E. SUPPORTING PATIENTS WHO REQUEST PHYSICIAN-ASSISTED SUICIDE: Towards a Nuanced Approach

In June 2016, the End of Life Option Act took effect in California, legalizing physician-assisted suicide. As was expected, many patients that I work with began requesting aid in dying. In fact, one patient was so anxious to end his life in this manner that he requested it fifteen days before it became legal; in this way, the mandatory fifteen-day waiting-period after requesting medical-aid in dying would be complete ahead of time, and he would thus be ready to utilize this new right on the very day that it became legal. A few days later, another individual came to meet with me to request Rabbinic support for her desire to engage in medical-aid in dying. She had a diagnosis that would only be terminal if untreated, she was not in pain and had decent quality of life, but she confided in me that she had suffered from depression for her entire life and wanted to take advantage of this new law by exaggerating her symptoms to finally put an end to her misery. Another patient asked me to visit to provide guidance on what are good and what are bad days to have a funeral according to Judaism. After a brief discussion I told this patient that our conversation was purely academic. "After all," I explained, "we can never know when the exact day of our death will occur, and we try to bury very soon after death, so we can't choose the date of our funeral." The patient then shocked me with his response, explaining that he had been prescribed the aid in dying medication and was working on planning his death and subsequent funeral on a date that would be most convenient for his friends and family.

These stories, and countless others like them, have forced us

to take this issue very seriously and come up with a sophisticated and principled approach to dealing with it.

As we have seen in previous chapters, any manner of active hastening of death is antithetical to Jewish values and strongly prohibited by Jewish Law. Judaism teaches that we do not own our bodies; we belong to God and do not have the right to destroy that which is not ours.[1] Furthermore, our lives are not simply needed for utilitarian purposes. Each person is sacred, having been created in the image of God, and there is thus a value to life regardless of one's relative quality or usefulness.[2] Not only is human life itself sacred, but every moment of life is valued, and there is thus an obligation to attempt to save all life, regardless of how much time a person has left to live.[3]

Accordingly, in Jewish Law, hastening death is considered murder, even if the victim is about to die anyway.[4] This is true even if a person wants their life taken from them,[5] because of the belief that God owns us and that we thus have very limited autonomy. Judaism also prohibits most forms of bodily damage,[6] suicide,[7] and assisted suicide.[8] Causing death indirectly is also a biblical prohibition.[9]

As we have seen, Jewish Law does not demand that we always pursue "heroic" measures, and there are certainly situations in which Jewish Law permits withholding aggressive life-sustaining treatments. However, there is little room for any nuance when it comes to euthanasia (in which a physician hastens the death of a patient) or physician-assisted suicide[10] (in which the patient performs the final act of taking their own life). Indeed, even "passive euthanasia" is sometimes prohibited when it involves the omission of certain therapeutic procedures or withholding medication, since physicians are charged with prolonging life.[11]

COMPASSION

Physician-assisted suicide is becoming legal in many states, and even where it remains illegal, certain forms of euthanasia and physician-assisted suicide still happen regularly.[12] What is the most appropriate attitude towards people who choose to pursue this forbidden activity, and what approach should we take when asked for guidance from an individual who is considering it?

Although some might think that it is proper for a religious individual to always take a firm stance against physician-assisted suicide, research

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in the states where it is legal is beginning to point towards a more effective strategy. Paradoxically, it turns out that a non-judgmental, supportive approach from clergy has been more effective in allowing patients to consider alternatives, and to ultimately change their minds, than active opposition to the patient's decision.[13]

A rabbi cannot permit physician-assisted suicide, but it is still possible to have compassion for the suffering of terminally ill individuals who are contemplating such a decision while not endorsing or even condoning it. After all, there are certain cases of suicide, such as that of King Saul recorded in the book of I Samuel (31:3–4), that Jewish Law does not endorse, but for which it offers sympathy and permits traditional burial and mourning practices.[14] Rabbinic authorities generally assume that most cases of suicide are not willful and instead "look for any mitigating circumstances, such as fear or anguish or insanity on the part of the one committing suicide, or if they thought it was a meritorious act to prevent other transgressions."[15] In fact, there are even times when Jewish Law may permit praying for a suffering terminal patient to die,[16] while at the same time obligating us to do everything possible, including violate the laws of Shabbat, to prolong his or her life.[17] Thus, even while prohibiting this behavior in practice, there is room for showing some level of understanding and compassion to the patient.[18]

IDENTIFYING AND ADDRESSING THE ROOT CAUSES

It is crucial to understand why individuals seek physician-assisted suicide so that we can offer the most effective interventions and appropriate alternatives. Studies of patients who opt for physician-assisted suicide in Oregon (where it is legal) consistently show that the primary motivation for making this choice is a desire for control.[19] These patients tend to express a strong desire to control the circumstances of their death (time and manner), to die at home, and to address their worries related to eventual loss of dignity and independence, fear of being a burden on others, quality of life, self-sufficiency, and ability to care for themselves. Interestingly, these concerns are more prevalent than concerns related to depression, poor social support, or uncontrolled pain and physical symptoms, which some had predicted would be the primary motivations to seek physician-assisted suicide.[20]

In light of these findings, the best way to encourage people who are

seeking physician-assisted suicide to explore other options would be to focus on interventions that help them maintain a sense of control, independence, and the ability to care for themselves, ideally in a home environment.[21] Instead of trying to convince people that physician-assisted suicide is wrong, it seems that it is most effective for clinicians to focus on eliciting and then addressing the patients' worries and apprehension about their future, with the goal of reducing anxiety about the dying process, educating the patient about how their disease may progress, and offering information about how to manage pain and discomfort while maintaining function and cognition, if that is what they would prefer.[22]

For rabbis, this means working with medical staff to provide information to empower the patient, as well as modeling a non-anxious presence while allowing the patient to work through their fears so they are likely to make a different choice. Many of the patients studied report the feeling of a lack of purpose and meaning in life as a reason for pursuing physician-assisted suicide. This implies that assessing the patient's existential concerns may be crucial in enabling them not to pursue this option.[23]

The assumption that a patient who requests aid in dying is depressed can lead to ineffective and even harmful antidepressant treatments that do not address root causes or lead the patient to change their mind. Similarly, focusing only on addressing physical discomfort ignores the fact that suffering is often existential and cannot be fully treated by pain management alone, and that not all physical pain can always be fully managed, even by expert palliative care.[24]

Nevertheless, symptom management is often a major issue for dying patients, and it should certainly be attended to. Instead of allowing aid in dying, Judaism advocates for improving medical care and comfort at the end of life. The alleviation of pain and suffering is a mitzvah[25] and should not be withheld out of concern for potential adverse effects.[26] It is halakhically permitted for patients to receive narcotic pain medication,[27] even when it may possibly hasten their death, provided that the *intent* is only to alleviate pain, not to shorten the patient's life, and that each dose on its own is not enough to certainly shorten the patient's life.[28] Some Rabbinic authorities have even permitted permanent/continuous sedation[29] for a suffering, terminal patient who so desires.[30]

CONCLUSION

Judaism forbids euthanasia and physician-assisted suicide. Nevertheless, the patients who request it should generally be treated with respect and compassion. It is essential that those who work with patients who are considering or requesting physician-assisted suicide take the time to sincerely listen to their patients and explore the reason(s) for their requests. Studies show that often simply listening to the patients' concerns helps to mitigate many of them.[31] One can then non-judgmentally provide options for an appropriate "substantive intervention" (medical control of pain or other symptoms; referral to a hospice program, a mental health, social work, chaplaincy, or palliative-care consultation; trial of anti-depressant medication when appropriate). This has also been proven effective in enabling patients to change their minds about wanting assisted suicide.[32] In particular, one should seek to address the patient's specific concerns, and determine if there is a way to meet them without opting for physician-assisted suicide.

Hopefully, in this way we can maintain our standards and fealty to Halakhah, while at the same time expressing compassion and finding the most effective method of avoiding physician-assisted suicide or euthanasia.

ENDNOTES

1. *Tzitz Eliezer* 5, *Ramat Rachel* 29(1). See also *Shulchan Arukh Ha-Rav,* CM, 4; *Radbaz*, *Sanhedrin* 18:6; *Mor U-Ketzia*, OC 328.

2. *Sanhedrin* 4:2; Rambam, *Hilkhot Rotzeach* 2:6–7; *Shulchan Arukh*, OC 329:4; *Bi'ur Halakhah*, s.v. *ela lefi*.

3. See *Nishmat Avraham*, YD 339:4.

4. Rambam, *Hilkhot Rotzeach* 2:7; *Minchat Chinukh*, mitzvah 34; *Gesher Ha-Chaim* 1:2(2), n. 3; *Arukh Ha-Shulchan*, YD 339:1; I. Jakobovits, *Jewish Medical Ethics*, 123–5.

5. *Tzitz Eliezer* 9:47 (5) argues that even if a patient begs not to be saved because their suffering makes them feel that death is preferable to life, everything must nevertheless be done to save and treat them. Similarly, see R. Nathan Friedman, *Netzer Mat'ai* 30.

6. Rambam, *Hilkhot Chovel U-Mazik* 5:1.

7. Rambam, *Hilkhot Avel* 1:11; *Tur*, YD 345. For further discussion, see *Gesher Ha-Chaim* 25. Regarding the prohibition to take one's own life even if one is in severe pain, see *Besamim Rosh* 348 and *Teshuvot Chatam Sofer*, EH 1:69. R. Shilat (*Refuah, Halakhah, V'kavanot Hatorah*, 49), argues (based on Rambam, *Hilkhot Rotzeach*, 1:1, 2:1–3) that suicide violates the prohibition against murder, which not only prohibits killing others, but any murder, even of oneself. *Tzitz Eliezer* 10:25(4) quotes Chatam Sofer on the Torah (beginning of *Parashat Vayeitzei*), who writes that suicide is even worse than murder because death normally atones for one's sins, but one who kills himself, even if he is suffering, forfeits this atonement.

8. The prohibition against active euthanasia is clear from the ruling of the Rambam that one may not kill a healthy person or even a sick person who will die in any case (*Hilkhot Rotzeach* 2:7). *Sefer Chassidim* (315–318, 723) also clearly states that one may not kill another person even if that person is suffering and asks to be killed. The prohibition can also be inferred from the prohibition against suicide. See also *Sefer Refuah Ke-Halakhah*, 446.

A person who convinces or enables someone to commit suicide violates the biblical prohibition of placing a stumbling block before the blind, "*lifnei iver*" (Lev. 19:14). If one person actively ends another's life, they would be guilty of murder. Additionally, there is an obligation to try to rescue someone whose life is endangered, "*lo ta'amod al dam rei'ekha*" (19:16). A person who sees another drowning has an obligation to try to save them, either by personally swimming to help the person or by hiring someone else to do so (Rambam, *Hilkhot Rotzeach* 1:14). According to many authorities, this duty to rescue applies even to the saving of someone who is attempting to commit suicide (*Iggerot Moshe*, YD 2:174 (3); *Minchat Yitzchak* 5:8). However, see the discussion of some Rabbinic authorities regarding the possibility that it is not forbidden for a non-Jewish person to engage in euthanasia when they feel that it is for their benefit (*Teshuvot Ve-Hanhagot* 3:365; *Shiurei Torah Le-Rofim* 4:286, 557, as well as 2:149, 589; *Iggerot Moshe*, CM 2:74[2]).

9. R. Goren, *Torat Ha-Refuah*, 77, and Steinberg, *Encyclopedia of Jewish Medical*

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Ethics, 1057, based on Rambam, *Hilkhot Rotzeach* 2:2.

10. It should be noted that those who support physician-assisted suicide object to it being referred to as "suicide" and prefer the term "physician aid in dying" or "medical aid in dying."

11. Bleich, *Bioethical Dilemmas* (Ktav, 1998), vol. 1, 72.

12. E.J. Emanuel, D.L. Fairclough, and L.L. Emanuel, "Attitudes and Desires Related to Euthanasia and Physician-Assisted Suicide Among Terminally Ill Patients and Their Caregivers," *Journal of American Medical Association* 284, 2460–68; A.L. Back, et al, "Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses," *Journal of the American Medical Association* 275 (1996), 919–25; D.E. Meier, et al., "A National Survey of Physician-Assisted Suicide and Euthanasia in the United States," *New England Journal of Medicine* 338 (1998), 1193–201; D.E. Meier, C.A. Emmons, A. Litke, S. Wallerstein, R.S. Morrison, "Characteristics of Patients Requesting and Receiving Physician-Assisted Death," *Archives of Internal Medicine* 163 (2003), 1537–42. Furthermore, where it is illegal, physicians report using alternative methods to assist their patients in hastening death; see K. Stone, "When a Patient Chooses Death," *Lancet Nuerology* 8(10) (2009), 882–3.

13. L. Ganzini and S.K. Dobscha, "If It Isn't Depression," *Journal of Palliative Medicine* 6 (2003), 927–30. The authors point out that patients who explore physician-assisted suicide are often very strong-minded, determined, and sensitive to perceived dominance in relationships, and they thus become very resentful of those who try to talk them out of it.

14. See Ramban, *Torat Ha-Adam, Sha'ar Ha-Sof – Inyan Ha-Hesped* 18; Rosh, *Mo'ed Katan* 3:94; *Shulchan Arukh*, YD 345:3; *Tzitz Eliezer* 5, *Ramat Rachel* 29:2. For a thorough summary and discussion of the approaches to the case of Saul, see A. Steinberg, "*Retzach Mitokh Rachamim Le-Or Ha-Halakhah*," *Assia* 3 (5743), 436–9; R. Zilberstein, *Shiurei Torah Le-Rofim* 3:200, 403–4; *Sefer Refuah Ke-Halachah*, 447–9; R. Z.N. Goldberg, *Moriah* 4–5(5738), 88–89; N. Zohar, "Jewish Deliberations on Suicide," in *Physician-Assisted Suicide* (Routledge Press, 1998), 367; forthcoming responsum of R. Asher Weiss on "Terminal Sedation."

15. *Arukh Ha-Shulchan*, YD 345:5. While this refers to most cases of suicide, physician-assisted suicide is a more complicated question because Jewish Law prohibits burial in a Jewish cemetery for one who intentionally and with a clear mind, knowing the severity of the prohibition, decides to nevertheless take their own life. Since most state laws require very clear informed consent before allowing a patient to do this, most cases of physician-assisted suicide are completely intentional, in which case the prohibition against burial in a Jewish cemetery should apply. However, some authorities have argued that one who takes their own life as a result of severe emotional distress, sorrow, or abject poverty, might not fall into the category of being unintentional (*Besamim Rosh* 345 quoted in *Pitchei Teshuvah* YD 345:2, however, see there for citations of authorities who reject this opinion). Therefore, some would argue that although the act of suicide is still forbidden for such an individual, it is not considered to have been done with a completely clear mind or heretical intention, and may even seem appropriate at the time ("*omer mutar*"), and they may thus be afforded full burial rites (*Maharsham* 6:123). Similarly, in a personal conversation, R. Asher Weiss argued that although suicide is certainly forbidden, after the fact, he would allow for burial based on this line of reasoning, because the emotional suffering

involved is just as significant as physical pain (Spring 2017). Moreover, R. Hershel Schachter notes, as reported to this author by R. Aryeh Lebowitz, that there is an opinion (*Orchot Chaim* 4, *Hilkhot Ahavat Hashem* 1, quoted in *Beit Yosef* YD 157) which permits suicide in order to avoid being tortured, as King Saul did. Although R. Schechter does not rule in accordance with this opinion since it refers specifically to avoiding religious persecution/forced conversion and is a minority view, but since such opinions exists, he argues, we may be able to rely on it after the fact to at least afford this individual proper burial. (See R. Schechter's discussion of this issue in his book *Ginat Egoz* 74, fn.) I also thank R. Nachum Sauer and R. Avrohom Union for pointing out some of these sources to me.

16. Ran, *Ketuvot* 104a; *Arukh Ha-Shulchan*, YD 335:3.

17. *Minchat Shlomo* 1:91(24); *Nishmat Avraham*, YD 339 (500 in 3rd ed.).

18. Many of the points in this paragraph are articulated by R. Mordechai Torczyner, with much more depth and clarity, in his talk available at http://www.yutorah.org/lectures/lecture.cfm/830798/Rabbi_Mordechai_Torczyner/Medical_Ethics:_Physician-Assisted_Suicide

19. L. Ganzini, et al., "Experiences of Oregon Nurses and Social Workers with Hospice Patients who Requested Assistance with Suicide," *New England Journal of Medicine* 347(8) (2002), 584; Ganzini, et al., "Why Oregon Patients Request Assisted Death: Family Members' Views," *Journal of General Internal Medicine* 23(2) (2007),154–7; Ganzini et al., "Oregonians' Reasons for Requesting Physician Aid in Dying," *Archives of Internal Medicine* 169(5) (2009), 489–92. See also Pearlman et al., "Motivations for Physician-Assisted Suicide," *Journal of General Internal Medicine* 20 (2005), 234–9; Monforte-Roy, et al., "What Lies Behind the Wish to Hasten Death? A Systematic Review and Meta-ethnography from the Perspective of Patients," *PLoS One* 7 (2012):e37117. A paradox of the control issue is that some patients have actually reversed the natural dying process, opting for aggressive measures to keep themselves alive longer (so that they will survive the mandatory waiting period), thereby prolonging their suffering, in order to be able to be in control and end their lives themselves. Some have argued that this desire for control functions as a terror-management strategy by providing an illusion of control (power), choice (options), dignity (meaning), and a "way out" (exit), which make the person's situation seem bearable and manageable, even though the act of bringing about one's own death in reality achieves none of these things, M. Johnstone, "Bioethics and Cultural Differences," *Journal of Medicine and Philosophy* 37 (2012), 193.

20. Ganzini, "Oregonians' Reasons," 489.

21. Ibid., 489, 491.

22. Ganzini, "Why Oregon Patients Request Assisted Death," 156.

23. Carlson, et al., "Oregon Hospice Chaplains' Experiences with Patients Requesting Physician-Assisted Suicide," *Journal of Palliative Medicine* 8(6) (2005), 1165.

24. T.E. Quill, "Doctor, I Want to Die. Will You Help Me?" *JAMA* 270 (1993), 870–3; G.A. Sachs, J.C. Ahtonheim, J.A. Rhymes, L. Volicer, J. Lynn, "Good Care of Dying Patients: The Alternative to Physician-Assisted Suicide and Euthanasia," *Journal of the American Geriatric Society* 43 (1995), 553–62.

25. R. Shlomo Zalman Auerbach argues that the alleviation of pain falls under the obligation to love one's neighbor as oneself (*Minchat Shlomo* 2–3:86). The *Tzitz Eliezer* (13:87) argues that severe pain is considered debilitating and dangerous,

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and administration of sophisticated pain medications is thus considered part of a physician's mandate to heal. The classical *poskim* affirmed this mandate even in risky scenarios if the intention is to relieve pain.

26. *Minchat Shlomo* 2–3:86. The concerns are related to opioids' potential to suppress breathing. However, current medical data suggest that judicious use of opioids does not usually shorten the life of terminally ill patients; see R.A. Mularski, et al., "Pain Management Within the Palliative and End-of-Life Care Experience in the ICU," *CHEST* 135 (2009), 1360–9). Healthcare professionals can offer patients and families choices for pain control. For example, patients who are alert may choose to receive adequate medication to keep them as comfortable as possible while retaining the ability to communicate. Others may prefer that medication be chosen for maximum comfort, even if it renders the patient less responsive (Loike, et al., "The Critical Role of Religion," 1–5).

27. *Tzitz Eliezer* 13:87; *Teshuvot Ve-Hanhagot* 3:361; J. D. Bleich, "Survey of Recent Halakhic Literature: Palliation of Pain," *Tradition* 36(1) (2002); *Shiurei Torah Le-Rofim*, vol. 3, 396.

28. *Nishmat Avraham*, YD 339:1 (4) (499 in 3rd ed.).

29. This is also known as "palliative sedation" (or "terminal sedation"), the complete sedation of those who are imminently dying and whose pain and symptoms cannot otherwise be adequately relieved. This always entails making the patient DNR, and sometimes includes the practice of withholding or withdrawing various forms of life-sustaining treatments, including nutrition, hydration, dialysis, and vent support. Removal of these interventions would be prohibited by Jewish Law (see next note). Even many secular ethicists view palliative sedation as a form of euthanasia, particularly when the patient is not imminently dying. See Jonsen, Siegler and Winslade, *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine* (McGraw-Hill, 2010), chap. 3. Some secular ethicists argue that while palliative sedation is a last resort when distressing symptoms cannot otherwise be controlled, it is an ethically appropriate approach to end-of-life care. See Blinderman and Billings, "Comfort Care for Patients Dying in the Hospital," *The New England Journal of Medicine* 373(26) (2015), 2559.

30. R. J.D. Bleich and R. Moshe David Tendler have been reported to permit this practice for a dying patient (and even mandated if there is no other effective option), as long as the patient continues to receive all necessary life-sustaining treatments and the intent is not to kill. See R. Dr. Jonah Bardos, "Palliative Sedation: Terminal or Palliation? An Ethical Analysis," *Verapo Yerape* 6 (2015), 24–25. This has also been permitted by R. Dr. Mordechai Halperin; see http://98.131.138.124/db/showQ.asp?ID=6936.

31. D.A. Matthews, A.L. Suchman, W.T. Branch, "Making 'Connexions': Enhancing the Therapeutic Potential of Patient-Clinician Relationships," *Annals of Internal Medicine* 118 (1993), 973–7.

32. Ganzini, et al., "Physicians' Experiences with the Oregon Death with Dignity Act," *New England Journal of Medicine* 342 (2000), 560.