

MAINTAINING COMPASSION FOR THE SUFFERING TERMINAL PATIENT WHILE PRESERVING LIFE

an Orthodox Jewish approach

DANIEL EISENBERG

ABSTRACT Regardless of one's religious beliefs, the process of making end-of-life decisions is inherently difficult and emotionally trying. The caregiver, family member, or friend is faced with making heart-wrenching decisions for loved ones where the line between support and cruelty may feel blurred. By evaluating the process by which traditional Judaism harmonizes the apparently conflicting obligations of the caregiver in end-of-life scenarios through three practical cases, all people can gain insight into managing this delicate balancing act and may develop generalizable approaches that recognize and appreciate the particularities of each patient's needs. The traditional Orthodox Jewish approach to terminal illness is guided by defined legal principles that facilitate greater understanding and promote more empathetic care for Jewish patients.

MODERN TECHNOLOGY OFFERS THE ability to prolong life by supporting physiologic processes in dying patients who would have succumbed more peacefully to their illnesses in the past. We prolong life, but witness the pain and suffering that our interventions cause. Regardless of one's religious beliefs, the process of making end-of-life decisions is inherently difficult and emotionally trying. The caregiver, family member or friend is faced with making heart-wrenching decisions for loved ones where the line between support and cruelty may feel blurred.

Albert Einstein Medical Center, Radiology, 5501 Old York Road, Philadelphia, PA 19141.
E-mail: eisenbda@gmail.com.

Perspectives in Biology and Medicine, volume 60, number 2 (spring 2017): 233–246.
© 2017 by Johns Hopkins University Press

This is the nature of ethical dilemmas that arise when core ethical principles collide, necessitating the establishment of the primacy of one over the other. It is instructive to people of all faiths to analyze how the Orthodox Jewish tradition, with an ethical literature extending back millennia, deals with the dichotomy between the very human emotional desire to offer comfort and reduce the suffering of the sick, and the intellectual moral imperative to preserve life.

The need for finding balance in this dichotomy is not unique to those practicing the Jewish religion: many people are torn between a desire, if not an obligation, to preserve life while maintaining compassion for suffering. While the specifics of the Jewish legal approach, *halacha*, may be particularistic in many ways, the issues dealt with are universal, and the traditional Jewish approach may serve as a model for any person who is confronted with the difficult moral issues of end-of-life care, regardless of their background. By evaluating the process by which those adhering to Jewish law harmonize the apparently conflicting obligations of the caregiver in end-of-life scenarios, all people can gain insight into dealing with this delicate balancing act. By analyzing how traditional Judaism deals with specific end-of-life issues, we may develop generalizable approaches that recognize and appreciate the particularities of each patient's needs.

This essay will acquaint the reader with the traditional Orthodox Jewish approach to terminal illness which is guided by defined legal principles so as to facilitate greater understanding and promote more empathetic care for Jewish patients. While some of the concepts may initially appear unfamiliar, to gain a meaningful understanding of the fundamental topic of terminal illness requires utilizing some of the original literature. The essay will also review traditional thinking about the tension between the desire to preserve life and the desire to end suffering through examining the concept of humans as stewards of their bodies and the general obligation to protect one's health. These principles will be applied to end-of-life treatments, discussing a traditional, *halachic* Jewish approach to pain and suffering, delving into the emotional aspects of end-of-life care, and particularly examining how prayer allows a manifestation of a deeply felt emotional need to express a desire for suffering to end while not undermining the necessity of continuing medical treatment.

PRESERVING LIFE AND MITIGATING SUFFERING

The Jewish tradition recognizes an obligation to decrease pain and suffering, while insisting on the limitless value of every moment of life. This would seem to produce a practical conflict between compassion for patient suffering (which would motivate a caregiver or patient to place comfort before painful treatment) and the custodial obligation created by reverence for the sanctity of the human body as a divine creation (which would limit patient and caregiver autonomy to forego or curtail treatment that might extend life at the expense of increased

patient anguish). Such a contrast exists in many faith-based ethical systems. This section will evaluate how traditional Judaism approaches this apparent contradiction and attempts to harmonize the various conflicting influences.

The protection of life is one of the most important Jewish values, taking precedence over virtually all other priorities. This moral imperative of life preservation is two-sided, usually both imposing an obligation to prolong life and prohibiting one from entering into any risk that might endanger one's life. Yet Judaism does not require preservation of life at all costs: it sanctions justifiable war, certain applications of the death penalty, and forfeiting one's life for certain ethical principles.

Traditional Judaism recognizes the validity of the natural inclination of suffering patients and those around them at times to desire death over life. Nevertheless, this emotional reaction to pain and suffering must be tempered by the recognition that there are limitations on which actions are permitted in caring for a terminally ill patient. It is a universal ethical requirement to neither improperly expedite the death of another person nor unnecessarily prolong that person's suffering.

It is crucial to appreciate how the concerns that inform the traditional Orthodox Jewish approach to end of life differ from the secular ones. Judaism approaches health from the perspective that humans function merely as stewards of their bodies, with true ownership rights retained by God (Freedman 1999). Like curators assigned the task of protecting delicate buildings, individuals are charged with guarding their bodies from preventable decay, destruction, and other imminent threats to their future, while mandated to use their bodies in a constructive way. This mandate obligates individuals to guard both their bodies *and* their lives by utilizing a "prudent man" standard. While difficult, it is necessary to find a balance between being overly cautious and being reckless.

This obligation is not a simple objective requirement to choose the course that will maximize the probability of prolonging life regardless of the consequences, but is modulated by a requirement to take into account the emotional state of the patient—in other words, the bailment extends beyond the physical body to also encompass considerations of physical and emotional discomfort.

As a result, Judaism grants the individual a degree of personal autonomy in two important areas: whether to accept life-extending treatment for an incurable terminal painful illness, and whether to accept a risky or experimental treatment that might cure a potentially fatal condition but may possibly bring about more rapid death (Eisenberg 2007).

Applying the Theory to Clinical Cases

Scenario 1: A 65-year-old man suffers from advanced prostate cancer, with osseous metastatic disease causing unrelenting pain. There is no efficacious treat-

ment for his disease that would be expected to cure his malignancy, and it is the consensus of his physicians that his life expectancy is approximately six months. He is, however, being offered palliative treatment that would be expected to prolong his life by three to five months but without pain relief or expectation of cure. Should we encourage him to accept the treatment? Is he obligated to accept the treatment?

Every important life-influencing decision is impacted by the background of the patient. For instance, while one may postulate that the prudent decision in any given situation is the commonsense choice, this is not necessarily the case from a Jewish perspective (nor for many other legally based theologies or homogenous ethnic groups). For example, when we discuss a prudent man standard for an observant Jewish patient, it would be appropriate to only include those choices that are permitted by Jewish law and tradition. Even with life and death decisions, Jewish law guides and circumscribes the possible choices. Similarly, from a traditional Catholic perspective, reproductive choices are governed by canon law, and therefore certain contraceptive options or pregnancy-terminating options are not within the spectrum of “acceptable” choices. This reality creates an obligation on the part of healthcare providers to be familiar with the particular needs of their patient population. This approach necessarily must be applied to people of all faiths and ethnic backgrounds, with acceptable end-of-life choices being modulated by religious upbringing, experience, and community standards.

For instance, Jewish law does not require the extension of life in all cases of illness or trauma. While the usual default position of Jewish law requires treatment of serious illness in almost all cases and requires the setting aside of almost all religious prohibitions to save a life, Judaism allows a degree of autonomy for suffering terminally ill patients, at times permitting refusal of life-prolonging palliative medical treatments (Feinstein 1982).¹ Of course, dependent on risk factors, a patient has the right to pursue such therapies, regardless of how unlikely it would be for an efficacious outcome to result. In the end, while therapeutic options are governed by Jewish law, decisions require the collaboration of the patient, the physician, and the rabbi. The patient in our first scenario is granted the autonomy by the Jewish tradition to choose whether to accept or reject the proposed treatment.

Scenario 2: A 47-year-old religiously observant Jewish woman with advanced emphysema lies dying in the ICU in end-stage heart failure. As her breathing becomes agonal, it becomes clear to the health-care team that her condition is irreversible and will inevitably result in death within hours to days. As her

¹It is not just the terminal nature of the disease per se that is operative, but the life expectancy also. That is, while there are certainly chronic disease processes (such as diabetes, emphysema, and Alzheimer’s disease) that will inevitably result in death if no other life-shortening event occurs, they are not considered terminal in a Jewish legal sense unless death is to be expected within one year.

condition is very delicate, vital signs and blood gas measurements are being performed frequently and intubation is being considered. The patient's husband arrives and requests that all interventions other than comfort measures that do not require unnecessarily moving the patient be stopped and that the patient not be intubated. The attending physician is surprised that such a course is being requested by an Orthodox Jewish family, but he hesitantly complies. The patient dies the next day.

Despite the modicum of autonomy offered by Jewish law, the life of even the sickest individual is imbued with the same value as the healthiest individual. Jewish law recognizes an advanced terminal state in which the patient, referred to as a *goses*, has exhausted all hope of effective treatment and is moribund, with an expectation that he or she will likely die within hours to days. The Code of Jewish Law forbids even touching such a patient, except for comfort measures, lest the physical contact hasten the patient's death (Karo 1563). Even blood pressure and temperature measurements, as well as other non-immediately therapeutic interventions are no longer permitted (Abraham 2003). Yet the moribund patient has all of the rights and privileges of any other living person, and anyone who does anything to speed up his or her death, even by seconds, is considered a "shedder of blood" (*Mishna Semachot* 1:1 and 1:4).

Nevertheless, certain forms of therapy must always be provided regardless of patient prognosis. Food, drink, and oxygen are basic life needs that may not be withheld unless they will harm the patient (Abraham 2003). Additionally, therapies that reverse treatable complications not directly related to the terminal illness must be provided, such as insulin for diabetes, antibiotics for pneumonia, and blood transfusion after hemorrhage (Abraham 2003; Steinberg 2003).

Withholding and withdrawing care are not synonymous in Judaism. The Code of Jewish Law clearly states that no action may be taken that will hasten the death of a *goses*. However, further medical treatment may not be required, and while life-sustaining therapies, such as respirators, may not be discontinued, new treatments need not be initiated. This may include not restarting current treatments when they lapse on their own accord.² This is because Judaism distinguishes between withdrawal and withholding of medical treatment in certain end-of-life situations. While withdrawal of life-sustaining therapy is generally prohibited, non-initiation of life-prolonging treatments is sometimes permitted.³

²For example, for a patient in irreversible multi-organ failure who is dependent on vasopressors for blood pressure support, the medication may not be actively withdrawn, but it need not be replenished when the current infusion is exhausted, despite the knowledge that this will lead to the patient's subsequent death. Even some life-supporting treatments may be modified (if the patient is not touched), such as turning down the oxygen saturation of the ventilator to room air (21%), if this will not lead to the immediate death of the patient (Steinberg 2003).

³Only impediments to death may be removed. Distinguishing between hastening death (which is forbidden) and removing an impediment to death (which is permitted) is a nuanced discussion beyond the scope of this essay. These concepts are further clarified in the Code of Jewish Law (Karo 1563).

In light of the distinctions described above, the requests of the patient's husband in scenario 2 now become understandable. The underlying message that the Orthodox Jewish tradition brings to the marketplace of ideas regarding end-of-life treatment is that dignity and value of life are not necessarily bound up with quality of life. While a point may arrive when further treatment is futile and may not be required or prudent, health-care workers should recognize and respect the intrinsic dignity of life that remains in even the sickest patients.

Scenario 3: A Jewish man watches his elderly mother wasting away before his eyes. She lies in a bed in her assisted living residence. She suffers with chronic intractable pain, slowly deteriorating from an incurable neurological condition that robs her of mobility and is expected to end her life within weeks to months. As the pain intensifies and her ability to interact with her family and friends becomes more difficult, she tells her son that each new day is torture and she feels increasingly hopeless, telling her son that she wishes to die. Her son feels pangs of guilt when he realizes that he too prays for his mother's demise and a speedy end to his mother's suffering.

This third scenario is potentially the most challenging and requires the most analysis. Intellectually, one can accept a paradigm that places the value of life at the pinnacle of moral values, thereby severely limiting any action that would curtail lifespan. This is the underpinning of the Jewish religious teaching that virtually always prohibits actively hastening death.

But does acceptance of such an approach delegitimize the emotional response that illness and despair may engender in both the patient and the caregiver, a response that may lead them to feel that a hastening of death would be preferable to a prolonged life of suffering? Specifically, is praying for a speedy death unethical within a framework that intrinsically values life? Millennia of Jewish texts offer examples of how such sentiments are melded into a tradition that respects life, a perspective that may resonate in many other faith-based traditions.

The Jewish tradition offers an outlet for the human desire to mitigate suffering in apparently hopeless cases through the prayer for the death of a suffering patient. Prayer for health, life, and for death has been practiced since antiquity as an efficacious nonphysical means of expressing our wish for a desirable ethical outcome in times of distress. Where does prayer, a qualitatively different "therapy" that involves no physical action, fit into the dichotomy of striving for life yet wishing for death in cases of suffering terminally ill patients?

There is a long tradition in Judaism to pray for salvation in times of suffering, including serious illness. Yet despite the strong belief that there is always hope, we also find instances in the Bible and Talmud of great men praying to die or praying for others to die. Several Biblical and post-Biblical characters prayed that their lives or the lives of others be shortened for a variety of reasons, some seemingly motivated by physical pain and some seemingly motivated by emo-

tional pain. However, the two motivations are manifestations of one overarching concept: the desire for death arises when physical or emotional pain becomes unacceptable or inexplicable.

Several Biblical figures pray to die, including Moses, Elijah, and Jonah (Exodus 32:32, Numbers 11:14–15, Kings I 19:4, and Jonah 4:1–9). These Biblical accounts offer legitimacy to the desire for death when life presents either intolerable emotional pain or unbearable physical pain. Yet many other Biblical figures suffered terribly without requesting to die. What do the particular scenarios presented above suggest? These personalities only requested death when motivated by emotional pain due to an undermining of their perception of God’s plan. This important concept is illustrated much more clearly in post-Biblical Jewish literature, which offers an ethical framework as to when it might be appropriate to desire death over life.

THE RATIONALE FOR PRAYING TO DIE

The classic argument for the legitimacy of desiring the death of a suffering terminally ill patient is found in the juxtaposition of two historical events recorded in the Talmud. Together, these events provide an approach to suffering at the end of life and serve as the basis for most subsequent rabbinic discussions as to the propriety of praying for a patient to die (Babylonian Talmud *Ketubot* 104A).

In the first narrative, Rabbi Judah the Prince (known as Rebbi), the generation’s leading scholar, lay dying of an intestinal illness. The rabbinic scholars declared a public fast and offered prayers for his recovery. Rebbi’s servant, a woman in daily contact with the patient, prayed for him to live—until she saw the suffering that he endured, at which point she changed her prayer, praying that he die rather than live with suffering. However, the rabbis continued praying for him to live. Seeing her prayers impeded by the power of the rabbi’s prayers, she threw a fragile jar from the roof of a nearby building. When the sound of shattering pottery startled the rabbis, momentarily distracting them from prayer, Rebbi immediately died.

In the second narrative, a discussion of the obligation to visit the sick, a rabbinical student lies deathly ill in his bed, alone without visitors, with no caretaker to see to his needs. After a prominent scholar visited the patient and saw to the improvement of his surroundings, the student declared that the rabbi had saved his life. In response to this incident, a prominent rabbi named Rav Dimi made the puzzling statement that “anyone who does not visit the sick does not pray for him to live and not for him to die” (Babylonian Talmud *Nedarim* 40A).

In his commentary on this second Talmudic statement, the medieval commentator Rabbi Nissim ben Reuben of Gerondi (Ran) references the death of Rebbi, making the bold statement:

It appears to me that the Talmud is saying that sometimes it is necessary to pray that a sick person should die. For example, when a sick person is suffering greatly from his illness and it is impossible for him to recover as we see . . . that since Rebbi's servant *saw* how many times he needed to . . . remove his phylacteries (*tefillin*), which caused him extreme suffering. . . she prayed that Rebbi should die. And for this reason Rav Dimi says that one who actually *visits* a sick person helps him with his prayers even to the point of saving his life . . . and one who does not visit a sick person, it is not even necessary to say that he does not help him to live, but rather even where the patient would benefit from death, even with that small favor [of praying for him to die] the non-visitor does not help the sick person.

Rabbi Nissim's words directly justify praying for the death of a patient who would "benefit" from death.⁴ This interpretation adds nuance to several other vignettes in the Talmud that follow a similar pattern: the account of prayers for the death of a great scholar after the passing of his contemporary left him bereft without an adequate study partner, and the account of prayers for the death of another rabbinic scholar due to his despair at the loss of his peers and social milieu (Babylonian Talmud *Bava Metzieh* 84a and *Taanit* 23a). Each of these Talmudic narratives shares a common theme, a loss of life's purpose.

The common thread in all of the scenarios thus far presented is that it was not the actual physical pain that motivated the desire to die or the prayer for someone else to die, but the anguish experienced due to a lack of interpretable meaning in the suffering. This idea offers a path to interpreting the suffering of all patients in times of adversity, particularly at the end of life.

There is a key difference between pain and suffering that helps to explain why some patients with terrible pain desire to continue treatment and prolong their lives while others desire a swift death. Pain may be approached as "physical" suffering or distress due to illness, injury, or other painful physical or emotional stimulus. On the other hand, suffering is the perception of pain. That is, suffering may be defined as the state of undergoing pain or distress, whether physical or mental.

To illustrate this distinction, consider a newly married young woman who is informed that she will be permanently incapable of bearing a child. The news may cause terrible suffering without creating any physical pain. Now consider the same woman 15 years later, having struggled with infertility for her entire marriage, now pregnant with her first child. She is in labor but has received no anesthesia or other pain medication. The pain is unbearable, yet she feels no suffering. To the contrary, like a marathon runner who feels the physical pain

⁴Rabbi Nissim's ruling allowing one to pray for the death of an irreversibly ill and suffering person remains controversial to the modern day, yet it has played a central role for centuries in end-of-life response, providing a source of practical guidance.

of exertion but experiences the uplifting euphoria of participating in the race, she feels elated and considers it the happiest day of her life. She experiences pain without suffering.

It is this distinction that allows the synthesis of the various texts cited thus far. Pain and suffering are dealt with very differently in Jewish thought. The objective experience of pain lacks moral dimension and should be mitigated, but suffering is more complex. After initially presuming that suffering is the unwanted result of divine judgment, the Talmud presents a deeper understanding of suffering, introducing the idea that when no reason for suffering can be found, it should be accepted as a positive experience intended to improve the person (Babylonian Talmud *Berachot* 5A). But why must a reason for suffering be found at all?

While pain is an inevitable part of life, suffering is not. Suffering in the Jewish tradition is pain (whether physical or psychological) without a perceptible purpose. Purpose redeems pain, giving it context and meaning. While this approach may appear strictly theological, it offers a universal approach to understanding why pain does not necessarily lead to suffering. The goal of the caregiver should be to help the patient find meaning in his or her remaining life. This leads to the realization that it is not so much the pain itself that must be mitigated (although pain relief is an essential role of the physician and other caregivers), but the lack of purpose that the dying patient experiences that must be alleviated.

Practical Applications to Terminal Illness

This concept is illustrated in the modern responsa of two of the preeminent Orthodox rabbinic figures of the 20th century whose legal opinions will serve as a basis for a generalizable and actionable real-world approach to the ethical treatment of the dying patient. Rabbi Moshe Feinstein (1895–1986), the American author of the multivolume *Igrot Moshe*, and Rabbi Shlomo Zalman Aurbach (1910–1995), the Israeli author of *Minchat Shlomo*, were considered to be among the greatest authorities in the area of medical ethics. Both authors incorporate the concepts that we have examined above into legal decisions that meld the constraints of end-of-life medical care with appropriate emotional responses to suffering within the parameters of the Jewish legal obligation to preserve life.⁵

In a landmark responsum integrating the aforementioned rabbinic sources and commentaries, Rabbi Feinstein (1985) writes that “there are times when it is necessary to pray for the death of a suffering person.”⁶ He advocates a concrete ob-

⁵Unlike the two major rabbinical opinions to be discussed, Rabbi Eliezer Yehuda Waldenberg (1915–2006), an eminent late 20th-century authority on Jewish medical ethics and author of the 22-volume encyclopedic treatise entitled *Tzitz Eliezer*, rejected the concept that it is ever appropriate to pray for the demise of patients, regardless of how ill they may be. He cites the fact that Rabbi Nissim’s ruling is not quoted by any major Jewish legal work until the 19th century as practical law, in order to argue that Rabbi Judah the Prince’s servant did not act appropriately in praying for Rebbi’s death (Waldenberg 1985).
⁶Rabbi Feinstein rejects the suggestion that the servant acted improperly and asserts that “it is sometimes proper to pray to God for the death of a critically ill person, if he is suffering greatly and his condition is truly terminal; that is, if there is no rational hope that he will recover.”

ligation to visit sick patients to help them and pray for their recovery, but allows that if one is convinced that there is no hope for recovery and further prayer for recovery would not be effective, one may pray for such patients to die quickly. Rabbi Feinstein accepted that praying for terminally ill patients to die may be appropriate in certain cases and applied this concept to medical treatment at the end of life for suffering patients. His fundamental approach is that once there is no rational hope of relieving the suffering of a terminally ill patient, one should no longer prolong life, though one may never actively shorten life.

In harmonizing the concept of autonomy with the previously discussed obligation of the prudent steward to guard the body, he rules that while every sick patient must receive basic care such as food, hydration, and oxygen, terminally ill patients in intractable pain have the option of refusing further life-saving therapy (such as chemotherapy) if they so desire (Feinstein 1985; see also Tendler 1996). He further explains that if the terminally ill suffering patient is incompetent, the default presumption would be not to treat, and that one should in fact not treat such a patient unless the family knows the patient's wishes to be otherwise. Nevertheless, Rabbi Feinstein is careful to emphasize that it is absolutely forbidden to do anything or to provide any drug that will shorten the patient's life for even a moment.

His central theme is that while active euthanasia is never proper, neither is prolonging unnecessary suffering. A fundamental aspect of end-of-life care is empathy for the impact of suffering on our ill patients, which must play a central role in medical decision-making.⁷ Rabbi Feinstein's opinion, accepted as the mainstream Orthodox Jewish approach, is that merely prolonging a life of pain without hope for recovery is not appropriate.

Rabbi Aurbach adds further nuance to the discussion in a ruling permitting a patient with a life-threatening condition to refuse surgical treatment that would result in paralysis even if successful. Like Rabbi Feinstein, he requires basic care for all patients and reiterates that autonomy is retained by the patient to choose death over life "when life is bad and bitter," permitting the patient to refuse life-prolonging therapy or surgery (Aurbach 1986). Yet he writes that while we cannot force the patient to accept the treatment, the patient should be encouraged to accept the therapy because of the intrinsic value of life lived even in extreme pain. As opposed to the opinion of Rabbi Feinstein, he adds the caveat that if the patient is competent, one should explain to him or her that a single moment of life in this world when utilized properly is worth more than the entire spiri-

⁷As he argues in a different responsum, the rabbis were unsuccessful in their pleas for Rabbi Judah the Prince to recover, leaving him in a state of limbo where he remained living, but continued suffering. Only when his servant saw his degree of suffering without recovery did she intervene to pray for his death. But Rabbi Feinstein (1985) once again reiterates that "we refer here only to prayer for the terminally ill patient's death, but not to committing an action which shortens his life."

tual afterlife. His message is that life with pain can be more desirable than a rapid death and relief from suffering, if one can appreciate the value of the suffering.⁸

Rabbi Aurbach writes that “a person is not master of his body to relinquish even one moment.” A patient may gain the necessary strength to persevere if he or she appreciates that since the Torah teaches that every moment of life is intrinsically valuable, life itself is never futile. He explains that it is not within our moral jurisdiction to decide for someone else what quality of life is “not worth living” and therefore unworthy of treatment. After stating that we have no “yardstick” by which to measure value of life and therefore we must do whatever is necessary to save even a deaf, demented elderly man, Rabbi Aurbach adds a fascinating caveat, concerning the tension between preservation of life and desire for death:

More than that, I think that even if the ill person is suffering greatly, to the extent that according to Jewish law it would be a *mitzvah* [religious obligation] to pray for him to die . . . nevertheless, *at the moment in which one requests and prays to God that the ill person die, one is also simultaneously obligated to strive to save him and to transgress the Sabbath even many times in so doing.*

This does not necessarily imply that every patient must be treated in every instance, nor does this mean that we do not appreciate that death may be subjectively preferable to a life of extreme pain (Epstein 1893). The key, according to Rabbi Aurbach (paralleling the ruling of Rabbi Feinstein), is that we may at times pray in good conscience for the death of a terminally ill patient who is in great pain, but we must never *do* anything to hasten that patient’s death.

It is clear from these sources that the son in scenario 3 need not feel guilty about praying for his mother’s death so long as he pursues the appropriate end-of-life care for her.

AN INTEGRATED APPROACH TO END-OF-LIFE SUFFERING

We are still left with two apparent contradictions whose resolution will result in a consistent and practical model for end-of-life care. First, why are terminally ill, suffering patients granted the autonomy to decline life-prolonging therapy when they are simultaneously being told that living in pain is preferable to death? Second, is not the existence of a *mitzvah* to pray for the death of suffering patients incompatible with being obligated to work to save them?

Both questions can be resolved by appreciating that while traditional Judaism takes it as a given that life has value and suffering has meaning when one evaluates

⁸In a similar vein, Rabbi Moshe Shternbach (1989), a contemporary rabbinic decisor with expertise in medical ethics, writes that one should not pray for the death of a patient who is still lucid and cognizant of his or her situation even if he or she is suffering greatly, so long as the patient has the capacity to repent. However, if the patient is terminal and the suffering is so great that the patient is unable to concentrate, then praying for death is permissible.

how Judaism relates to the dying patient, one must distinguish between the patient and the caregiver or visitor. The perspective of each party is different, with each having a different perception of where such value can be found.

When approaching this issue from the patient's perspective, the suffering terminally ill individual is granted autonomy regarding continuation of life via life-prolonging treatment. While individuals clearly have the right to continue treatment, if they cannot find sufficient meaning in extended life, there is no obligation for them to accept treatment that will merely prolong their intolerable suffering. But as Rabbi Aurbach articulates, those close to the suffering person have an obligation to convey to the ill person that his or her life does have value and meaning, even with suffering, and if such advice is accepted, the patient may choose to continue living, secure in the knowledge that the ordeal has value.

Why empower friends and family to encourage the patient to persevere? Because it may require a third party's encouragement to provide inspiration and free such suffering patients from their emotional prison, giving them confidence in the value and integrity of their painful experiences. Nevertheless, if the suffering individual cannot find solace and meaning, the individual retains the right to refuse life prolongation, as continued life has no value or merit if the person cannot find redemption in the painful experience. This concept is poignantly illustrated by a story in the beginning of the first tractate of the Talmud (*Berachot* 5B):

Rabbi Chiya bar Abba fell ill and Rabbi Yochanon went to visit him. When Rabbi Chiya bar Abba stated that he did not welcome his suffering, Rabbi Yochanon said to him: "Give me your hand" and he healed him. Rabbi Yochanon once fell ill and Rabbi Chanina went in to visit him. When Rabbi Yochanon stated that he did not welcome his suffering, Rabbi Chanina said to him: Give me your hand. He gave him his hand and he healed him. Why could Rabbi Yochanon not cure himself? They replied: The prisoner cannot free himself from [his own] prison (that is, a patient cannot cure himself)!

Thus, suffering terminally ill patients are granted the autonomy to decline life-prolonging therapy while they are simultaneously being encouraged to accept that living in pain is preferable to death.

To understand why the second question does not represent a true contradiction, one must appreciate that from the caretaker's perspective, when praying for a patient or evaluating one's emotional reaction to another's painful illness, one can only use one's own understanding of the situation to guide one's actions. When it appears to the supplicant that the ill person would find death more desirable than life, then praying for death is appropriate.⁹ Yet, given the subjective

⁹While several commentators suggest that one may obviate the need to pray for the death of suffering persons by simply praying for God to relieve their suffering, leaving the possibility of death or miraculous remission of terminal illness, we have concentrated exclusively on the question of the appropriateness of praying for the suffering person to die.

nature of suffering, it may be impossible for a third party to accurately determine or judge whether a sick individual is finding meaning in his or her suffering. As a result, if the patient is incompetent, one can only speculate as to how the patient's suffering is being internalized. Since we may presume that ill individuals cannot find meaning in their suffering due to their inability to consciously process their pain, we are instructed not to prolong such patients' life. Our rational understanding of the value of suffering persons' lives does not necessarily translate into a similar understanding on the part of the patients themselves.

But given the fundamental knowledge that one's body is not one's own to harm, the caretaker or health-care provider may never hasten death. It is crucial to recognize that Judaism draws a distinction between the shortening of life, which is virtually always forbidden, and the prolongation of life, which is sometimes inappropriate. Jewish law would mandate all appropriate therapy for the suffering patient, regardless of how much empathy the caregiver feels for the suffering patient. When further care is not required by Jewish law, then one should not provide it if he feels that the patient would not want it.

This approach, while inspired by Jewish tradition, offers a path for anyone wishing to assess the anguish of others. This nuanced understanding of end-of-life care integrates the apparent contradictions in Jewish sources regarding the recognition of individuals' limited ownership of their bodies and the recognition that meaning and value in suffering can only really be ascertained by the sick persons themselves. Judaism intrinsically values life, but recognizes that only when the individual can internalize the value of his suffering will pain have meaning to the suffering patient. While one may not shorten his life in any way, one does not always have an obligation to extend it, and prayer for the death of a patient or loved one may be appropriate if the supplicant feels that prolonged life will not have value for the terminally ill patient.

REFERENCES

- Abraham, A. S. 2003. *Nishmat Avraham. Vol. 2, Yoreh Deah*. Brooklyn: Mesorah Publications.
- Aurbach, S. Z. 1986. *Sefer Minchat Shlomo*. Jerusalem.
- Eisenberg, D. 2007. "A Traditional Jewish Approach to Risky Medical Treatment." *Cancer Invest* 25: 209–15.
- Epstein, Y. M. 1893. *Aruch Hashulchan Yoreh Deah 339:1*. Vol. 3. New Square, NY: Oz Vehadar, 2006.
- Feinstein, M. 1982. *Iggrot Moshe. Vol. Yoreh Deah III*: 36. New York: Moriah Offset.
- Feinstein, M. 1985. *Iggrot Moshe. Vols. Choshen Mishpat II*: 73–74. New York: Moriah Offset.
- Freedman, B. 1999. *Duty and Healing: Foundations of a Jewish Bioethic*. New York: Routledge.

- Karo, Y. 1563. *Shulchan Aruch (Code of Jewish Law), Yoreh Deah, 339:1 Laws Concerning a Moribund Patient*. Safed.
- Shternbach, M. 1989. *Responsa Teshuvot VeHanhagot*. Vol. 2. Jerusalem: Netivot HaTorah VeChesed.
- Steinberg, A. 2003. *Terminally Ill*. Vol. 3 in *Encyclopedia of Jewish Medical Ethics*, trans. F. Rosner, 1057–59. New York: Feldheim.
- Tendler, M. D. 1996. *Responsa of Rav Moshe Feinstein: translation and commentary. Vol. 1, Care of the Critically Ill*. Hoboken: KTAV.
- Waldenberg, E. Y. 1985. *Responsa Tzitz Eliezer*. 24 vols. Jerusalem: Baruch Bruchman, Zundel Berman.