to the life of the fetus.

43. Dr. Abraham Steinberg reports that R. Elyashiv forbids removing a brain-dead patient from a ventilator because he considers him to be alive though end-stage terminal (hai ha-noteh la-mut), and not to be moribund (goses) or dead. Encyclopedia of Jewish Medical Ethics, Volume 6, p. 40, f.n.87.

44. Hatam Sofer, Yoreh De’ah, vol. 2, no. 338. Brain death advocates maintain that R. Sofer’s criterion is actually that the patient “ceases to breathe” (pulmonary); in their reading, clear indication that the “body is silent as a stone, devoid of any beats/pulse” (cardiac) refers to the irreversibility of respiration.

45. A contemporary scenario of a patient whose respiration cannot be easily detected would be a victim of hypothermia. A hypothermia victim might be exposed to severe cold, and his breathing becomes slower and shallower, sometimes to a point of his falling unconscious.
46. *Iggerot Moshe, Yoreh De'ah* 3:132.
47. See notes 44 and 46. The panel's conclusions were presented to the full assembly of the Chief Rabbinate on November 3, 1986, and its recommendations were unanimously accepted. The proceedings were published in a number of Israeli journals (first appearing in *Tehumin* 7, 5746) and later translated into English with commentary by Dr. Yoel Jakobovits in *Tradition* 24:4 (Summer, 1989).
49. R. Auerbach's ruling, subsequent to this experiment, was published in *Assia*, 53-54 (5754), by Dr. Abraham Steinberg.
53. *Avnei Nezer, Yoreh De'ah*, 454.