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Decision-Making in Acute Critical Illness: A Rabbinic Postscript

Rabbi Dr. Judah Goldberg has written a masterful and important article, based on the seminal rulings of *Iggerot Moshe* and others, and drawing on his extensive real-life experience in acute emergencies. We begin these words of endorsement by noting that whether or not a patient *must* be treated should be differentiated from the halakhic allowance to desecrate Shabbat in order to do so. *Bi'ur Halakha* (329:4) allows the desecration of Shabbat even for a patient who has no possibility of performing future *mitzvot*: The source of the allowance, "And he should live by them" (Lev. 18:5; see *Yoma* 85b), refers to *any* life. Similarly, Rambam (*Hilkhot Shabbat* 2:3) explains that the laws of the Torah are "mercy, kindness, and peace in the world" and therefore do not constitute a barrier to life-saving treatment. However, this does not imply an obligation to initiate treatment in all circumstances. One patient may decline a certain treatment, even though another is allowed to desecrate Shabbat to pursue it.[1]

Refraining from treatment may sometimes be appropriate even when there is the possibility of survival, especially, as Dr. Goldberg has demonstrated, when there are possible downsides to treatment, such as: pain; indefinite, non-comatose life on a ventilator; or, in the words of R. Shlomo Zalman Auerbach, "a bitter, paralyzed life that is worse than death" (*Minhat Shlomo* I 91:24). While a patient may not arbitrarily cause himself harm, he may forego treatment in situations in which reasonable people might conclude that the downsides outweigh the benefits. If the patient lacks (sufficient) cognition, a family member or health-care proxy can decide to decline treatment based on the previously expressed directives of the patient, or, if necessary, by analyzing what the patient would want to be done in such a case.

[1] See also R. Uriel Eisenthal, *Megillat Sefer*, *Hilkhot Shabbat*, p. 168, and *Orehot Shabbat*, 2:252.

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That the harm of treatment may sometimes outweigh its benefit is true not only about initial treatments that are meant to stabilize critical illness, but also about further treatments down the line. For instance, a patient who cannot be weaned from a ventilator and is living in anguish may conclude that life has become burdensome for him and wish to forego life-extending therapies. Invasive procedures, such as tracheostomy or feeding tube placement, may be declined. And while a caretaker may not actively interrupt an ongoing treatment, such as mechanical ventilation, he may passively not apply or renew further treatments, such as the suctioning of a breathing tube or the administration of additional bags of artificial hydration or nutrition, when appropriate.

In this regard, we do not distinguish between different types of treatment (basic vs. extraordinary), between treatments that have become routine for a patient and those that have not yet been initiated, or between different life expectancies. R. Auerbach writes that if a patient is aware and not demented (*lo nitrefa da'ato*), he should be encouraged to pursue every treatment despite the physical or severe emotional pain involved. He should be told, "Better one hour of repentance and good deeds in this world than the entire life in the world to come" (*Avot* 4:22). Nevertheless, if the situation is so unfortunate that reasonable people might not want to continue living in these conditions, the patient has the authority to decline further care.

In our opinion, the same principles apply in situations of irreversible lack of cognition, such as advanced dementia or severe brain injury. In these circumstances, the continuation of the Mishna is relevant: "Better one hour of spiritual bliss in the world to come than the entire life of this world." This applies to life in this world when repentance and good deeds are no longer possible, in which case it need not be extended. No new therapy, such as oxygen or artificial hydration or nutrition, need be administered; the primary goal of care should be maintaining the comfort of the patient. Furthermore, reassessment may be appropriate as the medical situation evolves. For instance, if a patient has already been receiving artificial nutrition through a feeding tube but has now lost all cognition irreversibly, further feedings need not be given.

In our opinion, this information should be conveyed to patients and families, as it could, paradoxically, be lifesaving. The decision to intubate or not can be influenced by the fear of remaining on a ventilator even after there is no chance of meaningful recovery or of a return to cognition. If, in these eventualities, indefinite extension of a life of hopelessness or lack of awareness can be avoided by withholding further life-prolonging

treatment, it is more likely that initial, stabilizing treatments, including intubation, will be pursued. Patients will feel freer to attempt aggressive therapies if they are less worried about being sustained indefinitely by them.[2] This decision is lifesaving for those who can actually recover, as we have seen during the coronavirus pandemic.

In closing, we restate our position with regard to acute critical illness: The proper default position is to err on the side of caution and do everything possible to stabilize a critical patient, even if the chance of survival is very low. However, if time allows for careful deliberation, there is room for a patient or proxy to decline treatment and intubation, based on Dr. Goldberg's guidelines.

[2] The exact boundary between the withholding and the withdrawal of care is a matter of debate. For some relevant statements, see: R. Dr. Avraham Steinberg, "Halachic Guidelines for Physicians in Intensive Care Units," *ASSIA – Jewish Medical Ethics* 4:1 (February 2001), 5–6, available at https://www.medethics.org.il/article/rj041005a; and Hershel Schachter, "*Piskei Corona* #15: Triage in Medical Decisions" (April 6, 2020), and Mordechai Willig, "*Shu"t Corona*," in *Hokhmot Bantah Betah: In Memory of Mrs. Leah Adler z"l*, eds. Richard T. White, Shulamith Z. Berger, Shulamis Hes, Marlene Schiffman, Moshe Schapiro, and Zvi Erenyi (Yeshiva University Library, 2021 [forthcoming]), both available at www.torahweb.org.