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Whose Life Is It Anyway?

Susan Stern Conforti

Thesis submitted in partial fulfillment of the requirement for Ordination

Hebrew Union College–Institute of Religion
2001

Referee, Professor Mark Washofsky

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In memory of my father
Dr. Harold O. Stern (1926-1987)

In honor of my mother
Clara J. Stern

And dedicated to my family
Paul M. Conforti
Irene E. Stern Conforti
Hannah J. Stern Conforti

without whose patience, support, and love
this work would not have been possible

Digest

Traditional halacha is often modified in order to create Reform responsa. The modifications stem from Reform principles, many of which are derived from modern secular thought. Reform Jews, and especially Reform rabbis, can benefit from studying and understanding traditional halacha, Reform responsa, and secular legal and ethical writings. It is worthwhile to distinguish the points of similarity and dissimilarity among them – worthwhile not only as an intellectual exercise, but also as a way to approach everyday ethical and moral issues and in order to be able to make informed decisions about Reform Jewish practice. As a particular example, this thesis compares and contrasts the approaches to a particular ethical issue: the medical question of whether and under what conditions a patient may undergo life-threatening surgery for a non-life-threatening condition.

Keywords: Bioethics, Halacha, Law, Medical Ethics, Medicine, Reform Judaism, Responsa

Introduction

We Reform Jews live in two worlds at once: the Jewish world and the modern, secular world. As a rabbi, when faced with a question, I look first to halacha. If the halachic answer simply is outside the bounds of Reform principles, then the halacha may be put aside. The mental activity of going through the reasoning of the sages allows me to know from what angles I need to approach the formulation of an answer. For example, Reform Judaism is uniformly committed to the belief that men and women should be given equal access to and education about Judaism. If the halacha flatly denies that equal access, then a non-halachic answer will be reached. In the meantime, all the issues surrounding the question will have been discussed in a thorough, if unorganized manner.

Ethics and morality are intimately involved in religion, and Judaism, with its own legal system, defines our sense of what is ultimately important: what values trump what other values, and so on. A rabbi who is unfamiliar with halacha will, almost of necessity, decide ethical issues based on values absorbed from the surrounding secular culture. A question of abortion, for example, from a halachic perspective, does not begin with an unwavering commitment to the rights of the unborn child. Neither does it begin with an assumption that a woman has a right to do with her body what she will. Either assumption will guide us to an answer that seems to be final and unwavering, although, of course, the closer the fetus is to being viable, the more difficult the question and its answer become, as witnessed by the recent bans on late-term abortion.

The halachic answer for any particular pregnant woman may or may not sanction an abortion. Different opinions are offered by different rabbis, and each woman's pregnancy is a distinct case. As Mark Washofsky explains,

> From the discussion in the halakhic literature...we learn three things. First, serious and principled disagreement can exist over the acceptable grounds for abortion, even among the sages and scholars of a single religious tradition. Second, efforts to resolve a principled moral disagreement, to declare one side the winner by arbitrary means, may place an intolerable strain on the very process of moral decision making. Third, the morality of any particular decision for abortion must be judged on a case-by-case basis.[1]

In the case of abortion, at least in the view of some authorities[2], there is a respect for the "life" of the fetus in that one cannot destroy it for convenience. There is a greater respect, however, for the actual life of the mother. As long as the fetus is inside the woman's body, her life takes precedence over its life, and one may (in fact, should) remove the fetus if the woman's health is in grave danger. Now is this reasoning "pro-life"? Is it "pro-abortion"? It is neither. The woman herself does not decide the answer, and neither does the baby's father have any say in the decision. Instead, complex questions and answers bring us to a conclusion that will be specific for each individual woman.

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[1] "Morality and Choice: A Response to Daniel Callahan" by Mark Washofsky in Kogan, Barry S., editor, A Time to be Born and a Time to Die (Hawthorne, New York, Aldine de Gruyter, 1991): p. 76.

[2] See Shulman, Nisson E., Jewish Answers to Medical Ethics Questions (Northvale, New Jersey, Jason Aronson Inc., 1998): pp. 74-6. Also see the discussions in "Abortion to Save Siblings from Suffering" 5755.13, in Plaut, W. Gunther and Washofsky, Mark, Teshuvot for the Nineties (New York, Central Conference of American Rabbis, 1997): pp. 171-6, and in "Abortion," in Jacob, Walter, editor American Reform Responsa (New York, Central Conference of American Rabbis, 1983): pp. 541-3, and in "Jewish Views on Abortion" by Immanuel Jokobovits and "Abortion in Halakhic Literature" by J. David Bleich in Rosner, Fred, and Bleich, J. David, editors, Jewish Bioethics (Hoboken, New Jersey, 2000): pp. 139-54 and pp. 155-96, respectively.

The preceding discussion does not mean that secular ethical approaches are always final and unwavering; they can in fact be nuanced and moderate.[3] As Daniel Callahan notes, women themselves find that the evaluation of abortion requires moral compromises:

> Why is there, as public opinion polls suggest, a broad agreement on the general right of women to make an abortion choice, yet considerable disagreement on morally acceptable reasons for abortion? The most plausible reason is that most people are trying to find a suitable balance between the traditions of choice and those of respect for life.[4]

Clearly, neither halachic reasoning nor serious secular bioethical reasoning provides us with snappy sound bites and witty bumper stickers. Given two nuanced approaches – one secular and the other halachic – I would suggest that Reform rabbis be able to understand and give considerable weight to the halachic approach before any other. The specific answer, however, is much less important than an understanding of the way the question is approached and the underlying assumptions – stated or unstated – that inform the discussion. I make this assumption, and it is indeed an assumption, because I believe that how we get to an answer is as important as the final answer. It is not intellectually or religiously authentic to say something like, "I don't care where we begin our discussion or in what manner we decide, as long as we end up with an answer with which we are all comfortable." This type of statement assumes that communal agreement is a primary concern. For me, the answer must come out of a religiously-based set of values, and the discussion must start with religious texts and proceed from there in ways that mirror the discussions in the Talmud and the arguments of responsa.

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[3] See "Abortion in a Pluralistic Society: Can Freedom and Moral Probity Coexist?" by Daniel Callahan in Kogan, Barry S., editor, A Time to be Born and a Time to Die (Hawthorne, New York, Aldine de Gruyter, 1991): pp. 57ff.

[4] *Ibid.*, pp. 66-7.

Purpose

This thesis begins with the assumption that the study of halacha is worthwhile for many reasons: as intellectual exercise, for an understanding of our own legal system, for answers to theoretical and practical problems and questions, and, most especially, for the practice of ethical thinking and debate over the thorniest of today's problems.

On the subject of the permissibility of undergoing life-threatening surgery for a non-life-threatening condition, I will present a comparison of representative (but not comprehensive) medical ethical cases drawn from the world of halacha and from secular medical ethics. These examples are important not only in order to know the answers that are reached, but also because the analysis of *how* the answers are reached. I will look at the following questions and others like them:

- From what vantage point is the issue addressed?
- How does each define what is at stake?
- How does each go about the business of translating general principles into specific conclusions?
- What are the differences between the two methods?
- What are the points of contact?

Focus

I will consider the following general issue: the permissibility of undergoing life-threatening surgery for a non-life-threatening condition. There are many such conditions. One is the inability to conceive and bring a fetus to term: the procedures necessary to overcome infertility may pose a serious health risk to the mother. Facial deformities resulting from von Recklinghausen's disease can be psychologically devastating without being physically

threatening. Should one undergo the risks of surgery to correct these deformities? Another condition is the loss of a hand: the procedures necessary to transplant a cadaver's hand puts a patient at risk of losing his or her life, but successful surgery adds immeasurably to a patient's quality of life. Another condition is chronic, debilitating pain. Can one risk one's life in order to alleviate pain?

Assumptions

Now every action carries some risk to health. Simply becoming a hospital patient increases one's risk of infection. Every surgery, however minor, has some small chance of doing more harm than good to the patient. The more unstable the condition of the patient, the more inexperienced the doctor, and the more uncommon the procedure, the more risk there is to the patient. These and other such considerations all come into the equation. For the purposes of this study, we assume a perfect world where the doctor is talented, the hospital is not spreading germs and disease, etc. The only question is: for this patient and this disease, would the recommended procedure have a death rate of greater than 50%? (Note too that this figure itself is an assumption.) The procedure may have just been developed and has no known success rate. If this is so, we assume the doctor has designed the procedure. If the procedure is more common, we assume that the doctor in question has performed enough such surgeries that he or she is considered a skilled surgeon, if not an acknowledged expert.

Who makes the decision to undergo surgery? In this analysis, I will deal exclusively with competent adults (ignoring questions about health care for children and ignoring questions

about how one determines competency). However, this thesis will question the assumption that the correct question is "Who makes the decision?"

For the sake of ease of analysis and discussion, I will use the term "physician" and the pronoun "he" in all cases, even though health-care providers include many other people of both sexes, and even though standard licensed medicine is not the only type of health care available.

Why Study Halacha?

Many Reform rabbis consider medical ethics to be a secular discipline that comes under the heading of philosophy, but to me, it seems much preferable to consider medical ethics as a religious discipline that comes under the heading of halacha. Medical ethics is thus ultimately practical – able to guide our actions. When, as a rabbi, I am called to the hospital to see a patient who is one of my congregants, I do not wish to have the stress of the situation compounded by my not knowing beforehand the ways in which bioethical issues are approached. The hospital staff will approach any decisions from their own points of view, and the distressed family will come from yet another point of view. I, as the rabbi, must know at least the Jewish (that is, halachic) approach, for why else am I there than as a representative of accumulated Jewish knowledge? If I can have at my disposal an understanding of the secular approach to bioethical issues, so much the better, for I will understand how issues are framed and be able to evaluate arguments from all sides.

To step back from hospital scenarios, I, as a rabbi, may be called upon to answer halachic questions at any time. I may get questions about halacha even if I, for my own needs, do not feel the need to know any halacha. When I am faced with a question, I would prefer to know the halacha rather than having to learn it before giving an answer. As it happens, I do want know halacha for a number of reasons, some of which are listed below.[5]

1) I don't want to discard centuries of information and guidance without first learning it. The act of dismissing halacha out of hand without first knowing a major part of it is like the act of throwing away a jewelry box without checking whether there is any jewelry inside.
2) While Reform Judaism is fragmented as to its practices, its major theme has been "Tradition and Modernity," and its motto has been "Autonomy informed by tradition." Eugene Borowitz, a foremost theologian of Reform Judaism, wrote the Centenary Perspective on the occasion of the 100th anniversary of the Union of American Hebrew Congregations (1875). In it, Borowitz "called on Reform Jews to confront the differently perceived claims of Jewish tradition by 'exercising their individual autonomy, choosing and creating on the basis of commitment and knowledge.' It led to the phrase 'informed choice' which along with 'autonomy' became the watchwords of Reform Judaism."[6]

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[5] For fuller discussions of Reform halacha, see the introductions to Washofsky, Mark, Jewish Living (New York, UAHC Press, 2001), Plaut, W. Gunther and Washofsky, Mark, Teshuvot for the Nineties (New York, NY, Central Conference of American Rabbis, 1997), Jacob, Walter, Contemporary American Reform Responsa (New York, NY, Central Conference of American Rabbis, 1996), and Jacob, Walter, American Reform Responsa (New York, NY, Central Conference of American Rabbis, 1983). Also see the introduction and first three chapters of Zemer, Moshe, Evolving Halakhah (Woodstock, Vermont, Jewish Lights Publishing, 1999).

[6] From "Commentary to the [1999] Pittsburgh Principles" (CCAR document at http://www.ccarnet.org/platforms/commentary.html)

Richard Levy, president of the Central Conference of American Rabbis (CCAR), suggested the phrase "informed responses" in his August 1998 "Ten Principles for Reform Judaism."[7] And in the Statement of Principles for Reform Judaism, adopted at the 1999 Pittsburgh Convention of the CCAR, we read,

> We affirm the importance of studying Hebrew, the language of Torah and Jewish liturgy, that we may draw closer to our people's sacred texts.
>
> We are called by Torah to lifelong study in the home, in the synagogue and in every place where Jews gather to learn and teach. Through Torah study we are called to מצות (*mitzvot*), the means by which we make our lives holy.
>
> We are committed to the ongoing study of the whole array of מצות (*mitzvot*) and to the fulfillment of those that address us as individuals and as a community. Some of these מצות (*mitzvot*), sacred obligations, have long been observed by Reform Jews; others, both ancient and modern, demand renewed attention as the result of the unique context of our own times.[8]

From these statements I learn that as a Reform Jew, I need to make informed choices about my own observance, and that as a Reform rabbi, I must teach others halacha so that they can make informed choices also.[9]

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[7] Richard Levy's third draft of "Ten Principles for Reform Judaism" (August 1998) says:

> Though all the mitzvot are open to us as to all Jews, the Reform movement believes that changing times affect the way we understand the mitzvot. We respond to the call of Torah in two ways: out of the ever-growing body of interpretation by *Kenesset Yisrael*, the eternal community of the Jewish people, and out of our individual understanding of what is holy in our own time. Study, prayer and reflection on our actions will help us offer informed responses to the Torah's call to do God's will in our days.

(CCAR document at http://uahc.org/ccar/platforms/tenpri.html)

[8] (CCAR document at http://uahc.org/ccar/platforms/principles.html)

[9] That informed choice is a requirement for Reform Jews is an important assumption (I would say a principle) that underlies this thesis. My position is well-stated by Cheska Komissar, in a d'var Torah given on May 3, 1996 at congregation Sha'arei Shalom of Ashland, Massachusetts:

> [D]eclaring that one is Reform is not to be used as a rationale for ignoring or rejecting customs and practices at will. Rather, the Reform movement expects its adherents to make responsible decisions based upon knowledge and understanding of Jewish ideology and an appreciation of its history. This means that before any individual can make a decision about the Jewish customs he or she will follow, that individual must first understand the custom and the practice and then make an informed choice.

(www.rjca.org/emor.html)

3) I believe halacha to be a living and changing legal system. Halacha is not fixed and static, not even in the Orthodox community. As Moshe Zemer states, "Halakhah is by nature and practice evolutionary, flexible, ethical, and progressive."[10] I want to help in the process of continual refinement of what Jews think God desires of us and what Jews think is the best way to serve the deity. Simply put, I want to do my part, however small, to add to our understanding of "the way to walk."
4) I hold the value of Jewish unity in high esteem, and thus want Reform changes in halacha to come relatively slowly, so that they can filter out to other denominations over time. I want to have the knowledge to speak to others on their own terms, using their own sources to bring a minority opinion up for scrutiny.
5) I want to share the pleasure of learning Torah with others.

As Mark Washofsky writes, "That Reform rabbis continue to write and read responsa testifies to the enduring importance of halakhah, of traditional Jewish law, as a resource with which we compose, explain, and express our religious lives as Reform Jews."[11]

Additional discussion of this topic can be found in the Conclusions, below.
[10] Zemer, Moshe, Evolving Halakhah (Woodstock, Vermont, Jewish Lights Publishing, 1999): p. 38.
[11] Plaut, W. Gunther and Washofsky, Mark, Teshuvot for the Nineties (New York, NY, Central Conference of American Rabbis, 1997): p. xiv.

The Role of the Physician – The Secular View

There are various types of ethical theories that secular bioethicists use to undergird their thinking about the role of medicine, the role of the physician, and they ways in which moral dilemmas in medicine can be faced. There are considerations such as appealing to the consequences of our actions, appealing to rights, appealing to the virtues, and appealing to ideals of justice and equality, which are spelled out by secular bioethicists Baruch Brody and H. Tristram Engelhardt, Jr.[1] Many types of ethical theories are advanced, such as Kantian deontological (also known as formalist) theories of categorical imperative, Jeremy Bentham's utilitarian (also known as consequential) theories, Aristotelian theories of virtues, and theories that, though secular, draw from religious texts. Further, principles for both physicians and patients are enunciated, such as confidentiality, truth-telling, and the importance of patient autonomy. There is no easy way to summarize all the various approaches to secular bioethics, but writers Tom Beauchamp and James Childress[2] have divided ethical ideas into utilitarian and deonotological theories, which at times are diametrically opposed and at times overlap. Because this thesis seeks to examine a valid representative set of secular approaches, and not to present a complete survey of such approaches, this thesis will discuss the main ideas of Beuchamp and Childress and occasionally supplement those ideas with those of other well-known authors.

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[1] Brody, Baruch A., and Engelhardt, Jr., H. Tristram, Bioethics: Readings and Cases (Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1987).

[2] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979).

In the secular view, there are two central duties to which a physician is obligated: beneficence and nonmaleficence. Beauchamp and Childress define beneficence as the duty to do positive acts: "acts involving prevent of harm, removal of harmful conditions, and positive benefiting." They define nonmaleficence as the duty to refrain from doing negative acts; nonmaleficence is "the noninfliction of harm"[3] The two terms imply that the physician act in the following ways:[4]

1) Reduce or eliminate intentional evil or harm
2) Reduce or eliminate risk of evil or harm
3) Prevent evil or harm
4) Remove evil or harm
5) Do or promote good
6) Do not inflict evil or harm (what is bad)
7) Use due care in providing medical service
8) Use a risk/benefit analysis giving commensurate weight to the goal and the risk (e.g., the goals sought must be important enough to justify the magnitude and probability of harm)
9) Use a detriment/benefit analysis (e.g. "an amputation not only is subject to the risk/benefit analysis but also to the detriment/benefit analysis, and for the latter, the assessor must be interested in the loss of the limb itself as a detriment"[5])
10) Act thoughtfully and carefully, with appropriate knowledge, skill, and diligence

Brody and Englehardt suggest a similar list, but one focused on the patient and categorized according to negative and positive rights:[6]

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[3] *Ibid.*, p. 135.
[4] *Ibid.*, pp. 97ff. and pp. 135ff.
[5] *Ibid.*, p. 101.
[6] Brody, Baruch A., and Engelhardt, Jr., H. Tristram, Bioethics: Readings and Cases (Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1987): p. 14.

Negative rights:

1) The right not to be killed
2) The right not to have bodily injury or pain inflicted on oneself
3) The right not do be deceived by others
4) The right not to have one's confidences revealed to third parties

Positive rights:

5) The right to be aided in times of need
6) The right to have authority over decisions as to how one will be treated or how members of one's family will be treated
7) The right to be respected as a person and be treated as an end rather than as a means

The duty of beneficence requires "affirmative action."[7] Nevertheless, the American Medical Association says that a doctor "may decide to withhold or stop the use of 'extraordinary means to prolong life when there is irrefutable evidence that biological death is imminent.'"[8]

Interestingly, the duty of nonmaleficence has been used to argue that "intensive care for neonates may be 'harmful'" if the infant will not survive infancy and will live with severe pain in the meantime.[9] Beauchamp and Childress state that "the distinction between *withholding* treatment that was never started and *withdrawing* treatment already started is morally irrelevant to determining whether treatment is obligatory or optional."[10] They base this decision on a benefit/detriment analysis, imply that the difference between an act and an omission is immaterial, and state that

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[7] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): p. 108.
[8] *Ibid.*, p. 106.
[9] *Ibid.*, p. 121.

> [N]o particular treatment procedures can be classified as "obligatory" or "optional." These terms do not refer to the *nature* of the treatment procedures or to customary medical practice, but rather pertain to the patient's condition and interests. Even critical treatments such as intravenous feeding may be optional in some cases, as perhaps in the Karen Anne Quinlan case. Whether a particular treatment is *obligatory* depends on whether it serves the patient's interests, including interests in his comfort and in seeing that his autonomous wishes are carried out.[11]

With regard to the question of "Who should decide?," Beauchamp and Childress suggest that imperfect procedural justice should be used. They define imperfect procedural justice as a system in which "there is an independent standard of a right outcome, but the procedures are imperfect in that they cannot ensure the desired outcome."[12]

Beauchamp and Childress propose "a structure of serial decision making," with the patient making the decision if possible, and "the family as the central agent whenever the patient cannot make the decision."[13] The family should "receive the advice and counsel of physicians, who should appeal to the hospital committee or to the courts to protect the patient's interests when they have reason to think that the patient would be harmed by a family decision."[14] Secular bioethics suggests that if the right decision-maker is determined, the outcome will be the best possible. If, however, the outcome is not the best possible (in the view of the physicians), then the physicians take steps to make a different decision to alter the outcome (by which time, in the case of terminal patients, the outcome may be such that it cannot be altered). In effect, the bioethicists are saying, "We'll let you, the patient, decide, regardless of what you decide, because by definition

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[10] *Ibid.*, p. 126.
[11] *Ibid.*
[12] *Ibid.*
[13] *Ibid.*

(and the principle of autonomy), what ever you decide is morally right. If you, the patient, cannot decide, we will let your family decide. If the physicians don't like your decision, we'll attempt to change your decision."

The two duties of physicians, beneficence and nonmaleficence, can conflict with the principle of autonomy when what is best for the patient is not what the patient wants. When beneficence is favored over autonomy, the question of paternalism arises. Beauchamp and Childress write regarding two alternative models of informed consent:

> According to the first model, which may be called the autonomy model, consent is required because it respects autonomy by granting individuals the right to choose what shall be done to them. According to the second model, which may be called the protection model, consent in medical contexts functions to maximize benefits and minimize harms for individuals. The protection model, based on the duty of beneficence, would support paternalistic intervention, which the autonomy model would generally oppose it. For the autonomy model, the individual's own conception of good should determine what is done to him; for he protection model, not to maximize benefits and minimize harms for individuals, even against their wishes, is to violate the principle of beneficence.[15]

Beauchamp and Childress agree that "some acts of weak paternalism are justified acts of beneficence, e.g., preventing a person under the influence of LSD from killing himself."[16] They also suggest that paternalism may be justified when we are not sure that the patient is fully cognizant of the situation and/or making a fully voluntary decision.[17]

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[14] *Ibid.*
[15] *Ibid.*, p 154.
[16] *Ibid.*, p 160.
[17] An additional article discussing these secular issues is "Physician Recommendations and Patient Autonomy: Finding a Balance between Physician Power and Patient Choice," by Timothy Quill and Howard Brody (included in the Appendices). See also Thomasma, David C., "Beyond Medical Paternalism and Patient Autonomy" in Brody, Baruch A., and Engelhardt, Jr., H. Tristram, Bioethics: Readings and Cases (Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1987): pp. 113-121.

The Role of the Physician – The Halachic View

In these days, there is an automatic acceptance of medicine as a valuable part of Jewish life, as the Encyclopedia of Bioethics notes: "Jewish tradition is characterized by a strong duty ethic, with emphases on both physician and patient responsibility; a high value on human life; and a strong sense of justice."[1]

In order to heal, a physician may need to invade and/or injure the body. Doing damage includes marking and mutilation. What allows us to damage (חובל) a body? From the lack of halachic conflict over the following procedures, and from the discussions of how to do many on Shabbat,[2] I conclude that we are allowed to do damage in these situations, some of which are closely related:

1) To perform brit milah
2) To save a life
3) To remove a *rodef* (e.g., a fetus that is endangering its mother's life)
4) To improve health (e.g., surgery to correct a hernia)
5) To cure or ameliorate disease (e.g., providing insulin to a diabetic)
6) To remove pain (either mental or physical, e.g., setting a broken arm)

There are other procedures about which there have been halachic questions and differing halachic answers: ear or body piercing, tattoos,[3] and cosmetic surgery.[4] Although these subjects are legitimate, they outside the purview of this study.

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[1] Glick, Shimon M., "History of Medical Ethics," Encyclopedia of Bioethics (New York, Macmillan Library Reference USA , 1995): p.1460. See also the article on the halachic view of the physician, included in the Appendices.

[2] See, for example, Abraham S. Abraham, Halachot for the Physician on the Sabbath & Festivals (Volume 5 of Nishmat Avraham) (Jerusalem, Rimonim Publishing, 1995): *passim*.

[3] For more information on these topics, see the CCAR responsum "Tattooing, Body-Piercing, and Jewish Tradition" NYP no. 5759.4 (not yet in print; available online at the CCAR's website www.ccarnet.org).

[4] See the discussion in "Cosmetic Surgery" 5752.7, in Plaut, W. Gunther and Washofsky, Mark, Teshuvot for the Nineties (New York, Central Conference of American Rabbis, 1997): pp. 127-132, and the sources cited therein. See also the article on plastic surgery included in the Appendices.

Our current accepted understanding of acceptable medical procedures was not always so obvious or so accepted, and the history of the acceptance of medicine has implications for the duty of the ill to seek medical care and the duty of physicians to treat patients.

The first, most basic question is: "Is the physician permitted to practice medicine?" The Bible contains texts that tell us that all health and healing comes from God:

> If you will diligently listen to the voice of the Lord your God, and will do that which is right in his sight, and will give ear to his commandments, and keep all his statutes, I will put none of these diseases upon you, which I have brought upon the Egyptians; for I am the Lord that heals you. (Exodus 15:26)[5]
>
> See now that I am he, and there is no god with me; I kill, and I make alive; I wound, and I heal; nor is there any who can deliver out of my hand. (Deuteronomy 32:39)
>
> And Asa in the thirty ninth year of his reign was diseased in his feet, until his disease was severe; yet in his disease he did not seek the Lord, but the physicians. And Asa slept with his fathers, and died in the forty first year of his reign. (II Chronicles 16:12-13)

If illness is from God, then by what right does a physician seek to ameliorate God's punishment? The rabbis of the Talmud addressed this issue, and used other Biblical verses as justifications for their views that the physician has permission to practice medicine.

In the Mishnah Bava Kama 8:1 the rabbis explain how a man who injures another "shall cause him to be thoroughly healed." (Exodus 21:19):

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[5] Unless otherwise noted, the Talmud Bavli is used. Also, unless otherwise noted, all Biblical quotations are translated by Yechezkel Shatz, and Mishnaic and Talmudic quotations are from the translation edited by Isidore Epstein. (The CD used is from Davka Corporation, and is called "The Judaic Classics Library – Holy Scripts and Soncino Talmud." The names of the translators were obtained from the Soncino Press.) In Biblical, Mishnaic, and Talmudic quotations, I have changed the spelling of some words and reformatted the text for ease of reading. I have translated all other Hebrew texts, except where otherwise noted.

One who injures a fellow man becomes liable to him for five items: 1) for depreciation, 2) for pain, 3) for healing, 4) for loss of time and 5) for degradation.

1) How is it with "depreciation"? If he put out his eye, cut off his arm or broke his leg, the injured person is considered as if he were a slave being sold in the market place, and a valuation is made as to how much he was worth [previously]. And how much he is worth [now].
2) "pain" – if he burnt him either with a spit or with a nail, even though on his [finger] nail which is a place where no bruise could be made, it has to be calculated how much a man of equal standing would require to be paid to undergo such pain.
3) "healing" – if he has struck him, he is under obligation to pay medical expenses. Should ulcers [meanwhile] arise on his body, if as a result of the wound, the offender would be liable, but if not as a result of the wound, he would be exempt. Where the wound was healed but reopened, healed again but reopened, he would still be under obligation to heal him. If, however, it had completely healed [but had subsequently reopened] he would no more be under obligation to heal him.
4) "loss of time" – the injured person is considered as if he were a watchman of cucumber beds [so that the loss of such wages sustained by him during the period of illness may be reimbursed to him]. For there has already been paid to him the value of his hand or the value of his leg [through which deprivation he would no more be able to carry on his previous employment].
5) "degradation" – all to be estimated in accordance with the status of the offender and the offended.

Obviously, if the offender must pay medical expenses, it is to the physician, the medical practitioner. This is made clear by Bava Kama 85a's discussion of the Mishnah "If he has struck him he is under obligation to pay medical expenses": "The School of R. Ishmael taught: [The words] 'And to heal he shall heal' [are the source] whence it can be derived that authorization was granted [by God] to the medical man to heal."

In Yoma 85a-b, the rabbis question why the laws of Shabbat are suspended when there is danger to human life. After many proposals, Samuel's suggestion, based on Leviticus 18:5 ("וחי בהם"), is accepted as the best answer: "He shall live by them [which is the biblical verse], but he shall not die because of them [which is the midrash]" (Yoma 85b).

That is, all the laws of the Torah, save the "big three" (idolatry, murder, and incestuous or adulterous sexual intercourse; see Sanhedrin 74a), may be suspended for פקוח נפש *pikuach nefesh* (saving a life), because we are supposed to observe them in such a way that we do not bring our lives into danger [Rashi, Yoma 85b, *s.v.* דשמואל]. Samuel's dictum, that one should live by the halacha, underlies the halachic principle of sanctity of life.

The commandment from Leviticus 19:16, "You shall not … stand against the blood of your neighbor," is interpreted by a midrash to imply a positive duty to save life. Sanhedrin 73a makes this point:

> Whence do we know that he who pursues after his neighbor to slay him must be saved [from sin] at the cost of his own life? From the verse, Thou shalt not stand by the blood of thy neighbor. But does it come to teach this? Is it not employed for the following [baraita] that has been taught: Whence do we know that if a man sees his fellow drowning, mauled by beasts, or attacked by robbers, he is bound to save him? From the verse, Thou shalt not stand by the blood of thy neighbor! — That in truth is so. Then whence do we know that [the pursuer] must be saved at the cost of his own life?....The murderer is compared to a betrothed maiden; just as a betrothed maiden must be saved [from dishonor] at the cost of his [her violater's] life, so in the case of a murderer, he [the victim] must be saved at the cost of his [the attacker's] life....[To revert to] the above text: 'Whence do we know that if a man sees his neighbor drowning, mauled by beasts, or attacked by robbers, he is bound to save him? From the verse, Thou shalt not stand by the blood of thy neighbor.' But is it derived from this verse? Is it not rather from elsewhere? Viz., Whence do we know [that one must save his neighbor from] the loss of himself? From the verse, And thou shalt restore him to himself![6] — From that verse I might think that it is only a personal obligation, but that he is not bound to take the trouble of hiring men [if he cannot deliver him himself]: therefore, this verse teaches that he must.

[6] Sanhedrin 73a says that Deuteronomy 22:2 can be in interpreted as "you must return him to him," as Benjamin Freedman explains, you must "return to your brother his own (threatened) existence. Freedman, Benjamin, Duty and Healing (New York, Routledge, 1999): pp. 148-9.

Thus Leviticus 19:16 is taken to mean "You may not stand idly by while another human enters into pain, danger, or sin." Likewise, the adages in Deuteronomy 4:9 to "keep your soul diligently" and in Deuteronomy 4:15 "take good heed to yourselves" are interpreted such that they pertain to keeping guard over your life (נפש means both "soul" and "life"), as shown by Berachot 32b-33a:

> It is related that once when a certain pious man was praying by the roadside, an officer came by and greeted him and he did not return his greeting. So he waited for him till he had finished his prayer. When he had finished his prayer he said to him: Fool! is it not written in your Law, Only take heed to thyself and keep thy soul diligently, and it is also written, Take ye therefore good heed unto your souls? When I greeted you why did you not return my greeting? If I had cut off your head with my sword, who would have demanded satisfaction for your blood from me? He replied to him: Be patient and I will explain to you. If, [he went on], you had been standing before an earthly king and your friend had come and given you greeting, would you have returned it? No, he replied. And if you had returned his greeting, what would they have done to you? They would have cut off my head with the sword, he replied. He then said to him: Have we not here then an a fortiori argument: If [you would have behaved] in this way when standing before an earthly king who is here today and tomorrow in the grave, how much more so I when standing before the supreme King of kings, the Holy One, blessed be He, who endures for all eternity? Forthwith the officer accepted his explanation, and the pious man returned to his home in peace.

The above discussion is, of course, incomplete. The Talmud is full of references to physicians and healing (e.g., the discussion in Yoma 83a about listening to a physician if he says a patient must eat on Yom Kippur), such that it is clear medicine was acceptable.[7]

Even these texts do not completely answer the question, "May a physician cut a patient in order to heal him?" Remember that until recently (the first antibiotics were only

[7] Objections to medicine are raised within the Talmud, but are interpreted so as to ultimately vindicate the medical profession. For example, Rashi explains the famous maxim, "טוב שברופאים לגיהנם" (Kiddushin 82a, normally translated as "The best physician is deserving of hell") as referring either to a physician who

introduced in the 19th century), the chances of surviving an operation were slim. Cutting with a scalpel is an act of injuring the patient, even if the intent is to cure him of an illness.

We know that we can injure someone intentionally if we are imparting justice: "The judge shall cause [the wicked man] to lie down, and to be beaten in his presence" (Deuteronomy 25:2). How do we know that we can injure someone intentionally if we are trying to cure him? This question is answered by Berachot 60a, which discusses bloodletting, a recognized medical procedure of the time:

> On going in to be cupped one should say: "May it be Thy will, O Lord, my God, that this operation may be a cure for me, and mayest Thou heal me, for Thou art a faithful healing God, and Thy healing is sure, since men have no power to heal, but this is a habit with them." [this last phrase actually suggests that we ought not to resort to physicians at all. That is why Abaya has to counter that impression. And see Rashi, ad loc.] Abaye said: A man should not speak thus, since it was taught in the school of R. Ishmael: [It is written], He shall cause him to be thoroughly healed. From this we learn that permission has been given to the physician to heal.

Now that we know a physician is able to wound in order to heal, we need to show that it is acceptable to be a patient – that is, to allow oneself to be wounded in order to be healed.

The Bible seems to say that one cannot shed one's own blood: "And surely your blood of your lives will I require; at the hand of every beast will I require it, and at the hand of man; at the hand of every man's brother will I require the life of man" (Genesis 9:5). Rashi's comment on "your blood" explains: "Although I have permitted you to take the life of cattle yet your blood I will surely require from him amongst you who sheds his

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does not treat the poor or one who does not realize that God is the ultimate healer and the physician merely God's instrument of healing. And see Ramban's comment to Leviticus 26:11, below.

own blood." Yet this appears to refer to suicide, as we have seen that in the Talmud bloodletting was permitted.

In Bava Kama 90a-91a, Rabbi Akiba says that one is not allowed to damage (חבלה) oneself, but one is not culpable (חיב) for damaging for oneself. This means that if you do hurt yourself, then you aren't liable for punishment (nor, obviously, are you liable for paying compensation to yourself). With Raba's explanation, the Talmud tells us that one is not allowed to do damage to oneself, but one is allowed to embarrass (בושה) oneself, as the woman did when she uncovered her head to spread oil on her hair. One may not damage (חבלה) oneself, but doing so carries no penalty. Furthermore, the community and each individual has an obligation to admonish and warn someone about to sin. Even if a person were liable for hurting himself, he could not be punished if he were not warned.

The Talmud itself seems to say that one is allowed to damage oneself: in the story in Bava Kama 91b about R. Hisda walking through a thicket, we are told that damaging clothing is worse than damaging skin because clothing can't heal, whereas skin can heal. The Tosafot on Bava Kama 91b (s.v. second אלא) says that we knew all the time that one may not damage oneself needlessly,[8] but we are proving instead that one may not damage oneself for a monetary need. Therefore, the Talmud (with the Tosafot's explanation) says that one is not allowed to hurt oneself for a monetary need. It is, however, permissible to allow oneself to be wounded (by oneself or another) in order to be healed. That is, it is permissible to be a patient.

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[8] The prohibition about cutting off the corners of your beard (בל תשחית) is extended to mean "don't waste, don't destroy needlessly." Also, there is a general sin of becoming a *nazir* because one shouldn't deny oneself pleasure. Therefore one who hurts himself is all the more so a sinner. For example, someone who

So the answer to our basic question is: "Yes, a physician may heal." Does this mean he must heal? The answer is "Yes," because all Jews, not only physicians, are obligated to heal. Does this mean that a person with an illness is not only allowed but also obligated to see a physician? In spite of the views of Ibn Ezra and some of Ramban, the answer is ultimately "Yes."[9] A Jew must seek care in order to be responsible stewards of the body, which belongs to God.[10]

Ibn Ezra (1089-1164) and Ramban (1194-1270)

Ibn Ezra did not write favorably about the practice of medicine, and although Ramban (Nachmanides) was a physician,[11] his views about medicine seem inconsistent. Benjamin Freedman explains the historical disinclination towards accepting or seeking out human medical intervention:

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sits in a place where there is no food or worse: someone who physically hurts himself (see Bava Kama 91b).

[9] See the discussion below. Also see J. David Bleich's "The Obligation to Heal in the Judaic Tradition: A Comparative Analysis" (especially pp. 19ff) and Fred Rosner's "The Physician and the Patient in Jewish Law" in Rosner, Fred, and Bleich, David J., editors, Jewish Bioethics (Hoboken, New Jersey, KTAV Publishing House, Inc., 2000): pp. 3-57. Also see the discussion of medical practice as a mitzvah in "Physicians and Indigent Patients" 5754.18, in Plaut, W. Gunther and Washofsky, Mark, Teshuvot for the Nineties (New York, Central Conference of American Rabbis, 1997): pp. 373-380, and the sources cited therein.

[10] Moshe Chayim Luzzatto says as much: "גם זה מצוה עלינו לשמר את גופנו בתכונה הגונה לשנוכל לעבד בו את בוראנו" ([T]his is also a commandment upon us: to preserve [safeguard] our bodies in proper fitness in order to be able to serve our Creator through it). Luzzatto, Moshe Chaim, The Way of God (New York, Feldheim Publishers, 1977): 1:4:7 (p. 68).

Elliot Dorff, a modern Jewish bioethicist states the matter this way:

> For Judaism, God owns everything, including our bodies. God lends our bodies to us for the duration of our lives, and we return them to God when we die. Consequently, neither men nor women have the right to govern their bodies as they will; since God created our bodies and owns them, God can and does assert the right to restrict how we use our bodies according to the rules articulated in Jewish law. One set of these rules requires us to take reasonable care of our bodies. Just as we would be obligated to take reasonable care of an apartment on loan to us, so too we have the duty to take care of our own bodies.

Dorff, Elliot N., Matters of Life and Death (Philadelphia, The Jewish Publication Society, 1998): p. 15.

> There was some medieval resistance to this consensus [that a doctor may or must heal]. Ibn Ezra was of the view that persons may only seek medical assistance for man-made wounds, not for disease or internal afflictions (the latter, presumably, having been Divinely inflicted). His view did not prevail, nor did that of Ramban (Nachmanides), who, while not prohibiting recourse to medicine…felt that it reflects a lack of piety and faith: Ideally, the sick would need no physician other than G-d.[12]

Ibn Ezra's commentary on Exodus 21:19 ("If he rises again, and walks out with his staff, then shall he who struck him be acquitted; only he shall pay for the loss of his time, and shall cause him to be thoroughly healed.") says:

> "And shall cause him to be thoroughly healed" this is a sign that permission has been granted to physicians to heal blows and wounds that are visible on the surface [of the body]. However, it is in God's hand to heal any illness that strikes inside the body. It is thus written, "For he [God] makes sore, but binds up; he wounds, but his hands make whole" (Job 5:18). Furthermore, Scripture tells us concerning King Asa "And Asa in the thirty ninth year of his reign was diseased in his feet, until his disease was severe; yet in his disease he did not seek the Lord, but the physicians" (II Chronicles 16:12 [the Bible rebukes Asa, who was stricken with an internal disease, for seeking the help of physicians rather than the help of God]). Now Scripture distinguished between them [internal and external wounds]. It does not state *verafo yirpe* (and he shall surely heal), which is in the *kal* [and thus implies ease of effort]. It rather reads, *ve-rappo yerappe* (and shall cause him to be thoroughly healed). The latter is in the *pi'el* [which implies much effort, and thus it is used when man does the healing]. [13]

Ibn Ezra also says, "[A] person who observes the Torah has no need for a physician along with God the Revered."[14] So although a man-made wound may be treated by a physician, other illnesses may not.

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[11] Kaplan, Joseph, "Nahmanides," Encyclopaedia Judaica (CD-Rom edition), (Keter Publishing House Ltd., Jerusalem, Israel, 1997).

[12] Freedman, Benjamin, Duty and Healing (New York, Routledge, 1999): p. 142.

[13] My amended translation using Strickman, H. Norman, and Silver, Arthur M., translators, Ibn Ezra's Commentary on the Pentateuch (Volume 2, Exodus) (New York, New York, Menorah Publishing Company, Inc., 1996): p. 469.

[14] *Ibid.*, pp. 516-7.

Similarly, Ramban says the following (s.v. והנה הברכות האלה) in his commentary to Leviticus 26:11 ("And I will set my tabernacle among you; and my soul shall not loathe you"):

> And these blessings [listed in the previous verses] according to their simplest sense are many and in general form…unlike the brief blessings God has already blessed us with: "[And you shall serve the Lord your God, and] he shall bless your bread, and your water; and I will take sickness away from the midst of you" (Exodus 23:25). And it will be a blessing that no illness will happen to our bodies…and we will live full lives, as it is written, "None shall miscarry, nor be barren, in your land; the number of your days I will fulfill" (Exodus 23:26), and he said as much in the beginning: "For I am the Lord that heals you" (Exodus 15:26)….And these [blessings] are for even a single worshipping individual, because when there is a pious man who keeps all of God's commandments, God will keep him from illness.

Ramban continues (s.v. והכלל):

> In general, when the majority of Israel is completely [in accordance with God's commands]…God will remove illness from their midst until they do not need a physician or need to observe any of the ways of the physicians, as it is written, "For I am the Lord that heals you" (Exodus 15:26). And thus did the righteous people in the time of prophecy, when they did wrong and took sick, they did not take themselves to the physicians, but only to the prophets.
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> As in the matter of Hezekiah in his illness [who prayed to God and was healed] (2 Kings 20:2-3). And thus it is written (2 Chronicles 16:12) "[And Asa in the thirty ninth year of his reign was diseased in his feet, until his disease was severe;] yet in his disease he did not seek the Lord, but the physicians." In this case it was a matter of custom with them to seek the physicians. What is the point of mentioning the physicians? They were not to blame. The fault is [twofold:] he [Asa] didn't seek God [and he did seek physicians]. This is like what you will hear people say, "John Doe did not eat matza on Passover, and he ate leaven" [That is, he is guilty of two separate sins.] This sort of man seeks God through a prophet, rather than seeking physicians [in order to be healed]. And [after all] what part do the physicians play in a housewhere [the people] do the will of God? [Because he who serves God] is promised "he shall bless your bread, and your water; and I will take sickness away from the midst of you" [Exodus 23:25], whereas the physicians can do nothing except to caution against some food and drink and to prescribe other food and drink.

> And thus they say in Berachot 64a, "During all the time that Rabbah was head [of the Academy in Pubeditha], R. Joseph as second in command did not so much as summon a cupper to come to his house." And this is the rule for them: "A gate unopened for beneficence will be open for the physician" (Midrash Rabbah, Numbers 9:13).[15] And thus the clause of the blessing is "Men have no power to heal, but this is a habit with them [to be cupped]" (Berachot 60a). If [a pious man believes] it is not within the physician's power to heal, then such a man who falls ill is being punished for his sins and is healed by the will of God. But [the less pious] are accustomed to rely on physicians, and God allows them to [fall prey to] the accidents of nature. And this is the point of the rabbis saying that from "'He shall cause him to be thoroughly healed' [Exodus 21:19] we learn that permission has been given to the physician to heal."(Berachot 60a).
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> The rabbis did not say that the ill person is given permission to be healed. However, as soon as a man falls ill and goes to be healed, because he is accustomed to rely on physicians, and he is [therefore] not part of the community of God whose portion/lot is life, the physician is not prohibited from healing.
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> The physician should not fear that his patient die by his hand, as long as he is an expert in his work. And the physician shouldn't avoid [treating the sick] for fear that people will say "God alone is the healer of all flesh," because it is already customary [for people to visit physicians]. Therefore "if men quarrel together, and one strikes another with a stone, or with his fist, [and he dies not,] but keeps to his bed" [Exodus 21:18], then [the offender] must pay for healing,[16] because the Torah does not rely on miracles. As it is said, "Because the poor shall never cease out of the land" [Deuteronomy 15:11], and his understanding is that this is the natural order of things.
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> But it is the will of God that men should not occupy themselves with physicians.

Ramban points out that while physicians have permission to heal, the sick do not necessarily have permission to be healed by physicians. A truly pious person should have no need for physicians. Ramban gives grudging approval to medicine because he

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[15] A proverb equivalent to "Charity will keep the doctor away."

[16] If he rises again, and walks out with his staff, then shall he who struck him be acquitted; only he shall pay for the loss of his time, and shall cause him to be thoroughly healed (Exodus 21:19).

reluctantly acquiesces to reality: the majority of people are accustomed to relying on physicians rather than on God's healing powers.

Rambam (1135-1204)

The famous and influential codifier, Maimonides (the Rambam), made the case in favor of physicians that has remained with us to this day. In his work Yad Ha-Chazakah (strong hand), commonly known as the Mishneh Torah, he organizes halacha into fourteen divisions. Rambam, himself a physician, states that a physician's advice allows transgressions of the mitzvot:

> Regarding one who is ill and is close to death: if the physicians say, "John Doe's healing requires transgressing prohibitions of the Torah," then [the physicians' bidding] is done. When one's life is in danger, all of the prohibitions of the Torah may be transgressed, except idolatry, forbidden sexual relations, and murder.[17]

A person may not harm himself out of grief:

> One who cuts himself in mourning over a dead person is [punished with] lashes, as it is written: "You shall not make any cuttings in your flesh for the dead" [Leviticus 19:28]....One who makes a single cut for five dead people or five cuts for a single dead person [receives] five lashes...Cutting and wounding oneself are [governed by] a single [prohibition]...as it is written: "You shall not cut yourselves [nor make any baldness between your eyes for the dead]" [Deuteronomy 14:1].[18]

In The Laws of Personal Injury, Chapter 2, halachot 14-20, medicine as practiced by professional physicians is accepted and required for personal injury.

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[17] Mishneh Torah, The Laws [which are] the Foundations of the Torah, Chapter 5, halacha 6. The leniency for a sick person also applies to Yom Kippur: see Mishneh Torah, The Laws of Resting on the Tenth (Day of Tishrei), Chapter 2, halacha 8.

[18] Mishneh Torah, The Laws of the Worship of Stars and their Statutes, Chapter 12, halachot 12-13; see also halachot 15-16.

Pain and embarrassment are commonly considered as parts of the same injury, and when one is mentioned, the other is considered also. In The Laws of Personal Injury, Chapter 5, halacha 1, Rambam says (s.v. נציון *nitzayon* (strife), but also read as ביזון *bizayon* (humiliation)) that we are not allowed to injure or embarrass someone intentionally, in the manner of a quarrel:

> It is forbidden for a person to injure himself or another person. Not only a person who causes an injury, but also anyone who strikes a blow…in strife [or: of humiliation] violates a negative commandment, as it is written: "[Do] not add to his flogging."[19]. If the Torah warns against adding to the blows due a sinner, how much the more so with regard to striking a righteous person.[20]

Rambam does not give us Talmudic sources, but the commentators on the side tell us to look at the reference to חבל in the Talmud Bava Kama 90a-91b, cited above. We can't distinguish among damaging, touching, or hitting, because our source is the single verse regarding not adding to the prescribed lashes given to a criminal.[21] Nevertheless, it is a commonly accepted understanding of Rambam, as of the Talmud, that we are allowed to injure someone if our intent is to cure him. In other words, you can hurt yourself or others in order to ultimately heal, as long as you do not do so in a belligerent or humiliating manner (דרך נציון *derech nitzayon* (strife), but also read as דרך ביזון *derech bizayon* (humiliation)).

Rambam says that it is a positive commandment for a physician to heal, and he deduces this from the obligation to return lost objects to their owner (Exodus 23:4, Deutoronomy 22:1-3) and Talmud Bava Kama 46b (R. Ashi [said:] "Is it not common sense that if a

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[19] Deuteronomy 25:3 says, "Forty stripes he may give him, and not exceed; lest, if he should exceed, and beat him above these with many stripes, then your brother should seem vile to you."
[20] Mishneh Torah, The Laws of Personal Injury, Chapter 5, halacha 1.

man has a pain he visits the healer?") and from the prohibition of "do not stand idly by the blood of your neighbor" (Leviticus 19:16). Rambam states the commandment to heal when he discusses someone who has sworn not to receive benefit from another:

> Indeed it is prohibited for [the one who took the vow] to heal [the sick person] himself, but it it is not prohibited for [the sick person] to heal himself [by visiting a physician – even the physician who took the vow], because it is a commandment, which is to say that the physician is obligated by the Torah to heal the sick of Israel. And this is included in the interpretation of what is said in Deuteronomy 22:2, "and you shall return it to him," to heal his body when he sees him in danger and is able to rescue him – whether [he rescuses] with his body [i.e., by physical means], or with his money [e.g., by paying someone to rescue], or with his wisdom [e.g., with his medical knowledge].[22]

In The Laws of Murder and the Protection of Human Life, Chapter 1, halacha 14, Rambam uses Leviticus 19:16 ("You shall not…stand [idly by] the blood of your neighbor") to establish the duty of rescuing anyone of danger:

> Anyone who was able to rescue but did not rescue transgresses "do not stand idly by the blood of your neighbor" [Leviticus 19:16], and it is thus for anyone who sees someone drowning in the sea, or is accosted by robbers or a wild beast. If he is able to rescue him [but does not]...he transgresses "do not stand idly by the blood of your neighbor."[23]

In The Laws of Murder and of the Protection of Human Life, Chapter 11, halachot 4-5 have been the basis for later rulings in favor of seeking medicine and avoiding dangerous situations and lifestyles:

> [Regarding] all obstacles that pose a danger to life: it is a positive commandment to remove them, and to guard ourselves from them, and to be very very careful regarding these matters, as it is written: "Guard yourself, and guard your soul" (Deuteronomy 4:9). If he does not remove [a dangerous obstacle]…he fails to observe a positive commandment and

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[21] These points are summarized in Moshe Feinstein's Iggerot Moshe, Chosehen Mishpat, Simanim 66 and 73 (אגרות משה, חושן משפט, סימים סו, עג).

[22] Rambam's Peirush Hamishnayot, Nedarim 4.4 (רמב"ים פירוש המשניות - מסכת נדרים פרק ד משנה ד), sv. ואמנם אסור לו.

[23] Mishneh Torah, The Laws of Murder and of the Protection of Human Life, Chapter 1, halacha 14.

> transgress [the negative commandment]: "Do not cause blood [to be spilled]."
> Our Sages forbade many things because they involve a danger to life. And if anyone transgresses [these guidelines] saying: "I will risk my own life, for what does this matter to others?" or "I am not particularly careful about these things," then he is punished with lashes for rebelliousness.[24]

In The Laws of Murder and of the Protection of Human Life, Chapter 12, halacha 10, Rambam permits a Jew to consult a non-Jewish physician: "It is permitted to ask [the opinion of] a gentile physician [and follow his directives if] he says, 'Such and such a drug is good for you' or 'You should do such and such [in order to be healed].'"[25] Although in general Rambam sees non-Jewish physicians as threats to Jewish health and life, the Shulchan Aruch says that it is permissible to seek the care of non-Jewish physicians who are recognized professionals.

Thus Rambam, a renowned physician, codified our current Jewish understanding of the duty of a physician to heal and of an ill person to seek treatment.[26]

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[24] *Ibid.*, Chapter 11, halachot 4-5.
[25] *Ibid.*, Chapter 12, halacha 10.
[26] There is one situation where the duty of a physician to heal is modified by risk to himself. Fred Rosner describes such a situation and the halacha regarding it:

> What should a physician do if his patient is suffering from a contagious disease which the physician might contract? Is the physician allowed to refuse to treat the patient because of the risk or the fear by the physician of contracting the disease? What if the risk is very small? What is the definition of *sofek sakanah* [doubtful risk]? If there is a 50 percent chance of the physician contracting the disease from his patient, halachah would certainly agree that such odds are more than doubtful and the physician would not be obligated to care for that patient without taking precautionary measures to protect himself. If he wishes to do so in spite of the risk, his act is considered to be a pious act (*midat chasidut*) by some writers, and folly (*chasid shoteh*) by others.

Rosner, Fred, Modern Medicine and Jewish Ethics (New York, Yeshiva University Press, 1991): p. 53.

Ramban's Torat Ha-Adam

Later writers accepted Ramban's views on medicine as put forth in his Torat Ha-Adam.

Ramban's opinions in Torat Ha-Adam differ considerably from those he wrote in his commentary to Leviticus, as the following paragraphs from section 6 show:

> In the chapter on damages (פרק החובל *perek hachovel*) [Bava Kama, chapter 8], it says, "It was taught at the School of R. Ishmael [i.e., a baraita of the school of R. Ishmael reads:] that [the text] 'And to heal he shall heal' (ורפא ירפא *verapo yirapei*)[27] is the source from which it is learned that permission was granted [by God] to the physician to heal."[28] [*peirush*: The reason for this is:] Lest the physician say, "Why should I have all this trouble? Perhaps I will make a mistake and I find that I kill people inadvertently." Therefore, the Torah gave him the permission to practice medicine.
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> And it is difficult for me to understand this baraita in the Tosefta [i.e., the following statement of the Tosefta seems to contradict the above statement of the law]: "A skilled physician who practiced medicine by the permission/authority of the beit din and harmed or injured [his patient], this person is exiled."[29] Therefore he is punished for an accidental mistake.
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> We can resolve the contradiction thusly: The physician is comparable to the judge, who is commanded to render judgment. If he [the judge] errs without knowing it, then he isn't punished at all.
>
> As it says in Sanhedrin 6b: "And lest the judge should say: 'Why should I have all this trouble?' for this reason Scripture says 'He [God] is with you in giving judgment.'[30] [That is,] the judge is to be concerned only with what he actually sees with his own eyes."[31] [That is, the judge must do his best, but he isn't punished *if* he does his best. If he acts responsibly, judging on the basis of the evidence before him, then we do not punish him or hold him liable for mistakes.] Despite this, if the physician made a mistake, and the court was informed of his mistake, then they should make him pay damages in accordance with the usual procedures. And although in that case, if his judging was done by the permission of the beit din, then he is absolved of wrongdoing. Here too by man's laws he is exempt from

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[27] "[He who struck him] shall cause him to be thoroughly healed" (Exodus 21:19).
[28] Bava Kama 85b.
[29] Tosefta Bava Kama 9:3.
[30] "And he said to the judges, 'Take heed what you do; for you do not judge for man, but for the Lord, who is with you in the judgment'" (II Chronicles 19:6).
[31] Sanhedrin 6:2.

paying damages.[32] But he is not exempt according to God's laws until he repairs the damage, pays compensation, and goes into exile over the wrongful death, because it is known that he erred and the injury or the death was done by his hand [i.e., he was the direct and immediate cause of the patient's death; it wasn't a case of omission]. As they say in the Tosefta Bava Kama, concerning this: "They may be exempt from paying man's bill, but they are liable for paying God's. A skilled physician who practices medicine by the permission/authority of the beit din is exempt from man's laws and his judgment is consigned to heaven."[33]

And anyway, if he is not informed that his error caused the death, then he is not liable at all, just as the judge is completely exempt both from the judgments of man and from punishment by God, provided he takes due care with respect to capital cases and does not cause damage through negligence.

It is reasonable to say that the statement "The Torah gave a physician permission to heal" means that a physician is not forbidden to practice medicine because of his fear of making a mistake inadvertently. Also, [it is reasonable to infer that] people should not say, "God crushes and heals [i.e., God is responsible for health]. Men have no power to heal, but they are accustomed to it [visiting a physician],"[34] as the matter is written "Yet in his sickness, he did not seek the God, but rather the physicians."[35] [That is, we should *not* cite these arguments to "prove" that we should not practice medicine.]

Rather, this "permission" is in fact a mitzvah: he is commanded to heal by the rule of פקוח נפש *pikuach nefesh*, as the Mishnah says, "[A sick person] is fed at the word of experts [physicians]."[36] And our rabbis taught in a baraita: "If one was seized with a ravenous hunger, he is fed honey and all kinds of sweet things, because [these things] will improve and enlighten the eyes."[37] All these feedings are done according to the word of experts, because if there was an inflammatory fever in his ravenous hunger, then feeding him honey might kill him. We have also learned, "If one has

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[32] The terminology used regarding his being free from payment is reminiscent of this quote from the Talmud: "He who eats terumah of leaven on Passover but he does not know that it is terumah, must repay to the priest the principal plus a fifth; but he who eats terumah and knows it is terumah, he is free from payment and from [liability for] its value as fuel." (Pesachim 31b, amended for clarity).

[33] Tosefta Bava Kama 6:6.

[34] "On going in to be cupped one should say: 'May it be Thy will, O Lord, my God, that this operation may be a cure for me, and mayest Thou heal me, for Thou art a faithful healing God, and Thy healing is sure, since men have no power to heal, but this is a habit with them'"(Brachot 60a).

[35] "And Asa in the thirty ninth year of his reign was diseased in his feet, until his disease was severe; yet in his disease he did not seek the Lord, but the physicians" (II Chronicles 16:12).

[36] Yoma 82a.

[37] Yoma 83b, modified slightly by Ramban.

> pains in his throat, then one may pour medicine into his mouth on the Sabbath."[38] And Rabina did likewise on account of inflammatory fever.[39]
>
> Likewise, [the Talmud states:] "We may cure ourselves with all things, except with the wood of the asherah"[40] Skilled physicians may use all their power and all things to heal their patients, and it is impossible to know what these things are except according to the wisdom of medicine. It is also permitted to treat an inflamed eye with medicinal paint on Shabbat, provided the paint is considered one of the provisions of physicians [that is, the paint must be medicinal and not cosmetic]. Because the healing may desecrate Shabbat, physicians learn [in this case, treat] by the rule of פקוח נפש *pikuach nefesh*. Because saving a life is a great mitzvah, the physician must be quick in wisdom about evaluating the matter. One who acts quickly to save life on Shabbat, even if it violates the halacha of Shabbat, is considered praiseworthy; the one who asks questions [i.e., waits for an official rabbinic response] is guilty of bloodshed [because the patient might die while waiting for the ruling (פסק *pesak*].
>
> We learn from all this that every skilled and learned physician has an obligation to heal. But if he refrains from practicing medicine, then he is guilty of bloodshed.

A physician, like a judge, can only go by what he sees before him, and may therefore make a mistake. A physician may kill his patient inadvertently (e.g., by bloodletting improperly or by giving him too much medicine), just as a judge may rule incorrectly. But because maintaining health and maintaining justice are mitzvot, and because they must be performed by fallible humans, inadvertent mistakes committed by skilled and educated people are to be expected.

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[38] Yoma 84a.

[39] "Mar son of R. Ashi found Rabina rubbing his daughter with undeveloped olives of orlah [as a remedy]. Mar said to Rabina, 'Granted that the Rabbis ruled [that anything may be used for a remedy] in time of danger; was it [likewise] ruled when there is no danger?' 'This inflammatory fever is also like a time of danger,' Rabina answered Mar." Pesachim 25b. Ramban cites the story as being in paragraph 30 of ברתיה בגוהרקי דערלה.

[40] Pesachim 25a.

Jacob Ben Asher (1269-1340)

The words of Nachmanides (Ramban) in Torat Ha-Adam form the basis of the Tur's and the Shulchan Aruch's treatment of הלכות רפואה (*hilchot refuah* the laws of medicine). The Tur (full title: *Arba'ah Turim* (four rows)) is a code that contains laws from both Talmuds and decisions from earlier codes. Like the Mishneh Torah, the Tur organized the various laws. The four rows or divisions contain different kinds of laws, examples of which are given after the name:

1) Orach Chaim – daily conduct, prayers, and holidays
2) Yoreh De'ah – dietary laws, respect for teachers, medicine, and mourning
3) Even HaEzer – personal and family laws
4) Choshen Mishpat – courts, evidence contracts, and civil and criminal law

These divisions of the halacha were followed by all subsequent halachic writing. Here is the selection from Jacob Ben Asher's Tur (Yoreh De'ah 336):

> We have learned from Rabbi Ishmael "And he shall surely heal." From here is given permission to the physician to practice medicine, so he will not say, "Why should I have all this trouble? Perhaps I will make a mistake and I find that I kill people inadvertently." [The physician is permitted to practice medicine] provided that he exercises extreme caution, the caution appropriate to capital cases.
>
> And also [the physician is given permission so that he will not say] "God smites and *I* [a mere human, dare] to heal?" Men have no power to heal, but they adopted the custom of engaging in medicine [i.e., it wasn't part of God's plan that human beings should interfere in the realm of health and disease, see Berachot 60a, bottom], as it is said, "Yet in [Asa's] disease he did not seek the Lord, but the physicians"(II Chronicles 16:12). Therefore this comes to teach us that the Torah gave the physician permission to heal and [this permission is in fact] a mitzvah: he is commanded to heal by the rule of פקוח נפש *pikuach nefesh*. And he should be quick about evaluating the matter [and not delay by seeking halachic rulings] so that he may prevent himself from letting someone die.
>
> And even if there is someone else to do the healing, [a knowledgeable physician should not refrain from healing], because a patient does not

merit to be healed by everyone [i.e., it may be the patient's destiny to be healed by *you*, so you may not shirk your responsibility merely because another physician is available].

Be that as it may, he may not practice medicine unless he is an expert and knows his craft with wisdom and skill. He is not allowed to practice medicine if he is not knowledgeable about medicine. [And he may not practice] if there is another, more knowledgeable physician in the community. We learn this by a קל וחומר *kal va'chomer* [the rule of halachic jurisprudence of making an inference from the weaker to the stronger]: how can one presume to rule on a question of capital liability when there is another judge available who is more qualified than he?

Even if he is the best physician around, if he isn't fully knowledgeable about the rules of medicine, then he is considered a murderer and is certainly fit for hell. And if he practices medicine without the permission of the beit din, and he harms a patient, then he is responsible for indemnification. Even if he is an expert and he is the only physician around, he is not considered an expert if he doesn't have the permission of the beit din.

If his practice of medicine was done by the permission of the beit din, and if he made a mistake and harmed or injured his patient, then he is absolved of wrongdoing according to the laws of man but charged according to the laws of heaven [God's laws]. If he killed his patient, even if it is known that the killing was accidental, then the physician is exiled on that account. But anyway, it is not necessary for a physician to avoid treating patients because of a fear of making mistakes, as it was expressly explained above.

Regarding whether one is permitted to damage [i.e., provide medical care – the problem here is the prohibition against striking one's parent[41]. ומכה אביו ואמו; *makeh aviv ve'imo*] to his father: in Ramban's opinion it is permitted, but he wrote that R. Yitzchak Alfasi has ruled the opposite [that a son should not treat his father], as Rav Pappa would not permit his son to extract a thorn [from his flesh, since in drawing it out he would make a slight wound."[42]

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[41] ומכה אביו ואמו מות יומת And he who strikes his father, or his mother, shall be surely put to death. (Exodus 21:15)

[42] Sanhedrin 84b says, "Just as one who strikes an animal to heal it is not liable for damage, so if one wounds a man [his parent] to heal him he is not liable. Rab would not permit his son to extract a thorn [from his flesh, since in drawing it out he would make a slight wound]. Mar, the son of Rabina, would not permit his son to lance a fester for him, lest he wound him, thereby unintentionally transgressing a prohibition. If so, even a stranger should be forbidden? — In the case of a stranger, the unintentional transgression is in respect of a mere negative precept: but his son's involves strangulation. But what of that which we learnt: A small needle [lit. 'hand-needle'] may be moved [on the Sabbath] for the purpose of extracting a thorn? But should we then not fear that a wound might be made [in extracting it], and thus a

> Regarding the matter of fees: it is permissible for the physician to accept remuneration for interrupted labor [i.e., in order to remain available to heal] and for dispensing medical advice, but remuneration for his studies is prohibited. This is forbidden because "this is a case of *aveidat gufo*" (Deuteronomy 22:2, *hashevoto lo*; see Sanhedrin 73a). As such, medicine is a mitzvah and one cannot be paid for doing a mitzvah; *mah ani bechinam*: just as I [Moses] have taught you Torah for free, so you also must teach it for free [Bekhorot 29a, on Deuteronomy 4:5]. However, it is permissible for him [the physician] to receive payment for his expenses and the time he would otherwise have spent at gainful employment.
>
> Whoever has medicines – and another person is sick and needs them – is forbidden to charge him more than their proper value. Even if they had previously agreed on an inflated price due to the exigencies of the situation (for they could find no other drug but these), he [the seller] is nonetheless entitled only to their fair value. But if they contracted upon the physician's fee at an inflated price, he [the patient] must pay, because the physician is selling his knowledge, which is priceless. This is true even though it is a mitzvah for the physician to heal. This is based on the rule with respect to any positive commandment that is imposed on everyone [in this case, the commandment of פקוח נפש *pikuach nefesh*]: should a particular person have the opportunity to fulfill this commandment [that is incumbent upon everyone], then he is entitled to monetary compensation for fulfilling that commandment.

The Tur echoes Torat Ha-Adam's comparison between a physician and a judge. While Torat Ha-Adam permits a son to provide medical care to his father, the Tur forbids it. The Tur also discusses how a physician can be paid for doing the mitzvah of healing that is incumbent upon every individual ("all positive mitzvot that are imposed should be fulfilled by the whole world"). While everyone has the duty to heal, we delegate that duty to those most qualified to perform it. (Similarly, while everyone has the duty to pursue justice, we choose who shall be judges by selecting those most capable of rendering correct decisions.)

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prohibition involving stoning be unintentionally transgressed? — There by so doing he effects damage. Now, this agrees with the view that one who does damage on the Sabbath is not liable [to punishment]."

Joseph Karo (1488-1575)

Joseph Karo wrote Bet Yoseph (House of Joseph) as a commentary on Jacob ben Asher's Tur. Karo abbreviated his Bet Yoseph into the classic code, the Shulchan Aruch (The prepared table), which, with its Ashkenazic additions by Moses Isserles, is the one of the last great authoritative codes. The Shulchan Aruch follows the same four divisions of the Tur. In the following section (Yoreh De'ah 336:1) of the Shulchan Aruch, Karo summarizes the section of the Tur (Yoreh De'ah 336) quoted above:

> The Torah has given permission for the physician to practice medicine, and it is a commandment to do so. And this is according to the rule of פקוח נפש *pikuach nefesh*. And if he prevents himself [from practicing medicine], then it is as if he is guilty of bloodshed.
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> And even if there is someone else to do the healing, [a knowledgeable physician should not refrain from healing], because a patient does not merit to be healed by everyone [i.e., it may be the patient's destiny to be healed by *you*, so you may not shirk your responsibility merely because another physician is available].
>
> Be that as it may, he may not practice medicine unless he is an expert and has a great reputation among us, but if he does not meet these qualifications, then his practice is considered murder.
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> And if he practices medicine without the permission of the beit din, then he is obligated to indemnify any patient he harms, even if he is an expert. But if he practices medicine by the permission/authority of the beit din, and he made a mistake and damaged his patient, then he is exempt from the laws of man but obligated according to the laws of heaven [God's laws]. And if kills his patient, even though he knows it was due to an inadvertent error, then the physician is exiled because of this.

As is to be expected in an abbreviated code, the Shulchan Aruch gives a summary of the laws about medicine, stating that the practice of medicine is a mitzvah, and reiterating that a physician must be both skilled and authorized to practice.

Again, it should be stressed that this discussion is incomplete,[43] but is intended to highlight the views of some of the early great halachic thinkers on the subject. There is a progression of views that balance belief in God's healing with the recognition that humans seek healing from medical procedures. From sickness being God's punishment to acknowledgment of the need to provide restitution for injury, and from begrudging acceptance of physicians' permission to heal to the codification of providing medicine as a positive mitzvah, the halacha concludes that it is a duty for the physician to practice medicine and the ill person to seek medical treatment.

[43] For example, the comments of Nissim ben Rueben Gerondi (the Ran) on Sanhedrin 84b, which explain that all drugs can be dangerous, are not included.

Secular Approaches to Bioethics

General

The secular medical ethicist will talk about broad principles. The modern bioethicist will base his principles on an ethical theory that is systematic and whose "action guides" (a term coined by William Frankena and used by Beauchamp and Childress[1]) are "presumably valid for everyone."[2]

Secular bioethics also deals with public policy issues, such as funding for research, government standards of conduct, and allocation of public funds. In making a case for rights[3], Brody and Engelhardt also suggest that fetuses and non-humans (e.g., animals used for experimentation) may also have rights, whereas "defective newborns and the near-dying" may not have the same rights as other humans.[4]

Secular bioethics makes a distinction between acts that are morally right or wrong and policies relating to those acts. There is a relatively sharp distinction between morality and law, as Beauchamp and Childress state

> [T]he judgment that an act is morally wrong does not necessarily lead to the judgment that the government should prohibit it...For example, it is possible to hold that sterilization or abortion is morally wrong without simultaneously holding that the law should prohibit it... Nor does the

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[1] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): p. 5.
[2] *Ibid.*, p. 8. Note also that Monagle and Thomasma devote a chapter to the revival of causistry in bioethics, which is not theory-driven but instead case- or application-driven. See Monagle, John F., and Thomasma, David C., Health Care Ethics (Gaithersburg, Maryland, Aspen Publishers, Inc., 1994): pp. 387-400. In this study, I will focus exclusively on theory-driven ethics.
[3] For a definition of "rights," please see the chapter "A Question of Rights," below.
[4] Brody, Baruch A., and Engelhardt, Jr., H. Tristram, Bioethics: Readings and Cases (Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1987): p. 16.

> judgment that an act is morally acceptable in some circumstances imply that the law should permit it.[5]

Beauchamp and Childress say that there is a two-way process by which we determine the morality of our behavior: we have ethical theories, which imply principles, and that these principles determine behavioral rules, which then inform our judgments and actions.[6] Our judgments and actions, however, may make us re-examine our behavioral rules, principles, and ethical theories.

According to Beauchamp and Childress, moral action-guides have three characteristics:

1) a person or society accepts them as "*supreme, final,* or *overriding*"[7];
2) they are universal, "which requires that all relevantly similar cases be treated in a similar way"[8]; and
3) they "have some direct reference to the *welfare of others.*"[9]

The rules by which Beauchamp and Childress evaluate all ethical theories is by testing them for

1) consistency and internal coherence,
2) simplicity,
3) completeness and comprehensiveness,
4) capacity to take account of and to account for our moral experience, including our ordinary judgments.[10]

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[5] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): p. 12.
[6] *Ibid.*, p. 5.
[7] *Ibid.*, p. 15.
[8] *Ibid.*, p. 16.
[9] *Ibid.*, p. 17.
[10] *Ibid.*, p. 40.

Contemporary secular ethical thought can be grouped into two broad categories: utilitarian theories and deontological theories. The following sections will discuss these two major approaches to bioethics.

Utilitarianism

Utilitarian theories determine the worth of actions based on their consequences. Many ethicists, such as Brody and Engelhardt, question the moral wisdom of letting the consequences to the patient (to the exclusion of the consequences for those he loves, for example) be the ultimate decision-making tool. Brody and Engelhardt call this patient-focused method the *desire-satisfaction theory*. The real question they raise is: how do we rank consequences to all people involved?[11]

Utilitarian views assume that humans know what is intrinsically valuable, such as health and prevention or lack of pain. According to Beauchamp and Childress, a utilitarian would say that people "ought to seek certain experiences and conditions in life that are good in themselves."[12] But whence comes this knowledge? Because the authors of classical utilitarianism, such as Jeremy Bentham and John Stuart Mill, were raised Christian or in a Christian culture, this knowledge comes from Greek sources (Plato and Aristotle) as well as Christian sources. And the Christian sources begin with the Christian Bible. It seems as though utilitarians assume that what is good for English-speaking peoples is equally valued by the native peoples of Brazil, Indonesia, and the Congo.

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[11] Brody, Baruch A., and Engelhardt, Jr., H. Tristram, Bioethics: Readings and Cases (Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1987): pp. 6-9.
[12] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): p. 22.

Jeremy Bentham and John Stuart Mill, hedonistic (some say deliberative) utilitarians, define utility in terms of happiness or pleasure (e.g., benefit, advantage, or good). Bentham, in his criticism of natural rights, says,[13] "In proportion to the want of happiness resulting from the want of rights, a reason exists for wishing that there were such things as rights."[14] Bentham continues,

> What signifies it how governments are formed? Is it the less proper – the less conducive to the happiness of society – that the happiness of society should be the one object kept in view by the members of the government in all their measures? Is it the less the interest of men to be happy – less to be wished that they may be so – less the moral duty of their governors to make them so, as far as they can, at Mogadore than at Philadelphia?[15]

In Utilitarianism, Mill describes the creed of the hedonistic utilitarian: "The creed which accepts as the foundations of moral, Utility, or the Greatest Happiness Principle, holds that actions are right in proportion as they tend to promote happiness; wrong as they tend to produce the reverse of happiness. By happiness is intended pleasure and the absence of pain; by unhappiness, pain and the privation of pleasure."[16]

A definition of utilitarianism has been propounded that appeals to individual or group preferences. "What is intrinsically valuable is what individuals prefer to obtain,"[17] assuming that "a range of acceptable values can be formulated[,]....the utilitarian approach makes sense and is not wildly implausible if a theory of appropriate (nonmoral) values

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[13] In spite of his language, Bentham is not criticizing the language of rights or the theory of moral rights; instead, he is criticizing the theory of *natural* rights.
[14] Bentham, Jeremy, "Anarchical Fallacies," in Melden, A.I., editor, Human Rights (Belmont, California, Wadsworth University Press, 1970): p. 32.
[15] *Ibid.*, p. 34.
[16] Mill, John Stuart, II.2 of Utilitarianism, in Crisp, Roger, editor, J.S. Mill, Utilitarianism (New York, Oxford University Press, 1998): p. 55.
[17] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): p. 24.

could be provided."[18] This definition is helpful in certain contexts, such as discussions of health economics, for example.[19] Unfortunately, the definition is not self-consciously culture-specific, and only by inference is it specific according to economic region (e.g., city, county, state, or nation). As before, there is a certain unsettling assumption of general uniformity of preferences among the world's population.

The distinction between act and rule utilitarianism helps us to deem a single act as moral (or less immoral) under some circumstances and immoral (or less moral) under other circumstances. Act utilitarianism says that in the example of a doctor killing a moribund patient, if the killing is detected, then the act is less moral than if the killing goes undetected. This is because if the general populace knows that a doctor killed a patient, then the people's faith in doctors suffers. Conversely, a doctor's killing that goes undetected does not weaken the general populace's faith in the doctors' oath to "do no harm." For this reason, act utilitarianism has received criticism.

Beauchamp and Childress compare the theories of act and rule utilitarians:

> According to rule utilitarians, rules themselves have a central position in morality and cannot be disregarded because of the exigencies of particular situation....Because of the substantial contributions made to society by the general observance of rules of truth-telling [for example], the rule utilitarian would not compromise them for a particular situation. Such compromise would threaten the integrity and existence of he rule itself, and a rule is selected in the first instance because its general observance would maximize social utility better than would any alternative rule, or no rule. For the rule utilitarian, then, the conformity of an act to a valuable rule makes the act right, whereas for the act utilitarian the beneficial consequences of the act alone make it right.[20]

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[18] *Ibid.*, p. 25.
[19] *Ibid.*
[20] *Ibid.*, p. 30.

J.J.C. Smart gives the ludicrous example of the rule utilitarian being praised for saving Hitler from drowning, because, even if the rescuer knew whom he was saving,

> [B]y praising the [rescuer], he is strengthening a courageous and benevolent disposition of mind, and in general this disposition has great positive utility. (Next time, perhaps, it will be Winston Churchill that the man saves!) We must never forget that an extreme [rule] utilitarian may praise actions which he knows to be wrong. Saving Hitler was wrong, but it was a member of a class of actions which are generally right.[21]

Smart concludes by saying that rules can sometimes be obeyed and sometimes broken: "[I]n every case if there is a rule *R* the keeping of which is in general optimific, but such that in a special sort of circumstances the optimific behaviour is to break *R*, then in these circumstances we should break *R*."[22]

Another problem with rule utilitarianism is that there is no system for deciding what to do when more than one rule applies and the rules contradict. Without a system that ranks the various rules, there is little guidance for our behavior when we need guidance the most: when we can appeal to more than one ethical rule. (Note that I am implicitly giving greater weight to theories that help guide behavior, as opposed to those theories that do not help guide behavior.)

A problem with any type of utilitarianism is pointed out by Brody and Enelhardt: it fails significantly when applied to public policy issues because in a pluralistic society, it is impossible to come to a universal agreement upon a single standard by which to measure utility:

> One simple suggestion that might be made is that we should judge the actions that benefit the most people and harm the fewest as having the best

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[21] Smart, J.J.C., "Extreme and Restricted Utilitarianism," in Bayles, Michael D., editor, Contemporary Utilitarianism (Garden City, New York, Anchor Books, Doubleday & Company, Inc., 1968):.pp. 104-5.
[22] *Ibid.*, p. 113. For additional discussion, see Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): pp. 27-8.

> consequences....[This] suggestion supposes that we count the number of winners and the number of losers and use the difference to weigh the gains to some and the losses to others as we evaluate the consequences of our actions. That is clearly inadequate...we also need to take into account how *much* those who gain will gain and how *much* those who lose will lose. The trouble is that we have no way of systematically making such comparisons. In the technical literature of economics and ethics, this problem has come to be called the *problem of the interpersonal comparison of utility*.[23]

Deontology

Deonotological theories maintain that features other than consequences make some acts moral or immoral. "[T]o be a deontologist, one must hold that at least some acts are wrong and others are right independent of their consequences. Examples of right-making characteristics in deontological systems include fidelity to promises and contracts, gratitude for benefits received, truthfulness, and justice."[24]

Types of deontology include those that hold acts are right or wrong because of divine revelation to that effect, because of the rules of natural law or social contract, or because of common sense. As in utilitarianism, there are act and rule deontologists. However, Beauchamp and Childress note that "[f]ew philosophers or theologians have tried to defend act deontology [which holds] that an individual by intuition, or conscience, or faith in God's revelation and grace, can immediately and directly perceive what he or she ought to do."[25] One reason act deontology is problematic is that "we do not have firm grounds for confidence in our own or others' intuition, conscience, or faith to perceive right and

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[23] Brody, Baruch A., and Engelhardt, Jr., H. Tristram, Bioethics: Readings and Cases (Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1987): pp. 9-10.
[24] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): p. 33.
[25] *Ibid.*, p. 36.

wrong in the situation."[26] Another, more important reason that act deontology is problematic is that "to judge that a particular act is wrong in the situation is implicitly to appeal to a rule. If we are making a moral judgment when we say that act X is wrong, we are saying that all relevantly similar acts in similar circumstances are wrong [and such a statement] is at least an incipient rule."[27]

For those areas where more than one rule or principle applies and the rules contradict, there is no guidance from act deontology as to which rule takes precedence. For example, when the principle of "do no harm" conflicts with the principle of "produce benefit," there must be a ranking of such principles in order to make the right decision about one's actions. Thus, codified rule deontology, which ranks the importance of each rule, is the only type of deontology that helps guide behavior.

Deontological codes evaluate people and their actions in relation to one another, and duties between people are created. W. David Ross explains, "I [do not need to convince] most thinking people that there is a *prima facie* duty to fulfill promises, distinct from the *prima facie* duty to produce what is good."[28] As an example, Ross posits that *A*, a dying man, gives his property to *B*, "on the strength of *B*'s promise to hand it over to *C*, who knows nothing of *A*'s wishes or *B*'s promise. Suppose that *B* does not believe in immortality, or believes that at any rate the dead know nothing of the fortunes of the living."[29] In this case, assuming *B* tells no one about his promise to *A*, *B*'s keeping his promise or breaking it neither adds to nor lessens the good done to either the dead *A* or

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[26] *Ibid.*
[27] *Ibid.*
[28] Ross, W. David, Foundations of Ethics (Oxford, Clarendon Press, 1939): p. 105.

the ignorant *C*. Ross concludes, "Is it not clear that this utilitarian way of considering such a case is not the way in which honest men actually would consider it? We should, in fact, regard the breaking of this promise as an outrageous breach of trust...because we consider the act itself detestable."[30]

Later on, Ross lists other duties:

> It will be remembered that in our consideration of the epistemological questions connected with the judgement of duty, we have so far considered only the duty of producing the maximum good. But there are other duties that this, the duty of fulfilling promises, the duty of making reparation for wrongs we have done, the duty of making a return for good we have received.[31]

Beauchamp and Childress summarizes Ross's ideas this way: "Some...duties rest on one's own previous acts. For example, promises...give rise to *duties of fidelity*. And one's previous wrongful acts engender *duties of reparation*. Some other duties rest on the previous acts of other persons. When they render services to us, we have *debts of gratitude*."[32] Duties and obligations are also engendered by relationships between people, such as between parent and child. Further, past acts and promises engender future obligations.

One can voice an objection to deontology on the basis that (like most utilitarian thought), the set of theories assumes agreement across cultures as to what is moral and what is immoral. It is easier, however, to discover whether two people (or two cultures) agree on deontological grounds than on utilitarian grounds. For example, two people or cultures

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[29] *Ibid.*, p. 104.
[30] *Ibid.*, p. 105.
[31] *Ibid.*, p. 186.
[32] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): p. 36.

can agree or disagree about the idea that "justice is moral" more easily and more consistently that they can agree or disagree that a particular rule (e.g., "murderers should always be put to death") is always beneficial. Additionally, the basic form of deontology recognizes relationships between people and cultures, whereas basic utilitarianism does not.

Another issue that concerns both utilitarians and deontologists (i.e., formalists) is whether there are a set of rules that once defined and agreed to, should be followed in all cases, or whether each case should be evaluated separately. Robert Veatch explains:

> [There is a] conflict between those who insist that moral rules must be followed in specific cases and those who argue that each situation, each case, is unique and must be evaluated anew. The formalists are often accused of being legalistic, of insisting on the rules of truth-telling or promise-keeping or consent-getting. But the rules-situation debate is really independent of the utilitarian-formalist debate. It is quite possible to argue that a rule to tell the truth should be followed even if in a particular case it appears that the consequences would be better if the rule were not followed, and to argue this on the grounds that following the rule will produce the best consequences in the long run. It is also possible, even for the formalist, to argue that on the question of what to tell the patient every case must be treated as unique entity in which no general rules can be followed. In every case the situation would therefore have to be examined to determine what formal right-making characteristics are present and how they can be balanced, independent of the consequences or with the consequences being only one consideration.[33]

No one whose views I have read follows up on the "third possibility" (ala J.J.C. Smart, above), namely, that there could be a set of general rules whose guidelines about behavior govern the decisions about each unique case that is evaluated anew.

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[33] Veatch, Robert M., Case Studies in Medical Ethics (Cambridge, Massachusetts, Harvard University Press, 1977): p. 146.

A Question of Rights

The language of "rights" serves both rule utilitarianism and rule deontology. As John Stuart Mill wrote, "The only part of the conduct of anyone for which he is amenable to society is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign."[1] The language of rights is pervasive today, but it is relatively recent, as Beauchamp and Childress note, "[M]any languages, such as ancient Hebrew and Greek, do not have equivalent expressions for our terms 'a right' or 'rights.'"[2] The authors suggest that "rights are best seen as justified claims that individuals and groups can make upon others or upon society....a right implies that someone else has an obligation to act in certain ways. Right thus imply obligations."[3] This is interesting language in itself, because the Beauchamp and Childress do not wish to define human rights per se. In essence, they are saying that the language of rights makes most sense when it is understood as a language of duty, which is precisely the language of halacha.

While it is true that halacha is not based upon a fundamental concept of "rights," it *is* replete with a sense of duty and obligation. As a regime of Jewish religious law, based upon divine command, halacha imposes obligations and thus speaks in terms of *chovah* (חובה, obligation or duty) rather than *zechut* (זכות, right or privilege).

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[1] Mill, John Stuart, "Not All Can Be Free," in Brody, Baruch A., and Engelhardt, Jr., H. Tristram, Bioethics: Readings and Cases (Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1987): p.47.
[2] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): p. 48.
[3] *Ibid.*, pp. 48-9.

Yet the existence of duties and obligations reflects basic ethical and moral principles that enable us to infer the existence of corresponding "rights." For example, halacha does not speak of a "right" to own property, but it does forbid one to trespass against the property of another. Haim Cohn speaks of the concept of rights at length:

> Speaking of human rights concepts I must say at once that no explicit concept of this kind is to be found in Jewish law. It is not only that the formative sources of Jewish law precede by millennia the first enunciation of such slogans as civil liberties, citizens' rights, or individual freedom: Jewish law is in no way unique or isolated among ancient systems of law or of religion which fail to recognize human rights specifically. It is mainly that the particular structure of Jewish law qua religious law – with God as the central object of love and veneration, and the worship and service of God as the overriding purpose of all law – postulates a system of duties rather than a system of rights. It is true that the conferment of rights may be incidental to the fulfillment of duties: in many instances, the very imposition of a duty already implies the creation of a collateral right, and that right may even be legally enforceable; in other instances, there may exist a duty – but rather than incidentally conferring any enforceable right, the performance of the duty will result only in the conferment of a benefit. Thus, prohibitions such as "thou shalt not steal" (Exod. 20:15, Deut. 5:19) and "thou shalt not remove thy neighbor's landmark" (Deut. 19:14), and the injunction to return lost chattels (Deut. 22:1-3), all impose negative or positive duties; but they may be read to imply a right to property and possession – a right which is nowhere spelled out as such. Similarly, the duty of learning and teaching is reiterated several times (Deut. 6:7, 20-25), but there is no right to education articulated anywhere. There are a few isolated exceptions to this rule: in biblical law, for instance, the right of the accidental manslayer to refuge from the blood-avenger is laid down as right, not only as the duty of the blood-avenger to refrain from killing (Num. 35:11, 15; Deut. 4:42). Similarly, in talmudical law the duty to do charity is supplemented by explicit rights of the poor, if only with a view to settling priorities among them (M. *Horayot* 3:8, B. *Bava Metzia* 71a).
> In order to ascertain the existence and scope of "human rights" in Jewish law, we shall therefore have to look at "commandments" (*mitzvot*), including positive precepts (*mitzvot assei*) and negative injunctions (*mitzvot lo-ta'asse*), and start from the premise that the purpose of imposing duties toward your fellowmen was but the recognition and implementation of right of which these fellowmen stand possessed; or – and this comes to the same thing – the fulfillment of their legitimate expectations and legally recognized needs. It stands to reason that from the duty to assist and maintain the poor a fundamental human right of every human being to his

> livelihood may reasonably be inferred, as the fundamental right to life may justifiably be inferred from the prohibition of homicide.[4]

Brody and Engelhardt distinguish between inalienable (absolute) rights and those rights that can be waived or overridden. With regard to the right not to have bodily injury or pain inflicted on oneself, the authors say

> This clearly is a right that can be waived. After all, there are many cases in which for good reasons we allow providers to perform procedures that inflict pain on us or that diminish our bodily integrity (think of an amputation to save a life)....[These procedures are moral because] the patient has given consent, and in doing so has waived this right. We feel justified in performing many of these very same procedures, even when the patient does not agree because the patient is either incompetent or unconscious. It seems that it is the benefits that would be derived by the patient that override the nonwaived right not to have bodily injury inflicted on oneself.[5]

Brody and Engelhardt define rights as a negative obligation: "X has a right to Y against Z just in case Z has an obligation to X not to deprive X of Y or not to withhold Y from X." Again, this is precisely the language of Jewish law, and the basis upon which Haim Cohn feels we can speak of "human rights" in Jewish law. For X, a Jehovah's Witness named Mr. Jones, who requires a blood transfusion but whose religious beliefs reject the use of blood transfusions, here is the dilemma:

> [T]o say that Mr. Jones has a right against the health-care providers to decide whether or not he is going to get a transfusion of platelets is to say that the health-care providers have an obligation to Mr. Jones not to deprive him of the authority to make the decision as to whether he will get the platelets. Again, to say that Mr. Jones has a right to life against the health-care providers is simply to say that they have an obligation to Mr. Jones not to withhold from him the health care that he needs in order to survive.[6]

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[4] Cohn, Haim, Human Rights in Jewish Law (New York, KTAV Publishing House, Inc., 1984) pp. 17-19.
[5] Brody, Baruch A., and Engelhardt, Jr., H. Tristram, Bioethics: Readings and Cases (Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1987): p. 15.
[6] *Ibid.*, p. 11.

Although Brody and Engelhardt do not translate obligations as "duties," it is possible to restate the dilemma using the language of duties: Mr. Jones has a positive duty to make his own health-care decisions, and the health-care providers have a positive duty to allow Mr. Jones to make his own health-care decisions. The health-care providers have a negative duty not to interfere with Mr. Jones' decisions, but the health-care providers have a positive duty to provide Mr. Jones with the health care he needs (as opposed to what health care he chooses).

Some duties, say Beauchamp and Childress, such as the duties of "love, charity, and self-sacrifice [are not] restatable in terms of rights. It seems awkward in most instances to hold that one person can claim another person's love or charity as a matter of right.... [W]e believe that we ought to contribute substantially to charity, even though morality does not require it."[7] Here is where the authors, without realizing it, imply that "love, charity, and self-sacrifice" are universal values, when in fact they are particularly Christian values.

Brody and Engelhardt suggest that Greek philosophy plays a part in bioethical decision making. They suggest that in addition to the appeals to consequences and rights, appeals should be made to the virtues of "compassion, courage, honesty, and integrity."[8] After noting that compassion is "an *other-centered* [other-oriented] virtue" whereas integrity is not necessarily other-centered and is usually more self-oriented, they caution that "[t]o say

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[7] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): p. 49.
[8] Brody, Baruch A., and Engelhardt, Jr., H. Tristram, Bioethics: Readings and Cases (Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1987): p. 23.

that there is this distinction between compassion and integrity is not…to say that caution is a more important or more valuable virtue than integrity. We ought not to assume that the most important virtues are other-centered virtues."[9]

Beauchamp and Childress take their cue from Joel Feinberg[10] when they quote his distinction between positive and negative rights: "A *positive* right is a right to other persons' positive actions; a *negative* right is a right to other persons' omissions or forebearances. For every positive right I have, someone else has a duty to *do* something; for every negative right I have, someone else has a duty to *refrain* from doing something."[11] The authors then state that the right to health care is a positive right, whereas "the right not to be operated on without one's consent is a negative right, grounded in the principle of autonomy."[12]

There has been an attempt by Leon Kass[13], to define the sanctity of life and the principle of human dignity by arguing that murder is considered wrong because it "makes sense"[14] that

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[9] *Ibid.*, p. 28.

[10] Joel Feinberg, a political, social, and legal philosopher, is well-known for his 1973 work, Social Philosophy. According to Wadsworth Publishing, Joel Feinberg (Regents Professor of Philosophy and Law, emeritus, University of Arizona) is one of the world's pre-eminent ethical and jurisprudential philosophers. He has written eight books, and is editor or co-editor of three. He has taught at Brown University, UCLA, Princeton University, Rockefeller University, and the University of Arizona. He has held visiting appointments at Harvard Law School and New York University. Professor Feinberg was past president of the American Philosophical Association.
(http://philosophy.wadsworth.com/feinberg_reason/author.html)

[11] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): pp. 50-1.

[12] *Ibid.*, p. 51.

[13] Leon R. Kass has written two books and over eighty articles on the subjects of biomedical ethics, science and human affairs, and social thought. The books are: Toward a More Natural Science: Biology and Human Affairs, New York: The Free Press, 1985, and The Hungry Soul: Eating and the Perfecting of Our Nature, New York: The Free Press, 1994. Leon Kass is Addie Clark Harding Professor in Committee on Social Thought at the University of Chicago and the College of the University of Chicago. He is also a Brady Fellow at the American Enterprise Institute in Washington, DC. Kass is a graduate of the University of Chicago School of Medicine and also holds a Ph.D. in biochemistry from Harvard

murder is considered wrong. And why is it this? Because man's "*very being* requires that we respect his life."[15] And this respect is due because "the *sanctity* of human life rests absolutely on the *dignity* – the god-like-ness – of human beings."[16] Although Kass urges us not to "express suspicion at [his] appeal to a biblical text for what I will claim is a universal or philosophical explanation of the taboo against murder,"[17] this is simply impossible. Kass's argument is circular, not cogent, and suspiciously religious in tone. In short, if we analysis Kass's argument, it goes something like this: There is a God, and God is sacred. Humans are like God, so therefore humans have sanctity. One should not destroy sacred things, therefore one should not murder humans. This is a telling example of how every ethicist – secular or religious (or religious but claiming to be secular) – has the need to ground ethical principles in what are clearly assumptions or deeply held but unprovable convictions.

Others, such as Lenn Goodman, have written philosophical theories of rights that draw heavily from Jewish sources, while basing their theories on ideas of, for example, "authenticity": "all beings should be treated in accordance with what they are."[18] While these theories are authentically Jewish and interesting in themselves, they are outside the scope of this thesis, which compares *secular* philosophy with *halacha*.

University. He has served as a surgeon for the U.S. Public Health Service and has held positions in the field of medical ethics at the National Academy of Sciences, St. John's College, and the Kennedy Institute of Ethics at Georgetown University. (www.alteich.com/links/kass.htm and http://olincenter.uchicago.edu/kass_cv.html).

[14] "Death With Dignity and the Sanctity of Life" by Leon R. Kass in Kogan, Barry S., editor, A Time to be Born and a Time to Die (Hawthorne, New York, Aldine de Gruyter, 1991): p. 125.

[15] *Ibid.*, p. 127.

[16] *Ibid.*, p. 128.

[17] *Ibid.*, p. 143.

[18] Goodman, Lenn E., Judaism, Human Rights, and Human Values (New York, Oxford University Press, 1998): p. 24.

Halachic Approaches to Bioethics

There is no broader principle in halacha than the sanctity of life, which implies an obligation to treat, and an obligation to seek treatment to preserve life. Both patient and doctor have a positive mitzvah to heal and be healed. As we have seen, Biblical verses and their explications (such as "And you shall guard you own lives exceedingly"[1] (Deuteronomy 4:9 and 4:15) and "וחי בהם *vechai bahem*: he shall live by them [the laws]" (Leviticus 18:5)) are used to place the saving of life as higher than almost all other obligations. The duty to preserve one's own life and the life of others overrides all other commandments in the Torah, except for three: idolatry, murder, and incestuous or adulterous sexual intercourse (see Sanhedrin 74a).

Yet halacha has no broad principles nor ethical theory in the sense that the secular ethicists do. That is because halacha works from individual commandments. These commandments imply principles and thus behaviors in answer to questions that have not yet been addressed specifically by the Torah, the Talmud, the codes, or the responsa. Thus, while there is a methodology to deciding halacha, halacha itself is not systematic or carefully laid out as a philosophical treatise. Yet another difference between secular bioethics and halacha is that secular theories present themselves as valid for all humanity, whereas halacha explicitly and self-consciously declares itself to be valid only for Jews. That is to say, while some laws are valid for all humanity, halacha addresses itself to Jews and does not attempt to persuade non-Jews to follow its laws.

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[1] For a complete discussion of this subject, see Freedman, Benjamin, Duty and Healing (New York, Routledge, 1999): pp. 142-152.

Halacha has only recently begun to deal with modern bioethical issues. Within the books in the bibliography, some particular good examples are a responsum by Nisson Shulman,[2] Mark Washofsky's discussion of medical ethics,[3] and Elliot Dorff's treatment of issues such as hospice care, communal measures to prevent illness, and types of health delivery systems (such as managed care).[4] Understandably, halacha has not – at least not outside of Israel – addressed public policy issues with regard to funding for research, government standards of conduct, and allocation of public funds.[5]

Regarding the distinction between morality and legal policy, for Jews, the issues are conflicted, but in the end, our viewpoint comes to the same conclusion as does the secular ethicist's viewpoint. On the one hand, the halacha is the law for observant Jews, but on the other hand, the law of the land is the law also. We cannot assume that governmental laws are consistent with halacha. If halacha states that an act is morally wrong, then halacha must prohibit it. However, the government need not prohibit that morally wrong act. If an act is morally acceptable in some circumstances, halacha need not legislate its acceptability, and the government need not permit it.

What if the government prohibits a halachically obligatory action? Or what if the government requires us to perform a halachically prohibited action? In either case, the halacha must be followed. A *secular* ethicist need not break the governmental law, and

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[2] Shulman, Nisson, E., Jewish Answers to Medical Ethics Questions (Northvale, New Jersey, Jason Aronson Inc, 1998): pp. 135ff.
[3] Washofsky, Mark, Jewish Living (New York, UAHC Press, 2001): pp. 220ff.
[4] Dorff, Elliot N., Matters of Life and Death (Philadelphia, The Jewish Publication Society, 1998).
[5] Reform responsa has addressed the duty of Jewish physicians to treat indigent patients in "Physicians and Indigent Patients" 5754.18, in Plaut, W. Gunther and Washofsky, Mark, Teshuvot for the Nineties (New York, Central Conference of American Rabbis, 1997): pp. 373-380.

yet, because ethical principles are often held with religious fervor, the ethicist may also choose to ignore the governmental law. Of course, for a non-Jewish religious ethicist, religious morality may also determine action contrary to governmental law.

A point should be made about a seemingly universal concept of sanctity of life and the duty to uphold that sanctity against governmental law or even personal moral convictions. This concept and duty were enshrined in the Nuremberg trials, as J. David Bleich explains:

> The defense offered an apologia firmly rooted in ethical relativism....The prosecution contended that obedience to law is not sufficient justification for wantonly snuffing out innocent human life. If effect, runs the argument, there is a moral obligation to disobey an unjust law. But, much more significantly, the prosecution was forced to argue that this is a matter regarding which there cannot be honest disagreement. Otherwise, how can a person be called to task and condemned by a court of law for following the dictates of his moral conscience, particularly when those moral principles are enshrined in the law of the land? The Nuremberg trials were predicated upon acceptance of the sanctity of life as a compelling and overriding human value. But more than this – the charges against the defendants were predicated upon the acceptance of the sanctity of life as a self-evident, undeniable, irrefutable, *a priori* cardinal value. As such, it takes precedence not only over obedience to law but over virtually all other human values as well.[6]

While the dual process of having theories inform principles and actions, and conversely, having our behavior make us reevaluate our theories, makes sense and is generally applicable to modern secular society, it only tangentially describes a halachic Jew's view of the world. Our ethical theories (if one can say that we have theories as such) are described in the Torah, Talmud, the codes, and the responsa, and the principles that flow from them demand behavioral rules that must be followed. When our actions are not in accord with the rules, we do not call into question our principles or ethical theories. On

the contrary, our actions are either condemned or explained as being in accord with at least a minority opinion regarding our behavioral rules or justified in accordance with a different interpretation of the sources than that which grounds the prevalent "rule." An example of this is the custom of women not reclining at the Passover Seder, which is explained by saying that women follow a valid, if singular opinion.[7]

We saw that according to Beauchamp and Childress, moral action-guides have three characteristics:

1) a person or society accepts them as "*supreme, final,* or *overriding*"[8];
2) they are universal, "which requires that all relevantly similar cases be treated in a similar way"[9]; and
3) they "have some direct reference to the *welfare of others.*"[10]

It is self-evident that halacha is a moral action-guide (the "way to walk"), and yet it only has the first characteristic of supremacy. Jewish law is for Jews only, and even within the Jewish society, similar cases are treated differently (e.g., marrying a divorced woman is an acceptable act for everyone except a priest[11]). Also, there are a number of halachot that

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[6] Bleich, J. David, "Introduction: The A Priori Component of Bioethics," in Rosner, Fred, and Bleich, David J., editors, Jewish Bioethics (Hoboken, New Jersey, KTAV Publishing House, Inc., 2000): p. xxi.
[7] Shulchan Aruch, Orach Chayim 472:4.
[8] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): p. 15.
[9] *Ibid.*, p. 16.
[10] *Ibid.*, p. 17.
[11] "And he [a priest] shall take a wife in her virginity. A widow, or a divorced woman, or defiled, or a harlot, these shall he not take; but he shall take a virgin of his own people to wife" (Leviticus 21:13-14). "And no priest shall drink wine, when they enter into the inner court. And they shall not take widows or divorced women for wives, but they shall take virgins of the seed of the house of Israel, or a widow who is the widow of a priest" (Ezekiel 44:21-22).

are by definition moral, but that have no explanation at all, and that have no reference to our welfare (e.g., the prohibition of שעטנז *shatnez*[12]).

Utilitarianism determines worth based on consequences. Naturally, although Jewish law is sometimes given moral justification (e.g., keeping kashrut allows the soul to remain on a high spiritual plane), the fact remains that the consequences of keeping the halachot are irrelevant. If the written and oral law require that one wait after eating meat before eating dairy products, it does not matter whether there are any moral consequences that are understandable by humans. The absence of any moral explanation in no way diminishes the moral quality of the law. The presence of one or more moral explanations similarly does not increase the moral quality of the law.

In utilitarianism, an action that goes undetected is less immoral than one that is detected. In halachic thinking, no act goes undetected, for God is always aware of our actions. Judaism is somewhat more in line with the view of J.J. Smart, [13] who says that rules can be sometimes obeyed (as opposed to there being a set of rules that are always or never obeyed). Smart's view corresponds in a limited way to the view underlying the process by which a Jew asks a rabbi for a היתר *heter* (dispensation/permission). It should be noted, however, that a היתר *heter* is "legal" in that it is an example of the halachic process at work. Getting a היתר *heter* is not strictly a case of "not obeying the rule," but rather of determining that the rule does not apply to a specific case. Thus Judaism falls through the cracks of Smart's scheme. Smart takes a legal-positivistic position: law is entirely a

[12] "Nor shall a garment mixed of linen and woolen come upon you" (Leviticus 19:19) and "You shall not wear a garment of different sorts, like woolen and linen together" (Deuteronomy 22:11).
[13] Smart's views are discussed in a previous chapter.

matter of rules, so that if X is a rule, and one does *not*-X, then one is disobeying or acting outside the law. Judaism's position is more process-oriented, and understands law as more than simply a set of rules.

Here it is necessary to distinguish between Reform and non-Reform halacha. A Reform rabbi does not see the distinction between a priest and an Israelite as a relevant distinction with regard to acceptable marriage partners, whereas a non-Reform rabbi would. Part of the distinction between the two sets of halachot (if we can call them that, since Reform responsa are not binding[14]) is that Reform Judaism has adopted some new principles and a utilitarian valuation of consequences.

Reform Judaism has added principles (e.g., gender equality) whose rules require us to deem morally unacceptable that which non-Reform Judaism deems morally obligatory (and vice-versa). In this respect, Reform Judaism also leans toward the two-way process of determining moral behavior, because we have changed our principles as the result of evaluating our actions (e.g., the original dismissal of purely ritual actions in the first Pittsburgh platform of 1885 has been overturned in our day).

Reform Judaism will discard traditional halacha if, after careful review, the consequences are unacceptable. As Mark Washofsky writes, "As modern people, we reserve the right to

[14] As Mark Washofsky writes, "Reform responsa do not partake of anything resembling an authoritative halakhic process. Our answers are in no way binding upon those who ask the questions, let alone upon anyone else." Plaut, W. Gunther and Washofsky, Mark, Teshuvot for the Nineties (New York, Central Conference of American Rabbis, 1997): p. xxvii.

look critically at tradition and to reject its conclusions when persuasive necessity requires us to do so."[15] Washofsky continues,

> [W]e seek to uphold traditional halakhic approaches whenever fitting. But we reserve for ourselves the right to judge the degree of "fit." We will modify standards of halakhic observance to bring them into accord with the religious, moral, and cultural ideals to which we Reform Jews aspire and which, as we see it, characterize Jewish tradition at its best. And we will depart from the tradition altogether in those cases where even the most liberal interpretation of its sources yield conclusion which are unacceptable to us on religious or moral grounds.[16]

The Reform insistence of equal opportunity of men and women to count in a minyan is an example of how a modern principle (in this case, of gender equality) modifies traditional halacha.[17]

In a question about whether two lesbian parents should be permitted to participate in their child's *Bar Mitzvah* service, the responsum notes that halacha has little to say about lesbianism and concludes:

> We should be guided by these feelings and by our tradition's strong support of normative family life. Everything which we do should strengthen the family. We should, therefore, ignore the lesbian relationship and feel no need to deal with it unless the individuals involved are flagrant about their relationship and make an issue of it. If they do not, then their lesbian relationship is irrelevant; it should not be recognized. They should be permitted, along with other individuals both male and female, to participate in the *Torah* readings as well as other portions of the Friday-*shabbat* service. This will indicate to both the congregation and this household that

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[15] *Ibid.*, p. xxiv.
[16] *Ibid.*, pp. xxviii-xxix.
[17] In "Need for a *Minyan*" 5752.17, the CCAR's Responsa Committee states, "[T]here are good reasons why [the requiring of a quorum] deserves our attention and respect, with the proviso, of course, that any Reform *minyan* would count women as equal partners." Plaut, W. Gunther and Washofsky, Mark, Teshuvot for the Nineties (New York, Central Conference of American Rabbis, 1997): p. 24. Note also the statement in "Woman as a Scribe": "Our movement rejects any attempt to draw distinctions in ritual practice on the basis of gender....Since this is a matter of religious principle for us, we would maintain our dissent [from the halachic prohibition of women as scribes] even if it were impossible to argue cogently on textual grounds against the traditional prohibition." *Ibid.*, pp. 180-1.

> we recognize the love and care given to the child and do not focus on or recognize the lesbian relationship.[18]

Phrases such as "we should be guided by…feelings" and "everything which we do should strengthen the family" are used to support the idea that the lesbian parents should participate as any other parents do in their child's ceremony. The author(s) of the responsum do not justify their decision by citing any rule or principle, but by evaluating the consequences: the parents' participation "will indicate..that we recognize the love and care given to the child."

Reform Judaism thus takes on the characteristics of deontology in that some actions are deemed moral because they conform to modern principles (e.g., gender equality). It also takes on the characteristics of utilitarianism in that the consequences of an action are evaluated in making a decision.

Halacha for the most part does not use the language of "rights." Although the word may be used, there is no philosophical concept of "human rights." All halachot are commandments, whether positive or negative. Commandments are duties and obligations, whether between man and his fellow man, or between man and God. Asking whether someone has the right to do x is the same as asking whether there is any commandment forbidding him to do x, or whether there is halacha that recommends he do y rather than x. So while it is true that a man has the right to choose the color of his tie, this is true only because there is no halacha that determines appropriate tie color.

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[18] "200. Lesbians and their Children" March 1986. Walter Jacob, editor, Contemporary American Reform Responsa. 1987 (http://www.ccarnet.org/cgi-bin/respdisp.pl?file=200&year=carr)

An important issue for secular ethicists is whether there are a set of rules that once defined and agreed to, should be followed in all cases, or whether each case should be evaluated separately. Here halacha approaches the issue differently. First of all, (for the non-Reform Jews) there is Talmudic law, which is binding upon all Jews, and then there are post-Talmudic interpretations of that law.[19] For these interpretations of halacha, different Jewish communities follow their own local or regional traditions of פסק *pesak* (halachic ruling).[20]

Whenever it is unclear what the halacha says about a particular situation, a question will be asked of a rabbi or of a beit din. The case, in all its particulars, will then be evaluated separately. There is, in essence, a general set of rules, but each case [whether about medical ethics or any other difficult question] is evaluated anew.[21] In fact, non-Reform responsa are more authoritative than codified laws for that very reason, as Menachem Elon explains: "[M]ost halakhic authorities rank rules derived from responsa even higher

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[19] Rambam's Introduction to the Mishneh Torah says

> Each beit din that stood after the completion of the Talmud, in all lands, adjudicated and enacted regulations and established customs for their inhabitants or for those of many lands, [but their laws] did not extent to all Jews, because of the distance between their communities and the variations of their ways....However, all Jews are obligated to follow everything [all the laws] in the Talmud Bavli...[because] all Jews consented to them.

See also Elon, Menachem, Jewish Law (Philadelphia, The Jewish Publication Society, 1994): pp. 1228-9.

[20] The differences among communities became problematic whenever groups of Jews were exiled. As Menachem Elon notes,

> [T]his situation gave rise to many problems in all the areas of law. The previous inhabitants followed their own customs and enactments, and the newcomers brought with them the customs and life-style of their own communities. The establishment of new communities and the arrival of the new immigrants in places where Jewish communities already existed gave rise to [various] disputes....All these problems were brought before the Jewish courts, and the most significant and difficult issues reached the leading respondents. The responsa on all of these questions vastly enriched the responsa literature.

Elon, Menachem, Jewish Law (Philadelphia, The Jewish Publication Society, 1994): pp. 1482-3.

[21] See the article about how a rabbi decides a halachic issue, included in the Appendices.

than those based on the codificatory literature, to the point of resolving an inconsistency between a code and a responsum in favor of the responsum."[22] Although responsa and codes both aim at determining the correct rule, "the author of a responsum seeks and finds the rule in the course of deciding a concrete case that has actually arisen in real life, and he comes to his conclusion as part of the process of adjudication. The author of a codificatory work, on the other hand, arrives at his conclusion solely in the course of academic study."[23]

In evaluating the differences between halacha and secular ethics, it should be noted that that the way "law" is determined (law in general, and not simply halacha in particular) often is different from the way "ethics" is determined. Law may tend to favor discrete rules and to justify its decisions by reference to past authority to a much greater extent than does "ethics."

An argument may be made for the idea that principles of law are discovered through the process of creating responsa, but I am persuaded that these principles are less like overarching philosophical ideals than they are attempts to determine whether previous rulings are similar enough to have bearing on the question at hand.

A final point should be made about legal decisions: in secular law courts, there is a winner and a loser. In questions of ethics, in Reform responsa, and in halacha in general, arguments are made, and decisions (authoritative or not) are reached, but there is no winner and no loser, because all parties are trying to find the right answer, or the most-

[22] Elon, Menachem, Jewish Law (Philadelphia, The Jewish Publication Society, 1994): p. 976.
[23] *Ibid.*, p. 977.

right answer. This "win-win" situation is illustrated in the Talmud's prescription for behavior after a legal dispute has been settled: "One who leaves a court having his coat removed [i.e., the court ruled against him, giving the coat to his opponent] should sing a song as he goes on his way."[24] Rashi explains why he should sing: "He should be happy that wrongly acquired property was removed from his possession."[25]

Reform Judaism says that each individual Jew should make an educated decision about which halachot to follow.[26] While this allows an individual Jew to follow some laws and not others, there is still a knowledge of and implicit acceptance that the law requires one behavior rather than another. To illustrate, a Christian does not see a moral or ethical question about eating catfish. A Reform Jew, however, does (or should) know that catfish is not kosher. He will evaluate that information together with his own religious beliefs and will make a moral or ethical decision whether to eat catfish.

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[24] Sanhedrin 7a
[25] *ad locum*
[26] As noted in the Introduction, above, "informed choice" is a principle of Reform Judaism.

Specific Investigation – Secular Cases

As we have seen, both rule utilitarians and rule deontologists grapple with the question of whether there are a set of ethical rules that once defined and agreed to, should be followed in all cases, or whether each case should be evaluated separately. Patients' rights, patient autonomy, and patients' limits of choice are all issues that arise when secular bioethicists discuss life-threatening medical treatment and under what circumstances a patient may undergo such treatment. Interestingly, the physician's morality is called into question even about procedures with a practically non-existent risk of harm *if* there is an adverse event.

Case #1

The following case is related by Robert W. Allen:

> A patient of mine had a fatal reaction during urography. I was subsequently the defendant in a malpractice case which came to trial in June 1974.
>
> The issue of informed consent was raised in my case by the plaintiff's expert witness who was a pathologist and a lawyer. He stated that "It is the standard of medical practice for a radiologist to warn a patient of adverse reactions including death before doing urography." On cross examination he was unable to give the name of even one radiologist who did this.
>
> When I testified, my attorney asked me why I had not warned the patient of a possible reaction. I said that I did not warn the patient of a possible reaction because it does not do any good. I could have told her that there was a chance she might have a reaction and even die. After calming her down I would then have told her that she had seen two urologists in the past week and both of them had told her she needed urography. I have done 6-8 thousand urograms in the past 13 years and no one has ever had a fatal reaction. We have been doing urograms at this hospital for at least 25 years and no one has ever had a fatal reaction. Because the indications for urography were great and the chances for a reaction were remote I am sure I would have convinced Mrs. Edney to have the procedure. She would have then had the reaction and died and

the fact that I warned her would have done Mrs. Edney absolutely no good. [1]

Allen discusses the ethics of this case by saying that radiologists must make medical decisions, and that legal decisions that require informed consent are simply wrong:

> We have got into trouble in informed consent by getting legal opinions. What a physician tells a patient before performing urography is part of the practice of medicine. We must make informed consent a medical rather than a legal decision....the fact that you have warned the patient will in no way prevent a malpractice case from being filed. Your attorney may tell you it will help in the courtroom. However, it is not inconceivable that a plaintiff's attorney...will charge you with "frightening the patient to death."...
>
> [T]he American College of Radiology has...advised all radiologist of the following: Our responsibility is to our patients and to do what is best for our patients medically. Informing patients of risks and possible death from urography may not be in the best interest of the patient and...it may be dangerous.[2]

Beauchamp and Childress examine this case this way:

> [This case] illustrates these problems of informed consent and paternalism. A woman had a fatal reaction during urography (visualization of the urinary tract made after injection of an opaque medium). The radiologist had not informed her of a possible fatal reaction to urography on grounds that his duty was to do "what is best for our patients medically." He apparently thought it was best in this case not to inform the patient of risks of death because the information might actually have been "dangerous" instead of protective. In other words, he conceived the doctor's role in informed consent situations as that of making a judgment whether the presentation of information is more or less harmful to the patient. In this particular case he determined that it was not "in the best interest of the patient" to be informed because the risks of death were remote, while the possibility of causing undue alarm was immediate. This attitude is clearly paternalistic and grounded in beneficence, but is it justified to act on such an attitude?[3]

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[1] Allen, Robert W., "Informed Consent: A Medical Decision," *Radiology* 119 (Oak Brook, Illinois, Radiology Society of North America, Inc., April 1976): p. 233.
[2] *Ibid.*
[3] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): pp. 154-5.

Beauchamp and Childress answer the last question with an unqualified "No." The radiologist did not wish to "violate the duties of beneficence and nonmaleficence by causing the patient anxiety,"[4] (as evidenced by his contention that "telling her would only have upset her and would not have changed the outcome,"[5]). Nevertheless, Beauchamp and Childress believe the radiologist failed to act morally, because he violated more primary duties to be truthful and respect the patient's autonomy.

It seems that even in a case such as this one, where there is no medical choice to be made, Beauchamp and Childress insist that the rule be followed and the choice be given to the patient by way of informed consent. No matter how minor the risk, if unfavorable results occur, then the physician can be censured if he did not insist that the competent patient give written consent to the procedure.

The authors conclude by saying that "Even if such cases do not seriously threaten the relationship of trust, they involve violations of the principles of fidelity and autonomy. In particular, the radiologist denied the patient information necessary for informed consent and violated her right to make her own assessment of the risks and benefits."[6] Beauchamp and Childress rank the duty of beneficence against the duty to respect the patient's autonomy in such a way that autonomy always trumps beneficence, provided the patient is considered competent.

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[4] *Ibid.*, p. 205.
[5] *Ibid.*, p. 206.
[6] *Ibid.*

Case #2

The following case, which concerns risky surgery for pain, is presented by Brody and Engelhardt:

> Mr. B is a 39-year-old clerk-typist working for a local sheriff's office. Approximately two years ago, he began to experience severe pain between his shoulder-blades. He consulted a number of physicians who proscribed medications, but this failed to control the pain. He was finally referred to a neurosurgeon. A myelogram revealed findings compatible with a ruptured disk at the level of the fifth thoracic vertebra. The physician recommends an exploratory operation likely to lead to a laminectomy. In gaining consent for the procedure, the physician informs the patient that, in addition to the risk of death due to anesthesia, there is also the risk that the operation would not in fact cure the pain, that there could be injury to major blood vessels, that the spine might become unstable, and that he might suffer impaired muscle function. The physician does not indicate that, in rare cases, patients suffer paralysis, incontinence, and impotence. In the physician's judgment, the risk is sufficiently remote not to warrant disclosure.[7]

Although the authors do not discuss this case, they present the case under the rubric of "Consent of Adult to Treatment." In essence, the authors are asking whether the physician has the duty to disclose the remote risks of paralysis, incontinence, and impotence. If the physician discloses these remote risks, the duty of informed consent has been fulfilled and there is no question whether or not the patient has the right to undergo surgery.

It is thus the principle of informed consent that is at issue. There is no reason for the patient not to have surgery if he desires it, so long as the physician has met

> the so-called objective standard, the duty of the physician to explain to a patient enough about the procedure to be undertaken so as "to warn him of any material risks or dangers inherent in or collateral to the therapy, so as to enable the patient to make an intelligent and informed choice about

[7] Brody, Baruch A., and Englehardt, Jr., H. Tristram, Bioethics (Prentice Hall, Inc. Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1987): p. 285.

whether or not to undergo such treatment" [*Sard v. Hardy*, 397 A 2d 1014, 1020 (Md. 1977)].[8]

Case #3

Under the rubric of "Chronic Pain and Chronic Problems," Brody and Engelhardt present this case:

> Mrs. B. is a 37-year-old housewife and mother of three children, ages 15 to 7. She has always had profuse and painful periods, but over the last seven years her complaints have increased and her periods have become at times irregular, sometimes occurring every 20 days. She is a tense, somewhat anxious individual and is concerned that she may develop cancer of the cervix, as did her first cousin, who died of the disease eight years ago at the age of 37. After routine examination by a physician in her Health Maintenance Organization, she is referred to a gynecologist. Pap smears and all routine examinations, including a dilation and curettage, are normal. Mrs. B is then referred to an endocrinologist who performs further workup, again producing negative results. The complaints of Mrs. B continue, and she now wishes to find a physician who will perform a simple vaginal hysterectomy.[9]

The authors consider this case by asking these questions:

> Should a physician provide Mrs. B with a hysterectomy if she is willing to pay, even in the absence of demonstrable physical indications for the surgical procedure? What if her anxiety about developing cancer increases? It is proper to provide surgical treatment for what in all likelihood is an emotional difficulty?....At what point should physicians discourage further interventions, either through surgery or medication, and instead provide general supportive care? Finally, one must recognize that even further evaluation of complaints carries with it not only financial costs but also risks of morbidity and even mortality.[10]

The major focal point for this case and its ethical questions involves the physician deciding whether to perform surgery for Mrs. B. Brody and Engelhardt do not ask whether it is ethical for Mrs. B to ask for a surgery that is not medically indicated. They do not ask

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[8] *Ibid.*, p. 283.
[9] *Ibid.*, p. 312.

whether it is ethical for a patient to ask for "further evaluations [that carry] risks of morbidity and even mortality."

Presumably, the medical student answering some of the questions posed by the authors may make a cogent case for the view that if Mrs. B is willing to pay for the procedure and is properly informed of the risks entailed (in an effort to limit the risk of Mrs. B or her family bringing a lawsuit against the physician should the surgery not be successful), then there is no reason to question *her* behavior on the grounds of its ethics or morality. It may be unethical, however, for a physician to perform a procedure that he does not consider to be medically indicated. That is to say, the authors imply that paternalistic behavior *may* be warranted on the part of the physician, but that is a question for a physician to decide.

There is also a implicit denigration of the patient by including her tension and anxiety in the case history, because their inclusion suggests that those emotions weaken her claim to competency. Further, while it is a legitimate question to ask whether surgery is appropriate for mental diseases, the language of the authors (by labeling her complaint as an "emotional difficulty") shows a preference for dealing with organic diseases and a disinclination to address symptomatic complaints "or pains for which a physical basis cannot be discovered."[11]

In any case, there is no moral or ethical dilemma regarding the patient's request per se. Strangely, the question put to the medical student is not "What could I, as a physician, do

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[10] *Ibid.*, p. 313.

[11] For a discussion of modern medicine's inability or lack of desire to address pain that cannot be traced to a specific disease, see Brody, Baruch A., and Englehardt, Jr., H. Tristram, Bioethics (Prentice Hall, Inc. Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1987): pp. 310-313.

to alleviate Mrs. B's physical and emotional pain?" but rather, "Must I, as a physician, accede to a competent patient's autonomous request for surgery on her body?" That the answer to this question may be "Yes" suggests an extraordinarily high value placed on patient autonomy.

Case #4[12]

Robert Veatch describes a case where a Mrs. Nemser was diagnosed with "extensive gangrene of the right foot and heal... The attending physicians thought an above-the-knee amputation was probably preferable but, in view of Mrs. Nemser's general [poor] condition, suggested amputation above the ankle."[13] Her original doctor said that "If delay ensues, further physical deterioration will surely occur....If the deterioration is allowed to progress, death will follow." One delay was due to the fact that Mrs. Nemser "wanted to live, but also wanted to retain her foot."[14] In other words, she wanted mutually exclusive outcomes, and therefore she was judged to be incompetent. Mrs. Nemser's three sons could not agree on what to do, and the case went to court. The court's psychiatrist's report noted that the attending physicians agreed, among other things, that

1) The recommended procedure as proposed is not a life-saving measure, nor is it a medical emergency,
2) Its effectiveness is by no means assured, and

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[12] Veatch, Robert M., Case Studies in Medical Ethics (Cambridge, Massachusetts, Harvard University Press, 1977): pp. 43-46.
[13] *Ibid.*, p. 44.
[14] *Ibid.*

3) The same condition may recur in the stump, after surgery.[15]

In other words, the medical benefits of the treatment were uncertain. It appears that even had the doctors been more certain of success, they would not have operated without obtaining consent from the sons, or, failing their agreement, from the court.

Veatch's discussion of this case is revealing:

> The case shows, first, that in spite of the fact that the hospital psychiatrist has concluded that Mrs. Nemser is incapable of understanding the nature of a permit for surgery and three physicians have apparently all recommended the amputation, one of them believing it is a life-and-death matter, they do not act on their own....Legally at least, and most would say morally, physicians do not have the power to determine that Mrs. Nemser will be treated. Even if they are convinced that she is not competent to judge for herself and the treatment is necessary to save her life, they still must obtain some kind of consent....Had she, in equal confusion and incompetence, been demanding that the leg be amputated, the result certainly would have been different.[16]

The last line tells the whole story: if the incompetent patient demands the same course of action that the physicians wish to take, then there is no concern about the patient's competency. She would have been asked to sign a form saying she had been informed of the risks of surgery, and surgery would have been performed. Only when the patient's wishes cannot be ascertained or when the patient does not consent to the physician's proposals does the secular system question the patient's competency. When the patient is, at this stage, considered incompetent, then the next of kin are brought in. And only when the next of kin do not agree with the physician's proposals does the case go to court.

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[15] *Ibid.*, p. 45.
[16] *Ibid.*, p. 46.

Case #5

Although not a case per se, Veatch does question the ethics of undertaking an experimental procedure:

> [S]ome patients may want to claim a right to receive an experimental treatment. It is normally assumed that no physician is obligated to take on a patient without his consent. Certainly the notion of a physician being required to perform a particular medical treatment when he does not approve of that treatment seems abhorrent. Yet health care is also beginning to be seen as a right....[T]he patient has a right to control over decisions, including medical decisions, that affect his own body....[N]either the patient nor the physician is required to use "extraordinary" medical treatments. Whatever the definition of extraordinary, it would appear that experimental, radical surgery with only minute hope of limited success would qualify. If, however, the patient is not obligated to undergo the experimental surgery, does she have a right to? When the ethical tradition states that neither patient nor physician is obligated to participate in extraordinary treatment, does this include those cases where the patient is pleading for the treatment and the physician is reluctant?[17]

Veatch leaves these questions open without suggesting ways of arriving at answers, but Case #4, above, seems to answer the questions Veatch poses. Yes, the patient has a right to undergo risky surgery. Although the matter may be resolved by transferring the patient to a more willing doctor, if there is no other doctor, then the physician may be considered ethically obligated to perform the surgery. The matter may also be resolved in the courts, where the physician may be considered legally obligated to perform surgery he does not wish to perform.

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[17] *Ibid.*, pp. 278-279.

Specific Investigation – Halachic Cases

Case #1

The following discussion of coerced medical treatment was written in 1761 by Jacob Emden (also known as the "Yavitz") in his book Myrrh and Cassia.[1] Here he deals with the question of coerced medical treatment and from it we can conclude that there is no such thing as "patient autonomy" in traditional halacha.

> We compel the mortally-ill person who refuses medical treatment to accept the treatment only if all of the following conditions are met:
>
> 1) The sickness or wound is detectable [observable], and
> 2) the physician has sufficient knowledge about the matter, and
> 3) there are proven and tested remedies available.
>
> [This warrant of coercion applies] to all methods with which the Torah gave permission to the physician to heal. These include, for example, the following permitted actions to heal the disease:
>
> 1) severing living flesh that is infected
> 2) opening a blood vessel
> 3) splitting open an abscess
> 4) setting a broken limb
> 5) amputating a limb
> 6) mending with a plaster or compress
> 7) wounding and striking a sore
> 8) making the patient drink if he is perspiring
> 9) making the patient eat healthy things
> 10) making the patient feast or purge
> 11) clearing withered spots in the patient's eyes
> 12) examining the patient's ears
>
> We do all actions like these without being unnecessarily destructive or injurious. In order to save the patient's life, we do whatever is necessary even against the patient's will and we compel him to accept the treatment. The physician may not pay attention to the patient if he doesn't want the [concomitant] suffering and chooses death over life. Rather, the physician performs the surgery, even cutting off an entire limb, if this is necessary to

[1] Myrrh and Cassia (מור וקציעה) is a commentary on the Tur and the Shulchan Aruch, two codes by Jacob ben Asher and Joseph Karo, respectively.

> save the patient from death, so that the decay does not spread throughout his entire body.
>
> It is permitted to do all that is necessary to save a life, even against the will of the patient. [That is, a physician can forcibly heal or even injure part of a person if in doing so the person is certainly saved from death.] And everyone is cautioned [commended, obligated] about this under the rubric of the commandment "Do not stand [idly] by the blood of your neighbor" [i.e., Emden sees this commandment as the basis of the mitzvah of פקוח נפש *pikuach nefesh*]. And nothing depends on the consent of the sick person, and he is not given authority or permission to forfeit his own life.[2]

We see here that in the case of a life-threatening illness, the consent of the patient is not required. The physician is duty-bound to try to save the patient's life by all means necessary. It seems quite probable that many a physician was concerned about whether his treatments were halachically correct in the face of the patient's refusal to undergo surgery. Therefore Emden states emphatically that when a patient's life is at stake, no patient consent is wanted or needed; the physician must operate if the physician thinks by so doing the patient's life may be saved.

Notice that there is no mention of non-life-threatening illnesses. It stands to reason that if patients were not always willing to visit a physician and undergo medical treatment when their lives were endangered, they were even less likely to do so when their lives were not endangered. Presumably non-life-threatening illnesses and pains were treated with common remedies (including bloodletting) rather than by consulting a physician. Additionally, we may read Emden as saying that medical risk is acceptable only when one's life is already at risk.

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[2] Myrrh and Cassia Orach Chaim 328. Emden, Jacob, Myrrh and Cassia [מור וקציעה] (Altona, published by author, 1761), p. 363.

For the purposes of comparison in the following chapter, I will refer to the preceding discussion as Case #1.

Case #2

A modern physician and halachacist, Abraham S. Abraham[3] wrote Nishmat Avraham.[4] Abraham writes the following[5] specifically about risky surgery, and his discussion quotes Jacob Emden, above.

> [Regarding] one who is sick, but not in danger of dying – but is suffering from the disease, [the question is] whether it is permitted to treat him by means of surgery or the like, if the result is that the treatment puts him in danger of dying. This is what is written in the Sha'arim Metzuyanim Bahalacha[6]:
>
> > And they are accustomed to do surgery even if there is no risk of death; because he in pain anyway, it is permissible for him to undergo [surgery] in order to save him from his pain. This is similar to what the Tosafot (Nazir 59a, *s.v. deha*) writes. Moreover, even if he is experiencing no pain, so long as the surgery is part of his regiment of recovery, it is permitted, just as they used to do bloodletting, as it is written in the Gemara in Shabbat 129a ff.[7] And thus we

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[3] Professor Abraham S. Abraham is the head of the Shaare Zedek hospital's department of internal medicine, and author of the six-volume Nishmat Avraham, and, in English, The Complete Guide to Medical Halacha.
From Virtual Jerusalem – Shaare Zedek Hospital, August, 1999 (www.szmc.org.il/today/news64.html)

[4] Nishmat Avraham (soul/spirit/psyche of Abraham) is a commentary on the sections of the Shulchan Aruch that deal with medicine, following the order of the Shulchan Aruch, and citing the opinions of the latest authorities on all medical topics.

[5] Translation by Mark Washofsky of part of Yoreh De'ah Chapter 155 of Nishmat Avraham. Abraham, Abraham S., Nishmat Avraham [נשמת אברהם], volume 2 (Jerusalem, published by author, 1982): pp. 48-9.

[6] שערים מצויים בהלכה (Sha'arim Metzuyanim Bahalacha) is a commentary by שלמה זלמן ברוין on the Kitzur Shulchan Aruch with new halacha added.

[7] [I]t was stated, R. Hiyya b. Abin said in Samuel's name: If one lets blood and catches a chill, a fire is made for him even on the Tammuz [summer] solstice.... If one has let blood and has nothing to eat, let him sell the shoes from off his feet and provide the requirements of a meal therewith....R. Nahman b. Isaac said to his disciples: I beg of you, tell your wives on the day of blood-letting, Nahman is visiting us. [That they may prepare substantial meals!]....Rab and Samuel both say: He who is bled, let him, not sit where a wind can enfold [him], lest the cupper drained him [of blood] and reduced it to [just] a rebi'ith

read in the Tosafot (Ketubot 33b, *s.v. ilmaley*) and in the Ramban (Bereshit 32:26).

And the Garsha"z [HaGaon R. Shelomo Zalman] Auerbach wrote to me: "Perhaps any matter (medical procedure) that seems routine [easy/simple] to most people comes under the heading of "Today, God guards the simple" (Psalms 116:6) [see Yevamot 72a: when most people engage in a potentially dangerous behavior, perhaps we do not regard it as forbidden under the "guard yourselves" prohibition].

But see Myrrh and Cassia [מור וקציעה by Jacob Emden] in which it is written:

> But there are those who choose a procedure that is dangerous (*safek nefashot,* one that endangers their lives) in order to save themselves from great pain, as they who save themselves by going under the knife because of a kidney stone or a stone in the tendon or in the scrotum. [These types of injuries] hurt them a lot [such that their] hard suffering is like death, God forbid. And we permit these people to do as they wish; no one protests, since at times they are in fact saved and healed. Still, these people should consider their actions carefully, for all who [undergo dangerous surgery] when the pain does not endanger their lives are acting improperly. Even on weekdays [i.e., when we aren't talking about possible Shabbat violations, which are the general subject of Orach Chaim 328] it is not permitted to undertake potentially dangerous medical procedures, even if many people have been cured by them. After all, many drew nearer their deaths by having the surgery. Therefore, one is not completely permitted to do this even on weekdays.

But the Garsha"z Auerbach wrote to me: "Apparently the Tosafot (Bava Kama 85a) agrees with the Mor u'Ketzi'a, because they do not claim that the verse (Exodus 21:19) comes to permit this."

On the other hand, we see that we do not move a *goses* from his place because this draws him closer to his death. Nevertheless, if there is a fire we don't just leave him there; we take him away [even though that movement could be said to hasten his death]. Why is this? It would seem that because the intent is to save this person, and because the *goses* would suffer greatly should he be left in the path of the fire, then, even though the act of moving him necessarily hastens his death, it is permitted [to move

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[which was held to be the minimum quantity of blood which can sustain life], and the wind come and drain him [still further], and thus he is in danger (Shabbat 129a).

him] where there is pain because the intent is to save him. And see also in the Chazon Ish (Yoreh De'ah 69) the discussion of whether it is permissible to do an act of rescue even though doing so may also cause death.

Indeed, how is it permitted to administer medication to the sick person, because there is hardly a single medication that does not have dangerous side effects, perhaps that even endanger his life? Thus writes the Ramban in the Torat Ha-Adam:

> Regarding the subject of healing by one's son [the problem here is the prohibition against striking one's parent[8]. ומכה אביו ואמו; *makeh aviv ve'imo*]: we do not concern ourselves with the possibility that the medical procedure will cause the father's death, whether at the son's hands (and thereby violate the mitzvah) or by another physician, because the Torah requires him to heal, and there is no medicine that is free of danger. That which heals one person may kill another.

We see that when the Torah gave permission to practice medicine, the Divine wisdom took into account that there is no medicine that is entirely free of danger. Nevertheless, we were given permission to heal and to practice medicine, and it is a commandment to do so. And thus it appears that, with the consent of the sick person [patient], it is permissible to treat him when there is some danger to his life, if through this they heal him from his affliction. And this decision is also in the responsum of Tzitz Eliezer.[9]

Here Abraham, quoting Emden, the Ramban, and others, actually redefines medicine. Emden says that "all who [undergo dangerous surgery] when the pain does not endanger their lives are acting improperly," but Abraham disagrees. Abraham suggests that all medicine is risky, and that improving life by reducing or eliminating pain is a valid goal for both the patient and the physician even if one's life is not endangered and even if there is risk involved in the procedure. There is an implicit risk/benefit analysis that must be made

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[8] ומכה אביו ואמו מות יומת And he who strikes his father, or his mother, shall be surely put to death. (Exodus 21:15)

[9] The Tzitz Eliezer is a collection of responsa written by Eliezer Waldenberg, a contemporary authority on medical halacha. Tzitz Eliezer contains a classic statement of the permit to administer powerful pain-killing drugs to a terminal patient, even when the drugs will likely hasten his death, so long as the *intent* is to treat his pain and not to kill him (see 13 section 87).

before surgery can be performed: if the patient is more at risk of death by undergoing surgery than by avoiding surgery, then the halacha cannot allow the risk to the patient's life and thus cannot sanction the surgery.

Abraham's main point is that *all* medicine is inherently dangerous. Abraham needs this argument because Jacob Emden (the major authority on this question, as all others cite him and start their discussions from his words) does *not* condone a patient's undertaking potential danger to life (ספק סכנה *safek sakanah)* in anything less than a life-threatening situation. Emden accepts such procedures grudgingly as customary, but they clearly do not fit the logic of the rule of פקוח נפש *pikuach nefesh* as he understands it. The patient, says Emden, is not allowed to choose to endanger himself unless the danger is part of a regimen of livesaving (הצלת נפשות *hatzalat nefashot)*.

Until now, we have thought of medicine as therapeutic, as leading to healing, as *reducing* the life-threatening risks the patient faces. Now, we view medicine as a practice that inevitably involves risk, even in the most routine procedures, so that we can no longer reject a particular therapy merely on the grounds that it endangers the patient. Rather, since *all* medicine involves risk, the acceptability of a particular course of treatment rests upon an estimation of intent (כוונה *kavanah*): if the intent of the procedure is a proper one (and the relief of pain certainly is a proper goal of medicine – none of the rabbinic authorities (פוסקים *poskim)* disputes this), then a "dangerous" procedure designed to relieve pain is not necessarily to be rejected, even though it would submit the patient to a higher degree of life-threatening danger.

Note that Abraham is perhaps deliberately imprecise in this new definition: he uses the word קצת *ketzat* (some, a little) to describe the acceptable degree of danger. Perhaps he is mindful that his new definition of medicine justifies in theory the assumption of great degrees of risk, if, after all, medicine is risky by nature. Therefore, he may wish to impose a limit – vague as it is – on the degree of risk that is acceptable.

Case #3

Moshe Feinstein discusses coercing a patient to accept a treatment or a medicine against his will:

> If a patient refuses therapy, the halachic response depends on his reasons. If he refuses because the treatment is very painful and he wishes to avoid the expected discomfort, but the medical consensus holds that the treatment would benefit him and may lead to a cure, then it is required to coerce the patient, even against his will. This assumes, however, that physical force is not necessary, because the use of physical force may frighten and perhaps seriously depress the patient....
>
> If the patient lacks confidence in the medical staff, and that is why he hesitates to accept their advice, every effort should be made to call in consultants to assure him that he is being offered the best medical care available....
>
> If the treatment is risky, such as a surgical procedure that involves some possibility of mortal danger, or a drug with serious potential adverse reactions, even if the drug has been approved because the risk/benefit ratio is in favor of using it, coercion should not be applied to administer the drug if the patient refuses treatment.
>
> The use of drugs that have a potential for adverse reactions presents a very special halachic problem. It is extremely difficult to compare patients in clinical trials. A healthy person may very well tolerate a drug without ill effects, whereas a weakened one, suffering from a chronic disease and therefore in a debilitated state, may suffer ill effects from the same drug. Risk/benefit analysis is, of course, primarily the physician's responsibility, and whenever possible he should consult with his superiors to ensure that he makes the right decision as to whether the patient should be given the drug or not. Only when there is sufficient clinical evidence that patients in the same weakened condition can safely

> take this drug, with adverse reactions limited to only a small minority, may the drug be offered to the patient.
>
> I emphasize that it is very difficult to evaluate a patient's state of health with reference to potential adverse reactions, and therefore meticulous care must be used to consult and study as much as possible before making a clinical decision.[10]

There are cases where a patient who refuses treatment, but who should be given treatment against his will. But there are numerous caveats to coercion, as Feinstein says, "If the treatment is risky…even if the drug has been approved because the risk/benefit ratio is in favor of using it, coercion should not be applied to administer the drug if the patient refuses treatment."

Furthermore, even if the patient is willing to take the medicine, and even when the risk to the patient is greater from the illness than from the medicine, it is possible that for this ill person it poses a danger. To summarize further, Feinstein states that all of the following requirements must be met in order for a risky medication to be given or a risky surgery to be performed:

1. The patient must be willing to take the medicine or undergo the surgery;
2. The risk to the patient is greater from the illness than from the medicine or from the surgery;
3. The doctors have used "meticulous care" in study and consultation with each other about this patient;
4. The doctors know that "only a small minority" of patients in the same physical condition are harmed by this medicine or this surgery; and
5. The doctors must have made a "risk/benefit analysis" that favors giving the drug or performing the surgery.

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[10] Iggerot Moshe, Choshen Mishpat II:73, as quoted by Tendler, Moshe David, Responsa of Rav Moshe Feinstein (Hoboken, New Jersey, KTAV Publishing House, Inc., 1996): pp. 48-50.

The conditions of the last two requirements seem to be at odds with one another. It is not clear what a "small minority" means. A risk/benefit analysis implies that if >50% of the patients are healed by the risky medicine or risky surgery, then the medicine may be administered or the operation may be performed. If ≤ 50% of the patients are not healed, then even though the patient is willing to take the medicine or undergo surgery, the medicine should not be administered or the surgery should not be performed. As Feinstein doesn't specify the percentages, I am making an assumption as to what a risk/benefit analysis entails.

Case #4

The following question, answer, and comment come from Fred Rosner and Moshe Tendler, who are halachic experts in the field of bioethics.[11]

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[11] According to Jason Aronson publishers, "Dr. Moshe D. Tendler and Dr. Fred Rosner are two of the leading authorities in the field of medical ethics and the relationship of medicine and science to Jewish law." (www.aronson.com/bookstore/cgi-bin/jauthdetail.cgi?au=995&c=J). Also according to Jason Aronson publishers, "Dr. Fred Rosner is Director of the Department of Medicine of the Mount Sinai Services at the Queens Hospital Center and Professor of Medicine at New York's Mount Sinai School of Medicine. Dr. Rosner is an internationally known authority on medical ethics, has lectured widely on Jewish medical ethics, and is in great demand as a speaker on this and other related topics. He is the author of five widely acclaimed books on Jewish medical ethics, including Modern Medicine and Jewish Ethics and Medicine and Jewish Law. These books are up-to-date examinations of the Jewish view on many important bioethical issues in medical practice. Dr. Rosner is also a noted Maimonidean scholar and has translated and published in English more of Maimonides' medical writings." (http://www.aronson.com/bookstore/cgi-bin/bdetail.cgi?d=2&b=1035&c=J). According to The Institute for Jewish Medical Ethics, Rabbi Moshe Tendler, PhD, is Professor and Chair, Dept. of Biology; Occupant of the Issac and Bella Tendler Chair in Jewish Medical Ethics; Professor of Talmudic Law, Yeshiva University, New York. (www.ijme.org). The Institute for Jewish Medical Ethics also identifies Fred Rosner, MD, FACP as Medical Director, Mount Sinai Service at Queens Hospital Center, Jamaica; Professor of Medicine, Mount Sinai School of Medicine; Chair of the Medical Ethics Committee of the Medical Society of the State of New York and Co-Chair of the Medical Ethics Committee of the Federation of Jewish Philanthropies, New York; world's leading authority on the medical writings of Moses Maimonides. See also Yeshiva University Commentator, Volume 63, Issue 5 (undated; at www.yucommentator.com/v63i5/features/viagra.shtml)

Question: Is a patient allowed to accept and/or is the physician permitted to perform hazardous surgery? Is an experimental treatment with a new drug or vaccine permissible? Under what circumstances?

Answer and Comment: Jewish law is categorically opposed to any form of experimentation in which the human organism serves as an experimental animal, if there is the slightest hazard to the individual taking part in the experiment, without concomitant benefit to the same individual. Even the informed voluntary consent of an individual does not suffice to permit the physician to subject him to possibly hazardous medical procedures.

The evaluation of new surgical procedures, or the multiphasic study of new pharmacological agents, can occur only within a therapeutic protocol. If a patient is suffering from an illness for which there is no known medical treatment, he may then be subjected to new procedures if there is valid expectation of benefiting this patient. A careful evaluation of experiments done on animals should enable the physician to review the expected beneficial results, as well as the potential hazards of a new medical procedure. Only if the expectation of beneficial results exceeds the danger of causing harm to the patient can this new treatment be instituted.

Whenever the physician cannot recommend, on the basis of sound scientific principles, a specific experimental procedure, he is forbidden to offer it as "one chance in a million." It is a fundamental tenet of our faith that the personal God does not permit a patient to be "left to chance." The physician acts under a license restricted to actions definable on the basis of scientific principles, and must restrict himself to such actions.
When specific treatment cannot be recommended because of inadequate information as to the potential hazards, then such treatment is forbidden in Jewish law.[12]

A patient may not say, "What do I have to lose?" – that is, he may not have a defeatist attitude toward treatment. Based on Jacob Emden's reasoning, Nisson Shulman writes, "Obviously, if risk versus benefit is to be taken into account, then the greater the certainty of the fatal alternative, the greater is the risk allowed and the more latitude permitted for

[12] Rosner, Fred, and Tendler, Moshe D., Practical Medical Halachah (Northvale, New Jersey, Jason Aronson Inc., 1997): p. 90. Note that on the following page (p. 91), the same question is asked regarding a terminally ill patient, and the answer is that dangerous surgery is permissible with the following proviso: "The risk/benefit ratio must be carefully weighed in each case. A 90 percent risk would be acceptable only if there is a 10 percent possibility of 'healing the patient' (i.e., producing remission or cure)."

experimental surgery. It must, however be refuah bedukah umenusah, sound medical protocol and not quackery."[13]

Therefore, if a patient's condition is terminal, he "may subject himself to any risk, however great, if there is a small chance for cure."[14] But if a patient's condition is not terminal, then life-threatening surgery requires "better than a fifty percent chance of success in order to be permitted."[15]

These views strongly suggest that halacha forbids Jews to undergo non-therapeutic experimentation (that is, those studies designed specifically to gather scientific information). However, provided the risk/benefit assessment is favorable, Jews may undergo therapeutic experimentation (that is, those studies designed to help individual patients and only secondarily to provide scientific information). Reform Jewish views on medical experimentation are somewhat different from those above, and are discussed in a later chapter.

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[13] Shulman, Nisson, E., Jewish Answers to Medical Ethics Questions (Northvale, New Jersey, Jason Aronson Inc, 1998): p. 144.
[14] *Ibid.*, p. 145.
[15] *Ibid.*

Comparison of Specific Answers

In secular Case #1, the physician has duties to be truthful and to respect patient autonomy. It is the patient who needs the information about the procedure's very small risk of death, because it is the patient who makes the risk/benefit analysis to decide whether to have treatment. The physician is accused of paternalistic behavior for attempting to shield the patient from undue anxiety.

Likewise, in secular Case #2, the patient is the one who decides whether to undergo surgery. The physician has the duty to inform the patient of remote risks inherent in the surgery. Once the physician has fulfilled his duty of informed consent, there is no question that the patient has the right to undergo surgery.

In secular Case #3, the limits of patient autonomy are addressed. The secular bioethicists, as noted earlier, do not ask whether it is ethical for the patient to ask for a surgery that is not medically indicated, even though further tests (as well as the surgery) are potentially life-threatening. Interestingly, treating non-organic pain is not considered a valid medical goal.

It appears that if the patient is properly informed of the risks entailed, there is no moral or ethical question about the patient's desire to undergo additional tests and surgery. It may be unethical (or at least cause moral qualms) for a physician to perform a procedure that he does not consider to be medically indicated, regardless of the procedure's risks or lack thereof. In the end, the high value placed on patient autonomy may force the physician to perform surgery simply because the competent patient desires it.

It seems as though patient autonomy may have no limits, save those imposed by the availability of willing physicians, or those limits imposed by law. The secular ethicists do not provide answers to the questions raised by a physician's moral reservations. It appears that a physician's first avenue of recourse may be to refuse to take on as a patient a person whose desires he does not wish to fulfill (e.g., a person known to want an abortion, or a person known to wish to end his life by an overdose of medication). Once a person is already a patient, the physician may suggest that the patient find another, more willing, doctor to perform the procedure or to provide the desired prescription.

The patient may have a "right" to treatment, but if no doctor has a "duty" to give the patient what that right entitles him to, then the patient may have to take a physician to court in order to force him to perform a procedure. So far, however, this does not seem to be how the dilemma works itself out in actual practice. There are no legal cases that I know of that have forced a physician to provide treatment he does not deem morally right to provide. For example, as far as I know, in regions of the United States where no physician is willing to provide an abortion, no doctor has been forced to provide one. Nevertheless, from a theoretical point of view, the secular ethicists are close to saying that the right of patients to medical care may trump the physician's ethical qualms about providing that care.

Secular Case #4 shows that a patient's competency really only matters when the physician wants to perform surgery and the patient refuses. When the physician feels the surgery is necessary and the patient (competent or not) accedes to the surgery, all is well.

Paternalism on the part of the physician (and the next of kin and the courts) is warranted when the patient's competency is questioned, and the patient's competency is questioned when he or she does not agree to the physician's plans to operate.

Secular Case #5 suggests that a patient has a right not just to undergo but *to demand* highly risky surgery, even if the physician is reluctant to perform the surgery. Here, as in secular Cases #3 and #4, patient autonomy is paramount.

The following table summarizes some of these secular points:

	Physician Wants to Operate	Physician Does Not Want to Operate
Competent, Informed Patient Does Not Want Operation	Patient's competency is questioned	No operation is performed
Competent, Informed Patient Wants Operation	Operation is performed	Physician *may* be forced to operate[1]

Halachic Case #1 says that when the patient's condition is life-threatening, there is no concept of patient autonomy. The physician is not only required to be paternalistic, but actually coercive to save the patient's life if the treatment may save the patient's life.

While halachic Case #1 deals with a life-threatening illness, halachic Case #2 deals with the specific question: May a patient undergo life-threatening surgery for a non-life-threatening condition? First, halachic Case #2 says that the patient's pain is a valid disease (in contradistinction to secular Case #3), and the patient may undergo surgery to relieve pain. Second, because all medical treatment involves risk, the risk in this procedure cannot be

[1] However, the American Medical Association's Principles of Ethics, included in the Appendices, state that "A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve."

the only issue in deciding whether the treatment is permissible. One additional issue is whether the intent of the procedure is valid. Another additional issue is the patient's own wishes. Here, the patient must approve this surgery, as his condition is not life-threatening.

There is an implicit risk/benefit analysis being made: if the surgery is likely to cure him and unlikely to endanger his life, then it is permitted for him to undergo surgery if he desires it. Regarding this risk/benefit analysis, it is important to note that we are reading between the lines, and that the responsum suggests but is deliberately vague about this analysis.

In halachic Case #3, the certainty of halachic Case #1 is modified when the patient's condition is not life-threatening. The physician's duty to coerce is mitigated by his duty not to frighten or depress the patient by the use of physical force. Again, this fits the prevailing halachic definition of medicine as therapeutic. To frighten or to depress the patient actually increases the risk to his health, thereby defeating the purpose of the coercion in the first place. Thus, we can assume that the physician's duty to coerce is limited to vigorous verbal persuasion. Also, there is an implicit duty for the physician to be paternalistic. The physician wants the patient to accept the views of the doctors, and must calm his fears in order to get him to cooperate with the [relatively non-risky] medical treatment being proposed.

Halachic Case #3 specifically brings up risk/benefit analysis, but no percentages are given. We assume that the analysis allows risky surgery when there is a better than even (>50%)

chance of benefit and a low (<50%?) chance of risk. Feinstein, like Abraham, is deliberately vague, using the phrase "some possibility of mortal danger."

Only when the treatment is risky may the patient refuse to undergo what the physicians feel is the best medical treatment. This is true because at this point we are no longer talking about treatment of proven efficacy, and a patient is under no obligation to accept a treatment that is not clearly therapeutic (this again is based upon Emden's comments).

Furthermore, the physician may not provide risky treatment when that risk is death for more than "a small minority" of patients. Nor can the physician provide risky treatment if the expert medical opinions say that <50% of the patients have been healed. That is, if the risk/benefit analysis suggests risky surgery, and the patient is willing, and the risk of death is small, and the possibility of healing is greater than or equal to 50%, then the patient may undergo treatment and the physician may provide that treatment. Apparently, both the patient and the physician must be willing in order for the operation to proceed.

In halachic Case #4, to the specific question of life-threatening surgery is added the question of therapeutic experimentation. Or rather, it is implicit in the question that risky surgery is always in some sense experimental surgery. In this responsum, informed consent of the patient is brought up specifically, but that consent is of absolutely no value if there is "the slightest hazard" to the patient in an experiment. Further, the experiment

must be therapeutic to the actual patient, meaning I presume that the patient cannot be randomized into a double-blind study where the patient may receive placebo.[2]

If the patient suffers from an illness (which apparently need not be life-threatening), and if there is no known medical treatment for that illness, then he may undergo new treatment if "there is valid expectation of" the patient benefiting from the treatment. The risk/benefit analysis is somewhat specific: the expectation of benefit to the patient must exceed the danger of harm to the patient. Although the authors state that the patient's health cannot be "left to chance," the risk/benefit method implies that in order to allow surgery, the patient's chance of benefit must be >50%, the patient's chance of harm must be $\leq$ 50%, and there must be almost no chance of death.

In sum, the greater the possibility that the illness will kill the patient, the more halacha is willing to let the patient and doctor assume the risk of surgery. The greater the possibility that the patient will die from his illness, the more forceful is the halacha in demanding that the patient's life be saved if the procedure is medically or experimentally sound and promises a chance of cure.

If we assume that the risk/benefit analysis allows surgery, then the following table (see next page) summarizes some of the halachic rules.

[2] This is the view of non-Reform halacha. Reform Jewish views on medical experimentation are different and are discussed in a later chapter.

	Physician Wants to Operate	Physician Does Not Want to Operate
Patient Does Not Want Operation	If illness is life-threatening, then operation is performed. If illness is not life-threatening, then no operation is performed.	If illness is life-threatening, then a doctor must be found who will perform the operation.[3] If illness is not life-threatening, then no operation is performed.
Patient Wants Operation	Operation is performed.	If illness is life-threatening, then a doctor must be found who will perform the operation.[3] If illness is not life-threatening, then the patient is permitted to find a doctor who will perform the operation.

[3] An observant Jewish doctor would never refuse to operate under these circumstances, but, for example, a Catholic doctor may refuse to abort a fetus that is threatening the life of its mother.

Comparison of Assumptions

Both secular and halachic bioethicists agree that the purposes of medicine include saving lives and improving the quality of lives.

Secular bioethicists make broad assumptions about the importance of Greek philosophy and Christian virtues when they state that appeals should be made to the virtues of compassion, courage, honesty, and integrity or posit that there are duties of love, charity, and self-sacrifice. The importance of these virtues or duties is regarded as self-evident. Conversely, the secular ethicists caution us not to value other-oriented goals over self-oriented goals without saying why or on what basis we should judge.

Halacha approaches medical ethics as part of the set of mitzvot and will start from the idea that there is a mitzvah of healing that comes from the Torah. Halachic bioethicists present problems and their solutions as an exercise in religious law, and derive particular guidance from previous halachic rulings. Their known, but unstated assumption, is that there is a God who has given commandments to Jews.

As we have seen, secular bioethicists are the products of their Western culture (often including Greek philosophy and Christian religious ideas). They are often unaware of how their culture influences their thinking, so their assumptions remain present, but unstated. Halachic bioethicists, in contrast, are often acutely aware of the differences between Western culture and halacha. That is, while secular ethicists often attempt to (or pretend to) "start from scratch" regarding their assumptions, halachacists never do.

Secular ethicists assume that medical pain management techniques will not improve over time. Halacha's basic assumption is even more striking: the halachic system assumes that a competent, knowledgeable, and wise rabbi is called in to consult in moral decisions regarding health care.

Because pain is difficult to describe and quantify, doctors did not always attend to this area of care and seemed to have concerned themselves less with pain than have halachists. Recently, however, secular medical research has begun to study and improve pain management.

Emden and other, more modern halachic authorities say that relief of pain is a legitimate medical goal. It appears that risky surgery to remove pain the same thing as risky surgery to improve life. It may even be said that surgery to remove pain may be equated with surgery to save life. Moshe Feinstein says that mental anguish shortens life: "Our sages held that fear and depression were allies of the Angel of Death."[1] We can deal with mental anguish as a life-threatening illness because the patient has less of a will to live and has more stress and anxiety and less energy needed to fight his pain and his illness.

Both secular and halachic bioethicists assume that doctors and nurses know when a condition is life-threatening (or, conversely, virtually risk-free) or when a patient is actively dying. As numerous court cases will attest, medicine is not an exact science, and these assumptions are just that: a supposition that something is true. Regardless of the

[1] Iggerot Moshe, Choshen Mishpat II:73, as quoted by Tendler, Moshe David, Responsa of Rav Moshe Feinstein (Hoboken, New Jersey, KTAV Publishing House, Inc., 1996): p. 49.

statistics for medical procedures or conditions, we never know with certainty just what will happen to the individual patient.

In the secular view, the patient's autonomy and freedom are paramount, whereas in the halachic view, the sanctity of life is paramount. Both systems, however, assume that there are times when physicians need to be and should be paternalistic. Also in both systems, a patient can evaluate and improve the quality of his life. To clarify, both systems make decisions about a living person and his ability to live a life that has the minimum amount of pain and maximum amount of independence and mobility. As a living person, the patient can choose medical avenues to improve the quality of his life. In halacha, life itself has quality (value), so the question of a person's "quality of life" can never be answered by the conclusion, "This person's life is not worth living; he is better off dead."[2]

In secular systems, it is possible that the patient determines that his life is not worth living; in the halachic system, however, the patient is not allowed to choose death over life. That is, a Jew is not allowed to conclude, "My life is not worth living, so therefore I choose death." He is, however, allowed to say, "My life is miserable, so I am going to try to

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[2] The term "quality of life" may be misconstrued here, so I present David Bleich's statement about treating the terminally ill and defective newborn to explain the nuances of Jewish thinking regarding this term:

> "[I]t is the intrinsic sanctity of every moment of human life which prompts the conclusion that hazardous procedures need not be employed in treating the terminally ill or the defective neonate. The certainty of a short span of life must be weighed against the possibility of cure or long-term remission, if successful, but imminent death if unsuccessful. The decision against aggressive intervention in such circumstances is not a decision that the quality of life to be preserved is not of sufficient value to warrant the therapy in question, but a decision that even fleeting periods of life are too precious to be lightly gambled away."

Rosner, Fred, and Bleich, J. David, editors, Jewish Bioethics (Hoboken, New Jersey, 2000): p. xxii.

improve the quality of my life, even if there is a remote chance that my course of action results in my death."

Comparison of Methodology

As David Ellenson states, all rabbis – of all denominations – use classic "halakhic formalism"[1] to write a responsum or give an answer regarding ethical action. All rabbis use the same methodology: they study the text sources, find precedents for similar situations, determine the principles involved, and apply the principles to the case at hand. Sometimes "extralegal considerations"[2] such as the Shoah, are added factors in the decision, and sometimes an interpretation is made to provide a singular exception. The use of the same methodology does not preclude a variety of conclusions, even among members of the same denomination.

Halacha assumes that the halachically correct outcome is ultimately the desired outcome, and therefore tries to persuade patients and physicians to do their duties (perform their obligations, observe the positive and negative mitzvot, and go beyond the law to do the right and the good as necessary[3]) regardless of their individual desires. The halachic procedures are imperfect only insofar as the rabbi in the case knows and correctly interprets the law.

The ideal halachic situation is not found in deciding who should decide, but rather in deciding what is the law. In contrast, much time is spent in secular cases deciding who should decide. Therefore, taking a case to secular court often has the goal of a winning side and losing side, whereas taking a case to a beit din often has the goal of deciding

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[1] "Jewish Approaches to Mortal Choices" by David H. Ellenson in Kogan, Barry S., editor, A Time to be Born and a Time to Die (Hawthorne, New York, Aldine de Gruyter, 1991): p. 220.
[2] *Ibid.*, p. 226.

halacha, and both parties to the action are presumed to want to follow the halacha (which is equivalent to them both coming out "winners").

Halacha uses a risk/benefit analysis when it comes to the question of whether someone can undergo life-threatening surgery for a non-life-threatening condition. However, halacha does not consider a balance of benefits and harms to be the same as the principle of utility, but rather a rule to be used under the principle of sanctity of life. Furthermore, as we have seen, risk/benefit analysis is only one consideration when evaluating each halachic case.

In secular ethics, it is the patient who makes the risk/benefit evaluation and who decides whether to undergo life-threatening surgery. The principle of patient autonomy allows the patient to undergo – or at least request – any medical treatment he desires. Because of the importance placed on autonomy, after a patient's decision has been made, the secular ethicists may evaluate that decision based on utilitarian or deontological principles, but it seems that no patient has the responsibility of using those principles in order to come to his decision.

In utilitarianism "no rule (and hence no moral action) is absolutely wrong in itself, and no rule in the system of rules is absolute and unrevisable."[4] Deontology says that duties and obligations are built on relationships. In this regard, halacha and deontology coincide, because our acts as Jews are founded on the contract we made at Mount Sinai. Halacha is

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[3] See Aharon Lictenstein's discussion of supralegal conduct in "Does Jewish Tradition Recognize An Ethic Independent of Halakha?" in Fox, Marvin, Modern Jewish Ethics (Ohio, The Ohio State University Press, 1975): pp. 62-88.

[4] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): p. 32.

also a deontological theory insofar as both separate duty from consequences, and because halacha relies on divine revelation (although not only on divine revelation[3]).

Within the self-contained system of halacha, we religious Jews, like secularists, judge arguments according to the rules of consistency, simplicity, completeness, and the like. But there the similarity appears to end. In the final analysis, secular ethical theories try to "maximize good and minimize evil outcomes."[5] In contrast, halacha tries to identify what God wants us to do. While we assume that God also wants to maximize good and minimize evil outcomes for Jews, the consequences of our following God's law are not considered part of the argument in favor of following halacha.

Beauchamp and Childress (and other bioethicists and philosophers in general) have some difficulty proving that beneficence is a duty. Doing things beyond the call of duty is called "a supererogatory action," which has parallels in halachic life (e.g., beautifying the performance of a mitzvah[3]). The necessity of a Jew doing his duty – however narrowly or broadly defined – is grounded easily in halacha by the explicit contract between Jews and God at Mount Sinai. God, and the rabbis in interpreting God's word, define what our duties are. There is no further grounding needed.

For secular bioethicists, there is no such easy grounding. In the end, the secularists say that the principle of positive obligation towards others is taken as a duty because no man is an island. "Social claims on an individual...only arise in a social context. The duty to benefit others thus arises from complex social interactions."[6] This implicit social contract

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[5] *Ibid.*, p. 40.
[6] *Ibid.*, p 141.

involves the duties of fair play and/or reciprocity and/or promises and/or a general form of noblesse oblige. These groundings are mere assumptions, as is the assumption that it is wrong to kill someone because you do not like him. (Of course, one could say that the belief in God and the contract between God and the Jews is likewise a mere assumption.)

Halacha (at least non-Reform halacha) does not recognize a principle of autonomy, because it is a system grounded in the idea of individual and societal obligations. Although each individual has some autonomy, for example, to choose whether to eat strawberries rather than bananas (or, for example, to choose which rabbi to consult), moral decisions are not autonomous. Reform Jews can make autonomous decisions about their observance or non-observance of mitzvot, but this autonomy implies a commitment to know about halacha, as the 1999 Statement of Principles for Reform Judaism says, "We are committed to the ongoing study of the whole array of מצות(*mitzvot*)."[7]

As we have seen, in Judaism the seeking of health care is a duty, not a right, and in certain circumstances, others have the duty to provide health care in spite of an individual's lack of consent or even in the face of his protestations against it. Even something as simple in the secular system as the permissibility of cosmetic surgery is a moral decision in Judaism, and many responsa have been written about it.[8] Furthermore, the language of "autonomy"

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[7] CCAR document at http://uahc.org/ccar/platforms/principles.html

[8] See, for example, the responsum in Rosner, Fred, and Tendler, Moshe D., Practical Medical Halachah (Northvale, New Jersey, Jason Aronson Inc., 1997): p. 161. See also Halacha 34:5 of Abraham, Abraham S., The Comprehensive Guide to Medical Halachah (New York, Feldheim Publishers, 1990): p. 165 and the sources cited therein. See also "Cosmetic Surgery" 5752.7, in Plaut, W. Gunther and Washofsky, Mark, Teshuvot for the Nineties (New York, Central Conference of American Rabbis, 1997): pp. 127-132, and the sources cited therein. See also the article on plastic surgery included in the Appendices.

is limited in even Reform responsa, because the Jewish view is that no ethical principle or action can be held or made autonomously[9].

Some secular bioethicists claim that love, charity, and self-sacrifice are duties. We Jews are commanded to love God. One explanation of how we love God is given by Rambam in his Book of Mitzvot (ספר המצות *Sefer HaMitzvot*) regarding positive mitzvah #3:

> The third [positive] commandment is that we are commanded to love the Exalted One [God], that is, to contemplate and scrutinize his mitzvot and his acts until we apprehend him and delight in the attainment of our objective of joy. This is the love to which we are obligated. In the words of the Sifrei [halachic midrash] regarding the Shema [Deuteronomy 6:4 ff.]:
>
> > It is written, "And you shall love the Lord your God." [But] who knows how one loves The Place [God]? Therefore the verse continues, "And these words that I command you today shall be upon your heart," – for through them you recognize the one who said [spoke] and caused the world to come into being."
>
> Here they explain to you that in the consummation of your knowledge, the achievement thereof will cause you to arrive at the joy and [thereby] come to the love by necessity. And they said that this mitzvah also includes the requirement that all men be called to the service of the Exalted One and to the belief in him. And this is because when you love someone, you take heed to him and praise him and request men to love him. And this is an analogy to the way you love God. In truth, how you arrive to his [God's] truth is by your preaching and calling with certainty to the unbelievers and the confused [or foolish] ones to knowledge of the truth that you know. In the words of the Sifrei [halachic midrash regarding the Shema in Deuteronomy 6:4 ff.]:
>
> > "And you shall love the Lord" (etc.) is to make him loved by all people, as Abraham your father did, as it is written [Genesis 12:5], "And the souls that they made [converted to the belief in God] in Charan."
>
> They mean to say that as Abraham transferred [to others his] love of God, [so too should you,] as [the Bible] testified "Abraham who loved me" (Isaiah 41:8). And it was also to magnify his [Abraham's] attainment that he preached to men about his faith and [thereby] strengthened his love. So [too] you [should] love him until you preach to men about him.

[9] The arguments for and against autonomy as a supreme and overriding principle in Reform Jewish life are discussed at length in Plaut, W. Gunther and Washofsky, Mark, Teshuvot for the Nineties (New York, Central Conference of American Rabbis, 1997): pp. xiii-xxix.

Rambam says that being commanded to love God means being commanded to study and know the mitzvot and the Bible until we apprehend God and we are so full of joy that we preach our faith to others. This type of love may be similar to a Christian notion of love, but it is not the emotional affection normally denoted by the word "love" used in a secular context. Interestingly, we are commanded to honor our parents, not love them (Exodus 20:12 and Deuteronomy 5:16 both say "כבד את אביך ואת אמך"[10]).

Jews do not have any duty to be self-sacrificing (as a principle), and our term for "charity" (a word whose etymology is the Latin *caritas*, meaning Christian love[11]) is "justice" (צדקה *tzedakah*, as in Deuteronomy 16:20 "צדק צדק תרדף" "Justice, only justice shall you pursue"). Thus, although Beauchamp and Childress seem to embrace the correlation between rights and duties, I feel that ethical investigations are best served by stating principles in terms of duties, even though it is true that responsa occasionally do use the term "rights."[12]

If we assume (and an assumption it is) that Torah in its very widest sense can and should guide our lives, then this assumption grounds all others. If, on the other hand, we, as secularists, remove a divine commander who commands obligations, then we may choose our own basic assumptions that will ground our own behavioral guide. This ethical system

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[10] כבד *cabaid* means, among other things, honor and respect, but it does not mean "love."

[11] See the definition of "charity" in Woolf, Henry Bosley, editor, Webster's New Collegiate Dictionary (Springfield, Massachusetts, G. & C. Merriam Company, 1981): p. 186.

[12] For example, the following sentence is found in a Reform responsum: "According to rabbinic tradition, and according to the practice of Reform Judaism, the widower has absolute and complete rights in this matter." (*Contemporary American Reform Responsa* 88. Widower's Rights (January 1985) at www.ccarnet.org/cgi-bin/respdisp.pl?file=88&year=carr)

will determine what will be our own ethical and moral obligations, assuming we decide to ground our behavior on any obligations at all.

Even if we assume (falsely, I think) that a secular ethicist could divorce his thinking from his cultural upbringing (including the religious ideas around him and in his language), then the creation of obligations outside of religion still requires a set of assumptions, as I have said. Some assumptions might be that murder is wrong, and that benefiting others is a desirable action. But one could just as easily assume that it is preferable to have each person fend for him- or herself, taking food, clothing, shelter, and the like by force. Then the person with the strongest arm or armaments receives the greatest number of things he or she wants. At the very lowest level of decision-making, I would rather follow Blaise Pascal's suggestion to assume that there is a God: if you find out in the end that your assumption was incorrect, you have lost nothing.[13]

Although ethics is a branch of philosophy, none of the secular ethicists I have consulted discuss the fundamental philosophical issues that ground their ethical systems, with the absolute foundations of the ethics they advocate. In truth, few secular thinkers claim to

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[13] This is my loose translation of what is known as "Pascal's Wager" (also known as "God is a safe bet"), which, although originally written in defense of Christianity, can be applied in modified form to Judaism as well. The Encyclopedia Britannica writes regarding Blaise Pascal:

> Between the summers of 1657 and 1658, he put together most of the notes and fragments that editors have published under the inappropriate title *Pensées* ("Thoughts"; Eng. trans., *Pensées*, 1962). In the *Apologie*, Pascal shows the man without grace to be an incomprehensible mixture of greatness and abjectness, incapable of truth or of reaching the supreme good to which his nature nevertheless aspires. A religion that accounts for these contradictions, which he believed philosophy and worldliness fail to do, is for that very reason "to be venerated and loved." The indifference of the skeptic, Pascal wrote, is to be overcome by means of "wager": if God does not exist, the skeptic loses nothing by believing in him; but if he does exist, the skeptic gains eternal life by believing in him.

(http://www.britannica.com/bcom/eb/article/5/0,5716,114515+3+108317,00.html)

start "from scratch," yet few identify and explain their underlying basic assumptions – most merely posit their views as starting points and go from there. It is, after all, difficult to distance oneself from oneself, to completely detach one's thinking from one's life experiences, even for philosophers.

Naturally, any system of ethics is founded on non-debatable assumptions. If a system of secular ethics defends a particular set of substantive choices (e.g., beneficence, charity, and self-sacrifice) as positive goods that ought to guide our actions, then these choices presuppose assumptions based on, for example, Kant's categorical imperative or the utilitarian belief that we can identify what is "good."

If a system of secular ethics assumes that no assumptions are universal, and if it resists making substantive choices because societies and relationships differ such that no views are universally held, then this system may seem less valuable as a guide to our actions. The opposite is true, however. If a particular society generally agrees to certain assumptions, then it is those assumptions that may guide an individual's ethical behavior within that society. If, however, the society is pluralist and no set of assumptions commands widespread assent, then the default ethical principle is individual autonomy, unlimited except when the freedom of others or the overriding interests of the society demand limitation.

Comparison of Terminology

Terminology with regard to halacha is complex in that there are subtle shades of meaning and different conclusions based on different starting principles. For example, an act that is generally permissible (רשות *reshut*) can be sworn about, and is entirely different from an act that is an obligation (חובה *chovah*), about which one cannot swear an oath. From the beginning (לחתחלה *lihat'chilah*), an act may be forbidden, but once a fait accompli (בדיעבד *bedi'avad*), the act may accepted as valid without punishment. Or one may obtain a dispensation (היתר *heter*), a legal permission to do something that is otherwise prohibited.[1] As in secular law, there is a difference between someone being exempt from an action and someone being prohibited from doing that action.

The Jewish sources do not use a "letter of the law" vs. "spirit of the law" classification. In our normal way of speaking, the "spirit" of the law often clashes contradicts the "letter" of the law. That is, the law's letter frustrates its true intent, as expressed in its unwritten spirit. In halacha there is a distinction between the minimal standard (מצוה *mitzvah*) or strict line of the law (שורת הדין *shurat ha'din*) and the higher, more preferable standard (מצוה מהדרין *mitzvah mehadrin* (literally, "adorned mitzvah")) or beyond the strict line of the law (לפנים משורת הדין *lifnim mi'shurat ha'din*). These sets of terms do not quite parallel the "letter" vs. "spirit" tension, because in many cases the higher standard becomes the actual legal standard (i.e., the letter of the law) that a particular person or group of people are expected to follow.

[1] As noted earlier, a *heter* is not a suspension of the law. It is a permit to do something that would *seem* to be prohibited but which in fact is not prohibited, at least in the opinion of the present *posek*.

An example may be seen in the way Sukkot is celebrated: the minimal mitzvah for the lulav is one taking per day, but the rabbis ordained that we should take it more than once per day.[2] Furthermore, the mitzvah is in the taking up[3], not in the waving or shaking. But the right thing to do is to shake the lulav in six directions. Shaking is not the essence of the mitzvah, but it makes the mitzvah more complete (so to speak)[4] and is the expected way of performing the mitzvah. Additionally, for beautification of the mitzvah (הדור מצוה *hiddur mitzvah*), we should pick a particularly well-shaped lulav and pay for it a third more than what we otherwise would have spent.[5]

The language of secular bioethics is different from that of halacha in that the words themselves are different, and yet many of the concepts are similar. For example, Beauchamp and Childress define the terms saint and hero: "the saint resists inclination, desire, and self-interest; the hero resists fear and the desire for self-preservation [e.g., a doctor attending to a plague-ridden city]."[6] Beauchamp and Childress continue:

> By comparison to ordinary duties, saintly and heroic actions conform to ideals. They transcend our duties and indicate higher possibilities, but we do not expect many persons to realize them. Indeed, they mark out optional but praiseworthy conduct. With the addition of this sort of conduct, we have at least four categories of action: (a) actions that are right and obligatory (e.g., truth-telling); (b) actions that are wrong and prohibited (e.g., murder); (c) actions that are permissible in that they are not wrong; (d) actions that are morally optional but also supererogatory,

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[2] Aruch HaShulchan 651:21. Note that taking of the lulav on the 2nd day of Sukkot and onwards is a rabbinic ordinance (Sukkah 29b, and Midrash Rabbah, Numbers 14:4).

[3] The blessing is וצונו על נטילת לולב (who commanded us about taking up of a lulav). Taking up is sufficient to perform the mitzvah, but one should adorn the mitzvah by performing נענעים (*na'anu'im* – the waving or shaking of the lulav in six directions) See Berachot 30a, Sukkah 29b, 32b, 37b, 42a, Arachin 2b, which all use the verb נענע. See also Shulchan Aruch, Orach Chaim 651-8-11.

[4] For example, the noise made by the shaking adds to the joy of the holiday (Midrash Rabbah, Numbers 4:20).

[5] Bava Kama 9a-b.

[6] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): p. 228.

> meritorious, and praiseworthy....Actions that go beyond our duties may merit praise, but failure to perform them will not deserve blame.[7]

Each of the four categories listed by Beauchamp and Childress above has a halachic equivalent: 1) חובה *chovah*; 2) אסור *asur*; 3) מותר *mutar*; and 4) לפנים משורת הדין *lifnim mi'shurat ha'din*. While Jews would not use the terms "saint" or "hero" to describe people in the fourth category who go beyond their duties, they do talk about acts that go beyond fulfilling one's basic obligations, and consider their actions as following into the same four categories.

Interestingly, the above-quoted section about saintly and heroic actions appears last in Beauchamp and Childress's secular book of bioethics, as an afterthought or as the icing on the cake (good, but not absolutely necessary). In contrast, in almost every chapter of a code of halacha there are descriptions of what is the required minimum act to fulfill a mitzvah, as well as descriptions of the meritorious way of fulfilling a mitzvah. This information is basic, bread-and-butter information that is needed to describe duties that are incumbent upon all Jews alike, not just those interested philosophically in morality and ethics. In fact, this is perhaps one of the most telling differences between secular ethics and halacha: all Jews are required to know (whether or not they are interested) the questions that need to be asked to decide issues of morality and ethics. If they do not know enough halacha to have the answer, at least they know enough to ask the question, and they know to whom the question should be directed: the rabbis. That there should be Reform rabbis who are able to answer is so obvious a requirement that it almost goes without saying.

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[7] *Ibid.*, p. 230.

Many examples of meritorious deeds and pious acts are given in the Talmud, but three will suffice to make the point:

1) "A [baraita] taught: One who answers 'Amen' after his own blessings is to be commended" (Berachot 45b).
2) "R. Joshua b. Levi also said: A man should always rise early to go to synagogue so that he may have the merit of being counted in the first ten; since if even a hundred come after him he receives the reward of all of them. 'The reward of all of them', say you? – Say rather: He is given a reward equal to that of all of them" (Berachot 47b).
3) According to R. Eliezer, if a householder was traveling from place to place and was obliged to take the gleanings (Leviticus 19:9), the forgotten sheaf (Deuteronomy 24:19), or the corners of the field (Leviticus 19:9), or the Poorman's Tithe[8], then he may take them, and when he returns to his house he must make restitution [i.e., he must pay for the amount he had consumed to the first poor man who claims it. But R. Hisda said: They taught this only as a rule of conduct for the pious. [Strictly he is not bound to make any restitution, and his doing so is only in the nature of a pious and charitable act.] (Chullin 130b).

As Menachem Elon says, "When a respondent rules that certain conduct is permitted, he adds, 'but he who follows a stricter view will be blessed.'"[9]

Sometimes secular bioethical language sounds very much like a modern responsum:

> [T]he rule of confidentiality, which could be formulated as imposing duties on health care professionals or as creating rights for patients, states a prima facie duty. Anyone who thinks that a disclosure of confidential information is morally justified or even mandatory in some circumstances bears a burden of proof. While this approach

[8] The Poorman's Tithe was due in the third and sixth years of the Sabbatical cycle in lieu of the Second Tithe, and was to be distributed among the poor (Deuteronomy. 14:28, 29).
[9] Elon, Menachem, Jewish Law (Philadelphia, The Jewish Publication Society, 1994): pp. 1493-4.

> requires a balancing of conflicting duties, it also establishes a structure of moral reasoning and justification. It is not enough to determine which act will respect the most duties or maximize the good, for the strong presumption against revealing confidences establishes the direction and burden of deliberation and justification. Sometimes the health care professional has been viewed as having a "right" to violate confidences in some circumstances, but not as having a "duty" to do so. He is permitted, but not obliged, according to this view....Although some people interpret [the AMA Code] as permitting but not requiring the physician to break confidences, we interpret it differently: one may not break a confidence except to fulfill another and more stringent duty...There is no *right* to violate confidences...unless there is also a *duty* to do so. The health care professional's breach of confidentiality thus cannot be justified unless it is necessary to meet a strong conflicting duty. This conclusion means that rules protecting confidences must sometimes give way to rules protecting other interests.[10]

Halacha knows and uses the concepts of "prima facie" (לכאורה *lichorah*) and "burden of proof" (חובת הוראיה *chovat haraya*), while "duties" usually replaces "rights," and the reference to "maximizing the good" implies a utilitarian principle that is generally foreign to halacha. Nevertheless, the language of modern secular law is similar to the language of halacha in that halacha *is* law. Further, the emphasis on "duties," the presumption of certain rules, and the differentiation between "permission" and "obligation" give this pericope a halachic flavor. Note the similarities between the above secular text and the following selection from a Reform responsum:

> We might add another consideration, one which flows from our understanding of ourselves as a religious community. We do not maintain a neutral stance toward Jewish tradition; we rather seek to adopt and to adapt it when we can. We grant to tradition a distinct preference; it enjoys a considerable presumptive weight in our religious thinking. "As liberal Jews who seek to affirm our connection to our people in all lands and all ages, we should maintain the traditional practice in the absence of a compelling reason to abandon or alter it." Put simply, we do not see any such compelling reason to say "no" to the use of mikveh. It is not

[10] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): pp. 212-3.

> offensive, or demeaning, or unequal in application in any way that would render it unacceptable to our understanding of Judaism.[11]

Both selections explain on what the authors' reasoning is based and how their deliberations move from presuppositions to conclusions. Both give preference to basic rules, but acknowledge that there are considerations that may allow a different conclusion that the one pointed to by a strictly literal interpretation of the law.

As we have seen, halacha has many words about acts and their permissibility, each of which covers a different shade of meaning. This allows the halacha to be as precise as possible as to what should be done, what may be done, what need not be done, and what may not be done, in order to do the will of God correctly. As we saw in the last chapter, as soon as we use the word "love," we define it in terms of duties towards God. Responsa helps settle difficult questions so that observant Jews can live their lives as correctly as possible. Bioethics also tries to make the guidelines as clear as possible, and physicians' goal is to do the right thing medically for the patient. At least as strong as that goal, however, is the goal of making sure that actions in the clinical setting can survive legal scrutiny in court.

Moshe Silberg[12] compares some of terminology and underlying features of halacha to those of secular law:

> Let me pose a here a seemingly naïve question: Why should a man pay his debt or fulfill an obligation which he has undertaken? The Roman lawyers, as well as any modern lawyer, would be most surprised by such a question. It is clear, they would say, that the duty of payment of a debt is the correlative of the concept of ownership, and the one cannot exist without

[11] From CCAR responsum A "Proper" Reform Mikveh 5756.6.
[12] Moshe Silberg (1900-1975) was Associate Justice of the Supreme Court of Israel and Professor of Personal Law at Hebrew University in Jerusalem.

> the other....In Jewish law the question is more problematic and was regarded as such by the Sages of the Talmud.
> [In Ketubot 86a] there is a diversity of opinion among [the sages] whether the payment of a debt is a "precept" or not, *i.e.*, whether it is a religious-moral duty...or whether it is a civil-legal duty..."The paying of a debt is a precept," says Rabbi Papa....Rabbi Kahana said to Rabbi Papa, "According to the statement you made that the repayment of [a debt to] to a creditor is a religious act, what happens if [a debtor] says, 'I am not disposed perform the religious act.'?"...[Rabbi Papa answered,] "[H]e is flogged [if he persists in his refusal] until his soul departeth."
> Thus, when a person refuses to pay his debt he is physically coerced to fulfill his religious obligation to pay. The concern of the court is not the creditor's debt, his damages, but the duty of the debtor, his religious-moral duty, the fulfillment of the precept by him. The creditor receives his money almost incidentally, as a secondary result of the performance of this duty.[13]

Silberg also gives an example of the common law approach of saying a person may keep a dove he has found if it is found beyond "a reasonable distance" from a dovecote. The halacha, using the language of legal formalism, says that the dove must be returned to the owner of the dovecote if the dove was found within fifty cubits of the dovecote.[14] This example shows that halacha is more exacting than the common law. As Silberg says, "No legal system in the world is completely free from arbitrarily drawn boundaries, but it is true that there is a great variance in the inclination to do so, whether to coin and cast such molds indulgently or sparsely. The quantitative difference here becomes a qualitative one."[15]

Silberg continues his examination of the dovecote discussion:

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[13] Silberg, Moshe, "Law and Morals in Jewish Jurisprudence" *Harvard Law Review* 75 (1961-1962). (Cambridge, Massachusetts, The Harvard Law Review Association, 1962): pp. 311-313.
[14] Bava Batra 23b says, "A dove that is found on the ground within fifty cubits from a cote belongs to the owner of the cote; if found beyond fifty cubits from the cote, it belongs to the finder. If it is found between two cotes it belongs to the one to whose cote it is nearer. If it is exactly midway, they must share it."
[15] Silberg, Moshe, "Law and Morals in Jewish Jurisprudence" *Harvard Law Review* 75 (1961-1962). (Cambridge, Massachusetts, The Harvard Law Review Association, 1962): p. 323.

> Rabbi Jeremiah wanted to do away with the external, formal distinction between fifty cubits and more than fifty cubits and substitute for it a more abstract, more elastic measuring yard such as proximity, distance, or a determination in a more general and more abstract way....But who will decide what is "proximate" and what is "distant," what circumstances are to be considered, and what is the conclusion to be drawn from them? If the matter should come to trial, the judge could...[draw a] reasonable conclusion. But how is the common citizen, the man in the street...to determine the matter?[16]

Silberg notes that in the secular world, the finder of the dove could simply wait for someone to sue him, but if the finder is concerned with his conscience and with doing the right thing, then he must have strict guidance. Silberg thus asks, "Does not this consideration demand that the legal norm should be less elegant perhaps but clearer, less elastic but more concise, so that the subject to whom the instruction of the law is addressed should be in a position to apply and fulfill it without the continuous intervention of the judge?"[17] Thus the halachic system's goal is to give individuals rules for their behavior before the fact, so that as few conflicts as possible arise between people.

Benjamin Freedman explains another reason why the language used by a duty-based system differs from and is superior to the language used by a rights-based system:

> Justice Moshe Silberg...has claimed that the spirit of a jurisprudence of duty requires much more specific rules than does one grounded in rights. To borrow Justice Oliver Wendell Holmes's famous phrase, a law based upon rights satisfies the needs of the "the bad man,"[18] the person who wants to know how he can maximally exercise his power without running afoul of the law. By contrast, the scrupulous person is the proper object of a jurisprudence of duties, one who is focused upon the moral satisfaction of duties and obligations; and this person

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[16] *Ibid.*, p. 324-5.
[17] *Ibid.*, p. 325.
[18] As cited by Freedman, Benjamin, Duty and Healing (New York, Routledge, 1999): p. 66., the "bad man" standard as a definition of law originated in Oliver Wendell Holmes, Jr.'s The Common Law (London, Macmillan, 1882).

> seeks rules precise enough that no court decision to ascertain whether a given deed is permitted will be needed[19]

In the 1994 edition of Principles of Biomedical Ethics, Beauchamp and Childress flatly reject the idea that the language of rights can or should be replaced by the language of duties.[20] A main reason for their rejection is that a recipient of another's obligation "may leave the recipient in a passive position."[21] This argument is unpersuasive, because adjudication is a remedy for those in passive positions, just as it is for those who are trying to exercise their rights in the face of resistance.

It seems from the above discussion that the best way to make bioethical decisions first in the philosophical arena and then in the clinical setting is to decide upon a common terminology. The terminology then should be used to make the rules as clear and as exact as possible, noting where the law leaves off and individual religious, moral, or ethic beliefs begin. For a Jewish physician or bioethicist, the purpose of agreeing upon terminology and limits is not to avoid lawsuits, but rather to determine the law (that is, the right action) beforehand.

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[19] Freedman, Benjamin, Duty and Healing (New York, Routledge, 1999): pp. 56-7.
[20] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1994): p. 77.
[21] *Ibid.*

Who Has Authority?

In the cases examined, sometimes the physician, the patient's next of kin, or the court has the authority to decide what medical care should be or will be given. In other situations, the patient has the authority to refuse, agree to, or demand the medical care he is to receive. Authority and power are important in any discussion of health care and of bioethics, because the issues of "Who decides?" and "Who has the right or duty to act?" are related to who has the power and how he can or should use that power.

On the most basic level, we can ask, "Who can or should provide health care?" In the secular view, only a medical care professional has the duty to provide medical care,[1] whereas in halacha each person has that duty, although we delegate that duty to those most qualified to perform it.[2]

As we have seen, secular bioethicists generally discourage the physician from using his power to decide what is best for a patient. David Thomasma defines paternalism as "an action taken by one person in the best interests of another without their consent."[3] He further adds that "Paternalism is problematic precisely because it is difficult to defend the notion that the physician has better insight into the best interests of the patient than the patient."[4] The secular writers distinguish between strong paternalism and weak paternalism. Again, Thomsma explains:

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[1] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): p 143.
[2] Tur, Yoreh De'ah 336.
[3] Thomasma, David C., "Beyond Medical Paternalism and Patient Autonomy" in Brody, Baruch A., and Engelhardt, Jr., H. Tristram, Bioethics: Readings and Cases (Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1987): p. 115.
[4] *Ibid.*

> Strong paternalism is that exercised against the competent wishes of another. For example, the doctor in the Broadway play *Whose Life Is It, Anyway?* gives the main character, a quadriplegic, a sedative against his expressed wishes not to receive it....Weak paternalism is an action taken in the best interests of a patient on presumed wishes or in the absence of consent from those who cannot give consent.[5]

While secular bioethicists debate the morality of paternalism by noting that it is an invasion of autonomy, halacha is plainly, unabashedly, and unapologetically paternalistic. As Daniel Eisenberg[6] writes, "Judaism takes a paternalistic view of many human endeavors, including the practice of medicine."[7]

David Ellenson describes the traditional approach to Jewish medical ethics, which says that bioethical decisions should be made by rabbis when a Jewish patient is involved:

> One final point about the nature of "halakhic formalism" must be made if a full appreciation of the character of this methodology is to result. Simply put, individual autonomy is not prized as an independent variable in this approach to Jewish medical ethics....the decision must ultimately be made...not by the patient nor by his or her family, but by [a rabbi].[8]

Robert Veatch suggests that secular bioethicists and physicians walk a tightrope between "authoritarianism and radical egalitarianism":

> Even if signing out of a hospital against medical advice seems foolish...we still think it crucial to protect the patient's individual freedom to sign out.

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[5] *Ibid.*

[6] Daniel Eisenberg, M.D. is Attending Physician, Department of Radiology Albert Einstein Medical Center, Philadelphia, PA, National Medical Ethics Columnist, *Maimonides*, and National Community Co-Lecturer, Institute for Jewish Medical Ethics.

[7] Eisenberg, Daniel, "Medical Informed Consent in Jewish Law – from the Patient's Side," Jewish Law – Articles (Undated; http://jlaw.com/Articles/MedConsent.html), reprinted in the Appendices. See also the additional information on informed consent included in the Appendices.

[8] "Jewish Approaches to Mortal Choices" by David H. Ellenson in Kogan, Barry S., editor, A Time to be Born and a Time to Die (Hawthorne, New York, Aldine de Gruyter, 1991): pp. 226-7. Although Ellenson implies that a living, breathing rabbi must be consulted each time a medical decision is made, it is possible to consult a book as well as a live rabbi. We may infer that Ellenson means the decision must be made according to "Jewish law," the interpretation of which is a function of scholarly competence.

> The reason may be our belief that in the long run, in the majority of cases, the patient knows his own set of values better than anyone else. Or it may be our belief in the higher value of human freedom, even in those cases where we are confident that the individual is behaving unwisely. The choice of the proper authority for decision-making will have to reflect the value placed on human freedom.[9]

Indeed, our highest values will determine how we go about deciding whether the first question is "What is the right action?" or "Who should decide?" Our highest values may be autonomy, or they may be justice (just actions). Part of the answer is determined by the answers to the questions, "Who owns your body?" and "Who knows your body best?"

Brody and Engelhardt, in their discussion of the patient's right of decisional authority state flatly, "This right is rooted...in the idea that the patient's body is the patient's and not the provider's and that the patient has a right to determine the forms of treatment that he or she will receive."[10] No secular bioethicist has argued against the idea that the patient owns his body.

Conversely, Judaism says that we humans do not own our bodies and an individual does not have the right to do with himself what he will. We are the caretakers of our bodies, which are owned by God.[11] Interestingly, Benjamin Freedman argues in favor of at least limited patient authority on the basis of this caretaking agreement: "[B]ecause of the nature of the 'relationship' between a person and his or her body, nobody else can understand precisely what medical treatment will mean better than that same person. Hence, *only the patient can truly fulfill the demands of bodily preservation and*

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[9] Veatch, Robert M., Case Studies in Medical Ethics (Cambridge, Massachusetts, Harvard University Press, 1977): p. 41.
[10] Brody, Baruch A., and Engelhardt, Jr., H. Tristram, Bioethics: Readings and Cases (Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1987): pp. 19-20.

caretaking. [emphasis in original] And that duly cannot be properly fulfilled without the exercise of informed choice regarding medical treatment."[12]

Note that Freedman does not say that the patient should have a sole or overriding say in the caretaking. He does seem to say, however, that the patient knows his body better than anyone else does. I believe Freedman may be going a bit far in assuming that individuals know better than physicians what is going on inside the body. I would soften the statement to say that the person inside the body, assuming sufficient intelligence and clear thinking, must have a say in that body's medical caretaking. In sum, though, it seems cogent that information and consent [assuming the patient's ability and desire, as well as medical and halachic appropriateness] are required by the patient in order to act as a prudent caretaker of God's possession (the body and the life within it).

In halacha, there are times when a doctor's opinion is weighed more heavily than a patient's, and times when the reverse is true (see, for example, the Shulchan Aruch's discussion of whether a patient may eat on Yom Kippur[13]), but patient autonomy does not enter into the discussion. The legal justifications of informed consent are not in consonance with halachic views. Beauchamp and Childress quote Justice Cardozo's statement from *Schloendorff v. New York Hospital*:

> Every human being of adult years and sound mind *has a right to determine what shall be done with his own body*; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages....This is true except in cases of emergency where the patient is unconscious and where it is

[11] These beliefs were discussed earlier, in the chapter "The Role of the Physician – The Halachic View."
[12] Freedman, Benjamin, Duty and Healing (New York, Routledge, 1999): p. 176.
[13] Shulchan Aruch, Orach Chayim 618:1-6.

> necessary to operate before consent can be obtained. [italics added][14]

While halacha would agree with the majority of Justice Cardozo's statement, the italicized portion is most certainly against halachic law, as God, and not the individual, owns the body, and, as we have seen, there is no halachic "right" to do whatever one pleases with something owned by another. For the same reasons, the *Natanson v. Kline*[15] decision is most firmly at odds with halacha: "Anglo-American law starts with the premise of thoroughgoing self-determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of lifesaving surgery, or other medical treatment."[16]

Although the concept of personal autonomy is foreign to Judaism, some have argued that it need not be entirely foreign. "Information about the patient's condition should properly belong to the patient, and be under his control. While a patient may…waive information, this simply reflects that same right of control."[17] There is, it should be noted, a new methodology for making Jewish ethical decisions in which patient autonomy does play a major role. This methodology, described by David Ellenson, is called the "covenantal"

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[14] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): p. 65, quoting from *Schloendorff v. New York Hospital*. 211 N.Y. 125, 127, 129; 105 N.E. 92, 93 (1914).

[15] *Natanson v. Kline* (Irma Natanson v. John Kline, M.D. 186 Kan. 393, 350 P.2d 1093 (1960), rehearing denied, 187 Kan. 186, 354 P.2d (1960)) is a landmark case heard by the Kansas Supreme Court and cited in the dissenting opinion to *Cruzan v. Director* and cited in *Canterbury v. Spence*. The synopsis of *Natanson v. Kline* is as follows: "Kline gave Cobalt Rx to Natanson for breast CA; N. had lots of necrosis, sued on lack of informed consent. Supreme Court reversed trial Court, said 1st issue was if informed consent was obtained, then next if negligence occurred. Long review of medical practitioner rule for informed consent" (http://adhd.cmhc.com/law/natanson.html). See also *Canterbury v. Spence* and *Cruzan v. Director*, included in the Appendices.

[16] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): p. 65.

[17] Freedman, Benjamin, Duty and Healing (New York, Routledge, 1999): p. 160.

approach.[18] This intuitive approach balances a belief in God with "the affirmation of human autonomy."[19] Interestingly, autonomy is not seen as the "product of enlightenment thought. Rather, it receives a divine religious warrant."[20] In this new methodology, although the rabbi plays the role of the consultant in moral decisions, the individual himself ultimately decides what the Jewish moral answer should be.

[18] "Jewish Approaches to Mortal Choices" by David H. Ellenson in Kogan, Barry S., editor, A Time to be Born and a Time to Die (Hawthorne, New York, Aldine de Gruyter, 1991): p. 228.
[19] *Ibid.*, p. 229.
[20] *Ibid.*

Informed Consent

The doctrine of informed consent is part of the essence of American law, based on the principle of personal autonomy. The necessity of informed consent was included in the Nuremberg Code drafted after the Nazi medical experiments on humans and the requirement of informed consent has been refined through the courts from medical malpractice cases.

Informed consent means that a person, if capable of doing so, should know what is being done to him and why, as well as what harm or risks are involved in the medical procedure or experiment. Informed consent determines medical practice and medical research. From a secular view, informed consent functions primarily to "protect the autonomy of patients and subjects."[1] While this function does not enter into halachic discussions, other functions of informed consent do: protection of patients and subjects, avoidance of fraud and duress, and the promotion of rational decisions.[2]

The following selection is from *Canterbury v. Spence.*, 464 F.2d 772 (D.C. Cir. 1972), a major court decision requiring informed consent based on what a reasonable person would want to know:

> Suits charging failure by a physician adequately to disclose the risks and alternatives of proposed treatment are not innovations in American law. They date back a good half-century, and in the last decade they have multiplied rapidly. There is, nonetheless, disagreement among the courts and the commentators on many major questions, and there is no precedent of our own directly in point. For the tools enabling resolution of the issues on this appeal, we are forced to begin at first principles.

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[1] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): p. 63.
[2] *Ibid.*

> The root premise is the concept, fundamental in American jurisprudence, that "every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ."[3] True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each.

Interestingly, there is a convergence between secular and halachic views within the older, professional standard of disclosure, which *Canterbury v. Spence* acknowledges as valid. The professional standard says that the physician is "morally and legally required to disclose only such information about the diagnostic, therapeutic, or preventative procedures as is normally disclosed by other physicians in the community."[4] This standard allows for paternalism, as Brody and Engelhardt explain, quoting the decision:

> [A] remnant of the professional standard survives as the therapeutic privilege. Physicians are excused from giving full information when, on the basis of facts that would convince a reasonable person, the disclosure would likely render the patient "so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient."[5]

There is yet a third, newer standard of disclosure that requires informed consent based on what *this patient* would want to know – not what a hypothetical "reasonable person" would want to know. Interestingly, this standard is capable of being used even more paternalistically than the original professionals standard, as a physician can say that in his view, this particular patient did not want to know anything at all about the proposed

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[3] This quotation is from *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92, 93 (1914).

[4] Veatch, Robert M., Case Studies in Medical Ethics (Cambridge, Massachusetts, Harvard University Press, 1977): p. 302.

[5] Brody, Baruch A., and Engelhardt, Jr., H. Tristram, Bioethics: Readings and Cases (Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1987): p. 284.

procedures. This standard has, as far as I know, not yet been subject to secular legal scrutiny.

In secular thinking, the patient has a right to have or to refuse information about his medical condition. If the patient exercises that right to know, then the doctor has a duty to give information to the patient, in accordance with what doctors normally tell patients in this situation or in accordance with what a "reasonable patient" would want and need to know. Given the information, the patient may refuse all treatment, or consent to some or all treatment offered to him.

Informed consent, considered broadly, is a modern part of medicine and it is positive because it "helps to improve medical treatment, by insisting upon two-way communication between doctor and patient...[and it provides] the patient with the tools as well as the opportunity for decision making."[6] Also, as a principle it requires that the patient be seen as a human being, not the site of a disease, and it "demands that the practitioner adopt a multidimensional, biopsychosocial view of the processes of diagnosis and treatment."[7] In this respect, it is identical to Rambam's statement that a physician should be concerned with a patient's physical, mental, and social well-being.[8]

As we have seen, halacha denies a person "an absolute right to accept or to refuse *all* forms of medical treatment."[9] Halacha does not allow informed (or uninformed) refusal of treatment when that treatment is certain to save a patient from life-threatening illness.

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[6] Freedman, Benjamin, Duty and Healing (New York, Routledge, 1999): p. 156.
[7] *Ibid.*
[8] As explained by Freedman, Benjamin, Duty and Healing (New York, Routledge, 1999): pp. 148-9.
[9] *Ibid.*, p. 162.

In Jewish thinking, the patient has a general duty to know whatever is necessary to safeguard the body. Ignorance is acceptable if the patient has used due diligence in trying to ascertain the information necessary. The physician has a duty to give the patient the proper treatment, not necessarily to tell the patient all the physician knows.[10] As Abraham S. Abraham advises:

> One should not inform a patient of the serious nature of his or her illness if doing so might result in despair and lead thus to further deterioration. However, if the patient is likely to realize the nature of the illness (for example, a patient who is referred to an oncology or radiotherapy service), the physician should disclose the nature of the illness in a gentle, optimistic manner, without necessarily giving all the details of the prognosis.[11]

In this respect, halacha may tend to give the physician too much power to decide, assuming that the physician knows what is best for the patient without asking for the patient's opinion.

As we saw in halachic Cases #2-4, the patient must be willing to accept (that is, he must consent to) treatment in non-life-threatening situations. Nowhere do the cases require

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[10] "We do not tell a patient that his condition is terminal, lest his mind be consumed [with worry about it]. And we do not tear at his garment/dressing gown, and we do not cry and we do not bewail/eulogize in front of him, so that his heart will not break [and so his will to fight his disease will remain]. We silence our consolations in front of him." (Shulchan Aruch Yoreh De'ah 337).
Abraham S. Abraham comments on the Shulchan Aruch:
Regarding "Do not tell a patient that his condition is terminal": "But if he asks, [then avoid answering and] say to him that he still is alive. R. Shlomo Zalman Auerbach wrote this to me: 'Although we are obliged to visit the sick person, if one fears that his emotions will make the patient anxious, he is likely to endanger the patient further. It is then permissible for the mourner [i.e., the visitor] to do all that is necessary in order to make sure he doesn't make the patient more anxious.'"
Regarding "[Lest] his mind become anxious": "A patient (of sound mind) whose condition is terminal is bound to grieve and [his condition] will be known to him, if his health is such that he will die within seven days. But he doesn't need to conclude his last days prematurely because of the wailing and mourning." Nishmat Avraham Yoreh De'ah Chapter 337. Abraham, Abraham S., Nishmat Avraham [נשמת אברהם], volume 2 (Jerusalem, published by author, 1982): pp. 236.

[11] Halacha 35:13 of Abraham, Abraham S., The Comprehensive Guide to Medical Halachah (New York, Feldheim Publishers, 1990): p. 170.

informed consent. Nevertheless, where there are choices to be made, I believe there is value in having informed consent.

Only recently have bioethicists begun looking at the issue of whether (and if so, on what basis and when) halacha requires informed consent. The specific philosophical principles by which halacha may be said to endorse informed consent are not clear, but Benjamin Freedman suggests that the principle is, in Charles Weijer's words, "the moral obligation of health care professionals to respect patients and their capacity for rational decision-making. If this principle is to be upheld, Freedman argued, physicians have a duty to recognize valid consent."[12] Others say a doctor has the duty to inform his patient so that the patient can be a responsible steward of his body.[13]

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[12] Weijer, Charles, MD, Ph.D., "Duty and Healing: the Lifework of Benjamin Freedman," *CMAJ* [*Canadian Medical Association Journal*] 1997; volume 156, issue 11, 1553-5 in reference to ideas found in Freedman B., "A moral theory of informed consent." *Hastings Center Report* 1975; 5(4):32-9. (http://www.cma.ca/cmaj/vol-156/issue-11/1553.htm).

[13] See the 1999 Conference Program of The Tenth Annual International Conference on Jewish Medical Ethics and the article by Daniel Eisenberg, "Medical Informed Consent in Jewish Law – from the Patient's Side," both of which are reprinted in the Appendices.

Risks

What constitutes acceptable risk? What constitutes significant risk? Rabbis, physicians, and other professionals are loath to define "appropriate risk." No matter how talented and experienced the surgeon, the results of surgery are often unpredictable, which is why there are informed consent[1] forms that must be signed before a patient undergoes surgery.

An entire book would hardly do justice to the general subject of medical risk, so this chapter will merely touch on a few points.[2] The risks in a pharmaceutical product may involve relatively minor side effects (e.g., unwanted hair growth, nausea, or increased sensitivity to light), or may involve a threat to life (e.g., renal failure), even if the drug is administered and taken properly. A similar wide variety of risks are part and parcel of surgical procedures.

What may be acceptable to correct one condition is not necessarily acceptable to correct another. The risk of scarring is great but completely irrelevant in deciding whether to perform heart surgery. In contrast, the risk of scarring may be low but very relevant in deciding whether to remove a non-malignant mole on the face. These examples clearly show that is statistically significant may or may not be medically significant, and what is statistically insignificant may or may not be medically insignificant.

Furthermore, by necessity, I have glossed over the fact that risk/benefit analyses are not always zero-sum procedures, and the fact that the words "risk" and "benefit" are not always clearly defined. If the chance of risk is 75%, that does not imply that the chance

[1] In the United States, the legal requirement for informed consent for medical treatment rests on the moral doctrine of patient autonomy and can be traced to major cases such as *Canterbury v. Spence* (1972), which is included in the Appendices.

of benefit is necessarily 25%. The risk may be a possibility of sleeplessness, or it may be a possibility of paralysis. A benefit may be a return to full health, or it may be an avoidance of imminent death.

A simple example will suffice: Let us suppose that the risk of doing nothing for a person with brain cancer is certain death (100% mortality rate). Now, if a surgeon removes the patient's cancerous brain lesion, the risk of death may be 85% (85 out of 100 patients die during or because of the procedure), while the benefit (in this case, defined as allowing the patient not to die from the cancer) may be 5%. The other 10% of the patients, while not dying from the cancer, are not healed either; they are alive but permanently and irreversibly brain-damaged.

Please note that as I am neither a doctor nor a surgeon, these examples are not medically accurate, but are rather merely illustrations of the difficulties in discussing risks and benefits.

The secular bioethicists Beauchamp and Childress discuss risk in their statements on the subject of cost/benefit analysis:

> The level of risk willingly assumed by a consenting individual may…in some cases permissibly exceed the sum of benefits that persons other than the individual at risk believe likely to occur. A primary consideration in the determination that risk is acceptable is the worth of the therapeutic procedure or the research to the person who stands to benefit from it, especially if that person alone must bear the risk.[3]

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[2] See also the articles on risky surgery, included in the Appendices.
[3] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): p. 152.

As we have seen, secular theories place the individual as the primary determiner of what is appropriate risk and benefit under the principle of patient autonomy. Halacha also uses risk/benefit analysis, but the primary determiner is the physician under the principle of sanctity of life.

Benjamin Freedman states Jewish law this way: "In general, [the halachic] sources follow the principle that risks must be counterbalanced by proportional gains, so that even the gravest risks are allowable under extreme conditions."[4]

If the person's condition were life-threatening, says Rabbi Ya'akov Reischer, an eminent *posek* of the 18th century, "we cast aside the certainty [that he will die within one or two days] and grasp at a possibility that he will be healed [that the treatment will cure him rather than cause him to die within one or two hours]. But in any event, the doctor...must act with great deliberation...[and the concurrence of] a great majority, namely, a two-to-one margin [among expert physicians of the city]."[5]

Regarding exact risk/benefit ratios when the illness *is* life-threatening, Moshe Feinstein says:

> I have already written in a responsum in Yoreh De'ah 3:36 that if the risk/benefit ration is 1:1, i.e., there is a 50 percent likelihood of mortality and a 50 percent chance of a long-term cure, then the Talmud's ruling should be interpreted as permissive. If, however, the doctor is convinced that a cure can be achieved with a higher degree of probability, it is obligatory to undertake the risk in order to obtain long life....[W]hen the patient realizes that in the absence of treatment he will surely die, and is

[4] Freedman, Benjamin, Duty and Healing (New York, Routledge, 1999): p. 262.
[5] Responsum of R. Ya'akov Reisher, in *Sh'vut Ya'akov* 3, no. 75, as quoted by Freedman, Benjamin, Duty and Healing (New York, Routledge, 1999): p. 263.

> desirous of taking that chance, it would be best to accede to the patient's wishes.[6]

These statement show that the ultimate decision-maker is the physician who is following the halachic law, although the patient's wishes are taken into account.

In the case of non-life-threatening surgery, there are two ways to view the operation of the principle of sanctity of life. One way would be to say that because the person has a non-life-threatening condition, there is no valid reason to put one's life in jeopardy. The duty to avoid endangering life is much greater than the duty to heal. The other way would be to conclude that one's pain could become extreme enough to allow the extreme risk of death in the attempt to alleviate that pain.

Mark Washofsky states unequivocally that "patients are allowed to undergo risky surgery to relieve severe pain, even though the operation places them in mortal danger."[7] The reason is that "Halakhic insistence on the inviolability of human life is balanced – and at times outweighed – by its concern for the alleviation of human suffering."[8]

When the situation is not life-threatening, the patient has the right of refusal: Moshe Feinstein says, "If the treatment is risky, such as a surgical procedure that involves some possibility of mortal danger, or a drug with serious potential adverse reactions, even if the drug has been approved because the risk/benefit ratio is in favor of using it, coercion should not be applied to administer the drug if the patient refuses treatment."[9]

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[6] Iggerot Moshe, Choshen Mishpat II:74, as quoted by Tendler, Moshe David, Responsa of Rav Moshe Feinstein (Hoboken, New Jersey, KTAV Publishing House, Inc., 1996): pp. 60-1.
[7] Washofsky, Mark, "Nancy Cruzan and the 'Right to Die' – A Jewish Perspective," *Midwest Medical Ethics* (Fall 1990): p. 6.
[8] *Ibid.*
[9] Iggerot Moshe, Choshen Mishpat II:73, as quoted by Tendler, Moshe David, Responsa of Rav Moshe Feinstein (Hoboken, New Jersey, KTAV Publishing House, Inc., 1996): p. 49.

Although the above halachacists are not all strictly considered "authorities," their views help us see that halacha does not define risk so precisely that different people must come to the same conclusion about what is acceptable. In sum, there is no consensus about exactly what is acceptable risk, but it is clear that risky surgery to remove pain is the same thing as risky surgery to improve life, in at least the view of modern halachacists, if not necessarily in the view of secular bioethicists.

The fact that patients do undertake risky surgery to alleviate non-life-threatening conditions requires halachacists to arrive at alternative justifications for medical procedures. As we have seen, Abraham says that because all medical treatment involves risk, the risk/benefit analysis cannot be the only issue in deciding whether a treatment is permissible. The second issue is whether the intent of the procedure is a valid one, and the third is the patient's own wishes.

As with previous discussions of halachic literature, it should be stressed that the above discussion is not complete by any means, but is intended to highlight the different approaches used by halachacists and secular bioethicists and to shed light on terms that both use in their discussions of medical ethics.

Medical Experimentation

As Robert Veatch explains, "the concept of a 'medical experiment'...is a uniquely modern phenomenon. If the term refers to a procedure systematically designed and controlled for the purposes of gaining information instead of or in addition to curing a particular patient, the practice did not arise until...the nineteenth century."[1] There are two general types of medical experiments performed on humans: 1) therapeutic experiments, which are studies designed primarily to help individual patients and only secondarily to provide scientific information, and 2) non-therapeutic experiments, which are studies designed specifically to gather scientific information.

Therapeutic Experimentation

The secular ethicists Beauchamp and Childress discuss the importance of medical experiments, called in today's language "controlled clinical trials": "[They are necessary] in order to make sure that an observed effect...is really the result of a particular treatment rather than some other variable."[2] Beauchamp and Childress continue:

> [T]he RCT [randomized clinical trial] randomly assigns patients to different therapies or placebos....Many questions can be raised about RCTs: Are they as essential as their proponents say? Can they be used without compromising acknowledged responsibilities to patients? Proponent of RCTs often argue...that RCTs do not violate moral duties to patients, because there is genuine doubt about the merits of existing therapies or of standard and new therapies. No patient will receive a treatment that is

[1] Veatch, Robert M., Case Studies in Medical Ethics (Cambridge, Massachusetts, Harvard University Press, 1977): p. 266.
[2] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): pp. 221-2.

> known to be less effective or more dangerous than another available alternative.[3]

There are cases, however, where it is unclear that a placebo group is necessary in an RCT[4]; sometimes having had a placebo group in the clinical trial is judged – after the trial has ended – to be unethical. Although in general ethicists agree that therapeutic experimentation is necessary, they are concerned in a paternalistic way about the lack of information given to a clinical trial subject. The ethicists' concerns are not about the possible lawsuits that might be brought because of lack of informed consent, but rather that the patient may not be receiving the best medical care for his condition: "It must be determined whether medical knowledge and scientific progress with their undisputed benefits are optional or mandatory, whether the increased probabilities of the knowledge gained by randomized clinical trials are worth the moral costs, and whether the benefits outweigh the burdens."[5] Beauchamp and Childress conclude by saying:

> What is at stake is not merely who can and should protect patients' interests, but how much weight should be given to the interests of current patients and how much to future patients. Our view is that medical knowledge and scientific progress are important but often are optional. Generally the broader duty of beneficence is less stringent than the duty to

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[3] *Ibid.*, p. 222.

[4] *Ibid.*, pp. 222-3. See also Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1994): pp. 445-447.

[5] Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1979): pp. 224. Note that the conclusions of the 1994 edition, though using similar language, are even more hesitant about the moral acceptability of randomized clinical trials:

> [W]e take the view that medical knowledge and scientific progress are vital goals, but that particular research protocols are often optional. Our obligations to future patients are strong enough that we should permit, encourage, and support research that can generate knowledge, but without violating the rights and interests of current patients. The obligation of beneficence to future generations of patients is generally less stringent than the obligation to benefit the sick, who already have a relationship with clinicians.

Beauchamp, Tom L., and Childress, James F., Principles of Biomedical Ethics (New York, Oxford University Press, 1994): pp. 451-2.

> "benefit the sick," who already have a special relationship with health care professionals.[6]

Thus, regarding the issue of randomized clinical trials (especially blind and double-blind studies), because they do not allow for much, if any, patient autonomy, is the one area where secular ethicists are clearly paternalistic.

The non-Reform halachic cases we have reviewed allow therapeutic experimentation provided there is a positive risk/benefit ration for the *particular* individual participating in the experiment (see halachic Case #4, above). I infer from this that the patient cannot be randomized into a double-blind randomized pharmaceutical clinical trial where the patient may receive placebo instead of the most efficacious medicine currently available.

Reform Jewish views are somewhat different. When the Responsa Committee was asked whether therapeutic experimentation may be done in a situation where the patient cannot give his consent (namely, when the patient is in need of immediate cardiac resuscitation), the answer was a three-part affirmative: "[F]irst, that persons are allowed to subject themselves to controlled and careful scientific experimentation; second, that there exists in some cases a general ethical duty to submit to experimentation; and third, that in certain emergency situations physicians may within reasonable limits administer an experimental remedy to the patient."[7] What is salient about this answer is that it is based on faith in modernity: "[W]e liberals have historically placed great faith and trust in the power of

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[6] *Ibid.*, p. 225.

[7] "Testing Emergency Medical Procedures Without the Consent of the Patient" 5755.11 in Plaut, W. Gunther and Washofsky, Mark, Teshuvot for the Nineties (New York, Central Conference of American Rabbis, 1997): p. 383.

reason and science to improve the human condition. We therefore cannot ignore the critical importance of scientific experimentation to the advancement of medicine."[8]

Undergoing life-threatening surgery to correct a non-life-threatening condition can be considered as undergoing therapeutic experimentation. Assuming that the Nuremberg Code is to be followed, a Jewish person must accept that some type of informed consent is necessary in order for any therapeutic experimental surgery to take place.

If there is no necessity for informed consent (by whatever standard is followed), then we are at the mercy of the ethics (or lack thereof) of physicians of Dr. Mengele's ilk. Once there is informed consent, the patient, physician, and possibly the rabbi, must decide that the risks of surgery are reasonable in relation to the anticipated benefits of surgery.

Non-Therapeutic Experimentation

While the non-Reform halachic cases we have reviewed strongly suggest that Jews are forbidden to undergo non-therapeutic experimentation, and non-Reform Jewish bioethicists such as Immanuel Jakobovits, J. David Bleich, and Fred Rosner[9] clearly oppose non-therapeutic experimentation,[10] there is a view in Reform responsa[11] that holds we have permission to (and perhaps, when we have the opportunity, even a duty to)

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[8] Ibid., pp. 382-3.

[9] See the articles on Human Experimentation in Rosner, Fred, and Bleich, David J., editors, Jewish Bioethics (Hoboken, New Jersey, KTAV Publishing House, Inc., 2000): pp.409-434.

[10] In contrast, Eliezer Waldenberg, a contemporary non-Reform authority on medical halacha, allows non-therapeutic experimentation that poses no risk. The Tzitz Eliezer is a collection of responsa written by Eliezer Waldenberg. Tzitz Eliezer contains a responsum that permits a Jew to volunteer for medical experimentation so long as the experiment does not pose any risk to him (see 13 section 101).

[11] See Washofsky, Mark, Jewish Living (New York, UAHC Press, 2001): pp. 257-258, and "Testing Emergency Medical Procedures Without the Consent of the Patient" 5755.11 in Plaut, W. Gunther and

rescue our fellow humans in danger by volunteering to undergo experimentation in order to advance scientific and medical knowledge. Although there are limits placed upon this permission, the topic is couched in terms of duties, specifically the concern for others that is indispensable in an ethical community: "[W]e must draw here a balance between two moral obligations, that which we owe to others and that which we owe to ourselves."[12] Reform Judaism has always been as universal as it has been particularistic, so it comes as no surprise that the caring for the needs of the unknown other seems so reasonable as to be suggested as a halachic duty.

Washofsky, Mark, Teshuvot for the Nineties (New York, Central Conference of American Rabbis, 1997): pp. 381-389.

[12] Washofsky, Mark, Jewish Living (New York, UAHC Press, 2001): p. 258.

Conclusions

Cindy Hoffman's grandmother: "Oy, cooking Pesach seder for 16 people is so much work!"
Cindy to me: "If it's so much work, why does she do it?"

The above conversation took place almost twenty five years ago, but it still stands in my memory as the paramount example of two people living in different worlds. Cindy's grandmother considered it a duty to cook *seder* for her large family, and it was permissible to *kvetch* a little about the effort involved. Cindy couldn't imagine taking on so much work unless she wanted to, unless she derived pleasure or benefit from the task. The two women were blood relations and lived in the same town, but they were in separate worlds. They didn't know enough to ask the right questions of each other, to question each other's basic assumptions about their lives, to discover all the things they did and didn't have in common.

Secular bioethicists say that moral values are societal conventions, or that moral values can be perceived solely through the intellect, the way the postulates of algebra are perceived. However they present their theories and principles, they speak to all of us, not only Jews.

Halachic bioethicists regard halacha as a set of mitzvot and start from the idea that there is a mitzvah of healing that comes from the Torah. They present bioethical questions as an exercise in religious law, and derive particular guidance from the rules and principles of

religious law. Unlike the secular bioethicists, they speak only to Jews, at least in the present age.[1]

In the introduction to this thesis, I posited that Reform Jews should make informed decisions about their religious observance. This assertion seemed and seems self-evident to me, for "informed choice" was the phrase that led me to Reform Judaism in the first place and was the tenet that girded my desire to become a Reform rabbi. In spite of the support offered for my view, others may see it simply as an assumption. In response to these readers, I present the following argument: Even if "informed choice" is merely an assumption that applies to a minority of Reform Jews, then I submit that of all Reform Jews, the Reform rabbis are the ones who ought to be best informed. If teaching Jewish tradition and laws is not part of the rabbi's job description, then why are we given the title "rabbi"? And even if we say that few Reform Jews want to learn about Jewish tradition and laws, to whom should these few Reform Jews turn if not to their own rabbis?

Reform Jews who are informed about their religious tradition participate in two different worlds at once: in Modern Western civilization (the secular world) and in halacha. At first glance, the broad systems of thought seem contradictory; they seem to present us with an either-or choice between rights and duties. Yet there are possibilities of common ground between them, and there is room for both to enhance and enrich our lives if we know enough to ask the right questions and to discover the assumptions of each. By focusing

[1] Halacha assumes implicitly that its system is ultimately the best for everyone (see end of the Alenu prayer), but until the Messiah or messianic age arrives, halacha speaks only to Jews and does not presume to make law for non-Jews (other than the seven Noahide commandments, although these are irrelevant in a situation where the batay din have no way of enforcing their decisions on those who do not wish to abide by them, let alone on non-Jews).

on a small, esoteric question of bioethics, I hoped to show that rabbis can learn from and derive benefit from both traditions.

We Reform Jews who care about modernity and about Jewish tradition are both Cindy and her grandmother at once. We, like other secular Westerners, "ascribe tremendous significance to our capacity to make decisions concerning [ourselves]. We want to decide where we shall live, how we shall spend our money, with whom we will associate, and so forth."[2] At the same time, we want to decide how and to what extent we will follow halacha, which means in effect, autonomously deciding to give up some of our autonomy.

Many, if not most, *poskim* agree that various halachic proscriptions depend on the accepted norms of the society in which the Jews are living. For example, men were forbidden to look in mirrors in the society of Joseph Karo.[3]. He based his ruling on the Torahitic proscription that a male should not wear women's clothing. Another example of the halacha changing according to societal norms is the question regarding whether married women should cover their hair, and if so, how much of it can remain showing.[4] In this vein, we Reform Jews follow tradition and adjust halacha to our own society and our own times. As halachacists, we follow much the same process as our non-Reform siblings (whose conclusions differ among themselves), but our conclusions may differ also because we have brought secular principles such as equality of the sexes into the discussion.

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[2] Brody, Baruch A., and Englehardt, Jr., H. Tristram, Bioethics (Prentice Hall, Inc. Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1987): p. 342.
[3] See Deuteronomy 22:5 and Bet Yosef, Yoreh De'ah 126:2.
[4] This topic is discussed in detail by Ner-David, Haviva, Life on the Fringes (Needham, Massachusetts, JFL Books, 2000): pp. 58-64.

As I have said before, I believe Reform Jews should make informed decisions about their religious observance, and that Reform rabbis ought to make informed decisions for themselves and help their fellow Reform Jews do the same. If most Reform Jews do not know or care that halacha has something to say about almost every facet of life, then we rabbis need to teach them to know and to care. And if the Reform rabbis themselves don't know or care, then it seems we have a problem bigger than "Johnny can't read."[5]

I urge the Reform rabbis living in America to try to see the points of contact and divergence between halacha and the secular world in which we live. Jews who are halachically knowledgeable don't ask questions about, for example, how courageous we are, how muscular we are, or whether we have achieved the highest level of personal fulfillment. Rather, we ask questions about obedience and faithfulness and piety. Is there a balance between religious autonomy (individual choice and freedom) and communal authority (and obligation)? I think so. Can we, by understanding the ways secular ethicists approach and define issues of morality, refine our discussions of moral dilemmas? Again, I think so.

In comparing secular ethics and halacha, I am positing a Reform Judaism that shares parts of both approaches. This may not be the reality of Reform Judaism today, but I am making a normative statement: I am describing what I think Reform Judaism ought to be and can become.

[5] My tone may be harsh or tough, but I am speaking from deep conviction, not from haughty superiority.

Regarding the topics addressed in this thesis, I have my own modest observations. First, I think it makes the most sense to translate the language of rights into the language of duties wherever possible. Not only in the field of medicine, but in education, business, and other fields, it does more good to speak of, for example, the duty of businesses to employ workers whose demography mirrors the neighborhood than it does to speak of the right of minorities to have equal access to jobs. Not only is this language ultimately more useful (because I think it produces the most good), but also this language coincides with the way I believe Jews generally think (or should think) about the world. That is, we ask not "What does this world owe me?" but rather "What duties do I have in this life toward myself and others?" Again, if this is not a description of reality, then I posit it as the way I believe Jews ought to think about the world.

As long as the final ethical system we choose (syncretic or otherwise) is based upon clear criteria for ranking moral goods and is helpful in deciding among choices, it will be useful. A secular ethic that concerns itself solely or primarily with questions of patient autonomy does not qualify. What does qualify, and qualifies best for Jews (in my opinion), is a system that bases its conception of moral goods on Torah, modified by Reform Jewish principles (some of which are decidedly secular, and which do include the principle of autonomy).

I believe that Benjamin Freedman is precisely correct when he says that secular and halachic approaches are complementary: secular bioethics is best at answering questions such as "Who should decide?" while halacha is best at answering questions such as "How

should decisions be made?"[6] Both secular and halachic approaches to issues are necessary at different times, but I would say that asking "What should be done?" is the primary question, and one whose answer often obviates the need for the other two.

If I am a physician, the question is "What should be done for this patient in front of me?" If I am a congregational rabbi, I ask the same question, substituting "congregant" for "patient." Other examples could be given, but the point is that asking "What should be done?" is the same as asking, "What is the right way to walk?" which is the same as asking, "What is the halacha?"

Regarding the question of "Who has the authority?" I do not think it difficult in the least to defend the notion that the physician has better insight into the best *medical* interests of the patient. Who better than a professional healer to solve our medical problems? Should we, when we have a religious or moral problem, go to the religious professional (the rabbi) and then decide that we know best after all?[7] We don't do this when we have a problem with our house's plumbing, and the reason is self-evident: unless we are plumbers, we trust our pipes to professionals.

At the same time, halacha could benefit from using, at appropriate times, the language of informed consent (with an emphasis on "informed") within its framework of decision-making. As a Reform Jew, and especially as a Reform rabbi, I feel it is my duty to help

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[6] Freedman, Benjamin, Duty and Healing (New York, Routledge, 1999): p. 18.

[7] I believe there is a direct parallel between a physician's expertise and rabbi's. I believe that providing care of the mind and body and providing care of the Jewish soul (for example, via the interpretation of halachic texts in a contemporary context) require very similar skills: higher education, experience, wisdom, and a sense of caring and compassion about people and what is best for them as individuals.

others make informed decisions about their lives, whether the decision is to keep kosher or to keep their father on a respirator.

Also, halacha has yet to use cost/benefit analysis for social policy issues. I believe it is possible for halacha to add to the discussion of such questions as how much society should pay for expensive medical treatment and how much taxpayer money should be allocated, and in what ways, for medical research. All of us, Jews and non-Jews alike, have an interest in becoming informed about such matters that affect our pocketbooks as well as our health.

An ethical question remains regarding non-therapeutic experimentation: it seems that non-Reform halacha instructs us to let *goyim* be the guinea pigs for risky surgery until the risk of death is less than 50%, a rule which seems morally repugnant. On the other hand, Reform halacha posits it as at least commendable, if not a duty, for us Jews to give medical and scientific information to the world. During World War II, Jews (and Chinese) gave vast amounts of medical and scientific information to the world completely involuntarily. Perfectly healthy humans were killed and dissected to produce anatomy books; others were deliberately infected with diseases or subjected to extreme temperatures. And these are just a few of the myriad examples of how Jews gave great amounts of scientific knowledge to the world. To suggest, while survivors still live, that we owe the world yet more information (even if voluntarily given) is, well, *premature*, to put it as mildly as possible.

As someone about to become a rabbi, I am dismayed by my awareness of what I do not know. I am just beginning my career in terms of reading and studying and learning. For rabbis, it seems easy and common for there to be a large gap between our knowledge and our pretensions of knowledge; I hope very much to narrow that gap for myself as I continue my lifelong learning. It seems to me, as I look back upon my experiences at Hebrew Union College-Jewish Institute of Religion, that the process of becoming a rabbi is, more than anything, an introduction to humility. I am humbled by how many brilliant scholars and teachers and rabbis have come before me, and I cannot hope to reach their level of knowledge or wisdom. I can however, be pleased and grateful to have the opportunity of becoming a part of the ongoing tradition of Reform Judaism.

However one rules on the issue of medical experimentation – or any other moral or ethical question – it seems imperative to first know what the halacha is, or what the different views of halacha are, and then train our fellow Reform Jews to ask the moral and ethical questions of us, their rabbis. There can be honest disagreement about the halachic answers, and that is how it should be, as long as the questions keep being asked and the conversations continue.

Whose life is it, anyway? Ours at the moment, but ultimately God's.

Appendix A – Halacha Meets the Principle of Informed Consent

The Tenth Annual International Conference on Jewish Medical Ethics
1999 Conference Program

Saturday Evening Program

7:30 PM	Introduction to Session on Informed Consent by Ernest Rosenbaum, MD
7:45 PM	Lecture by Michael Thaler, MD: "Making Ethics: Varieties of Informed Consent in American Medicine and Science"
8:15 PM	Lecture by Paula Walter, JD: "The Law of Informed Consent - the Parameters of the Physician's Duty to Inform"
9:00 PM	Lecture by Avraham Steinberg, MD: "Informed Consent and the Physician-Patient Relationship"
9:30 PM	Panel Discussion chaired by Ernest Rosenbaum, MD

Appendix B – Informed Consent in Halacha

Rosner, Fred, and Tendler, Moshe D., Practical Medical Halachah (Northvale, New Jersey, Jason Aronson Inc., 1997): p. 53.

Question: Must the physician inform the critically ill patient of the seriousness of the illness? Is it sufficient to inform the patient's next of kin?

Answer: In Jewish law, patients suffering from a fatal illness should be told only that they are seriously ill, but the disease should not be identified nor the true prognosis revealed if such revelation might increase the psychotrauma of the patient.

Comment: In the Jewish view, patients suffering from a fatal illness should not be so informed if there is the slightest chance that such knowledge may further impair the physical or mental well-being of the patient. Jewish ethics permit and even require that the facts concerning the true severity of the illness be withheld from the patient. The patient should be made aware that he is seriously ill so that he may be forewarned to "set his house in order," but this should be done without giving the patient a totally negative outlook. Rather, the positive side of the illness including the chance for cure, however remote, should be emphasized. Only in exceptional circumstances should the truth be divulged to the patient. Even then it should be emphasized that medical prognostications may be grossly inaccurate, lest they further reduce the morale and defense capabilities of the patient and his family. Mention of death should be avoided, if possible, lest the will to live be undermined.

Jewish Law – Articles (http://jlaw.com/Articles/MedConsent.html)
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Medical Informed Consent in Jewish Law- from the Patient's Side

Daniel Eisenberg, MD

The usual secular understanding of informed consent is predicated upon the right of the individual to express his autonomy by deciding which actions he will or will not allow to be performed on his body. But as I have written previously, Judaism takes a paternalistic view of many human endeavors, including the practice of medicine. Since man was created in the image of G-d and his body is the property of the Creator, man is given only custodial rights to his body. But if man is charged with being the prudent steward of his body, *required* to accept medical treatment, this would seem to preclude the possibility of there being a meaningful concept of informed consent in Jewish law.
This is not the case! Judaism requires a type of informed consent that while not identical to the secular concept, in some ways is actually more stringent than its secular

counterpart. The key distinction between the secular and the Jewish approaches to informed consent is the difference between rights and obligations. The secular emphasis on autonomy inescapably leads to the conclusion that the patient has the right to refuse any and all medical information. In Judaism, both becoming informed and giving consent for appropriate treatment are required.

The situation is akin to a money manager entrusted with the funds of a client. He is obligated to research all reasonable investment options. After accumulating the necessary information, he MUST decide where to invest his client's money. He MUST invest the money because that is his mandate. Only if he feels that all investment options are unacceptable for his client, based on sound reasoning, may he leave the money as cash. Similarly, as the prudent steward of one's own body, one MUST acquaint oneself with all reasonable medical options, including inaction, before making a decision. But after evaluating all reasonable options, the Torah requires one to choose the sensible option, the one that the prudent steward would choose.

Were medicine to be a monolith, with every problem having an obvious answer upon which all physicians agreed, then the individual would have little say in what medical treatments he wishes to have. All of the patient's research would necessarily lead to the same treatment option and he would be compelled to follow his physician's advice. But in reality, most medical decisions are composed of multiple issues, not all of which are purely medical (social/psychological), but each of which requires evaluation and consultation. Only the most straight-forward problems have obvious answers.

Some decisions are so obvious, that the individual really has no choice. A person diagnosed with bacterial meningitis requires an antibiotic. Refusal to accept the medicine means almost certain death. The risk of ingesting the drug is only a slim chance of a (usually treatable) allergic reaction. The prudent steward MUST accept the antibiotic once the medical reality is laid before him, and in such a circumstance, we may coerce him to "voluntarily" consent to the treatment. How can coerced consent be valid? We merely coerce him to fulfill his obligation of being the prudent steward. This is analogous to the reality of the American "voluntary" tax system that coerces one to voluntary fulfill his obligation to pay taxes.

But what of the patient faced with hazardous surgery? There are many issues to be investigated and clarified before a judicious decision can be made. What are the risks? How long may the surgery be safely postponed? What is the expected outcome? Are there other reasonable options. Answering these questions represents the "informed" part of Jewish informed consent. But once all of the information has been gathered and assimilated, the patient MUST make a decision.

Insight can be gained into the view of informed consent in Judaism from a responsa of Rabbi Moshe Feinstein. He clearly accepted that patient input is crucial in medical decision-making. Only in cases where the treatment is obvious and unequivocal does he advocate coercion (and clearly not physical coercion). But in cases where the patient refuses treatment, he distinguishes between and the patient who is afraid of the pain associated with efficacious treatment and the patient who does not trust the judgment of his doctor (Igros Moshe, Choshen Mishpat II:73e). The former patient should be convinced to fulfill his obligation to receive the appropriate therapy. For the latter patient, we must find a physician whom the patient trusts in order to receive the patient's consent.

This distinction drives home the concept that one is required to accept the rational therapy, but may refuse treatment until he is convinced that the proposed course of treatment is prudent.

Appendix C – The Halachic View of the Physician

(http://ijme.org) *The Institute for Jewish Medical Ethics of the Hebrew Academy of San Francisco.* Reprinted from *Maimonides*: Health in the Jewish World Vol. 2, No. 2 (Summer 1996).

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The Role of a Physician in Jewish Law

Daniel Eisenberg, M.D.

The Torah states: **"I am the L-rd that heals you** !" (Exodus 15:26) This verse implies that G-d does not need man to cure the afflictions that He creates. If so, by what virtue does man attempt to "short circuit" His will and attempt his own meager cures? Does man have any right to heal at all, and if he does, are there any limitations on how it may be accomplished. Is every action done in the name of therapy justified, solely because a physician performs it? Because Judaism recognizes the enormity of these questions, it requires direct permission from G-d to permit the practice of medicine and carefully circumscribes the limits of medical practice. Fortunately, the duty to save one's fellow man is well grounded in the Torah and the restrictions are discussed at length in our codes of Jewish law.

The Talmud derives the obligation to rescue one's endangered fellow from the verse "Do not stand idly by the blood of your neighbor" (Leviticus 19:16). This verse requires one to prevent accidents or injuries, it does not imply any duty to heal . The obligation to heal is traditionally derived from Exodus 21:18-19: "And if two men fight, and one hits the other with a stone or his fist, and [the victim] does not die. . . [the aggressor] shall cause [the victim] to be thoroughly healed (i.e. pay the physician's bill)". It naturally follows that if one must pay the doctor's bill, the physician must be allowed to treat the patient. Alternatively, Maimonides derives the obligation to heal from the verse "and you shall return it [a lost object] to him"(Deuteronomy 22:2). While other commentators interpret this verse to command us to return a person's "lost body" as well as his lost property (i.e. aid one's friend in times of danger), Maimonides goes further and derives the obligation of physicians to treat patients from this verse. Further, he states that this verse represents a Biblical commandment to every person, each according to his ability, to restore the health of his fellow man. So not only may we not stand idly by as our neighbor is endangered, but we must aggressively attempt to return his health to him, including utilizing medical treatments.

But with the sacred privilege of healing comes inherent limitations. For example, the thought of a physician assisting a patient to commit suicide is anathema to a Jewish view of medicine. Physicians (and for that matter, anyone else with medical knowledge such as nurses, EMT's, or lifeguards) are granted a mandate to heal. However, it is unequivocally clear from halacha that permission is granted to a physician to treat a patient only when he

can offer that patient therapy that can be reasonably expected to be efficacious (this, at times, may include even experimental treatments which could be helpful).
When a physician cannot offer effective therapy, cannot alleviate pain, and cannot cure the patient, he ceases to function as a physician. In such a case, he has no more of a license than anyone else to cause harm to another person. Physician-assisted suicide is just plain wrong because it undermines the mandate which the Torah grants to physicians to be G-d's partners in the treatment of the sick.
The Jewish view of medicine is possibly best expressed by the Shulchan Aruch (Code of Jewish Law) when it explains both the great opportunity and the awesome responsibility that is granted to physicians:
The Torah gives permission to the physician to heal; moreover, this is a religious obligation and it is included in the obligation of saving a life. If he withholds his services, he is considered a shedder of blood. . . . However, one may not engage in healing unless he is an expert and there is none better qualified than him present, because if this is not the case, he is considered a shedder of blood. (Yoreh Deah 336: 1)

Your responses to my previous column were greatly appreciated and I encourage your continued input. I can be reached at *eisenber@pol.net.*

Appendix D – Secular Medicine – Between Paternalism and Autonomy

(http://www.acponline.org/journals/annals/01nov96/balance.html)

Physician Recommendations and Patient Autonomy: Finding a Balance between Physician Power and Patient Choice

Annals of Internal Medicine, 1 November 1996. 125:763-769.
Timothy E. Quill, MD, and Howard Brody, MD, PhD

Medical care in the United States has rapidly moved away from a paternalistic approach to patients and toward an emphasis on patient autonomy. At one extreme end of this spectrum is the "independent choice" model of decision making, in which physicians objectively present patients with options and odds but withhold their own experience and recommendations to avoid overly influencing patients. This model confuses the concepts of independence and autonomy and assumes that the physician's exercise of power and influence inevitably diminishes the patient's ability to choose freely. It sacrifices competence for control, and it discourages active persuasion when differences of opinion exist between physician and patient. This paper proposes an "enhanced autonomy" model, which encourages patients and physicians to actively exchange ideas, explicitly negotiate differences, and share power and influence to serve the patient's best interests. Recommendations are offered that promote an intense collaboration between patient and physician so that patients can autonomously make choices that are informed by both the medical facts and the physician's experience.

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Patients faced with serious medical decisions are subject to being over- or under-influenced by physicians. Imagine a patient who is admitted to an intensive care unit with a chronic, progressive illness and has a small but real chance of leaving the hospital alive if he submits to invasive treatment. The patient feels that he has suffered enough, and he requests supportive care only. By the luck of the draw, he has been assigned one of three hypothetical physicians. Dr. Able minimizes the patient's request for supportive care, heavily emphasizes the patient's small chance of recovery and her own strong belief that the patient should not "give up," and convinces the patient to continue receiving aggressive therapy. Dr. Baker makes sure that the patient understands his options and the statistics associated with them and then accedes to the patient's request for supportive care without sharing his own opinion, which is that the patient is making a serious mistake. Dr. Charlie enters into an extended dialogue with the patient, explores various alternatives,

and recommends that the patient try aggressive therapy. When the patient continues to request a palliative approach, Dr. Charlie struggles openly with the patient about her concern that he is making this transition prematurely. Through conversation, Dr. Charlie learns the rationale behind the patient's decision and assures herself that the patient is well informed. She then initiates a palliative care plan.

Data from SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment [1]) suggest that the dominant mode of decision making in acute care hospitals may still be the paternalism evidenced by Dr. Able. However, recognition of the value of patient autonomy has gained strength in the United States, and a new generation of physicians has been trained in a "patient-centered" approach (2). Some "patient-centered" physicians have gone beyond encouraging patients to participate in medical decisions, forcing them to make decisions almost independently. Dr. Baker allowed the patient in the above scenario to take full control of a critical decision, but he avoided the intense interaction that would have resulted if he had shared his own reservations. He tried to respect his patient's autonomy, but he did so at the cost of withholding his recommendations. On the other hand, Dr. Charlie allowed her patient to have a central role in the final decision but only after fully exploring the implications of that decision and sharing her belief that palliative care was not the patient's best choice. Such intense interactions between patient and physician may allow patients to exercise autonomy more powerfully by making choices that fully integrate the physician's experience with their own.

The Shift from Paternalism to Autonomy

Twenty-five years ago, most major medical decisions were left exclusively in the hands of physicians. They were usually made with beneficent intent but without open discussion, much less the full participation of the patient (3-6). This paternalistic approach had some benefits. Physicians struggled to make the best possible decisions on behalf of patients, and they spared patients and their families from agonizing about interventions that had little chance of working. Practitioners also had much more control over the way that medical technology, with its increasing potential to help as well as to harm, was used. In retrospect, physicians now see obvious problems with excessive paternalism: It can be difficult to determine what a patient's best interests are (7); inappropriate biases caused by sex, race, and socioeconomic status can affect decision making (8, 9); and patients can be deprived of the opportunity to make decisions that reflect the reality of their conditions. However, some of the truly beneficent potential of medical paternalism has been lost.

In the United States in the late 20th century, the pendulum has swung away from paternalism and toward patient autonomy (10, 11). Too often, "autonomous" patients and families are asked to make critical medical decisions on the basis of neutrally presented statistics, as free as possible from the contaminating influences of physicians. The causes of this trend are multifactorial. The consumer movement has taught patients to be more assertive, to question physicians' recommendations, and to demand interventions that might otherwise be withheld (12, 13). Many physicians feel that giving patients the full range of choices and withholding their own recommendations are safeguards against lawsuits (14, 15). The probabilistic nature of medical decision making in real life is in unnerving contrast to the grand successes and simplistic solutions suggested in the mass

media (16, 17). The information explosion within the field of medicine has left physicians and their patients uncertain about whether the limitations they encounter are inherent in medicine or are a reflection of deficits in the physician's expertise (18, 19). Furthermore, when a bad outcome results from a good clinical decision, the chagrin that a physician feels is more emotionally painful-and the risk for being sued is higher-if that decision was recommended to the patient (16, 20). Many physicians have come to believe that the safest course is to withhold their recommendations and give patients the "choice" of any treatment they might "want."

We intend to show that physicians fail to use their power appropriately when they withhold their guidance. This failure reflects a misunderstanding about the moral requirements of respecting patient autonomy. We compare an "independent choice" model of medical decision making with an "enhanced autonomy" approach (Table) and suggest ways to achieve a more effective, respectful balance between physician recommendations and patient choice.

Independent Choice

According to the independent choice model, the physician's primary role in medical decision making is to inform patients about their options and the odds of success. Patients should be free to make choices unencumbered by the contaminating influence of the physician's experience or other social forces (19). The independent choice model is literally "patient-centered" and requires that physicians withhold their recommendations because they might bias the patient (21). The physician should objectively answer questions but should avoid influencing the patient to take one path or another, even if the physician has strong opinions or if the patient asks for advice. After the patient makes the decision, the physician's duty is to implement the medical aspects of that decision. As evidence of the force and pervasiveness of the independent choice model, debates rage about whether patients have the right to choose futile treatment (22, 23) and continue it indefinitely (24).

A generation of physicians has now been trained under the independent choice model, and this has created new problems as serious as those posed by medical paternalism. The physician as a person, with values and experience, has become an impediment to rather than a resource for decision making. More objective treatment algorithms could better be presented by using interactive computer systems. Physicians may gradually regress from refusing to express their recommendations to not valuing them or to not even formulating them. Too often, the intense exchanges on medical rounds about what should be done have been replaced by a bland recitation of statistics. The primary intellectual exercise is to cover all of the possibilities, the odds associated with them, and their implications for treatment. The central clinical tasks are to inform patients about their medical options and then to carry out patients' decisions. Patients in this situation often navigate treacherous medical terrain without adequate medical guidance.

Enhanced Autonomy

The independent choice model reflects a limited conceptualization of autonomy (25-27). Under this model, it is thought that an independent choice is best made with no external

influence, even when one's competence to make the choice is limited. However, autonomous medical choices are usually enhanced rather than undermined by the input and support of a well-informed physician. Only after a dialogue in which physician and patient aim to influence each other might the patient fully appreciate the medical possibilities (28-31). Consider, by analogy, the decision to select medicine as a career. Few potential physicians made this decision by wandering alone in the desert to avoid being influenced by the biases of others. Most engaged both peers and senior mentors in extended conversations, confident that they could correct for any biases. The absence of valuable advice that would result if they did not engage experienced persons outweighed the danger that the final choice would be made as a result of inappropriate influence. It is patronizing to imagine that our patients cannot make decisions in a similar manner, especially when many are desperately asking for guidance.

Enhancing patient autonomy requires that the physician engage in open dialogue, inform patients about therapeutic possibilities and their odds for success, explore both the patient's values and their own, and then offer recommendations that consider both sets of values and experiences. This model is "relationship-centered" (both patient and physician, and sometimes family members and others, are included in the decision making process) rather than exclusively patient-centered (32). It denies neither the potential imbalance of power in the relationship nor the fact that some patients might be inappropriately manipulated or coerced by an overzealous physician. It assumes that an open dialogue, in which the physician frankly admits his or her biases, is ultimately a better protector of the patient's right to autonomous choice than artificial neutrality would be. Because the biases of a physician will probably subtly infiltrate the conversation even if he or she tries hard to remain neutral, it may be better to explicitly label these values than to leave them outside of the conscious control of either participant. Empirical studies have shown that enhanced support of patient autonomy has been associated with better outcomes in substance abuse treatment, weight reduction, and adherence to treatment regimens (29-31).

The physician-patient dialogue that characterizes the enhanced autonomy model includes active listening, honest sharing of perspectives, suspension of judgment, and genuine concern about the patient's best interests (33). In contrast, discussions typical of the independent choice model are often restricted by concern over the potential for domination and control and therefore fail to fully explore positions and perspectives. In these discussions, physicians objectively share medical information but refrain from expressing their personal experiences and recommendations, ostensibly to enhance the patient's power to make an independent choice. Dialogues that enhance autonomy engender a different dynamic between physician and patient; their primary objective is to achieve as full an understanding of the meaning of the problem as possible. The assumptions, values, and perspectives of both participants are fully explored. Sometimes, this process of mutual exploration leads to the invention of new solutions; at other times, the meaning of an intervention changes for one or both participants.

The enhanced autonomy model allows the physician to support and guide the patient's decision making without surrendering the medical power on which the patient depends. The independent choice model assumes that if the patient is to gain power to make autonomous choices, the physician must correspondingly lose power. The enhanced autonomy model understands that power in the physician-patient relationship is not a zero-

sum quantity (34). Accepting the physician's power to offer recommendations-while obligating the physician to fully understand the patient's reasoning when those recommendations are rejected-enhances rather than reduces the patient's power and competence.

Although the enhanced autonomy model discourages physicians from underusing their personal influence, the potential for the abuse of physician power should not be minimized. A trainee, by analogy, might unconsciously select medicine as a career to appease a dominating parent, only to find him- or herself conflicted and unhappy with the choice. Similarly, a dying patient made vulnerable by disease may agree to continue receiving aggressive life-sustaining treatment to appease a physician who cannot "give up." The obvious risks associated with the overuse of physician power and control mirror the risks associated with their underuse. A more nuanced balancing of risks and benefits is needed, in which neither the patient nor the physician acts in isolation from the other. Patients want physicians who are not afraid to use their power, but they also want to trust them to use that power to assist them through a crisis and not to control or coerce them.

Implementing Enhanced Autonomy: Tailoring Power to the Person

An 84-year-old man presented to the emergency department with acute abdominal pain that was probably the result of a ruptured diverticulum. When he refused to have surgery, his primary care physician and his family were summoned to convince him to consent. They confirmed that the patient's refusal of treatment was consistent with his long-stated and deeply held beliefs. The patient had previously completed an advance directive, which stated that he wanted no medical intervention other than morphine for pain no matter what the problem or situation.

The physician had difficulty in accepting the patient's decision because the patient's condition was relatively easy to treat and the patient's quality of life seemed to be excellent. The physician tried to persuade the patient to accept treatment, promising that the treatment could be stopped if the suffering became too great. In addition to explaining the clinical reasoning behind her recommendation for surgery, the physician also explored the patient's reasons for refusal. The patient spoke movingly about watching his spouse and many friends die "in pieces" from the gradual deterioration of their bodies and minds. He feared ending up in a nursing home, dependent on strangers, or a burden to his children. He spoke about the loneliness of outliving his wife and most of his friends and about his limited quality of life even before this illness. He felt that he would be joining his wife in the next life, and he was emotionally and existentially prepared for death. After hearing his entire story, ensuring that he understood his alternatives, and discussing the situation with his family, the physician agreed to provide comfort measures only. The patient was put on a morphine drip and died quietly and comfortably within 24 hours.

To use medicine's power in a personalized way, physicians must become expert not only in the science of clinical medicine but also at learning about patients as unique human beings with life histories and values that must be used to guide treatment (35-38). Treating a ruptured diverticulum only with morphine makes no sense from a purely medical point of view. However, given this patient's values and views about quality of life, an appropriately expanded notion of the "medical viewpoint" might concur with the conservative treatment plan.

One might have resolved this clinical situation by resorting to simple ethical principles. For example, our obligation to fight for life might have driven us to question this patient's competence to refuse treatment. If he had been delirious when he arrived at the hospital, he would probably have had surgery despite his advance directive and his physician's and family's knowledge of his wishes. Doubt could easily have been created about whether the advance directive covered this particular situation. On the other hand, one might appeal to the autonomy-based maxim that states that all competent patients have the right to refuse treatment. According to this principle, the morphine drip should have been started as soon as the patient's ability to make an informed decision could be confirmed. Instead of taking either of these approaches, the physician struggled through the issues with the patient, fully exploring his wishes until they were more comprehensible and making sure he fully appreciated what he was giving up. The physician actively tried to persuade the patient to consent to surgery. However, as the physician explored the patient's story of loneliness, his diminished quality of life, and his fears of the future, a more meaningful conceptualization of the problem began to emerge. This potentially divisive decision became part of a process during which patient, physician, and family all felt connected. The central philosophical point of autonomy is respect for the patient as a person (39). It is not respectful to spare persons from advice or counsel just to maintain neutrality, nor is it respectful to treat persons according to rigid protocols, whether for "aggressive treatment" or "palliative care." Respecting a person means taking the time to listen to that person's unique story and ensuring that medical decisions are integrated into the current chapter of the patient's biography (35-39). If a patient's decision does not make sense in the context of his or her unique story, physicians must explore and come to understand discrepancies by asking detailed questions and openly sharing discomfort. Although the final decisions belong to patients, the decisions that result from the intense exchange of medical information, values, and experiences between physician and patient are generally more informed and autonomous than are those made simply on the basis of patient requests.

Patients and surrogate decision makers need their physicians' recommendations, as long as they have the freedom to accept or reject them. Because patients ultimately reap the benefits and burdens of medical decisions, we must end by respecting patient autonomy unless there is a very compelling reason not to do so. Yet to accept a patient's choice when it flies in the face of strong recommendations, without a full exploration and vigorous exchange of ideas and perspectives, can be tantamount to abandonment (40). This exchange between two persons who disagree but who both care deeply about what happens to the patient often yields better decisions than those that would have been made by either the physician or the patient independently. Sometimes the decision itself does not change, but the meaning of the decision to both participants is more fully appreciated. At other times, exploration leads to a better decision, one that can embrace the best of both positions.

Recommendations for Enhancing Patient Autonomy

1. Share your medical expertise fully while listening carefully to the patient's perspective. Medical information should be transmitted in digestible pieces in language the patient can understand, and sufficient time should be allowed for questions. Physicians must also learn

about the personal meaning that the decision being made has in the context of the patient's values and experience. Significant discrepancies between the patient's values and experiences and those of the physician require careful exploration to look for common ground. These exchanges take time.

2. Recommendations must consider both clinical facts and personal experience. Most patients want to hear their physician's perspective, but the patient's values and experience, as perceived by the physician, should be integrated into any recommendation. If the physician has strong personal views about the dilemma that the patient faces, he or she should openly acknowledge those views and give the patient some understanding about where they come from. Biases and relevant experiences should not be hidden but should be an integral, explicit part of the discussion.

3. Focus first on general goals, not technical options. Negotiating with the patient about the technical aspects of management without articulating the general goals of therapy often leads to the "choosing" of treatments that are not in the patient's best interests (41, 42). "Advance directive" questions, such as "Would you want to be put on a machine to clean your blood in case your kidneys stop working?" should be replaced by questions that focus on overarching goals ("If, in the future, you become severely ill and lose the ability to speak for yourself, would you want medical treatments used to prolong life or to keep you comfortable?") (43, 44). Of course, requests by patients for more details about the technicalities should be fully answered.

4. Disagreements should initiate a process of mutual exchange. When the physician's recommendations and the patient's wishes differ seriously, careful exploration should determine areas of agreement as well as differences (11, 41, 42). Agreement about the methods of treatment is unlikely when patient and physician disagree about the nature of the problem, the prognosis, or the goals of treatment. Dissecting the problem into its component parts and exploring each aspect usually leads to a more meaningful conceptualization and the opportunity for creative problem solving.

5. Final choices belong to fully informed patients. It is hoped that during the process of informing one another, physician and patient will reach a common understanding of the clinical dilemma, the underlying values, and the best course. However, if serious disagreements persist, the final decision belongs to the patient. If the chosen course violates the physician's fundamental values, he should inform the patient of that fact and perhaps help the patient find another physician. It is hoped that such transfers will be rare.

6. Physicians must work to refine and express their own voices. We must do a better job of training medical students, residents, and practitioners to articulate their values and opinions in an open and modulated way. Recommendations are often the beginning rather than the end of an exchange that will ultimately determine the course the patient chooses. Deciding what and how to recommend, learning how to negotiate without dominating, and taking the risk of sharing responsibility for the bad outcomes that can result from good decisions requires practice and improves with experience. Being direct and honest with patients without over- or under-influencing them is a skill that should be developed during clinical training by integrating negotiation and power sharing skills with training in medical interviewing, clinical reasoning, and self-awareness.

Discussion

If these recommendations are to work, some of the sociocultural factors that make it risky for physicians to share recommendations also need to be addressed (12-20). Educational efforts directed exclusively toward physicians are likely to have limited effectiveness unless there is a simultaneous increase in public understanding of the consequences of two trends: 1) the increasing "medicalization" of our lives (12, 13) and 2) the overuse of medical technology in a futile attempt to eliminate uncertainty (45). Because these trends reflect complex sociologic phenomena, finding the middle ground between physician recommendations and patient choice is not simple.

Other moral considerations may override an individual patient's right to autonomous choice or even to participation in a decision. Justice may demand that one patient is not given what is individually optimal because another patient has a greater moral entitlement to a scarce resource. Thus, if the hospital's intensive care unit is full and no patient is stable enough to be transferred from it, the relatively stable patient may be sent to a more distant intensive care unit. Professional integrity may also require that the physician refuse to provide requested treatments that have been established to be either futile or harmful (46). Furthermore, mental competence must be assured before patients can be allowed to make decisions that appear to be against their own best interests (for example, a suicidal patient who wants to be discharged probably should not be). These limitations can make the process of shared decision making more complex; however, they do not detract from the physician's primary duty, which is to support and enhance patients' abilities to make autonomous choices about health care.

By taking the risk of informing patients about their own feelings, values, and recommendations, physicians can deepen and enrich medical decisions so that they are both personal and professional. All medical decisions have value-laden consequences and thus should be made in the context of a multidimensional exchange of ideas, values, feelings, and experiences between physicians and patients. The physician is as much guide and fellow traveler as technician and medical expert. The spirited exchange that characterizes joint decision making by persons who care deeply about the patient's outcome, described in the enhanced autonomy model, is a far cry from both the coerciveness of paternalism and the remoteness of the independent choice model. Final choices belong to patients, but these choices gain meaning, richness, and accuracy if they are the result of a process of mutual influence and understanding between physician and patient.

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Appendix E -- A Court Case Regarding Risky Surgery Performed Under Nonemergency Conditions

(http://laws.findlaw.com/7th/951523.html)

In the United States Court of Appeals For the Seventh Circuit No. 95-1523
LORETTA MURREY, as Administratrix of the Estate of THOMAS D. MURREY, Plaintiff-Appellant, v. UNITED STATES OF AMERICA, Defendant-Appellee.
Appeal from the United States District Court for the Northern District of Illinois, Eastern Division. No. 92 C 2609--George W. Lindberg, Judge.
ARGUED SEPTEMBER 29, 1995--DECIDED JANUARY 18, 1996 Before POSNER, Chief Judge, and KANNE and DIANE P. WOOD, Circuit Judges.
POSNER, Chief Judge.

Thomas Murrey died of massive internal bleeding the day after his prostate gland was removed in an operation in a Veterans Administration hospital in North Chicago. His estate brought suit under the Federal Tort Claims Act. After a bench trial, the district judge rendered judgment for the United States. The appeal presents a number of issues, which a simple narrative of the events culminating in Murrey's death can best organize. Murrey first visited the hospital in 1986. He was 65, and had just retired. He came to the hospital with multiple ailments--high blood pressure, obesity, chronic bronchitis, emphysema, psoriasis, and hypoglycemia--for which various medications, and changes in diet, were prescribed. He returned in 1989, now aged 68, with urological complaints, and was diagnosed as having prostate cancer. It was, we infer from the medical records, a fairly aggressive, fairly advanced case of prostate cancer, but it was not believed to have spread yet outside the prostate. The urologists at the hospital advised Murrey to have a radical prostatectomy--that is, surgical removal of the entire prostate. The widow testified that because of her husband's fear of surgery, both of them asked the urologists about the alternative of radiation treatment and were told that surgery was the better alternative because of Mr. Murrey's "great" physical condition and because the hospital did not offer radiation treatment. The government admits that the urologists advised the Murreys that he should have the operation. There is evidence, forming the basis of the plaintiff's claim that the hospital failed to obtain Murrey's informed consent to the operation, that given his age and the stage of his cancer the choice between surgery and radiation was pretty much a toss-up in terms of the efficacy of the respective treatments--quite apart from the greater risk of death from the operation than from radiation (Craig Fleming et al., "A Decision Analysis of Alternative Treatment Strategies for Clinically Localized Prostate Cancer," 269 JAMA (Journal of the American Medical Association) 2650, 2652 (1993)) and the greater likelihood of unpleasant side effects, such as impotence and incontinence. The district judge did not make any findings on whether the hospital had obtained Mr. Murrey's informed consent. The judge held, without discussion, that failure to obtain informed consent is a species of misrepresentation and is therefore excluded from the Tort Claims Act's waiver of sovereign immunity by 28 U.S.C. sec. 2680(h). The government does not defend the ground of the judge's ruling, but does argue that the claim is barred by not having been included in the administrative claim that the Act requires be filed within

two years of the accident. 28 U.S.C. secs. 2401(b), 2675(a). Neither ground is tenable. The exclusion of claims of misrepresentation is designed to protect the government from being sued for fraud and other torts that come under the general legal heading of misrepresentation, whether intentional or negligent, United States v. Neustadt, 366 U.S. 696, 702 (1961); Office of Personnel Management v. Richmond, 496 U.S. 414, 430 (1990), injuring merely the pocketbook. It does not exclude claims of physical injury that happen to involve, as many do, an element of communication or misleading silence. United States v. Neustadt, supra, 366 U.S. at 711 n. 26; Krejci v. U.S. Army Material Development Readiness Command, 733 F.2d 1278 (7th Cir. 1984). Battery, for example, is battery, not fraud, even when it takes the form of sexual penetration permission for which was obtained by the "batterer's" concealing the fact that he has a sexually transmittable disease. Crowell v. Crowell, 105 S.E. 206 (N.C. 1920); Desnick v. American Broadcasting Cos., 44 F.3d 1345, 1352 (7th Cir. 1995). The negligent infliction of personal injury, which is the classic tort that the Tort Claims Act allows the United States to be sued for, does not cease to be such when the negligence consists of a failure to warn. That is a feature of many garden-variety personal injury suits. If a train fails to blow its whistle at a crossing and a pedestrian crossing the tracks is lulled by the silence into thinking he is safe, and is killed, we call the railroad's tort negligence, not misrepresentation. Failing to advise the defendant of the risks of a medical procedure (which later materialize), or of the advantages of an alternative procedure that would involve fewer risks, is likewise a failure to warn that if it results in personal injury is classified as a tort of negligence, not a tort of misrepresentation. Keir v. United States, 853 F.2d 398, 411 (6th Cir. 1988); Ramirez v. United States, 567 F.2d 854, 857 (9th Cir. 1977) (en banc); Hicks v. United States, 511 F.2d 407, 414 (D.C. Cir. 1975). But to base a suit on lack of informed consent Murrey's estate was required to include, or at least to allude to, the issue of informed consent in the administrative claim. The statute requires a plaintiff to file his or her "claim" with the relevant agency, 28 U.S.C. sec. 2675(a), but it does not define "claim." The word could mean the same thing it means in the Federal Rules of Civil Procedure--what used to be called a "cause of action," or in layman's terms a legal basis for suit. The plaintiff has two such bases. The main one, to which we shall come in a moment, is negligence in the treatment of Mr. Murrey when, on the morning following the operation, he began to hemorrhage internally. The subordinate one is the failure to obtain his informed consent to the operation. These are distinct grounds of liability arising from distinct facts. They are therefore separate claims within the meaning of the civil rules. The cases interpreting section 2675(a) say that the administrative claim is to be interpreted more liberally than a complaint. Johnson by Johnson v. United States, 788 F.2d 845, 848-49 (2d Cir. 1986); Broudy v. United States, 722 F.2d 566, 568-69 (9th Cir. 1983); Bush v. United States, 703 F.2d 491, 494 (11th Cir. 1983). There is a tiny textual hook to hang this distinction on: "claim" as used throughout the civil rules is short for "claim for relief," Fed. R. Civ. P. 8(a), whereas "claim" in the Tort Claims Act may carry its ordinary-language meaning of demand. (The tort claimant is required to demand money damages in a "sum certain." 28 C.F.R. sec. 14.2(a); Manko v. United States, 830 F.2d 831, 840 (8th Cir. 1987).) A "claim" under the civil rules is embedded in a complaint, which also contains a demand for relief. The free-standing "claim" to which the Tort Claims Act refers is the counterpart of the complaint, rather than of the claim, under the

civil rules. A more important consideration is that complaints can be amended at any time with leave of court, which "shall be freely given when justice so requires." Fed. R. Civ. P. 15(a). Even if the amendment adds a claim after the statute of limitations has run, the new claim will not be barred if it arises out of the same transaction or occurrence as the original claim. Fed. R. Civ. P. 15(c)(1). As a result, the penalty for failing to state the right claim or all your claims in the original claim is usually small and often nonexistent. But if your administrative tort claim is found to have been inadequate, the court is divested of jurisdiction over your suit. There is no "relation back" provision corresponding to Rule 15(c)(1) of the civil rules. Lee v. United States, 980 F.2d 1337, 1339 (10th Cir. 1992). The purpose of the requirement of filing an administrative claim is to make sure that the plaintiff exhausts his administrative remedies before bringing suit. The purpose would be thwarted if he could add new claims after suit has begun. But the fact that failing to file a timely administrative claim has such a fell consequence argues for greater liberality in determining whether the administrative claim is adequate. It is imprecise, however, to say that section 2675(a) requires less formality than Rule 8(a). When cases like Johnson by Johnson v. United States contrast the requirements of the Tort Claims Act with "formal pleading requirements," 788 F.2d at 848, they forget how relaxed and informal are the pleading requirements under the civil rules' "notice pleading" regime, Conley v. Gibson, 355 U.S. 41 (1957); Jackson v. Marion County, 66 F.3d 151 (7th Cir. 1995), and how ultraliberally those relaxed and informal requirements are interpreted when the plaintiff is unrepresented. Haines v. Kerner, 404 U.S. 519 (1972) (per curiam). It is unclear just how much space there is between a minimal complaint adequate under the civil rules and a minimal claim adequate under the Tort Claims Act though not under the civil rules. There is a deeper objection to viewing section 2675(a) as a step beyond Rule 8(a) along the path of ever-diminishing formality. By leaving "claim" undefined, Congress invited the Department of Justice to define the word through regulations. The Department has done that, more or less, in 28 C.F.R. sec. 14.2(a), which provides that "a claim shall be deemed to have been presented when a Federal agency receives from a claimant, his duly authorized agent or legal representative, an executed Standard Form 95 or other written notification of an incident, accompanied by a claim for money damages in a sum certain for injury to or loss of property, personal injury, or death alleged to have occurred by reason of the incident." The reference to "Standard Form 95" indicates that a claim, to pass muster, must contain the information required by the form. By examining the form, we can determine how much detail is required and whether Murrey's submission satisfied the requirement. The document that the plaintiff's lawyer submitted to the Department of Veterans Affairs is captioned "Claims," not "Claim." The document has four sections, of which the first is captioned "The Claim" and the second "Thomas D. Murrey Biography" (the third and fourth concern the amount of damages sought). "The Claim" is the two-page Standard Form 95, which asks for, among other things, the "Basis of Claim." The form explains what this means by telling the claimant to "state in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof." The form adds, "Use additional pages if necessary"--for the space allotted to the detailed statement of "known facts and circumstances" is only two inches long. Although the only events that the plaintiff narrated in the space provided are the surgery and its sequel and

the only "claim" mentioned concerns the treatment of Murrey's postoperative bleeding, the "biography" that follows the standard form includes the following statement: "On November 15, 1989, Tom [Murrey] entered the Veterans Hospital in North Chicago to undergo a radical prostatectomy. He was extremely fearful of this surgery. However, V.A. physicians assured him and his family that surgery was the only available therapy, and that it would extend his life by 15 years." This is a statement of the essential facts underlying a claim of failure to obtain informed consent. Standard Form 95 resembles a civil complaint in not requiring a statement of legal theories, but differs in requiring a detailed statement of facts. It is in this respect more demanding, more "formal" if you will, than the civil rules--a throwback, perhaps, to the era of "fact pleading" that preceded the adoption of those rules. But as no statement of legal theories is required, only facts plus a demand for money, the claim encompasses any cause of action fairly implicit in the facts. The reader of the "Claims" document submitted by Murrey's estate was not invited to stop with the standard form; nor does 28 C.F.R. sec. 14.2(a) require that the narrative of facts be confined to the form. The form itself, as we saw, invites supplementation with additional pages. Clearly, the entire "Claims" document was intended to be read, and if it was read the informed-consent claim would leap out at the legally sophisticated reader. The government thus had all the notice that the law required--a conclusion strongly supported by Rooney v. United States, 634 F.2d 1238, 1242-43 (9th Cir. 1980), a factually similar case.

We do not go so far as the Fifth Circuit, which in Frantz v. United States, 29 F.3d 222 (5th Cir. 1994), held that a claim of failure to obtain informed consent is implicit when the administrative claim alleges medical negligence and investigation would turn up the facts showing that failure. We agree rather with the Eleventh Circuit in Bush v. United States, supra, 703 F.2d at 495, that the administrative claim must narrate facts from which a legally trained reader would infer a failure to obtain informed consent. But it did. The judge's refusal to make findings on whether the hospital obtained Murrey's informed consent to the operation was therefore error. We offer no opinion on the merits of the claim. To conceal from a patient the alternatives to major surgery is a serious form of medical negligence, Zalazar v. Vercimak, 633 N.E.2d 1223, 1226 (Ill. App. 1993); Magana v. Elie, 439 N.E.2d 1319, 1321 (Ill. App. 1982); Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972), but the evidence is in conflict over what the Murreys were told. The operation took seven hours, and afterward Murrey was placed in the Intensive Care Unit. He seemed fine. The plaintiff believes that the hemorrhaging which occurred the next day and killed Murrey may have been due to some negligent mishap in the operation itself. But the evidence was very thin, and the judge did not commit a clear error in rejecting this theory of liability. The cause of the hemorrhaging has never been determined, in part because no autopsy was performed on Murrey. The plaintiff argues that the hospital misled the family about the cause of Murrey's death, leading them to believe that an autopsy was unnecessary, and as a result the hospital committed a distinct tort of failing to preserve evidence for the suit. However, this tort, if it is a tort, is barred by the exemption for torts of misrepresentation. At 8:35 on the morning after the operation, Murrey was given morphine because he was complaining about abdominal discomfort. Within five minutes his blood pressure was observed by the nurses to have

dropped significantly, and a critical-care resident assigned to the Intensive Care Unit, Dr. Jankowski, was immediately summoned. Murrey's blood pressure had dropped so low--to 64/51--that Jankowski strongly suspected that Murrey was in shock. Shock in the medical sense can be induced by various things, including infection, a heart attack, a pulmonary embolism--and bleeding. Although Jankowski suspected that Murrey's shock was caused by internal bleeding, she administered tests designed to exclude the other possibilities and was not sure that the cause was bleeding until the tests were completed at 9:57 a.m. The plaintiff argues that Jankowski should not have waited for the completion of the tests before concluding that Murrey was hemorrhaging and should therefore be dispatched immediately to an operating room for surgery. But we think the district judge did not commit clear error in finding that the delay of an hour or so in making a definitive diagnosis was within the outer bounds of a responsible professional judgment. The decision to start cutting into someone looking for a source of internal bleeding (for Jankowski had already ascertained that the wound from the surgery was not bleeding) is not a step to be taken lightly. What is true is that by 9:57, as it now appears in hindsight, Murrey's prospects for survival were dim. His own expert testified that even if Murrey had been operated on immediately to stop the internal hemorrhaging, he would have had only a 5 to 10 percent chance of surviving. It does not matter, as far as liability is concerned, how good or bad his prospects were (obviously it matters greatly to the amount of damages). The government does not deny that under the law of Illinois (which governs the substantive issues because the alleged tort occurred there, see 28 U.S.C. secs. 1346(b), 2674), the loss of a chance is compensable. Actually, the question is unsettled in Illinois. Hajian v. Holy Family Hospital, 652 N.E.2d 1132, 1137-38 (Ill. App. 1995). But the government is bound by its concession, and our guess is that the Supreme Court of Illinois, should the question ever be put to it, will answer in favor of liability. A loss is a loss even if it is only probable, as are most things in life. No doubt Murrey would have paid a lot (if he had had a lot to pay) for a 5 percent chance of survival if the alternative was a certainty of immediate death. This shows that he lost something by being deprived of that chance. If 200 people were in Murrey's situation and received improper care, we would expect 10 to have survived if all 200 had received proper care, so that if none of the 200 was entitled to any damages the hospital would have escaped liability for malpractice that had caused a number of deaths in a realistic sense of "cause." Damages for loss of a chance are necessary to prevent the underdeterrence of medical negligence. We add that the issue of informed consent, unlike the issue of negligence in responding to postoperative complications, does not involve the loss of a chance. If Murrey would not have elected surgery had he been given an accurate picture of the choices, he would not have died on November 16. At 10:00 a.m., doubts about the cause of Murrey's shock having been dispelled, he was ready for surgery. But he was not moved to an operating room until 11:30. The surgery began at noon. The hour and a half delay in getting him to an operating room may have been fatal. He died on the operating table at 3:10 that afternoon. There is disagreement over why it took an hour and a half, rather than a few minutes, to get him to an operating room. There is evidence to support the plaintiff's theory that the time was taken up in finding Murrey's attending physician, pursuant to a rule of the hospital that only the attending physician could authorize surgery. There is also evidence to support the government's theory that the reason for the delay was that all the

operating rooms in the hospital that are equipped for the administration of a general anesthetic, of which there are four or five (odd that the exact number was not pinned down at trial), were in use and that it is a rule that an operation may not be interrupted just because another patient has a desperate need for an operation. The evidence that all the operating rooms were occupied during the hour and a half that Murrey was bleeding to death was given by a nurse named Wagner, and the plaintiff objected violently to her being allowed to testify, because her name had not been given in answer to a plaintiff's interrogatory that asked for the names of all the nurses who had "monitored" Murrey's condition on the fatal day. Probably her name should have been given, but she was listed as a witness in the pretrial order and the plaintiff's lawyer had plenty of time to depose her, but failed to do so. It was a judgment call for the district judge whether to let her testify and we cannot say that he abused his discretion in making the call that he did. The evidence she gave, however, had little bearing on the issue of the hospital's due care without foundation or corroboration never supplied. No evidence was presented that all the operating rooms were occupied by patients who were under a general anesthetic and who could not have been moved without risk to an operating room not equipped for general anesthesia, or that the hospital had made any contingency plan to deal with a surgical emergency (perhaps by arrangement with a nearby hospital) when its limited number of operating rooms were full, or that it is a sound principle of medical practice that all operations are created equal and therefore none may be interrupted even if one could be interrupted at trivial risk to the patient and the interruption would save the life of another patient who is bleeding to death elsewhere in the hospital. Such a principle might be hard to square with the principle of triage, that is, of prioritizing medical care when resources are inadequate to take care of all patients at once. Prostate surgery is risky, especially for elderly patients, as so many of the patients in veterans hospitals are--and this hospital seems to have made a specialty of prostate operations, hardly a surprise considering its clientele. We find it difficult to imagine that such a hospital has no duty to make arrangements for the kind of contingency that arose in this case, where a patient is left to bleed to death either because of a rule requiring the consent of the attending physician regardless of the patient's condition and of whether the attending physician can be located, or because no one has foreseen the possibility of all the operating rooms being in use when another patient needs emergency surgery. One of the government's witnesses opined that only a hospital that performs "emergency" operations, which is to say a hospital with a trauma center, need have an operating room available at all times for emergency. We shall not conceal our skepticism. Risky surgery performed under nonemergency conditions, such as the operation to remove this elderly and unhealthy man's prostate gland, can be expected in a small but not trivial fraction of cases to produce a postoperative crisis requiring emergency surgery. The failure to foresee and take measures to cope with this possibility strikes us as presumptively negligent. We need not decide, however, whether the judge's conclusion that the delay in getting Murrey to an operating room was not a result of negligence on the part of the hospital was clearly erroneous, as we suspect. A serious evidentiary error requires a new trial of the issue in any event. Several months after Murrey died, the Secretary of Veterans Affairs, Edward Derwinski, received anonymous letters complaining about patient care at the veterans hospital in North Chicago. At his direction the Inspector General of the Department of

Veterans Affairs conducted an investigation of the hospital. The investigation included reviews by several teams of physicians of the medical records of a number of the hospital's patients--including Murrey. The report of the investigation specifically criticized the care that had been provided to Murrey. Several days after receiving the report, Derwinski publicly announced that poor care had contributed to the deaths of six patients at the hospital between June 1989 and March 1990, including Murrey. The department's lawyers informed Murrey's widow personally that his death had been "caused by a medical misadventure" and actually invited her to file an administrative claim against the department under the Tort Claims Act. The judge gave no weight to these admissions. He was right not to treat them as judicial admissions of liability, which would normally be conclusive. If the answer to a complaint or to a request for admissions admits liability, the defendant cannot then deny liability on the ground that there is evidence that the admission was mistaken. Fed. R. Civ. P. 36(b); United States v. Kasuboski, 834 F.2d 1345, 1350 (7th Cir. 1987); Keller v. United States, 58 F.3d 1194, 1198 n. 8 (7th Cir. 1995). A judicial admission trumps evidence. Tobey v. Extel/JWP, Inc., 985 F.2d 330, 333 (7th Cir. 1993). This is the basis of the principle that a plaintiff can plead himself out of court. E.g., Warzon v. Drew, 60 F.3d 1234, 1239-40 (7th Cir. 1995); Esmail v. Macrane, 53 F.3d 176, 179 (7th Cir. 1995); Conn v. GATX Terminals Corp., 18 F.3d 417, 419 (7th Cir. 1994). The statements by Derwinski and by the representatives of the department who spoke with the widow were not judicial admissions; they were not made in a pleading or in a response to a request for admissions. Extrajudicial admissions by a party opponent are admissible as evidence, however. Fed. R. Evid. 801(d)(2); Keller v. United States, supra, 58 F.3d at 1198 n. 8. The fact of admission is a badge of reliability sufficient to overcome the hearsay objection to out-of-court statements offered for their truth. People usually don't make damaging admissions unless they are true. Usually, but not always. People sometimes do make mistaken admissions, which is why an extrajudicial admission, not being made with the same deliberateness as a judicial admission, is not conclusive on the issue admitted. But it is evidence. Murrey's estate wanted the judge to treat the statements by the department and its head as judicial admissions, and the judge was right to refuse. But the plaintiff also wanted him to treat them just as evidence, to be considered with the other evidence in making an overall assessment of negligence. The judge ignored this request. The government argues that this doesn't matter because the plaintiff called as her experts two of the physicians who had reviewed Murrey's records for the Department of Veterans Affairs, and the judge found their testimony less persuasive than that of the government's witnesses. The argument overlooks the independent evidentiary significance of the department's statements of mea culpa. The admissions that the plaintiff wanted the judge to weigh were not the views of the two physicians--who weren't employed by the department and, having been retained as outside medical auditors, probably weren't any other kind of agent of the department either, so that their statements were not the admissions of a party opponent, Fed. R. Evid. 801(d)(2)(D)--but the assessment placed on these statements by the Department of Veterans Affairs and its head. Whether or not the judge personally found the physicians' criticisms of Murrey's care persuasive, the fact that the alleged tortfeasor did so has independent significance. Casey v. Burns, 129 N.E.2d 440, 445 (Ill. App. 1955). If we may judge from the history of the concealment of government negligence in a variety of settings, the Department of

Veterans Affairs was no more likely than a private hospital to admit, either publicly or privately (and it did both), that the medical care which it rendered hastened the death of several patients within a period of months. The fact that it made this admission is some evidence, not conclusive of course, that it really was guilty of malpractice. The government argues that to give any weight to Secretary Derwinski's admission would violate the rule of Illinois law that expert testimony is required to establish medical malpractice. Graham v. St. Luke's Hospital, 196 N.E.2d 355, 360-61 (Ill. App. 1964). A threshold question is whether the rule is to be considered "substantive" and thus part of the Illinois law of medical malpractice incorporated into the federal law of this case by 28 U.S.C. secs. 1346(b) and 2674, or "procedural" and hence governed by the federal law of procedure and evidence. It is almost certainly the former, because it is a rule limited to a particular area of law and motivated by concerns about the potential impact on primary behavior (here, medical treatment) of making it too easy for plaintiffs to win a particular type of case. (On the general principle, see S.A. Healy Co. v. Milwaukee Metropolitan Sewerage District, 60 F.3d 305, 310 (7th Cir. 1995), and for its application to state laws erecting procedural barriers to medical malpractice plaintiffs, see Jones v. Griffith, 870 F.2d 1363, 1368 (7th Cir. 1989), and Hines v. Elkhart General Hospital, 603 F.2d 646, 648 (7th Cir. 1979).) No matter. Expert testimony was offered on behalf of the plaintiff, and there is no rule that the expert testimony offered by the plaintiff in a medical malpractice case cannot be supplemented by other evidence. So obvious is the point that we cannot find a case on it. The government has a back-up argument against the use of this admission--that it would violate the statutory limit of $25,000 on an agency's authority to settle a claim under the Tort Claims Act. 28 U.S.C. sec. 2672. The argument would have some merit if all admissions made by an agency were treated as judicial admissions, for then by making admissions an agency could effectively bypass the $25,000 limitation; or if they were treated as settlement offers, which Fed. R. Evid. 408 makes inadmissible to prove liability. Even then, so far as the statutory exception is concerned, the admissions would presumably be usable to establish the first $25,000 of liability. (Actually $100,000, because the Attorney General had at the time of the Derwinski admission authorized the Department of Veterans Affairs to settle cases for up to that amount, as he is authorized to do by 28 U.S.C. sec. 2672. The current maximum is $200,000. 28 C.F.R., Part 14, App. sec. 1(a).) When the admissions are used only as evidence, the argument collapses. The fact that an agency makes a case more difficult to defend by the Department of Justice because the head of the agency or one of its officers makes damaging admissions is a peril of litigation, not an unauthorized settlement offer. Since the question of the hospital's negligence in treating Murrey's hemorrhagic shock was so close, the judge's error in excluding the evidence of admissions cannot be regarded as harmless, and so the negligence issue must be retried along with the issue of informed consent. The error did not, however, affect the judge's determination, which we have said was not clearly erroneous, that Murrey's death was not the result of negligence in the operation itself. So no retrial of that issue is warranted. For the further guidance of the parties on remand, we point out that the damages requested--more than $3.5 million--obviously are excessive (and by a considerable multiple, in the case of the lost-chance damages), since the government is not liable for punitive damages. REVERSED AND REMANDED.

Appendix F – Modern Halachic Response to Risky Surgery

(www.ijme.org) from) *The Institute for Jewish Medical Ethics of the Hebrew Academy of San Francisco.* . Reprinted from *Maimonides*: Health in the Jewish World, Vol. 4, No. 3 (Fall 1998).

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Risky Medical Treatment In Jewish Law

Daniel Eisenberg, M.D.

A 75 year old woman is informed that she has severe aortic stenosis, a diagnosis that carries a very high risk of death within one year. She is also told that she is a very poor operative candidate and that she has a high risk of dying on the operating table during surgery that is proven to correct her type of ailment; nevertheless, if she survives the surgery for valve replacement, her cardiac problem will be cured and she could live many more years. Considering the tremendous value Judaism places on every moment of life and the prohibition of shortening life by even moments, does Jewish law permit her to undergo the surgery?

Three hundred years ago, Rabbi Yaakov Reischer (known as the Sh'vus Yaakov after his book of responsa) was asked whether a critically ill patient with a life expectancy of days, on whom the doctors had given up hope of cure, could undergo an experimental treatment that would either kill him immediately or possibly cure him. He set a modern halachic precedent by permitting a patient to risk his 'short-term' life for a chance at 'long-term' life, bringing a clear proof from an exchange in the Talmud, based upon a fascinating story in the book of Kings II (7:3-4). The Assyrian army, not known for their kind treatment of POWs, besieged Jerusalem causing a tremendous famine. Four leprous men were outside the walls of the city and starving to death. ". . and they said to each other, ?Why are we sitting here until we die? If we say that we will come into the city, with the famine in the city, we will die there, and if we stay here we will die. So now, now let us go and let us defect to the Aramean camp. If they spare us we will live, and if they kill us we will die.' "

The Talmud (Avoda Zara 27b) uses this story to justify risking remaining short-term life for a chance of long-term survival. The Talmud asks, ". . .But what of the limited time [that would have been his] that he stands to lose if the physician kills him right away? The answer is that such limited duration of life can be disregarded [in this case]. And whence do we know this? It is learned from the story of the four lepers."

How short of a life expectancy justifies gambling one's remaining life on a cure and how remote of a cure may be attempted? There is significant debate regarding how good the odds of cure must be to permit therapy. Opinions range from requiring a greater than 50% chance of cure, to allowing even a "remote" chance of cure. While Sh'vus Yaakov and the Talmud deal with cases of only a few days life expectancy, 20th century Rabbinical experts have clearly explained that even longer periods of time are still considered short-term life in Jewish law.

The leader of early 20th century European Jewry, Rabbi Chaim Ozer Grodzenski, was asked a question regarding dangerous surgery in a patient with a maximal life expectancy of six months. He wrote that based upon the Talmud and the Sh'vus Yaakov, "one may attempt dangerous treatment even if there is only a remote chance [of cure]. . . and it is logical that there is no distinction between short-term life of a few days or a few months". Rabbi Moshe Feinstein, the preeminent American halachic authority, clearly states that any life expectancy less than a year can be considered 'short-term' life. In two responsas eleven years apart, he reiterates his opinion that dangerous therapy is permitted even if there is even a remote chance of cure.

Some Rabbinic authorities require that the treatment be known to be efficacious for the patient's illness. There is an important distinction between a therapy that is known to work but is very risky and one that is completely experimental with no reason to believe that the risk promises any benefit. In the first situation, the treatment is known to be appropriate, but dangerous. In the second situation, we do not even know if the the risky treatment could possibly work.

A fascinating related question is whether one may risk his life for relief of extreme pain from a condition that is not life-threatening. 250 years ago, Rabbi Yaakov Emden ruled that "in such cases we allow them to do as they wish without protesting because sometimes they are cured and saved." Nevertheless, he subsequently states: "In any event, people should be concerned about themselves and when there is no danger in the suffering, it is not proper to [undergo dangerous surgery for relief of pain alone]. . . a person is not permitted to enter into a situation of possible danger, for even though many did so and were saved, many hastened their deaths by such surgery. Therefore, it is not completely permitted. . ." The consensus among experts in Jewish law is that one should not undergo significant risk for a non-life threatening condition.

Based upon the above considerations, all opinions would allow our patient to undergo the risky valve replacement if the probability of success is greater than 50%. If the odds were less, than 50%, most experts would still allow the surgery, while a few might not. Nevertheless, the consensus of Jewish law is that there is no obligation to undergo very dangerous treatment, even if refusal of the treatment means certain death.[1]

Please keep the letters coming. My e-mail address is eisenber@pol.net.

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[1] It is interesting to note that at least one Catholic bioethicist came to the same conclusion:

> I would regard as *extraordinary* and non-compulsory, those operations which carry little hope of a beneficial result or which involve a notable risk of death – as reflected in the medical statistics of the day....It is a familiar fact that *highly technical surgical operations* often involve a cumulative array of such factors as: great expense, only scattered surgeons capable of performing the operation and these men often resident in a distant city, notable and often grave risk in the operation itself, no real surety of a prolonged beneficial outcoe, and even the so-called success of the operation often leaving the patient in a handicapped condition. Surely operations such as the above are *extraordinary* and not morally binding on a patient.

McFadden, Charles J., Medical Ethics (Philadelphia, F.A. Davis Co., 1961): p. 237.

Appendix G – How a Rabbi Decides a Medical Issue

(http://www.jlaw.com/Articles/decide.html)
The Institute for Jewish Medical Ethics of the Hebrew Academy of San Francisco.

How A Rabbi Decides A Medical Halacha Issue

Synopsis of Presentation
Conference on Jewish Medical Ethics
San Francisco, CA
February 18-20, 1996

Rabbi Yitzchok A. Breitowitz

I. Secular law is primarily concerned with who gets to make a decision. Courts and legislatures are thus preoccupied with advance directives, surrogate decision-making, ethics committee, IRB's etc. This is so because the primary value the law seek to enshrine is the autonomy of the individual. Thus, once we identify the "who", we essentially have no interest in the "what". By contrast, Jewish law is far more interested in the substance of what the decision should be and in theory, the resolution should not depend on the identity/personal predilections of the decider. Secular law asks who decides; Jewish law asks what is to be decided.

II. Limited Role of Autonomy in Jewish Law

A. My body is not my own; it is the property of G-d who has entrusted it to me for care and preservation. Thus, the premise of the pro-choice movement (we have absolute control over our bodies) is fundamentally flawed (even apart from the fact that abortion involves a fetus as well as a mother). There is even discussion in halachic literature concerning the permissibility of elective cosmetic surgery both in terms of the surgical risks and in terms of the "mutilation" of G-d's property. (By and large, however, it has been validated).

B. R. Shlomo Yosef Zevin wrote a classic article demonstrating that in the Merchant of Venice, Antonio's contract with Shylock to pay a pound of flesh in the event of a loan default is unenforceable under Jewish law. Just as Antonio cannot pledge assets that he doesn't own, he cannot create such a pledge on his body.

III. Limited Role of Charisma/Inspiration

Halachic decision-making is not a matter of a Rabbi secluding himself in a room and getting a direct answer from G-d which he then communicates with ex cathedra authority. Indeed, based on the verse, "It [the Torah] is not in Heaven", the Talmud declares that prophecy and Divine inspiration cannot be taken into account in the resolution of halachic questions. All halachic resolution depends on a solid empirical grounding in the facts coupled with a reasoned application from the primary texts that Jewish law considers to be definitive, e.g. Talmud, Codes. Ad hoc decision-making that is not rooted in these texts is generally illegitimate.

IV. Written Torah/Oral Torah

Although the Pentateuch is the highest source of law in Judaism, the meaning of that written Torah can be understood only by means of the simultaneous oral interpretation that was handed down with it (the Torah She'Bal Pe). In its essence, the Torah She'Bal Pe was a core of principles and interpretations. Like a snowball, the core which originated in Divine revelation grew larger and larger as each generation had to apply these core principles to new situations, applications which sometimes generated disagreement (machloket). Although the core principles were part of a received tradition, the specific applications were the function of the Torah leadership/halachic authorities in each community to apply.

This growing "snowball" or avalanche was preserved orally for hundreds of years. Indeed, Jewish law forbade the writing down of the oral law, perhaps to insure that the meaning of the tradition would be communicated through flesh and blood human interaction, rather than exclusively through a literary medium. (It should be noted that many cultures - Native American, ancient Greece - preserved huge amounts of data through oral transmission for hundreds of years.) Only when (as a result of Roman persecutions in the first and second centuries of the common era) the oral law was in grave danger of being forgotten was it reduced to some type of written form as the Mishna. Several hundreds of years of commentary on the Mishna eventually formed the work known as Gemara. (There is both a Babylonian and Palestinian Gemara though the Babylonian is regarded as the more authoritative.) Mishna and Gemara together form the work known as Talmud, second in importance only to the Pentateuch but whose influence on Jewish law has even been greater.

V. Talmud: Source of Principles of Jewish Law

The Talmud, particularly the much larger portion known as Gemara, is not a code of law; it rarely provides definitive halachic rules. It is rather a transcript of hundreds of years of debates espousing a multiplicity of positions. It illuminates the process and conceptual structure of halacha through reasoned analysis, logic, analogy, and proof-text but does not indicate a final rule. All halachic decision-making, however, is ultimately grounded in Talmudic conceptualization. The classic and definitive codifications of Judaism - Rambam's Mishna Torah, Tur, and Shulchan Aruch are all based on conclusions derived from the Talmudic sugyot (treatments). The responsa literature - a vast body comprising thousands of volumes from every part of the world - attempts to apply Talmudic discussions and the rulings of the codes to contemporary situations, thereby insuring that halacha remains a living, vital tradition.

VI. Halachic Reasoning: Combination of Inductive and Deductive Logic

Halachic reasoning, in common with all reasoning by analogy, involves a combination of inductive and deductive logic. First, relevant primary data - rulings in particular cases extracted from Talmud and Codes - have to be identified and collected. Second, through inductive reasoning, a hypothesis is formulated that explains the specific collection of rulings by reference to a more general principle. Third, through deductive reasoning, this principle can be utilized to apply to new situations that are not explicitly covered by the

earlier rulings but can now be subsumed under the principle that is believed to explain those earlier rulings. Uncertainty, ambiguity, and disagreement among halachic scholars can arise at any stage of this three-stage process.

Identification of Primary Data: Widely scattered, not centrally located, no real indexing. Especially in case of Talmud, concepts that are highly relevant in one area, e.g., laws of Shabbat, may be discussed extensively in an apparently unrelated areas, e.g., marriage. Moreover, various rulings or conclusions that appear to be stated as definitive in the course of a discussion may not survive the conclusion of a debate though the Talmudic text does not always make this point clear. Moreover, even conclusions that appear to be "final" may be contradicted, superseded, or modified by other sugyot or subjected to limitations or conditions not apparent from a particular discussion but derivable by implication from another Talmudic source.

Even after the primary data and rulings have been identified, there remains the problem of interpretation - what does Rule X say? What does Rule X mean? There may be sharp disagreements among commentators and codes.

Generalization: As is true in physical science, data may often a variety of hypothesis and the plausibility of a given explanation may to multiple views.

Application: Finally, the third stage which involves the application of the generalized principle to new cases may pose difficulties in determining whether nor not the "new case" fits the parameters enunciated by the principle. This may require a reexamination or reformulation of what the generalization really encompasses as well as a careful understanding of the factual aspects of the "new case" to determine whether it is embraced by the paradigm.

"Cheating": Not every rabbi engages in this process for every question. In daily practice, we do not always reinvent the wheel and will often rely on the decisions of the great poskim of our day. Nevertheless, even if in practice most rabbis simply "follow the authorities", someone - e.g., R. Moshe, must go through all the steps of the process.

VII. The Crucial Importance of Knowing and Understanding the Facts on the Ground:
Even if the rabbi has full mastery of the halachic sources, his decisions are likely to be incorrect unless he fully understands the medical background of the case. Garbage in = Garbage out. See Dr. Keilson's article reproduced in the loose-leaf that rabbis may be characterized along the lines of the Four Sons of the Pesach Hagada:

(1) Wise - the one who knows how to ask the proper questions and evaluate the response.
(2) Evil (or incompetent) - fairly rare, the one who halachic expertise to render a valid decision.
(3) Simple - a rabbi who doesn't really understand the issue in a case.
(4) One Who Doesn't Even Ask - a rabbi even if learned who rules without even consulting with the physicians as to what the medical facts are.

VIII. The "Art"/Judgment of Proper Pigeonholing:
The critical importance of defining the question so that the appropriate analogies will be drawn. If an external phenomenon is perceived or described in a certain way, then one set of halachic categories and constructs will be brought to bear. If the situation is perceived differently, other halachic concepts may become relevant. The process of "shaping" or

identifying the critical and significant components of the phenomenon is often the most crucial step in being able to resolve the halachic quandary properly. Thus, sheealat chacham chatzi teshuvah" - "the question of a wise man is half the answer."

IX. The Role of Subjectivity in Psak

In theory, psak halacha should not be subjective but is to predicated exclusively on the posk's objective understanding of the principles of Jewish law as derived from its authoritative sources. In cases, however, of genuine unresolved disagreement (some authorities conclude one way, others conclude another way), the halachic system does contain within its own structure the recognition of extenuating circumstances that may allow the consideration of particular "extralegal" factors in a case. These include, in part, concepts such as "hefsed merubah" (great financial loss), "shaat ha'dechak" (a situation of urgency), "shalom bayit" (promotion of domestic tranquility in a marriage), "darchai noam" (the ways of the Torah are ways of pleasantness, not dissention). It must be emphasized that these factors alone are rarely taken into account in determining halacha on a primary level. In the event that the objective halachic considerations are balanced in both directions, however, these subjective factors will often tip the scale.

(I should also note that some subjective conditions become objectively significant even on the primary level. For example, abortion is halachically permitted if the continuation of the pregnancy endangers the mother's life. This endangerment may very well include severe psychiatric trauma which carries a suicide risk. Whether or not a given event, e.g., rape or incest, creates such a risk depends entirely on the subjective mental state of the women. Obviously, the Rabbi cannot answer such a question with his nose buried in the books, but must be sensitive to the individual characteristics of the questioner.)

X. Hearing the Question Not Asked

The burden of identifying the question and ferreting out the information does not rest on the questioner who after all may be ignorant of what Jewish law regards as significant. Moreover, it is not enough to simply answer the precise question asked - the rabbi must have the sensitivity to address the "questions behind the questions" - concerns that might be implicit in the question asked but which were not explicitly articulated by the questioner. Thus, the rabbi must be more than the equivalent of an on-line database.

Story: A woman once asked the Bais Ha'Levi (the Rav of Brisk; great-grandfather and namesake of Rabbi Joseph B. Soloveitchik of Boston) whether one could fulfill the obligation of the Four Cups at the Seder with milk? The Bais HaLevi answered in the negative and immediately gave the woman funds to buy meals for all of Passover. His disciples asked him why didn't he just give her enough money for wine. His answer - the last two cups of the seder are drunk after the meal. If the woman plans to use milk for the last two cups, it could only be because she has neither meat nor chicken to serve at the Seder meal. If there is no meat or chicken for the Seder - usually the most festive Pesach event - there is obviously none for the rest of the holiday. She accordingly needs funds for the entire holiday. The duty of the rabbi is to address the entire problem or more accurately, the whole person - not merely the segment of the problem that is explicitly raised.

Lesson: A rabbi answers a questioner - not a question.

XI. The Individualized Nature of Psak Halacha

R. Yitzchok Hutner, a renowned Rosh Yeshiva, once told a disciple: "Do not rely on anything that I ever said to someone else. Each psak is unique."

See also the comments of R. Moshe Feinstein in the introduction to his first volume of responsa (Igrot Moshe Orach Chayim I) where he writes that his responsa represent suggested approaches and general guidelines with each rav using his own judgment and discretion in applying the responsa to the facts of his particular case. Moreover, R. Moshe argues that each rav bears the responsibility of analyzing the primary sources on his own rather than blindly accept R. Moshe's reading of them.

Note: These warnings are commonly disregarded in practice. We often "cheat" and apply R. Moshe's rulings mechanically without analysis of the sources, without full knowledge of all the circumstances of R. Moshe's own psak (some of which may not always be stated) and without full consideration of all of the unique circumstances of the case upon which the rabbi is called to rule.

XII. The Importance of Empathy and Respect for the Feelings of the Questioner Even Where Consideration of Such Feelings Has No Direct Impact on Halachic Resolution. (This is equally true for physicians as well.)

XIII. Pluralism and Mutual Respect in Halacha

Unlike mathematic truth where there can only be one "true" answer (1 + 1 can only be two - but even here, there may be multiple answers in non-Euclidean systems), halachic truths can be multiple. Thus, the Talmud states concerning the opposing and inconsistent views of Bait Hillel and Bait Shammai: "Elo U'Elo Divrei Elokim Chayim". "These and those are words of the Eternal G-d". This is so because ultimate truth is not a point but a process - as long as there is commitment to the theological postulates of the system (e.g., the Divine origin of the Torah) and to the accepted halachic methodology and use of authoritative texts, any conclusion that the conscientious rabbi arrives at will have the imprimatur of valid psak even if in some sense it is not quite "what G-d may have intended."

Story: The Talmud relates that R. Eliezer disputed the view of the Sages concerning the ritual impurity of an oven. Refusing to concede his position, he declared: "If the law is like me, let the carob tree uproot itself." The tree did but the Sages declared, "We don't listen to trees." He then continued, "If the halacha is like me, let the river reverse its course." It did but the Sages stated, "we don't listen to rivers." He then said, "If the halacha is like me, let the walls of the study hall collapse " The walls were about to collapse but R. Yehoshua ordered them to remain. Uncertain how to proceed, the walls remained in a slanted position. Finally, R. Eliezer called out the big guns: the support that had in fact been the basis for the three miracles, G-d Himself. G-d declared, "R. Eliezer is correct." Amazingly, the Sages refused to accept even the direct opinion of G-d and declared, "Lo BaShamayim He" - the Torah is no longer in heaven. It was given to human beings to interpret and apply to the best of their abilities; prophecy, charisma, miracles are not determinative and even if a given halachic decision may be in error, it is validated by adherence to the process which the Torah itself sets up. When there is a supreme body like the 70-member Sanhedrin, their decision (by a majority) would be binding and preclusive

on the minority dissenters but in the absence of such an authoritative body (as is the case today), there can indeed be multiple halachic approaches to many questions with none of them being "wrong" or "illegitimate". (Note, however, that I am not suggesting infinite flexibility - there are clearly standards and parameters that are absolute but as is obvious to any student of halacha, within the framework there is room for play at the joints.)

XIV. The obligation to develop a relationship with a rav on a permanent rather than ad hoc basis: "Aseh l'cha Rav" - "make for yourself a teacher." (Pirkei Avot).
A. Rav should be knowledgeable in particular area - whether medicine, business, etc.
B. Know you as a person to be able to take account of individual circumstances.
C. Improper to "shop around" - looking for the rav who will always give you the answer you want. However, with respect to categories of questions, it is legitimate to have one authority you turn to for medical issues and one for kashrut or marriage counseling if you feel that one rav is less qualified in a particular area. I reiterate, however, this should not be done simply because you like one rabbi's answers more. Rather your decision, should be based on general considerations of competence, judgment, and experience.
D. A good rav like a good doctor knows when to refer to greater authorities or to non-rabbinic experts, e.g., therapists, psychiatrists and the like.
See generally Berel Wein's article reproduced in the loose-leaf materials.

APPENDIX

Valuable Halachic Sources in Medical Halacha (very partial)

Dr. Abraham, Nishmat Avraham (4 Volume).
Assia (Israeli journal on medical halacha - ed. by Dr. Steinberg).
Bar-Ilan Computerized Responsa Project - hundreds of volumes of responsa on CD-Rom with search capacities; full text retrievals; in Hebrew only.
Rabbi Bleich, Contemporary Halachic Problems (4 volumes to date)
Rabbi Bleich, Judaism and Healing
Nehorai - Specialized computer data base for medical halacha; special strength is its list of search terms.
Dr. Rosner, Modern Medicine and Jewish Law
Dr. Steinberg, Encyclopedia L'Hilchot Refuah (5 volumes to date)

Appendix H – Halacha on Plastic Surgery and Cosmetic Surgery

http://home.earthlink.net/~etzahaim/halakha/Cosmetic_Surgery.html#basic

Rabbi David Bassous
Congregation Etz Ahaim
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One of the wonders of modern medicine is the new found ability of surgeons to 'sculpt' different parts of the human anatomy to minute detail with in most cases amazing effect. Stomach tucks, face lifts, nose construction and lipo suction are gaining in popularity.

Medically indicated plastic surgery for trauma victims is definitely allowed by Jewish law, whereas there are divergent opinions regarding pure cosmetic surgery, which is the focus of this article.

The halachic and philosophic issues involved in cosmetic surgery include the following:

1) Is one allowed to wound others?

The first issue is the question of wounding. The source for not wounding (1) someone is the negative commandment mentioned in Deuteronomy 25:3. "Forty shall he strike him, he shall not add; lest he strike him an additional blow beyond these, and your brother will be degraded in your eyes." (2) The Sifri comments: "If the judge will exceed the forty lashes he will violate this negative commandment." All the major halachic authorities (Rif, Rosh, Rambam, Shulchan Aruch) agree that wounding another without a great need is prohibited. (3) The guiding principle is that a person has no proprietary rights over others. (4)

Wounding oneself is also prohibited. (5) A person has no proprietary rights over him or herself. (6) Is the patient allowed to submit himself or herself to any procedure of wounding unless there is a great need? (7)

2) Is one allowed to voluntarily expose oneself to danger?

All the legal decisors (poskim) agree that there is prohibition of voluntarily exposing oneself to danger for no valid reason. The only disagreement is whether this is a Torah law based on Deuteronomy 4:9 "Only guard yourselves and guard your souls very carefully..." or a Rabbinic proscription.

It is well known that any kind of surgery necessitates a variety of risks, from reaction to anesthesia, to post operative complications. (8) Jewish Law clearly allows taking minor risks for significant benefits. As the risks increase and the benefits decrease the question of prohibition becomes significant and a competent Rabbinic authority should be consulted.

A cornerstone of halachah is the primacy of 'Pikuach Nefesh' (9) - the preservation of human life in the face of risk or danger. All the commandments of the Torah are set aside in deference to Pikuach Nefesh, except the three cardinal sins of: murder; idolatry and adultery.(10)

Life may not be shortened by any positive action, and extreme care is required lest life be accidentally shortened.(11)

3) Does the dispensation to heal apply to cosmetic surgery?

Is cosmetic surgery without medical necessity included in the dispensation given to physicians to heal someone even by wounding them? (12) A doctor is not allowed to touch a patient without this dispensation to heal.

4) Is a person allowed to improve the handiwork of G-d?

Rabbi Eliezer Waldenberg raised the following philosophical issue: If a person was born with, or later developed certain non life threatening cosmetic defects, would that person be allowed to interfere with and improve G-d's handiwork?(13)

5) If women are the ones who usually go for cosmetic surgery would men be allowed to do so?

Rabbi Joseph Karo forbade men to look in mirrors based on the biblical proscription that a male should not wear women's clothing. (14) Many authorities state that this proscription depends on the accepted norms of a particular society.

6) Does psychological well being play an important role in this decision?(15)

Aesthetically motivated plastic surgery contains risks but is devoid of any physically curative purpose, although it may serve to enhance one's self esteem and one's psychological well-being. Is this enough grounds to allow one to take risks to undergo this procedure?

7) If a person is unable to find a mate because of aesthetic factors or if cosmetic surgery can prevent marital problems which develop after the wedding, can this be taken into account when making a decision?
8) How vain is a person allowed to be? Some people may just want cosmetic surgery for no other reason than to satisfy their vanity. Is this allowed? (16) Beauty has value and is not to be denigrated. However, if one's good looks causes their evil inclination and desires to grow, it is spiritually detrimental and excessive.

Rulings by Eminent Halachic Authorities(17)
There are two basic approaches to this issue:

- Opinions that prohibit pure cosmetic surgery
  Rabbi Eliezer Waldenberg(18) argues forcefully against pure cosmetic surgery.(19)
  (a) He states that the Torah does not give the physician permission to practice his craft in a non-healing(20) context.
  (b) As a result of this being a non-healing context the prohibitions of wounding oneself and others(21) are operative.
  (c) He points out that there is also a prohibition of exposing oneself to danger of anesthesia and the risk of surgical infection and other outcomes.
  (d) He also states philosophically, that it is a chutzpa to interfere with our G-d given individuality and to declare his creation to be flawed to the extent that it needs our correction.(22)
  Rabbi Y. Y. Weiss(23) concludes that elective plastic surgery is forbidden.
  (a) He does maintain that Maimonides(24) only prohibits wounding if performed in a contentious and purposefully harmful manner.
  (b) Rabbi Weiss however, agrees with Rabbi Waldenberg that the prohibition of putting oneself in danger would apply to cosmetic surgery.(25)
- Opinions that allow cosmetic surgery:
  Rabbi Moshe Feinstein(26)
  (a) Like Rabbi Weiss, Rabbi Feinstein interprets Maimonides' prohibition on wounding oneself and others as only applying when done in a contentious manner. (27) Cosmetic surgery is done usually to undo the humiliation being suffered and therefore would not be considered a wound in the halachic sense.(28)
  (b) Rabbi Feinstein goes one step further in finding a leniency for cosmetic surgery even without this last interpretation in Maimonides. He posits that all halachic authorities would agree that any operation which is: (1) With the patient's consent and (2) for his benefit would be allowed, and is even an obligation.(29)
  (c) Entering into danger is also not an operative principle here since the Talmud(30) points out that a person may engage in commonplace activities even if there is an element of danger once it has become a universally accepted risk. (31)
  Cosmetic surgery today, with all it's contingent risks is so commonplace it may be considered a universally accepted risk in the same categories as car travel and living in an earthquake zone.
  Author's addition: Whereas smoking is today universally recognized as a health hazard and is categorically prohibited.(32)
  Rabbi Lord Immanuel Jakobovitz, (33) formerly Chief Rabbi of the United Kingdom and the British Commonwealth and a leading expert in the field of medical ethics, concludes the following:
  All reservations could be set aside:
  a) If the procedure is medically indicated. e.g., following an accident or for grave psychological reasons.
  b) If the deformity to be corrected was serious enough to make it difficult for a person to find a marriage partner or to maintain a happy marriage.
  c) To enable a person to play a constructive role in society and in particular to earn a decent livelihood.
  This seems to be the most widely followed opinion today.

Rabbi Jakobovitz & Rabbi Feinstein do not distinguish between cosmetic surgery for men or women.(34)

The proper course of action for any individual contemplating elective surgery would be serious personal consultation with a competent rabbinic authority.

References

1. Even hitting someone else without wounding him or her is prohibited. See Maimonides Laws of Hovel U' Mazik Chapter 5:1.

2. This verse deals with the lashes that it was customary to punish a guilty party in Biblical times. Although the positive mitzvah of giving lashes is not applicable today the negative command which is mentioned by it's side of not exceeding the limits of the law, is still applicable.

3. According to the reasoning of Rabbi Eliezer Waldenberg which is reviewed later on in this article all contact sports like boxing, wrestling, American football or British Rugby or any other violent human sport should be disallowed for this very reason. According to Rabbi Moshe Feinstein's critical reading of Maimonides a contact sport which is not contentious might not be prohibited for this reason (see Note 22), however, other reasons prohibiting them may apply. (This note was meant to draw attention to and cause further discussion of this topic which will hopefully be discussed in a forthcoming article.)

4. See Maimonides Hil. Chovel Chapter 5 :1 "it is forbidden for a person to injure anyone whether himself or someone else. Not only is it forbidden to injure someone, but whoever strikes a 'kasher' Jew whether man or woman.....transgresses a negative commandment...."

5. Baba Kama 91a - 91b is the main source for the discussion of this type of wounding. It records a dispute between two students of Rabbi Akiba if a person is allowed to wound himself. The possible Biblical references discussed by the gemara for this prohibition are:

(a) A verse in Vayikra 5 regarding oaths. The Torah describes oaths to do good and oaths to do bad. The gemara understands that one of the oaths for bad that a person can make is an oath to wound himself. The gemara says no, the worst oath a person is allowed to make is an oath to fast (in a non life threatening way). Since wounding is forbidden, an oath to wound oneself would not take effect. (By fasting one is wounding by omission rather than commission.)

(b) Another possible source for not wounding oneself is the verse in Bereishit 9 "but the blood of your souls I will requite from you." The gemara answers that that verse may only be discussing suicide but not wounding.

(c) Rabbi Elazar says that another possible source is the prohibition of 'Bal Tashchit' Devarim 20:19. The mitzvah of not destroying fruit trees, which is applied to a general category of not wasting anything useful. If a mourner may not tear his clothes more than the necessary 'tefach' (approximately four inches) because of 'Bal Tashchit', not being wasteful, how much more so he may not damage himself. The Talmud says that tearing clothes may be forbidden because they do not repair themselves whereas wounds which do heal themselves may not be prohibited by Bal Tashchit. (Wounds which do not heal would however be prohibited by this negative commandment as well.)

d) According to Rabbi Eliezer Hakappar we can learn the restriction of wounding oneself from the laws of a Nazir. A Nazir has to bring a sin offering because he withdrew himself from the pleasure of drinking wine (Bemidbar 6). What sin was he guilty of? Rabbi Eliezer posits that he is considered a sinner for afflicting himself by depriving himself of the benefits of drinking wine. If a person is considered a sinner just for abstaining from one of the enjoyments created by G-d, how much more so a person who afflicts himself by wounding his body would be considered a sinner.

Rambam in Hilchot Chovel 5:1 and in Shevuot 5:17 follows the opinion that self inflicted injury is forbidden. Rambam is joined by the Smag, Rashba, Ran and Sefer Chasidim. Rashba and Tosfot prohibit self inflicted injury even if it will lead to pleasure. However, Rav Meir Abulafia and the Bayit Chadash - Bach allow it (if it serves some purpose, Yam Shel Shlomo).

6. This idea has major ramifications in the area of organ donation. What right does anyone have to donate or refuse to donate organs which are not really theirs in the first place but belong to their Creator? Do relatives have a right to donate the deceased's organs? (This topic will hopefully be discussed in a later issue.)

7. A doctor or surgeon is allowed to wound for the sake of healing, however if they cut or wound more than necessary they would also be transgressing the law of not wounding another, albeit unintentionally.
8. For an average healthy adult under the age of sixty the risk of major complications from elective surgery is minimal approximately 1 in 100,000. Risks increase with age and with blood loss involved, as in breast reconstruction or stomach tucks. Elective surgery is not advised for people who suffer with other illnesses like diabetes and heart problems. A person who suffered a heart attack over six months ago has a 5% increased risk of complications. If a heart attack was suffered within six months a 15% increase in risk, within three months there is a 30% increase in risk. Surgery on areas of the body like the hands and face which are vascular and suffer low blood loss are much less risky.
9. Vayikra 18:5 "..and live with them (the mitzvot)".
10. See Rambam Hilchot Yesodei Hatorah Chapter 5:2 for further clarification. According to Rambam if a person gave his life in order to fulfill another mitzvah apart from the three cardinal sins he is held accountable for committing suicide. See Yoma 85b and Tosfot Avodah Zara 27b "Yachol" who argues on Rambam that if a person wishes to die and not transgress any mitzvah it is to be considered a righteous act.
11. Other examples of laws made to prevent injury include:
(a) The Torah in Devarim 22:8 explicitly demands that a fence be erected around a flat roof which is in use.
(b) A similar ruling prohibits any potentially dangerous objects or conditions in a dwelling. The Mishna in Baba Kama 15b forbids keeping a vicious dog or a defective ladder in the house because either of these things may cause bodily harm.
(c) The Mishna in Trumot 8:4 forbids the drinking of liquids that are susceptible to being poisonous if they have not been properly covered or sealed.
(d) A warning was issued regarding the eating of fish and meat together because it was thought to cause leprosy. (Shulchan Aruch Yoreh Deah 116:2).
12. "and he shall cause him to be thoroughly healed." Exodus 21:9. If the cosmetic surgery being performed were not halachically permissible the doctor would be transgressing this law and the patient could transgress the law of 'mesayaia'. (See Shulhan Aruch Yoreh Deah 181:4 in the case of a person who allowed a barber to shave his beard or 'peot' with a razor).
13. The Talmud in Nida 31a says that there are three partners in man, G-d, the person's father and mother. Beauty of features is attributed to G-d. See also Taanit 23b.
14. Deuteronomy 22:5. See Bet Yoseph Yoreh Deah 126:2.
Other applications of this rule are:
(a) In Shulhan Aruch Yoreh Deah 182:5 Rabbi Joseph Karo discusses if a male is allowed to remove under arm hair. The Ben Ish Hai, Rabbi Yoseph Haim of Baghdad (Rav Pealim 3 Yoreh Deah 18) addresses the issue of men shaving their body hair. Although the Shulhan Aruch expressly forbade it, even if men in that particular area do it, nevertheless the Ben Ish Chai gave testimony that this was the minhag among the men of Baghdad and he defended the minhag.
(b) See Shulhan Aruch Orach Chaim 340:1 regarding men plucking white hair from black hair in order to look younger.
(c) Rabbi Ovadia Yoseph in Yehave Daat 6:49 discusses the issue if men may look at their reflection in a mirror. He concludes that in today's day and age since men do look at mirrors there is no problem for any man, even Rabbis, to gaze at their own reflection. In fact Rabbis especially should be careful with their appearance because of 'kavod haTorah'.
(d) A man dying his hair. The same logic used by Hacham Ovadia to allow men to gaze at mirrors, and the Ben Ish Hai to allow shaving body hair should apply to allow men to dye their hair in places where this is an acceptable norm, as is the case in most civilized countries today. There are varying opinions among the later authorities regarding this issue. See Shoel Umeshiv Mahdura A, Vol. 1 Siman 210; Minchat Yitzchak Vol. 6:81; Igrot Moshe Yoreh Deah 1:82.
Sreedei Esh Vol. 2:81 concludes that a man may not dye his hair if it is solely for the sake of enhancing his looks, which is the reason that women dye their hair. However, for the sake of averting a potential financial loss or to avert shame or disgrace a man may dye his hair. (This topic will hopefully be dealt with in a later article.)

15. Rabbi Lord Immanuel Jakobovitz former Chief Rabbi of the United Kingdom and commonwealth, does take the psychological factor into account. Today we are much more aware of the importance of psychological well being playing a crucial role in physical well being.
16. The Torah praises the beauty of the matriarchs. There are many sources in the Talmud that praise beautiful men and women for their looks:
(a) Hulin 134b: Lists the qualifications for high priest: 'And the priest that is highest among his brethren,' implies that he shall be highest among his brethren in beauty, in wisdom and in wealth.
(b) Avodah Zara 20a: It happened that Rabbi Shimon Ben Gamliel, while standing on the step of the Temple-mount saw a heathen woman who was especially beautiful, and he exclaimed; How great are Your works, O L-rd. Likewise, when Rabbi Akiva saw the wife of the wicked Tyranus Rufus, he spat then laughed, and then wept"..'wept' that ultimately such beauty would decay in the ground.
(c) Sanhedrin 100b: Happy is the man whose wife is beautiful; the number of his days is doubled.
(d) Sanhedrin 22b: 'The king has his hair trimmed every day.' As it is written, Your eyes shall see the king in his beauty.
(e) Baba Batra 58a: Rav Kahana was a reflection of the beauty of Rav; the beauty of Rav was a reflection of the beauty of Rav Abbahu; the beauty of Rav Abbahu was a reflection of the beauty of our father Jacob, and the beauty of our father Jacob was a reflection of the beauty of Adam.
(f) Baba Metzia 84a: Rabbi Yochanan used to go and sit at the gates of the mikweh. He said: "When the daughters of Israel ascend from the bath let them look at me so that they may bear sons as beautiful and as learned as I."
(g) Sotah 10b: 'Abshalom gloried in his hair etc.' Our Rabbis have taught: Abshalom rebelled against his father through his hair, as it is said: There was none praised as much as Abshalom for his beauty" Therefore he was hanged by his hair.
(h) Nedarim 66a: .. In that time Rabbi Yishmael wept and said, "The daughters of Israel are beautiful but poverty disfigures them.
(i) Brachot 57b: Three things enhance a man's self esteem: a beautiful dwelling, a beautiful wife; and beautiful accessories.
(j) Nedarim 9b: Rabbi Shimon the Just said: Only once have I eaten of the sin offering of a Nazir. On one occasion a Nazir came from the south, and I saw that he had beautiful eyes, was of handsome appearance and with thick locks of hair symmetrically arranged. I said to him: "My son, why do you want to destroy this beautiful hair of yours?" He replied: "I was a shepherd for my father in my town. Once I went to draw water from a well when I gazed at my reflection in the water my evil desires overcame me and sought to drive me from the world through sin. But I said unto it: "..I swear that I will shave this beautiful hair off for the sake of Heaven."
I immediately arose and kissed his head, saying "My son, may there be many more Nazirites such as you in Israel!"
What we can deduce from the above sources is that beauty has value and is not to be denigrated. However, if the beauty causes a person's evil inclination and desires to grow it is detrimental and should not be exaggerated.
A person may not adjust their appearance to be identical to someone else, Sanhedrin 38a: Why are men's faces not like one another? - Lest a man see a beautiful dwelling or a beautiful woman and say she is mine. Rabbi Meir used to say: In three things man differs from his fellow: In voice, appearance and mind. In voice and appearance to prevent immorality; In mind because of thieves and robbers.
17. For the Jew the Halachic process has always involved the application of fundamental principles as described in the written and oral laws to new situations of human endeavor. All of the principles of Jewish Law are universal but there are differences in opinion among later authorities as to how these principles apply to new developments and technologies.
18. The former Head of the Jerusalem Beth Din author of the responsa Tzitz Eliezer.
19. Tzitz Eliezer. Vol. 11:41. In his responsa Rabbi Waldenberg discusses in great detail whether the Torah law in Exodus 21:19 "and he shall surely heal him." is valid for divinely caused diseases like cancer and other maladies or for only human inflicted maladies, or whether there is a distinction between external maladies visible to the human eye or internal maladies, see also Ibn Ezra and Rabenu Bechaye on this verse. Tosfot in Baba Kama 85 however, writes that it is allowed to heal a sickness which seems to be

Divine in origin. This is not considered to be transgressing the decree of the King. The Bayit Chadash - Bach Yoreh Deah 336 gives testimony that the halachah today is that we seek to heal all kinds of maladies without distinction of their cause or whether they are external or internal. The Rashba (Rabbi Shlomo Ben Aderet in his responsa 120) gives testimony that the Ramban who was also a doctor was paid to heal sterile gentile women, we see that he held that it is allowed to cure Divinely caused sickness. If so obviously healing sterile Jewish women is allowed.

20. The issue may be raised: What is the definition of a sick person? Is it someone who is in danger because of a physiological condition or someone whose body does not match the norms of society even though they are as 'healthy' as everyone else? For instance a person who is sterile, would he or she be classified as healthy, since he or she is not in any physical danger or pain, or be classified as sick since the normal bodily reproductive functions do not work. Rabbi Waldenberg comes out heavily in favor of the second definition.

Rabbi Waldenberg quotes from the Book of Responsa Shaarei Tzedek (Yoreh Deah 143). This deals with the case of a woman who was sterile from birth, she is otherwise perfectly healthy and experiences no physical pain or discomfort. Does her condition warrant medical intervention? The author of 'Shaarei Tzedek' answers: "I don't know of any sources from the Torah to allow her treatment." Rabbi Waldenberg rejects this spurious decision and allows a sterile woman to seek medical intervention. He bases his decision on the verse in Isaiah 48:18 "He did not create the world for emptiness, He fashioned it to be inhabited." G-d created the world to be populated.

Furthermore a woman has an obligation to bear her husband's children and help him fulfill the mitzvah of Genesis 1:22 "Be fruitful and multiply." He gives witness that this has always been the custom for sterile women to seek medical intervention. The Rashba (Rabbi Shlomo Ben Aderet in his responsa 120) gives testimony that the Ramban who was also a doctor was paid to heal sterile gentile women, if so, obviously healing sterile Jewish women is allowed.

21. Rabbi Waldenberg does not distinguish between wounding which is contentious or not. According to his opinion any wounding which is not mandated by Jewish law or is not for physical well being is prohibited.

22. Regarding the beautifying of women using plastic surgery he disallowed it based on the following reasoning:

(a) The famous verse of King Solomon we say every Friday night at the Shabbat table: "False is grace and vain is beauty, a woman who fears G-d should be praised." (Proverbs 31:30)

(b) If she is looking for a mate desperately and is finding it hard because of her physical appearance. She should still not allowed to go for cosmetic surgery since desires vary from person to person, maybe she will find someone who will like her.

(c) Rabbi Waldenberg concludes with this anecdote from the Talmud in Taanit 23b Rabbi Mana went to his Rebbi, Rabbi Yitzchak and asked him to pray for his wife to be pretty Rabbi Yitzchak blessed him and she was beautiful. As a result she became very domineering. Rabbi Yitzchak then prayed that she would revert to her former self. He learns from this story that it is not good to change G-d's creation. When the external shape is changed the character may also change for the worse.

A question on this last reasoning may be raised from the Midrash Rabbah Genesis 11:6. A pagan philosopher asked Rabbi Oshaia: "If circumcision is so beloved of G-d, why was the Adam not created already circumcised?" (Giving a child a Brit is a chutzpah for changing G-d's creation, for if G-d wanted us to be circumcised he would have created us so.)

Rabbi Oshaia replied: According to your reasoning, why should a man like you shave the hair with which you were born?" (According to your logic we should never get hair cuts for that is changing the way G-d created us?)

The Pagan replied: "Because the hair grows in the days of foolish childhood.

Rabbi Oshaia then argued: "If so, a person should blind his eyes, cut off his hands and break his legs because they grew in his foolish childhood.

The philosopher was unable to answer the Rabbi so he exclaimed: "Have we come down to such garbage?"

Rabbi Oshaia replied: "I cannot let you go without a proper answer. So observe that everything that was created during the six days of creation needs finishing: mustard needs sweetening, wheat needs grinding, and even man needs finishing."

According to this Midrash man was empowered by G-d to perfect creation.
23. In his responsa entitled Minchat Yitzchak, Vol. 6: 105:2.
24. Chapter 5 Halachah 1 of Hilchot Chovel.
25. Rabbi Weiss does not discuss minor cosmetic surgery which does not involve danger. Or the situation today with more modern surgical practices which are less dangerous.
26. Igrot Moshe Choshen Mishpat 2 Siman 66.
27. Tosfot in Baba Kama 91 says that it is forbidden to wound oneself even for the sake of profiting from it.
28. R. Moshe Feinstein learns this from an exacting analysis of the text of the Rambam. There is a difference in the text of the Rambam. Wounding is forbidden if it is "derech nitzayon", according to the main text, which means it was contentious. Or, according to an emendation, wounding is forbidden if it is done "derech bizayon", in a way that disgraces the person being wounded.
Rabbi Moshe Feinstein of blessed memory in his responsa, asks why a special prohibition of not ripping one's flesh is required for a mourner. Deuteronomy 14:1 "you shall not cut yourselves and you shall not make a bald spot between your eyes for a dead person." This prohibition should be included in the more general proscription of not wounding oneself. He answers brilliantly based on the qualification of the Rambam that only wounding which is contentious (or degrading) is forbidden. When a person rips their flesh in mourning it may be that the suffering incurred will ease the pain of the memory of the loss of their dear one this is comforting and not contentious or degrading, and therefore would not be prohibited by the general proscription of wounding. Therefore the Torah has to explicitly forbid it.
29. He bases this ruling on the classic mitzvah of "and you shall love your friend as yourself". (Leviticus 19:18). Especially in the case of woman who needs to find a spouse, for whom beauty is of a greater need than for a man, see Ketubot 59b.
Rabbi Feinstein at the end of his responsa brings another proof to allow elective surgery even in the case of a man. The Mishna in Bechorot 45a. states that "If a Cohen had an extra finger and he cut it off, if it contained a bone he is disqualified for service but if it did not contain a bone the he would be qualified." The fact that the Mishna does not say that he is prohibited to cut it off in the first place, an act which can be categorized as elective surgery, implies that the act itself is condoned.
30. Shabbat 129b. The Talmud discusses the most opportune time for a medical procedure. The section involved is of an aggadic nature and is therefore ignored by the major poskim, however Rabbi Feinstein as was his customary practice sifts this logical idea from it.
How is one to differentiate between permitted and forbidden risks? The answer of the Talmud is that it depends on the accepted convention of society. If something is recognized as dangerous and people refrain from doing it because of this, it is forbidden. However if society accepts the risks involved it becomes a permitted risk. Elective surgery is in this category, it is so commonplace. There may however be a greater level of risk if implants are used.
Another source is in Nida 45a. The Talmud discusses Rabbi Bibi's idea that three categories of women may use a diaphragm (mooch) when having marital relations, because of danger to the woman or her child: A girl under twelve; a pregnant woman and a woman who is breast feeding her child. The Hachamim argue with Rav Bibi and say that she should have marital relations normally, based on the rationale that society generally accepts the risks involved in having relations under these circumstances. The rationale is clear: To insist that a person avoid every possible situation that might bring him harm would effectively prevent much of normal every day living. Crossing the street could result in being run over. Eating fish could lead to choking on a bone. Walking alone could result in being attacked or injured. Implicit in this approach is the recognition of the possibility of change, in accordance with social trends and habits in terms of what would be considered an acceptable risk.
The Binyan Zion (Rabbi Jacob Ettlinger d. 1871) makes a distinction between a present and immediate danger on one hand and a potential future danger on the other. When it comes to a present immediate danger the Halachah insists on every possible precautionary step to avoid the danger. But, in the case of a future danger one may rely on the principle of 'rob'. - That in most cases such instances are carried to a safe conclusion, then one may engage in them and invoke faith and trust in the Almighty.
31. Rabbi Moshe Feinstein does not discuss this issue of the dangers involved in surgery in his responsa on cosmetic surgery. However this rationale is elaborated on by him in other responsum, such as in Igrot

Moshe Hoshen Mishpat 2 Siman 76 which discusses the issue of smoking. It is also discussed in less detail in Igrot Moshe Yoreh Deah 2 Siman 49 dated Hanukah 5724.
While warning not to start smoking or getting habituated to smoking he does not forbid it's practice based on this idea. Since it was a universally accepted risk that a great many people were not careful to refrain from, we may rely on the verse 'G-d protects the simple...' Psalms 116:6.
In those days evidence was not as well developed to blame tobacco for illnesses as it is now, and there were no government health warnings on cigarettes or widespread movements to ban smoking..
32. In today's day and age there is no doubt about the hazards of smoking. Since many people are careful not to smoke, it is not a generally accepted risk and thus is forbidden. As per a recently heard decision of Hacham Ovadia Yoseph Shlita
33. In his book on Jewish Medical Ethics.
34. One could however argue that in the case of males cosmetic surgery would only be allowed if: It is common practice for males in the place concerned; and one of the above conditions is also satisfied.

Appendix I – AMA Current Opinions of the Council on Ethical and Judicial Affairs

[Section] E- Principles of Medical Ethics

Preamble:
The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Appendix J – *Canterbury v. Spence.*, 464 F.2d 772 (D.C. Cir. 1972)

The Center for Public Health Law
Consent and Informed Consent
Case Compliments of Versuslaw

Canterbury v. Spence., 464 F.2d 772 (D.C. Cir. 1972)
[Editor's note: footnotes (if any) trail the opinion]

[1] UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT
[2] Jerry W. CANTERBURY, Appellant, v.
[3] William Thornton SPENCE and the Washington Hospital Center,
[4] a body corporate, Appellees
[5] No. 22099 BLUE BOOK CITATION FORM: 1972.CDC.138 (http://www.versuslaw.com)
[6] Date Decided: May 19, 1972
[7] Rehearing Denied July 20, 1972.
[8] APPELLATE PANEL:
[9] Wright, Leventhal and Robinson, Circuit Judges.
[10] DECISION OF THE COURT DELIVERED BY THE HONORABLE JUDGE ROBINSON
[11] This appeal is from a judgment entered in the District Court on verdicts directed for the two appellees at the conclusion of plaintiff-appellant Canterbury's case in chief. His action sought damages for personal injuries allegedly sustained as a result of an operation negligently performed by appellee Spence, a negligent failure by Dr. Spence to disclose a risk of serious disability inherent in the operation, and negligent post-operative care by appellee Washington Hospital Center. On close examination of the record, we find evidence which required submission of these issues to the jury. We accordingly reverse the judgment as to each appellee and remand the case to the District Court for a new trial.

I
[12] The record we review tells a depressing tale. A youth troubled only by back pain submitted to an operation without being informed of a risk of paralysis incidental thereto. A day after the operation he fell from his hospital bed after having been left without assistance while voiding. A few hours after the fall, the lower half of his body was paralyzed, and he had to be operated on again. Despite extensive medical care, he has never been what he was before. Instead of the back pain, even years later, he hobbled about on crutches, a victim of paralysis of the bowels and urinary incontinence. In a very real sense this lawsuit is an understandable search for reasons.
[13] At the time of the events which gave rise to this litigation, appellant was nineteen years of age, a clerk-typist employed by the Federal Bureau of Investigation. In December, 1958, he began to experience severe pain between his shoulder blades.*fn1 He consulted two general practitioners, but the medications they prescribed failed to eliminate the pain. Thereafter, appellant secured an appointment with Dr. Spence, who is a neurosurgeon.

[14] Dr. Spence examined appellant in his office at some length but found nothing amiss. On Dr. Spence's advice appellant was x-rayed, but the films did not identify any abormality. Dr. Spence then recommended that appellant undergo a myelogram -- a procedure in which dye is injected into the spinal column and traced to find evidence of disease or other disorder -- at the Washington Hospital Center.
[15] Appellant entered the hospital on February 4, 1959.*fn2 The myelogram revealed a "filling defect" in the region of the fourth thoracic vertebra. Since a myelogram often does no more than pinpoint the location of an aberration, surgery may be necessary to discover the cause. Dr. Spence told appellant that he would have to undergo a laminectomy -- the excision of the posterior arch of the vertebra -- to correct what he suspected was a ruptured disc. Appellant did not raise any objection to the proposed operation nor did he probe into its exact nature.
[16] Appellant explained to Dr. Spence that his mother was a widow of slender financial means living in Cyclone, West Virginia, and that she could be reached through a neighbor's telephone. Appellant called his mother the day after the myelogram was performed and, failing to contact her, left Dr. Spence's telephone number with the neighbor. When Mrs. Canterbury returned the call, Dr. Spence told her that the surgery was occasioned by a suspected ruptured disc. Mrs. Canterbury then asked if the recommended operation was serious and Dr. Spence replied "not anymore than any other operation." He added that he knew Mrs. Canterbury was not well off and that her presence in Washington would not be necessary. The testimony is contradictory as to whether during the course of the conversation Mrs. Canterbury expressed her consent to the operation. Appellant himself apparently did not converse again with Dr. Spence prior to the operation.
[17] Dr. Spence performed the laminectomy on February 113 at the Washington Hospital Center. Mrs. Canterbury traveled to Washington, arriving on that date but after the operation was over, and signed a consent form at the hospital. The laminectomy revealed several anomalies: a spinal cord that was swollen and unable to pulsate, an accumulation of large tortuous and dilated veins, and a complete absence of epidural fat which normally surrounds the spine. A thin hypodermic needle was inserted into the spinal cord to aspirate any cysts which might have been present, but no fluid emerged. In suturing the wound, Dr. Spence attempted to relieve the pressure on the spinal cord by enlarging the dura -- the outer protective wall of the spinal cord -- at the area of swelling.
[18] For approximately the first day after the operation appellant recuperated normally, but then suffered a fall and an almost immediate setback. Since there is some conflict as to precisely when or why appellant fell,4 we reconstruct the events from the evidence most favorable to him.5 Dr. Spence left orders that appellant was to remain in bed during the process of voiding. These orders were changed to direct that voiding be done out of bed, and the jury could find that the change was made by hospital personnel. Just prior to the fall, appellant summoned a nurse and was given a receptacle for use in voiding, but was then left unattended. Appellant testified that during the course of the endeavor he slipped off the side of the bed, and that there was no one to assist him, or side rail to prevent the fall.
[19] Several hours later, appellant began to complain that he could not move his legs and that he was having trouble breathing; paralysis seems to have been virtually total from the waist down. Dr. Spence was notified on the night of February 12, and he rushed to the

hospital. Mrs. Canterbury signed another consent form and appellant was again taken into the operating room. The surgical wound was reopened and Dr. Spense created a gusset to allow the spinal cord greater room in which to pulsate.

[20] Appellant's control over his muscles improved somewhat after the second operation but he was unable to void properly. As a result of this condition, he came under the care of a urologist while still in the hospital. In April, following a cystoscopic examination, appellant was operated on for removal of bladder stones, and in May was released from the hospital. He reentered the hospital the following August for a 10-day period, apparently because of his urologic problems. For several years after his discharge he was under the care of several specialists, and at all times was under the care of a urologist. At the time of the trial in April, 1968, appellant required crutches to walk, still suffered from urinal incontinence and paralysis of the bowels, and wore a penile clamp.

[21] In November, 1959 on Dr. Spence's recommendation, appellant was transferred by the F.B.I. to Miami where he could get more swimming and exercise. Appellant worked three years for the F.B.I. in Miami, Los Angeles and Houston, resigning finally in June, 1962. From then until the time of the trial, he held a number of jobs, but had constant trouble finding work because he needed to remain seated and close to a bathroom. The damages appellant claims include extensive pain and suffering, medical expenses, and loss of earnings.

II

[22] Appellant filed suit in the District Court on March 7, 1963, four years after the laminectomy and approximately two years after he attained his majority. The complaint stated several causes of action against each defendant. Against Dr. Spence it alleged, among other things, negligence in the performance of the laminectomy and failure to inform him beforehand of the risk involved. Against the hospital the complaint charged negligent post-operative care in permitting appellant to remain unattended after the laminectomy, in failing to provide a nurse or orderly to assist him at the time of his fall, and in failing to maintain a side rail on his bed. The answers denied the allegations of negligence and defended on the ground that the suit was barred by the statute of limitations.

[23] Pretrial discovery -- including depositions by appellant, his mother and Dr. Spence -- continuances and other delays consumed five years. At trial, disposition of the threshold question whether the statute of limitations had run was held in abeyance until the relevant facts developed. Appellant introduced no evidence to show medical and hospital practices, if any, customarily pursued in regard to the critical aspects of the case, and only Dr. Spence, called as an adverse witness, testified on the issue of causality. Dr. Spence described the surgical procedures he utilized in the two operations and expressed his opinion that appellant's disabilities stemmed from his pre-operative condition as symptomatized by the swollen, non-pulsating spinal cord. He stated, however, that neither he nor any of the other physicians with whom he consulted was certain as to what that condition was, and he admitted that trauma can be a cause of paralysis. Dr. Spence further testified that even without trauma paralysis can be anticipated "somewhere in the nature of one percent" of the laminectomies performed, a risk he termed "a very slight possibility." He felt that communication of that risk to the patient is not good medical practice because it might deter patients from undergoing needed surgery and might

produce adverse psychological reactions which could preclude the success of the operation.

[24] At the close of appellant's case in chief, each defendant moved for a directed verdict and the trial judge granted both motions. The basis of the ruling, he explained, was that appellant had failed to produce any medical evidence indicating negligence on Dr. Spence's part in diagnosing appellant's malady or in performing the laminectomy; that there was no proof that Dr. Spence's treatment was responsible for appellant's disabilities; and that notwithstanding some evidence to show negligent post-operative care, an absence of medical testimony to show causality precluded submission of the case against the hospital to the jury. The judge did not allude specifically to the alleged breach of duty by Dr. Spence to divulge the possible consequences of the laminectomy.

[25] We reverse. The testimony of appellant and his mother that Dr. Spence did not reveal the risk of paralysis from the laminectomy made out a prima facie case of violation of the physician's duty to disclose which Dr. Spence's explanation did not negate as a matter of law. There was also testimony from which the jury could have found that the laminectomy was negligently performed by Dr. Spence, and that appellant's fall was the consequence of negligence on the part of the hospital. The record, moreover, contains evidence of sufficient quantity and quality to tender jury issues as to whether and to what extent any such negligence was causally related to appellant's post-laminectomy condition. These considerations entitled appellant to a new trial.

[26] Elucidation of our reasoning necessitates elaboration on a number of points. In Parts III and IV we explore the origins and rationale of the physician's duty to reasonably inform an ailing patient as to the treatment alternatives available and the risks incidental to them. In Part V we investigate the scope of the disclosure requirement and in Part VI the physician's privileges not to disclose. In Part VII we examine the role of causality, and in Part VIII the need for expert testimony in non-disclosure litigation. In Part IX we deal with appellees' statute of limitations defense and in Part X we apply the principles discussed to the case at bar.

III

[27] Suits charging failure by a physician6 adequately to disclose the risks and alternatives of proposed treatment are not innovations in American law. They date back a good half-century,7 and in the last decade they have multiplied rapidly.8 There is, nonetheless, disagreement among the courts and the commentators9 on many major questions, and there is no precedent of our own directly in point.10 For the tools enabling resolution of the issues on this appeal, we are forced to begin at first principles.11

[28] The root premise is the concept, fundamental in American jurisprudence, that "every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ."12 True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each.13 The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision.14 From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible.15

[29] A physician is under a duty to treat his patient skillfully16 but proficiency in diagnosis and therapy is not the full measure of his responsibility. The cases demonstrate that the physician is under an obligation to communicate specific information to the patient when the exigencies of reasonable care call for it.17 Due care may require a physician perceiving symptoms of bodily abnormality to alert the patient to the condition.18 It may call upon the physician confronting an ailment which does not respond to his ministrations to inform the patient thereof.19 It may command the physician to instruct the patient as to any limitations to be presently observed for his own welfare,20 and as to any precautionary therapy he should seek in the future.21 It may oblige the physician to advise the patient of the need for or desirability of any alternative treatment promising greater benefit than that being pursued.22 Just as plainly, due care normally demands that the physician warn the patient of any risks to his well-being which contemplated therapy may involve.23

[30] The context in which the duty of risk-disclosure arises is invariably the occasion for decision as to whether a particular treatment procedure is to be undertaken. To the physician, whose training enables a self-satisfying evaluation, the answer may seem clear, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie.24 To enable the patient to chart his course understandably, some familiarity with the therapeutic alternatives and their hazards becomes essential.25

[31] A reasonable revelation in these respects is not only a necessity but, as we see it, is as much a matter of the physician's duty. It is a duty to warn of the dangers lurking in the proposed treatment, and that is surely a facet of due care.26 It is, too, a duty to impart information which the patient has every right to expect.27 The patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with armslength transactions.28 His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject. As earlier noted, long before the instant litigation arose, courts had recognized that the physician had the responsibility of satisfying the vital informational needs of the patient.29 More recently, we ourselves have found "in the fiducial qualities of [the physician-patient] relationship the physician's duty to reveal to the patient that which in his best interests it is important that he should know."30 We now find, as a part of the physician's overall obligation to the patient, a similar duty of reasonable disclosure of the choices with respect to proposed therapy and the dangers inherently and potentially involved.31

[32] This disclosure requirement, on analysis, reflects much more of a change in doctrinal emphasis than a substantive addition to malpractice law. It is well established that the physician must seek and secure his patient's consent before commencing an operation or other course of treatment.32 It is also clear that the consent, to be efficacious, must be free from imposition upon the patient.33 It is the settled rule that therapy not authorized by the patient may amount to a tort -- a common law battery -- by the physician.34 And it is evident that it is normally impossible to obtain a consent worthy of the name unless the physician first elucidates the options and the perils for the patient's edification.35 Thus the physician has long borne a duty, on pain of liability for unauthorized treatment, to make adequate disclosure to the patient.36 The evolution of the obligation to

communicate for the patient's benefit as well as the physician's protection has hardly involved an extraordinary restructuring of the law.

IV

[33] Duty to disclose has gained recognition in a large number of American jurisdictions,37 but more largely on a different rationale. The majority of courts dealing with the problem have made the duty depend on whether it was the custom of physicians practicing in the community to make the particular disclosure to the patient.38 If so, the physician may be held liable for an unreasonable and injurious failure to divulge, but there can be no recovery unless the omission forsakes a practice prevalent in the profession.39 We agree that the physician's noncompliance with a professional custom to reveal, like any other departure from prevailing medical practice,40 may give rise to liability to the patient. We do not agree that the patient's cause of action is dependent upon the existence and nonperformance of a relevant professional tradition.

[34] There are, in our view, formidable obstacles to acceptance of the notion that the physician's obligation to disclose is either germinated or limited by medical practice. To begin with, the reality of any discernible custom reflecting a professional consensus on communication of option and risk information to patients is open to serious doubt.41 We sense the danger that what in fact is no custom at all may be taken as an affirmative custom to maintain silence, and that physician-witnesses to the so-called custom may state merely their personal opinions as to what they or others would do under given conditions.42 We cannot gloss over the inconsistency between reliance on a general practice respecting divulgence and, on the other hand, realization that the myriad of variables among patients43 makes each case so different that its omission can rationally be justified only by the effect of its individual circumstances.44 Nor can we ignore the fact that to bind the disclosure obligation to medical usage is to arrogate the decision on revelation to the physician alone.45 Respect for the patient's right of self-determination on particular therapy46 demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves.47

[35] More fundamentally, the majority rule overlooks the graduation of reasonable-care demands in Anglo-American jurisprudence and the position of professional custom in the hierarchy. The caliber of the performance exacted by the reasonable-care standard varies between the professional and non-professional worlds, and so also the role of professional custom. "With but few exceptions," we recently declared, "society demands that everyone under a duty to use care observe minimally a general standard."48 "Familiarly expressed judicially," we added, "the yardstick is that degree of care which a reasonably prudent person would have exercised under the same or similar circumstances."49 "Beyond this," however, we emphasized, "the law requires those engaging in activities requiring unique knowledge and ability to give a performance commensurate with the undertaking."50 Thus physicians treating the sick must perform at higher levels than non-physicians in order to meet the reasonable care standard in its special application to physicians51 -- "that degree of care and skill ordinarily exercised by the profession in
[the physician's] own or similar localities."52 And practices adopted by the profession have indispensable value as evidence tending to establish just what that degree of care and skill is.53

[36] We have admonished, however, that "the special medical standards54 are but adaptions of the general standard to a group who are required to act as reasonable men possessing their medical talents presumably would."55 There is, by the same token, no basis for operation of the special medical standard where the physician's activity does not bring his medical knowledge and skills peculiarly into play.56 And where the challenge to the physician's conduct is not to be gauged by the special standard, it follows that medical custom cannot furnish the test of its propriety, whatever its relevance under the proper test may be.57 The decision to unveil the patient's condition and the chances as to remediation, as we shall see, is ofttimes a non-medical judgment58 and, if so, is a decision outside the ambit of the special standard. Where that is the situation, professional custom hardly furnishes the legal criterion for measuring the physician's responsibility to reasonably inform his patient of the options and the hazards as to treatment.

[37] The majority rule, moreover, is at war with our prior holdings that a showing of medical practice, however probative, does not fix the standard governing recovery for medical malpractice.59 Prevailing medical practice, we have maintained, has evidentiary value in determinations as to what the specific criteria measuring challenged professional conduct are and whether they have been met,60 but does not itself define the standard.61 That has been our position in treatment cases, where the physician's performance is ordinarily to be adjudicated by the special medical standard of due care.62 We see no logic in a different rule for nondisclosure cases, where the governing standard is much more largely divorced from professional considerations.63 And surely in nondisclosure cases the fact-finder is not invariably functioning in an area of such technical complexity that it must be bound to medical custom as an inexorable application of the community standard of reasonable care.64

[38] Thus we distinguished, for purposes of duty to disclose, the special and general-standard aspects of the physician-patient relationship. When medical judgment enters the picture and for that reason the special standard controls, prevailing medical practice must be given its just due. In all other instances, however, the general standard exacting ordinary care applies, and that standard is set by law. In sum, the physician's duty to disclose is governed by the same legal principles applicable to others in comparable situations, with modifications only to the extent that medical judgment enters the picture.65 We hold that the standard measuring performance of that duty by physicians, as by others, is conduct which is reasonable under the circumstances.66

V

[39] Once the circumstances give rise to a duty on the physician's part to inform his patient, the next inquiry is the scope of the disclosure the physician is legally obliged to make. The courts have frequently confronted this problem but no uniform standard defining the adequacy of the divulgence emerges from the decisions. Some have said "full" disclosure,67 a norm we are unwilling to adopt literally. It seems obviously prohibitive and unrealistic to expect physicians to discuss with their patients every risk of proposed treatment -- no matter how small or remote68 -- and generally unnecessary from the patient's viewpoint as well. Indeed, the cases speaking in terms of "full" disclosure appear to envision something less than total disclosure,69 leaving unanswered the question of just how much.

[40] The larger number of courts, as might be expected, have applied tests framed with reference to prevailing fashion within the medical profession.70 Some have measured the disclosure by "good medical practice,"71 others by what a reasonable practitioner would have bared under the circumstances,72 and still others by what medical custom in the community would demand.73 We have explored this rather considerable body of law but are unprepared to follow it. The duty to disclose, we have reasoned, arises from phenomena apart from medical custom and practice.74 The latter, we think, should no more establish the scope of the duty than its existence. Any definition of scope in terms purely of a professional standard is at odds with the patient's prerogative to decide on projected therapy himself.75 That prerogative, we have said, is at the very foundation of the duty to disclose,76 and both the patient's right to know and the physician's correlative obligation to tell him are diluted to the extent that its compass is dictated by the medical profession.77

[41] In our view, the patient's right of self-decision shapes the boundaries of the duty to reveal. That right can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need,78 and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked.79 And to safeguard the patient's interest in achieving his own determination on treatment, the law must itself set the standard for adequate disclosure.80

[42] Optimally for the patient, exposure of a risk would be mandatory whenever the patient would deem it significant to his decision, either singly or in combination with other risks. Such a requirement, however, would summon the physician to second-guess the patient, whose ideas on materiality could hardly be known to the physician. That would make an undue demand upon medical practitioners, whose conduct, like that of others, is to be measured in terms of reasonableness. Consonantly with orthodox negligence doctrine, the physician's liability for nondisclosure is to be determined on the basis of foresight, not hindsight; no less than any other aspect of negligence, the issue on nondisclosure must be approached from the viewpoint of the reasonableness of the physician's divulgence in terms of what he knows or should know to be the patient's informational needs. If, but only if, the fact-finder can say that the physician's communication was unreasonably inadequate is an imposition of liability legally or morally justified.81

[43] Of necessity, the content of the disclosure rests in the first instance with the physician. Ordinarily it is only he who is in position to identify particular dangers; always he must make a judgment, in terms of materiality, as to whether and to what extent revelation to the patient is called for. He cannot know with complete exactitude what the patient would consider important to his decision, but on the basis of his medical training and experience he can sense how the average, reasonable patient expectably would react.82 Indeed, with knowledge of, or ability to learn, his patient's background and current condition, he is in a position superior to that of most others -- attorneys, for example -- who are called upon to make judgments on pain of liability in damages for unreasonable miscalculation.83

[44] From these considerations we derive the breadth of the disclosure of risks legally to be required. The scope of the standard is not subjective as to either the physician or the patient; it remains objective with due regard for the patient's informational needs and with suitable leeway for the physician's situation. In broad outline, we agree that "
[a] risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy."84
[45] The topics importantly demanding a communication of information are the inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely if the patient remains untreated. The factors contributing significance to the dangerousness of a medical technique are, of course, the incidence of injury and the degree of the harm threatened.85 A very small chance of death or serious disablement may well be significant; a potential disability which dramatically outweighs the potential benefit of the therapy or the detriments of the existing malady may summons discussion with the patient.86
[46] There is no bright line separating the significant from the insignificant; the answer in any case must abide a rule of reason. Some dangers -- infection, for example -- are inherent in any operation; there is no obligation to communicate those of which persons of average sophistication are aware.87 Even more clearly, the physician bears no responsibility for discussion of hazards the patient has already discovered,88 or those having no apparent materiality to patients' decision on therapy.89 The disclosure doctrine, like others marking lines between permissible and impermissible behavior in medical practice, is in essence a requirement of conduct prudent under the circumstances. Whenever nondisclosure of particular risk information is open to debate by reasonable-minded men, the issue is for the finder of the facts.90

VI

[47] Two exceptions to the general rule of disclosure have been noted by the courts. Each is in the nature of a physician's privilege not to disclose, and the reasoning underlying them is appealing. Each, indeed, is but a recognition that, as important as is the patient's right to know, it is greatly outweighed by the magnitudinous circumstances giving rise to the privilege. The first comes into play when the patient is unconscious or otherwise incapable of consenting, and harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment. When a genuine emergency of that sort arises, it is settled that the impracticality of conferring with the patient dispenses with need for it.91 Even in situations of that character the physician should, as current law requires, attempt to secure a relative's consent if possible.92 But if time is too short to accommodate discussion, obviously the physician should proceed with the treatment.93
[48] The second exception obtains when risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view. It is recognized that patients occasionally become so ill or emotionally distraught on disclosure as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient.94 Where that is so, the cases have generally held that the physician is armed with a privilege to keep the information from the patient,95 and we think it clear that portents of that type may justify the physician in action he deems medically warranted. The critical inquiry is whether the

physician responded to a sound medical judgment that communication of the risk information would present a threat to the patient's well-being.
[49] The physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs.96 That attitude presumes instability or perversity for even the normal patient, and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself.97 Nor does the privilege contemplate operation save where the patient's reaction to risk information, as reasonable foreseen by the physician, is menacing.98 And even in a situation of that kind, disclosure to a close relative with a view to securing consent to the proposed treatment may be the only alternative open to the physician.99

VII

[50] No more than breach of any other legal duty does nonfulfillment of the physician's obligation to disclose alone establish liability to the patient. An unrevealed risk that should have been made known must materialize, for otherwise the omission, however unpardonable, is legally without consequence. Occurrence of the risk must be harmful to the patient, for negligence unrelated to injury is nonactionable.100 And, as in malpractice actions generally,101 there must be a causal relationship between the physician's failure to adequately divulge and damage to the patient.102
[51] A causal connection exists when, but only when, disclosure of significant risks incidental to treatment would have resulted in a decision against it.103 The patient obviously has no complaint if he would have submitted to the therapy notwithstanding awareness that the risk was one of its perils. On the other hand, the very purpose of the disclosure rule is to protect the patient against consequences which, if known, he would have avoided by foregoing the treatment.104 The more difficult question is whether the factual issue on causality calls for an objective or a subjective determination.
[52] It has been assumed that the issue is to be resolved according to whether the fact-finder believes the patient's testimony that he would not have agreed to the treatment if he had known of the danger which later ripened into injury.105 We think a technique which ties the factual conclusion on causation simply to the assessment of the patient's credibility is unsatisfactory. To be sure, the objective of risk-disclosure is preservation of the patient's interest in intelligent self- choice on proposed treatment, a matter the patient is free to decide for any reason that appeals to him.106 When, prior to commencement of therapy, the patient is sufficiently informed on risks and he exercises his choice, it may truly be said that he did exactly what he wanted to do. But when causality is explored at a postinjury trial with a professedly uninformed patient, the question whether he actually would have turned the treatment down if he had known the risks is purely hypothetical: "Viewed from the point at which he had to decide, would the patient have decided differently had he known something he did not know?"107 And the answer which the patient supplies hardly represents more than a guess, perhaps tinged by the circumstance that the uncommunicated hazard has in fact materialized.108
[53] In our view, this method of dealing with the issue on causation comes in second-best. It places the physician in jeopardy of the patient's hindsight and bitterness. It places

the fact-finder in the position of deciding whether a speculative answer to a hypothetical question is to be credited. It calls for a subjective determination solely on testimony of a patient-witness shadowed by the occurrence of the undisclosed risk.109

[54] Better it is, we believe, to resolve the causality issue on an objective basis: in terms of what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance.110 If adequate disclosure could reasonably be expected to have caused that person to decline the treatment because of the revelation of the kind of risk or danger that resulted in harm, causation is shown, but otherwise not.111 The patient's testimony is relevant on that score of course but it would not threaten to dominate the findings. And since that testimony would probably be appraised congruently with the fact-finder's belief in its reasonableness, the case for a wholly objective standard for passing on causation is strengthened. Such a standard would in any event ease the fact-finding process and better assure the truth as its product.

VIII

[55] In the context of trial of a suit claiming inadequate disclosure of risk information by a physician, the patient has the burden of going forward with evidence tending to establish prima facie the essential elements of the cause of action, and ultimately the burden of proof -- the risk of nonpersuasion112 -- on those elements.113 These are normal impositions upon moving litigants, and no reason why they should not attach in nondisclosure cases is apparent. The burden of going forward with evidence pertaining to a privilege not to disclose,114 however, rests properly upon the physician. This is not only because the patient has made out a prima facie case before an issue on privilege is reached, but also because any evidence bearing on the privilege is usually in the hands of the physician alone. Requiring him to open the proof on privilege is consistent with judicial policy laying such a burden on the party who seeks shelter from an exception to a general rule and who is more likely to have possession of the facts.115

[56] As in much malpractice litigation,116 recovery in nondisclosure lawsuits has hinged upon the patient's ability to prove through expert testimony that the physician's performance departed from medical custom. This is not surprising since, as we have pointed out, the majority of American jurisdictions have limited the patient's right to know to whatever boon can be found in medical practice.117 We have already discussed our disagreement with the majority rationale.118 We now delineate our view on the need for expert testimony in nondisclosure cases.

[57] There are obviously important roles for medical testimony in such cases, and some roles which only medical evidence can fill. Experts are ordinarily indispensable to identify and elucidate for the fact-finder the risks of therapy and the consequences of leaving existing maladies untreated. They are normally needed on issues as to the cause of any injury or disability suffered by the patient and, where privileges are asserted, as to the existence of any emergency claimed and the nature and seriousness of any impact upon the patient from risk-disclosure. Save for relative infrequent instances where questions of this type are resolvable wholly within the realm of ordinary human knowledge and experience, the need for the expert is clear.119

[58] The guiding consideration our decisions distill, however, is that medical facts are for medical experts120 and other facts are for any witnesses -- expert or not -- having sufficient knowledge and capacity to testify to them.121 It is evident that many of the

issues typically involved in nondisclosure cases do not reside peculiarly within the medical domain. Lay witness testimony can competently establish a physician's failure to disclose particular risk information, the patient's lack of knowledge of the risk, and the adverse consequences following the treatment.122 Experts are unnecessary to a showing of the materiality of a risk to a patient's decision on treatment, or to the reasonably, expectable effect of risk disclosure on the decision.123 These conspicuous examples of permissible uses of nonexpert testimony illustrate the relative freedom of broad areas of the legal problem of risk nondisclosure from the demands for expert testimony that shackle plaintiffs' other types of medical malpractice litigation.124 IX

[59] We now confront the question whether appellant's suit was barred, wholly or partly, by the statute of limitations. The statutory periods relevant to this inquiry are one year for battery actions125 and three years for those charging negligence.126 For one a minor when his cause of action accrues, they do not begin to run until he has attained his majority.127 Appellant was nineteen years old when the laminectomy and related events occurred, and he filed his complaint roughly two years after he reached twenty-one. Consequently, any claim in suit subject to the one-year limitation came too late.

[60] Appellant's causes of action for the allegedly faulty laminectomy by Dr. Spence and allegedly careless post-operative care by the hospital present no problem. Quite obviously, each was grounded in negligence and so was governed by the three-year provision.128 The duty-to-disclose claim appellant asserted against Dr. Spence, however, draws another consideration into the picture. We have previously observed that an unauthorized operation constitutes a battery, and that an uninformed consent to an operation does not confer the necessary authority.129 If, therefore, appellant had at stake no more than a recovery of damages on account of a laminectomy intentionally done without intelligent permission, the statute would have interposed a bar.

[61] It is evident, however, that appellant had much more at stake.130 His interest in bodily integrity commanded protection, not only against an intentional invasion by an unauthorized operation131 but also against a negligent invasion by his physician's dereliction of duty to adequately disclose.132 Appellant has asserted and litigated a violation of that duty throughout the case.133 That claim, like the others, was governed by the three-year period of limitation applicable to negligence actions134 and was unaffected by the fact that its alternative was barred by the one-year period pertaining to batteries.135 X

[62] This brings us to the remaining question, common to all three causes of action: whether appellant's evidence was of such caliber as to require a submission to the jury. On the first, the evidence was clearly sufficient to raise an issue as to whether Dr. Spence's obligation to disclose information on risks was reasonably met or was excused by the surrounding circumstances. Appellant testified that Dr. Spence revealed to him nothing suggesting a hazard associated with the laminectomy. His mother testified that, in response to her specific inquiry, Dr. Spence informed her that the laminectomy was no more serious than any other operation. When, at trial, it developed from Dr. Spence's testimony that paralysis can be expected in one percent of laminectomies, it became the jury's responsibility to decide whether that peril was of sufficient magnitude to bring the disclosure duty into play.136 There was no emergency to frustrate an opportunity to disclose,137 and Dr. Spence's expressed opinion that disclosure would have been unwise did not foreclose a contrary conclusion by the jury. There was no evidence that

appellant's emotional makeup was such that concealment of the risk of paralysis was medically sound.138 Even if disclosure to appellant himself might have bred ill consequences, no reason appears for the omission to communicate the information to his mother, particularly in view of his minority.139 The jury, not Dr. Spence, was the final arbiter of whether nondisclosure was reasonable under the circumstances.140

[63] Proceeding to the next cause of action, we find evidence generating issues as to whether Dr. Spence performed the laminectomy negligently and, if so, whether that negligence contributed causally to appellant's subsequent disabilities. A report Dr. Spence prepared after the second operation indicated that at the time he felt that too-tight sutures at the laminectomy site might have caused the paralysis. While at trial Dr. Spence voiced the opinion that the sutures were not responsible, there were circumstances lending support to his original view. Prior to the laminectomy, appellant had none of the disabilities of which he now complains. The disabilities appeared almost immediately after the laminectomy. The gusset Dr. Spence made on the second operation left greater room for the spinal cord to pulsate, and this alleviated appellant's condition somewhat. That Dr. Spence's in-trial opinion was hardly the last word is manifest from the fact that the team of specialists consulting on appellant was unable to settle on the origin of the paralysis.

[64] We are advertent to Dr. Spence's attribution of appellant's disabilities to his condition pre-existing the laminectomy, but that was a matter for the jury. And even if the jury had found that theory acceptable, there would have remained the question whether Dr. Spence aggravated the pre-existing condition. A tort-feasor takes his victim as he finds him, and negligence intensifying an old condition creates liability just as surely as negligence precipitating a new one.141 It was for the jury to say, on the whole evidence, just what contributions appellant's pre-existing condition and Dr. Spence's medical treatment respectively made to the disabilities.

[65] In sum, judged by legal standards, the proof militated against a directed verdict in Dr. Spence's favor. True it is that the evidence did not furnish ready answers on the dispositive factual issues, but the important consideration is that appellant showed enough to call for resolution of those issues by the jury. As in Sentilles v. Inter-Carribbean Shipping Corporation,142 a case resembling this one, the Supreme Court stated,

[66] The jury's power to draw the inference that the aggravation of petitioner's tubercular condition, evident so shortly after the accident, was in fact caused by that accident, was not impaired by the failure of any medical witness to testify that it was in fact the cause. Neither can it be impaired by the lack of medical unanimity as to the respective likelihood of the potential causes of the aggravation, or by the fact that other potential causes of aggravation existed and were not conclusively negated by the proofs. The matter does not turn on the use of a particular form of words by the physicians in giving their testimony. The members of the jury, not the medical witnesses, were sworn to make a legal determination of the question of causation. They were entitled to take all the circumstances, including the medical testimony into consideration.143

[67] We conclude, lastly, that the case against the hospital should also have gone to the jury. The circumstances surrounding appellant's fall -- the change in Dr. Spence's order that appellant be kept in bed,144 the failure to maintain a side rail on appellant's bed, and the absence of any attendant while appellant was attempting to relieve himself -- could

certainly suggest to jurors a dereliction of the hospital's duty to exercise reasonable care for the safety and well-being of the patient.145 On the issue of causality, the evidence was uncontradicted that appellant progressed after the operation until the fall but, a few hours thereafter, his condition had deteriorated, and there were complaints of paralysis and respiratory difficulty. That falls tend to cause or aggravate injuries is, of course, common knowledge, which in our view the jury was at liberty to utilize.146 To this may be added Dr. Spence's testimony that paralysis can be brought on by trauma or shock. All told, the jury had available a store of information enabling an intelligent resolution of the issues respecting the hospital.147

[68] We realize that, when appellant rested his case in chief, the evidence scarcely served to put the blame for appellant's disabilities squarely on one appellee or the other. But this does not mean that either could escape liability at the hand of the jury simply because appellant was unable to do more. As ever so recently we ruled, "a showing of negligence by each of two (or more) defendants with uncertainty as to which caused the harm does not defeat recovery but passes the burden to the tort-feasor for each to prove, if he can, that he did not cause the harm."148 In the case before us, appellant's evidentiary presentation on negligence survived the claims of legal insufficiency, and appellees should have been put to their proof.149

[69] Reversed and remanded for a new trial.

[70] CASE RESOLUTION

[71] Reversed and Remanded. ***** BEGIN FOOTNOTE(S) HERE *****

[72] *fn1 Two months earlier, appellant was hospitalized for diagnostic tests following complaints of weight loss and lassitude. He was discharged with a final diagnosis of neurosis and thereafter given supportive therapy by his then attending physician.

[73] *fn2 The dates stated herein are taken from the hospital records. At trial, appellant and his mother contended that the records were inaccurate, but the one-day difference over which they argued is without significance.

[74] *fn3 The operation was postponed five days because appellant was suffering from an abdominal infection.

[75] *fn4 The one fact clearly emerging from the otherwise murky portrayal by the record, however, is that appellant did fall while attempting to void and while completely unattended.

[76] *fn5 See Aylor v. Intercounty Constr. Corp., 127 U.S.App.D.C. 151, 153, 381 F.2d 930, 932 (1967), and cases cited in n. 2 thereof.

[77] *fn6 Since there was neither allegation nor proof that the appellee hospital failed in any duty to disclose, we have no occasion to inquire as to whether or under what circumstances such a duty might arise.

[78] *fn7 See, e.g., Theodore v. Ellis, 141 La. 709, 75 So. 655, 660 (1917); Wojciechowski v. Coryell, 217 S.W. 638, 644 (Mo.App.1920); Hunter v. Burroughs, 123 Va. 113, 96 S.E. 360, 366-368 (1918).

[79] *fn8 See the collections in Annot., 79 A.L.R.2d 1028 (1961); Comment, Informed Consent in Medical Malpractice, 55 Calif. L.Rev. 1396, 1397 n. 5 (1967).

[80] *fn9 For references to a considerable body of commentary, see Waltz & Scheuneman, Informed Consent to Therapy, 64 Nw.U.L.Rev. 628 n. 1 (1970).

[81] *fn10 In Stivers v. George Washington Univ., 116 U.S.App.D.C. 29, 320 F.2d 751 (1963), a charge was asserted against a physician and a hospital that a patient's written

consent to a bi- lateral arteriogram was based on inadequate information, but our decision did not touch the legal aspects of that claim. The jury to which the case was tried found for the physician, and the trial judge awarded judgment for the hospital notwithstanding a jury verdict against it. The patient confined the appeal to this court to the judgment entered for the hospital, and in no way implicated the verdict for the physician. We concluded "that the verdict constitutes a jury finding that
[the physician] was not guilty of withholding relevant information from
[the patient] or in the alternative that he violated no duty owed her in telling her what he did tell her or in withholding what he did not tell her. . . ." 116 U.S.App.D.C. at 31, 320 F.2d at 753. The fact that no review of the verdict as to the physician was sought thus became critical. The hospital could not be held derivatively liable on the theory of a master-servant relationship with the physician since the physician himself had been exonerated. And since there was no evidence upon which the verdict against the hospital could properly have been predicated independently, we affirmed the trial judge's action in setting it aside. 116 U.S.App.D.C. at 31-32, 320 F.2d at 753-754. In these circumstances, our opinion in Stivers cannot be taken as either approving or disapproving the handling of the risk-nondisclosure issue between the patient and the physician in the trial court.
[82] *fn11 We undertake only a general outline of legal doctrine on the subject and, of course, a discussion and application of the principles which in our view should govern this appeal. The rest we leave for future litigation.
[83] *fn12 Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 105 N.E. 92, 93 (1914). See also Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093, 1104 (1960), clarified, 187 Kan. 186, 354 P.2d 670 (1960); W. Prosser, Torts § 18 at 102 (3d ed. 1964); Restatement of Torts § 49 (1934).
[84] *fn13 See Dunham v. Wright, 423 F.2d 940, 943-946 (3d Cir. 1970) (applying Pennsylvania law); Campbell v. Oliva, 424 F.2d 1244, 1250-1251 (6th Cir. 1970) (applying Tennessee law); Bowers v. Talmage, 159 So.2d 888 (Fla.App.1963); Woods v. Brumlop, 71 N.M. 221, 377 P.2d 520, 524-525 (1962); Mason v. Ellsworth, 3 Wash.App. 298, 474 P.2d 909, 915, 918-919 (1970).
[85] *fn14 Patients ordinarily are persons unlearned in the medical sciences. Some few, of course, are schooled in branches of the medical profession or in related fields. But even within the latter group variations in degree of medical knowledge specifically referable to particular therapy may be broad, as for example, between a specialist and a general practitioner, or between a physician and a nurse. It may well be, then, that it is only in the unusual case that a court could safely assume that the patient's insights were on a parity with those of the treating physician.
[86] *fn15 The doctrine that a consent effective as authority to form therapy can arise only from the patient's understanding of alternatives to and risks of the therapy is commonly denominated "informed consent." See, e.g., Waltz & Scheuneman, Informed Consent to Therapy, 64 Nw.U.L.Rev. 628, 629 (1970). The same appellation is frequently assigned to the doctrine requiring physicians, as a matter of duty to patients, to communicate information as to such alternatives and risks. See, e.g., Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396 (1967). While we recognize the general utility of shorthand phrases in literary expositions, we caution that uncritical use of the "informed consent" label can be misleading. See, e.g., Plante, An Analysis of "Informed Consent," 36 Ford.L.Rev. 639, 671-72 (1968).

[87] In duty-to-disclose cases, the focus of attention is more properly upon the nature and content of the physician's divulgence than the patient's understanding or consent. Adequate disclosure and informed consent are, of course, two sides of the same coin -- the former a sine qua non of the latter. But the vital inquiry on duty to disclose relates to the physician's performance of an obligation, while one of the difficulties with analysis in terms of "informed consent" is its tendency to imply that what is decisive is the degree of the patient's comprehension. As we later emphasize, the physician discharges the duty when he makes a reasonable effort to convey sufficient information although the patient, without fault of the physician, may not fully grasp it. See text infra at notes 82-89. Even though the fact-finder may have occasion to draw an inference on the state of the patient's enlightenment, the fact-finding process on performance of the duty ultimately reaches back to what the physician actually said or failed to say. And while the factual conclusion on adequacy of the revelation will vary as between patients -- as, for example, between a lay patient and a physician-patient -- the fluctuations are attributable to the kind of divulgence which may be reasonable under the circumstances.

[88] *fn16 Brown v. Keaveny, 117 U.S.App.D.C. 117, 118, 326 F.2d 660, 661 (1963); Quick v. Thurston, 110 U.S.App.D.C. 169, 171, 290 F.2d 360, 362, 88 A.L.R.2d 299 (en banc 1961); Rodgers v. Lawson, 83 U.S.App.D.C. 281, 282, 170 F.2d 157, 158 (1948).

[89] *fn17 See discussion in McCoid, The Care Required of Medical Practitioners, 12 Vand.L.Rev. 549, 586-97 (1959).

[90] *fn18 See Union Carbide & Carbon Corp. v. Stapleton, 237 F.2d 229, 232 (6th Cir. 1956); Maertins v. Kaiser Foundation Hosp., 162 Cal.App.2d 661, 328 P.2d 494, 497 (1958); Doty v. Lutheran Hosp.Ass'n, 110 Neb. 467, 194 N.W. 444, 445, 447 (1923); Tvedt v. Haugen, 70 N.D. 338, 294 N.W. 183, 187 (1940). See also Dietze v. King, 184 F. Supp. 944, 948, 949 (E.D.Va.1960); Dowling v. Mutual Life Ins. Co., 168 So.2d 107, 116 (La.App.1964), writ refused, 247 La. 248, 170 So.2d 508 (1965).

[91] *fn19 See Rahn v. United States, 222 F. Supp. 775, 780-781 (S.D.Ga.1963) (applying Georgia law); Baldor v. Rogers, 81 So.2d 658, 662, 55 A.L.R.2d 453 (Fla.1955); Manion v. Tweedy, 257 Minn. 59, 100 N.W.2d 124, 128, 129 (1959); Tvedt v. Haugen, supra note 18, 294 N.W. at 187; Ison v. McFall, 55 Tenn.App. 326, 400 S.W.2d 243, 258 (1964); Kelly v. Carroll, 36 Wash.2d 482, 219 P.2d 79, 88, 19 A.L.R.2d 1174, cert. denied, 340 U.S. 892, 71 S. Ct. 208, 95 L. Ed. 646 (1950).

[92] *fn20 Newman v. Anderson, 195 Wis. 200, 217 N.W. 306 (1928). See also Whitfield v. Daniel Constr. Co., 226 S.C. 37, 83 S.E.2d 460, 463 (1954).

[93] *fn21 Beck v. German Klinik, 78 Iowa 696, 43 N.W. 617, 618 (1889); Pike v. Honsinger, 155 N.Y. 201, 49 N.E. 760, 762 (1898); Doan v. Griffith, 402 S.W.2d 855, 856 (Ky.1966).

[94] *fn22 The typical situation is where a general practitioner discovers that the patient's malady calls for specialized treatment, whereupon the duty generally arises to advise the patient to consult a specialist. See the cases collected in Annot., 35 A.L.R.3d 349 (1971). See also Baldor v. Rogers, supra note 19, 81 So.2d at 662; Garafola v. Maimonides Hosp., 22 A.D.2d 85, 253 N.Y.S.2d 856, 858, 28 A.L.R.3d 1357 (1964); aff'd, 19 N.Y.2d 765, 279 N.Y.S.2d 523, 226 N.E.2d 311, 28 A.L.R.3d 1362 (1967); McCoid, The Care Required of Medical Practitioners, 12 Vand.L.Rev. 549, 597-98 (1959).

[95] *fn23 See, e.g., Wall v. Brim, 138 F.2d 478, 480-481 (5th Cir. 1943), consent issue tried on remand and verdict for plaintiff aff'd., 145 F.2d 492 (5th Cir. 1944), cert. denied,

324 U.S. 857, 65 S. Ct. 858, 89 L. Ed. 1415 (1945); Belcher v. Carter, 13 Ohio App.2d 113, 234 N.E.2d 311, 312 (1967); Hunter v. Burroughs, supra note 7, 96 S.E. at 366; Plante, An Analysis of "Informed Consent," 36 Ford.L.Rev. 639, 653 (1968).

[96] *fn24 See text supra at notes 12-13.

[97] *fn25 See cases cited supra notes 14-15.

[98] *fn26 See text supra at notes 17-23.

[99] *fn27 Some doubt has been expressed as to ability of physicians to suitably communicate their evaluations of risks and the advantages of optional treatment, and as to the lay patient's ability to understand what the physician tells him. Karchmer, Informed Consent: A Plaintiff's Medical Malpractice "Wonder Drug," 31 Mo.L.Rev. 29, 41 (1966). We do not share these apprehensions. The discussion need not be a disquisition, and surely the physician is not compelled to give his patient a short medical education; the disclosure rule summons the physician only to a reasonable explanation. See Part V (infra). That means generally informing the patient in non-technical terms as to what is at stake: the therapy alternatives open to him, the goals expectably to be achieved, and the risks that may ensue from particular treatment and no treatment. See Stinnett v. Price, 446 S.W.2d 893, 894, 895 (Tex.Civ.App.1969). So informing the patient hardly taxes the physician, and it must be the exceptional patient who cannot comprehend such an explanation at least in a rough way.

[100] *fn28 That element comes to the fore in litigation involving contractual and property dealings between physician and patient. See, e.g., Campbell v. Oliva, supra note 13, 424 F.2d at 1250; In re Bourquin's Estate, 161 Cal.App.2d 289, 326 P.2d 604, 610 (1958); Butler v. O'Brien, 8 Ill.2d 203, 133 N.E.2d 274, 277 (1956); Woodbury v. Woodbury, 141 Mass. 329, 5 N.E. 275, 278, 279 (1886); Clinton v. Miller, 77 Okl. 173, 186 P. 932, 933 (1919); Hodge v. Shea, 252 S.C. 601, 168 S.E.2d 82, 84, 87 (1969).

[101] *fn29 See, e.g., Sheets v. Burman, 322 F.2d 277, 279-280 (5th Cir. 1963); Hudson v. Moore, 239 Ala. 130, 194 So. 147, 149 (1940); Guy v. Schuldt, 236 Ind. 101, 138 N.E.2d 891, 895 (1956); Perrin v. Rodriguez, 153 So. 555, 556-557 (La.App.1934); Schmucking v. Mayo, 183 Minn. 37, 235 N.W. 633 (1931); Thompson v. Barnard, 142 S.W.2d 238, 241 (Tex.Civ.App.1940), aff'd, 138 Tex. 277, 158 S.W.2d 486 (1942).

[102] *fn30 Emmett v. Eastern Dispensary & Cas. Hosp., 130 U.S.App.D.C. 50, 54, 396 F.2d 931, 935 (1967), See also, Swan, The California Law of Malpractice of Physicians, Surgeons, and Dentists, 33 Calif.L.Rev. 248, 251 (1945).

[103] *fn31 See cases cited supra notes 16-28; Berkey v. Anderson, 1 Cal.App.3d 790, 82 Cal.Rptr. 67, 78 (1970); Smith, Antecedent Grounds of Liability in the Practice of Surgery, 14 Rocky Mt.L.Rev. 233, 249-50 (1942); Swan, The California Law of Malpractice of Physicians, Surgeons, and Dentists, 33 Calif.L.Rev. 248, 251 (1945); Note, 40 Minn.L.Rev. 876, 879-80 (1956).

[104] *fn32 See cases collected in Annot., 56 A.L.R.2d 695 (1967). Where the patient is incapable of consenting, the physician may have to obtain consent from someone else. See, e.g., Bonner v. Moran, 75 U.S.App.D.C. 156, 157-158, 126 F.2d 121, 122-123, 139 A.L.R. 1366 (1941).

[105] *fn33 See Restatement (Second) of Torts §§ 55-58 (1965).

[106] *fn34 See, e.g., Bonner v. Moran, supra note 32, 75 U.S.App.D.C. at 157, 126 F.2d at 122, and cases collected in Annot., 56 A.L.R.2d 695, 697-99 (1957). See also Part IX (infra).

[107] *fn35 See cases cited supra note 13. See also McCoid, The Care Required of Medical Practitioners, 12 Vand.L.Rev. 549, 587-91 (1959).
[108] *fn36 We discard the thought that the patient should ask for information before the physician is required to disclose. Caveat emptor is not the norm for the consumer of medical services. Duty to disclose is more than a call to speak merely on the patient's request, or merely to answer the patient's questions; it is a duty to volunteer, if necessary, the information the patient needs for intelligent decision. The patient may be ignorant, confused, overawed by the physician or frightened by the hospital, or even ashamed to inquire. See generally Note, Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship, 79 Yale L.J. 1533, 1545-51 (1970). Perhaps relatively few patients could in any event identify the relevant questions in the absence of prior explanation by the physician. Physicians and hospitals have patients of widely divergent socio-economic backgrounds, and a rule which presumes a degree of sophistication which many members of society lack is likely to breed gross inequities. See Note, Informed Consent as a Theory of Medical Liability, 1970 Wis.L.Rev. 879, 891-97.
[109] *fn37 The number is reported at 22 by 1967. Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396, 1397, and cases cited in n. 5 (1967).
[110] *fn38 See, e.g., DiFilippo v. Preston, 3 Storey 539, 53 Del. 539, 173 A.2d 333, 339 (1961); Haggerty v. McCarthy, 344 Mass. 136, 181 N.E.2d 562, 565, 566 (1962); Roberts v. Young, 369 Mich. 133, 119 N.W.2d 627, 630 (1963); Aiken v. Clary, 396 S.W.2d 668, 675, 676 (Mo.1965). As these cases indicate, majority rule courts hold that expert testimony is necessary to establish the custom.
[111] *fn39 See cases cited supra note 38.
[112] *fn40 See, e.g., W. Prosser, Torts § 33 at 171 (3d ed. 1964).
[113] *fn41 See, e.g., Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396, 1404-05 (1967); Comment, Valid Consent to Medical Treatment: Need the Patient Know?, 4 Duquesne L.Rev. 450, 458-59 (1966); Note, 75 Harv.L.Rev. 1445, 1447 (1962).
[114] *fn42 Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396, 1404 (1967); Note, 75 Harv.L.Rev. 1445, 1447 (1962).
[115] *fn43 For example, the variables which may or may not give rise to the physician's privilege to withhold risk information for therapeutic reasons. See text Part VI (infra).
[116] *fn44 Note, 75 Harv.L.Rev. 1445, 1447 (1962).
[117] *fn45 E.g., W. Prosser, Torts § 32 at 168 (3d ed. 1964); Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396, 1409 (1967).
[118] *fn46 See text supra at notes 12-13.
[119] *fn47 See Berkey v. Anderson, supra note 31, 82 Cal.Rptr. at 78; Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396, 1409-10 (1967). Medical custom bared in the cases indicates the frequency with which the profession has not engaged in self-imposition. See, e.g., cases cited supra note 23.
[120] *fn48 Washington Hosp. Center v. Butler, 127 U.S.App.D.C. 379, 383, 384 F.2d 331, 335 (1967).
[121] *fn49 Id.
[122] *fn50 Id.
[123] *fn51 Id.

[124] *fn52 Rodgers v. Lawson, supra note 16, 83 U.S.App.D.C. at 282, 170 F.2d at 158. See also Brown v. Keaveny, supra note 16, 117 U.S.App.D.C. at 118, 326 F.2d at 661; Quick v. Thurston, supra note 16, 110 U.S.App.D.C. at 171, 290 F.2d at 362.
[125] *fn53 E.g., Washington Hosp. Center v. Butler, supra note 48, 127 U.S.App.D.C. at 383, 384 F.2d at 335. See also cases cited infra note 119.

[126] *fn54 Id. at 383 ns. 10-12, 384 F.2d at 335 ns. 10-12.
[127] *fn55 Id. at 384 n. 15, 384 F.2d at 336 n. 15.
[128] *fn56 E.g., Lucy Webb Hayes Nat. Training School v. Perotti, 136 U.S.App.D.C. 122, 127-129, 419 F.2d 704, 710-711 (1969); Monk v. Doctors Hosp., 131 U.S.App.D.C. 174, 177, 403 F.2d 580, 583 (1968); Washington Hosp. Center v. Butler, supra note 48.
[129] *fn57 Washington Hosp. Center v. Butler, supra note 48, 127 U.S.App.D.C. at 387-388, 384 F.2d at 336-337. See also cases cited infra note 59.
[130] *fn58 See Part V (infra).
[131] *fn59 Washington Hosp. Center v. Butler, supra note 48, 127 U.S.App.D.C. at 387-388, 384 F.2d at 336-337; Garfield Memorial Hosp. v. Marshall, 92 U.S.App.D.C. 234, 240, 204 F.2d 721, 726-727, 37 A.L.R.2d 1270 (1953); Byrom v. Eastern Dispensary & Cas. Hosp., 78 U.S.App.D.C. 42, 43, 136 F.2d 278, 279 (1943).
[132] *fn60 E.g., Washington Hosp. Center v. Butler, supra note 48, 127 U.S.App.D.C. at 383, 384 F.2d at 335. See also cases cited infra note 119.

[133] *fn61 See cases cited supra note 59.
[134] *fn62 See cases cited supra note 59.
[135] *fn63 See Part V (infra).
[136] *fn64 Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396, 1405 (1967).
[137] *fn65 See Part VI (infra).
[138] *fn66 See Note, 75 Harv.L.Rev. 1445, 1447 (1962). See also authorities cited supra notes 17-23.
[139] *fn67 E.g., Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 154 Cal.App.2d 560, 317 P.2d 170, 181 (1957); Woods v. Brumlop, supra note 13, 377 P.2d at 524-525.
[140] *fn68 See Stottlemire v. Cawood, 213 F. Supp. 897, 898 , new trial denied, 215 F. Supp. 266 (1963); Yeates v. Harms, 193 Kan. 320, 393 P.2d 982, 991 (1964), on rehearing, 194 Kan. 675, 401 P.2d 659 (1965); Bell v. Umstattd, 401 S.W.2d 306, 313 (Tex.Civ.App.1966); Waltz & Scheuneman, Informed Consent to Therapy, 64 Nw.U.L.Rev. 628, 635-38 (1970).
[141] *fn69 See, Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396, 1402-03 (1967).
[142] *fn70 E.g., Shetter v. Rochelle, 2 Ariz.App. 358, 409 P.2d 74, 86 (1965), modified, 2 Ariz.App. 607, 411 P.2d 45 (1966); Ditlow v. Kaplan, 181 So.2d 226, 228 (Fla.App.1965); Williams v. Menehan, 191 Kan. 6, 379 P.2d 292, 294 (1963); Kaplan v. Haines, 96 N.J.Super. 242, 232 A.2d 840, 845 (1967) aff'd, 51 N.J. 404, 241 A.2d 235 (1968); Govin v. Hunter, 374 P.2d 421, 424 (Wyo.1962). This is not surprising since, as indicated, the majority of American jurisdictions find the source, as well as the scope, of duty to disclose in medical custom. See text supra at note 38.
[143] *fn71 Shetter v. Rochelle, supra note 70, 409 P.2d at 86.

[144] *fn72 E.g., Ditlow v. Kaplan, supra note 70, 181 So.2d at 228; Kaplan v. Haines, supra note 70, 232 A.2d at 845.
[145] *fn73 E.g., Williams v. Menehan, supra note 70, 379 P.2d at 294; Govin v. Hunter, supra note 70, 374 P.2d at 424.
[146] *fn74 See Part III (supra).
[147] *fn75 See text supra at notes 12-13.
[148] *fn76 See Part III (supra).
[149] *fn77 For similar reasons, we reject the suggestion that disclosure should be discretionary with the physician. See Note, 109 U.Pa.L.Rev. 768, 772-73 (1961).
[150] *fn78 See text supra at notes 12-15.
[151] *fn79 See Waltz & Scheuneman, Informed Consent to Therapy, 64 N.W.U.L.Rev. 628, 639-41 (1970).
[152] *fn80 See Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396, 1407-10 (1967).
[153] *fn81 See Waltz & Scheuneman, Informed Consent to Therapy, 64 N.W.U.L.Rev. 628, 639-40 (1970).
[154] *fn82 Id.
[155] *fn83 Id.
[156] *fn84 Id. at 640.
[157] The category of risks which the physician should communicate is, of course, no broader than the complement he could communicate. See Block v. McVay, 80 S.D. 469, 126 N.W.2d 808, 812 (1964). The duty to divulge may extend to any risk he actually knows, but he obviously cannot divulge any of which he may be unaware. Nondisclosure of an unknown risk does not, strictly speaking, present a problem in terms of the duty to disclose although it very well might pose problems in terms of the physician's duties to have known of it and to have acted accordingly. See Waltz & Scheuneman, Informed Consent to Therapy, 64 N.W.U.L.Rev. 628, 630-35 (1970). We have no occasion to explore problems of the latter type on this appeal.
[158] *fn85 See Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396, 1407 n. 68 (1967).
[159] *fn86 See Bowers v. Talmage, supra note 13 (3% chance of death, paralysis or other injury, disclosure required); Scott v. Wilson, 396 S.W.2d 532 (Tex.Civ.App.1965), aff'd, 412 S.W.2d 299 (Tex.1967) (1% chance of loss of hearing, disclosure required). Compare, where the physician was held not liable. Stottlemire v. Cawood, supra note 68, (1/800,000 chance of aplastic anemia); Yeates v. Harms, supra note 68 (1.5% chance of loss of eye); Starnes v. Taylor, 272 N.C. 386, 158 S.E.2d 339, 344 (1968) (1/250 to 1/500 chance of perforation of esophagus).
[160] *fn87 Roberts v. Young, supra note 38, 119 N.W.2d at 629-630; Starnes v. Taylor, supra note 86, 158 S.E.2d at 344; Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396, 1407 n. 69 (1967); Note, 75 Harv.L.Rev. 1445, 1448 (1962).
[161] *fn88 Yeates v. Harms, supra note 68, 393 P.2d at 991; Fleishman v. Richardson-Merrell, Inc., 94 N.J.Super. 90, 226 A.2d 843, 845-846 (1967). See also Natanson v. Kline, supra note 12, 350 P.2d at 1106.
[162] *fn89 See text supra at note 84. And compare to the contrary, Oppenheim, Informed Consent to Medical Treatment, 11 Clev.-Mar. L.Rev. 249, 264-65 (1962); Comment, Valid Consent to Medical Treatment: Need the Patient Know, 4 Duquesne

L.Rev. 450, 457-58 (1966), a position we deem unrealistic. On the other hand, we do not subscribe to the view that only risks which would cause the patient to forego the treatment must be divulged, see Johnson, Medical Malpractice -- Doctrines of Res Ipsa Loquitur and Informed Consent, 37 U.Colo.L.Rev. 182, 185-91 (1965); Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396, 1407 n. 68 (1967); Note, 75 Harv.L.Rev. 1445, 1446-47 (1962), for such a principle ignores the possibility that while a single risk might not have that effect, two or more might do so. Accord, Waltz & Scheuneman, Informed Consent to Therapy, 64 Nw.U.L.Rev. 628, 635-41 (1970).

[163] *fn90 E.g., Bowers v. Talmage, supra note 13, 159 So.2d at 889; Aiken v. Clary, supra note 38, 396 S.W.2d at 676; Hastings v. Hughes, 59 Tenn.App. 98, 438 S.W.2d 349, 352 (1968).

[164] *fn91 E.g., Dunham v. Wright, supra note 13, 423 F.2d at 941-942 (applying Pennsylvania law); Koury v. Follo, 272 N.C. 366, 158 S.E.2d 548, 555 (1968); Woods v. Brumlop, supra note 13, 377 P.2d at 525; Gravis v. Physicians & Surgeons Hosp., 415 S.W.2d 674, 677, 678 (Tex.Civ.App.1967).

[165] *fn92 Where the complaint in suit is unauthorized treatment of a patient legally or factually incapable of giving consent, the established rule is that, absent an emergency, the physician must obtain the necessary authority from a relative. See, e.g., Bonner v. Moran, supra note 32, 75 U.S.App.D.C. at 157-158, 126 F.2d at 122-123 (15-year old child). See also Koury v. Follo, supra note 91 (patient a baby).

[166] *fn93 Compare, e.g., Application of President & Directors of Georgetown College, 118 U.S.App.D.C. 80, 331 F.2d 1000, rehearing en banc denied, 118 U.S.App.D.C. 90, 331 F.2d 1010, cert. denied, Jones v. President and Directors of Georgetown College, Inc., 377 U.S. 978, 84 S. Ct. 1883, 12 L. Ed. 2d 746 (1964).

[167] *fn94 See, e.g., Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, supra note 67, 317 P.2d at 181 (1957); Waltz & Scheuneman, Informed Consent to Therapy, 64 Nw.U.L.Rev. 628, 641-43 (1970).

[168] *fn95 E.g., Roberts v. Wood, 206 F. Supp. 579, 583 (S.D.Ala.1962); Nishi v. Hartwell, 52 Haw. 188, 473 P.2d 116, 119, 52 Haw. 296 (1970); Woods v. Brumlop, supra note 13, 377 P.2d at 525; Ball v. Mallinkrodt Chem. Works, 53 Tenn.App. 218, 381 S.W.2d 563, 567-568 (1964).

[169] *fn96 E.g., Scott v. Wilson, supra note 86, 396 S.W.2d at 534-535; Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396, 1409-10 (1967); Note, 75 Harv.L.Rev. 1445, 1448 (1962).

[170] *fn97 See text supra at notes 12-13.

[171] *fn98 Note, 75 Harv.L.Rev. 1445, 1448 (1962).

[172] *fn99 See Fiorentino v. Wenger, 26 A.D.2d 693, 272 N.Y.S.2d 557, 559 (1966), appeal dismissed, 18 N.Y.2d 908, 276 N.Y.S.2d 639, 223 N.E.2d 46 (1966), reversed on other grounds, 19 N.Y.2d 407, 280 N.Y.S.2d 373, 227 N.E.2d 296 (1967). See also note 92 (supra).

[173] *fn100 Becker v. Colonial Parking, Inc., 133 U.S.App.D.C. 213, 219-220, 409 F.2d 1130, 1136-1137 (1969); Richardson v. Gregory, 108 U.S.App.D.C. 263, 266-267, 281 F.2d 626, 629-630 (1960); Arthur v. Standard Eng'r. Co., 89 U.S.App.D.C. 399, 401, 193 F.2d 903, 905, 32 A.L.R.2d 408 (1951), cert. denied, 343 U.S. 964, 72 S. Ct. 1057, 96 L.

Ed. 1361 (1952); Industrial Sav. Bank v. People's Funeral Serv. Corp., 54 App.D.C. 259, 260, 296 F. 1006, 1007 (1924).
[174] *fn101 See Morse v. Moretti, 131 U.S.App.D.C. 158, 403 F.2d 564 (1968); Kosberg v. Washington Hosp. Center, Inc., 129 U.S.App.D.C. 322, 324, 394 F.2d 947, 949 (1968); Levy v. Vaughan, 42 U.S. App. D.C. 146, 153, 157 (1914).
[175] *fn102 Shetter v. Rochelle, supra note 70, 409 P.2d at 82-85; Waltz & Scheuneman, Informed Consent to Therapy, 64 Nw.U.L.Rev. 628, 646 (1970).

[176] *fn103 Shetter v. Rochelle, supra note 70, 409 P.2d at 83-84. See also Natanson v. Kline, supra note 12, 350 P.2d at 1106-1107; Hunter v. Burroughs, supra note 7, 96 S.E. at 369.
[177] *fn104 See text supra at notes 23-35, 74-79.
[178] *fn105 Plante, An Analysis of "Informed Consent," 36 Fordham L.Rev. 639, 666-67 (1968); Waltz & Scheuneman, Informed Consent to Therapy, 64 Nw.U.L.Rev. 628, 646-48 (1970); Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396, 1411-14 (1967).
[179] *fn106 See text supra at notes 12-13.
[180] *fn107 Waltz & Scheuneman, Informed Consent to Therapy, 64 Nw.U.L.Rev. 628, 647 (1970).
[181] *fn108 Id. at 647.
[182] *fn109 Id. at 646.
[183] *fn110 Id. at 648.
[184] *fn111 See cases cited supra note 103.
[185] *fn112 See 9 J. Wigmore, Evidence § 2485 (3d ed. 1940).
[186] *fn113 See, e.g., Morse v. Moretti, supra note 101, 131 U.S.App.D.C. at 158, 403 F.2d at 564; Kosberg v. Washington Hosp. Center, Inc., supra note 101, 129 U.S.App.D.C. at 324, 394 F.2d at 949; Smith v. Reitman, 128 U.S.App.D.C. 352, 353, 389 F.2d 303, 304 (1967).
[187] *fn114 See Part VI (supra).
[188] *fn115 See 9 J. Wigmore, Evidence § 2486, 2488, 2489 (3d ed. 1940). See also Raza v. Sullivan, 139 U.S.App.D.C. 184, 186-188, 432 F.2d 617, 619-621 (1970), cert. denied, 400 U.S. 992, 91 S. Ct. 458, 27 L. Ed. 2d 440 (1971).
[189] *fn116 See cases cited infra note 119.
[190] *fn117 See text supra at notes 37-39.
[191] *fn118 See Part IV (supra).
[192] *fn119 Lucy Webb Hayes Nat. Training School v. Perotti, supra note 56, 136 U.S.App.D.C. at 126-127, 419 F.2d at 708-709 (hospital's failure to install safety glass in psychiatric ward); Alden v. Providence Hosp., 127 U.S.App.D.C. 214, 217, 382 F.2d 163, 166 (1967) (caliber of medical diagnosis); Brown v. Keaveny, supra note 16, 117 U.S.App.D.C. at 118, 326 F.2d at 661 (caliber of medical treatment); Quick v. Thurston, supra note 16, 110 U.S.App.D.C. at 171-173, 290 F.2d at 362-364 (sufficiency of medical attendance and caliber of medical treatment); Rodgers v. Lawson, supra note 16, 83 U.S.App.D.C. at 285-286, 170 F.2d at 161-162 (sufficiency of medical attendance, and caliber of medical diagnosis and treatment); Byrom v. Eastern Dispensary & Cas. Hosp., supra note 59, 78 U.S.App.D.C. at 43, 136 F.2d at 279 (caliber of medical treatment), Christie v. Callahan, 75 U.S.App.D.C. 133, 136, 124 F.2d 825, 828 (1941) (caliber of

medical treatment); Carson v. Jackson, 52 App.D.C. 51, 55, 281 F. 411, 415 (1922) (caliber of medical treatment).
[193] *fn120 See cases cited supra note 119.
[194] *fn121 Lucy Webb Hayes Nat. Training School v. Perotti, supra note 56, 136 U.S.App.D.C. at 127-129, 419 F.2d at 709-711 (permitting patient to wander from closed to open section of psychiatric ward); Monk v. Doctors Hosp., supra note 56, 131 U.S.App.D.C. at 177, 403 F.2d at 583 (operation of electro-surgical machine); Washington Hosp. Center v. Butler, supra note 48 (fall by unattended x-ray patient); Young v. Fishback, 104 U.S.App.D.C. 372, 373, 262 F.2d 469, 470 (1958) (bit of gauze left at operative site); Garfield Memorial Hosp. v. Marshall, supra note 59, 92 U.S.App.D.C. at 240, 204 F.2d at 726 (newborn baby's head striking operating table); Goodwin v. Hertzberg, 91 U.S.App.D.C. 385, 386, 201 F.2d 204, 205 (1952) (perforation of urethra); Byrom v. Eastern Dispensary & Cas. Hosp., supra note 59, 78 U.S.App.D.C. at 43, 136 F.2d at 279 (failure to further diagnose and treat after unsuccessful therapy); Grubb v. Groover, 62 App.D.C. 305, 306, 67 F.2d 511, 512 (1933), cert. denied, 291 U.S. 660, 54 S. Ct. 377, 78 L. Ed. 1052 (1934) (burn while unattended during x-ray treatment). See also Furr v. Herzmark, 92 U.S.App.D.C. 350, 353-354, 206 F.2d 468, 470-471 (1953); Christie v. Callahan, supra note 119, 75 U.S.App.D.C. at 136, 124 F.2d at 828; Sweeney v. Erving, 35 App.D.C. 57, 62, 43 L.R.A., N.S. 734 (1910), aff'd, 228 U.S. 233, 33 S. Ct. 416, 57 L. Ed. 815 (1913).
[195] *fn122 See Waltz & Scheuneman, Informed Consent to Therapy, 64 Nw.U.L.Rev. 628, 645, 647 (1970); Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396, 1410-11 (1967).
[196] *fn123 See Waltz & Scheuneman, Informed Consent to Therapy, 64 Nw.U.L.Rev. 628, 639-40 (1970); Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396, 1411 (1967).
[197] *fn124 One of the chief obstacles facing plaintiffs in malpractice cases has been the difficulty, and all too frequently the apparent impossibility, of securing testimony from the medical profession. See, e.g., Washington Hosp. Center v. Butler, supra note 48, 127 U.S.App.D.C. at 386 n. 27, 384 F.2d at 338 n. 27; Brown v. Keaveny, supra note 16, 117 U.S.App.D.C. at 118, 326 F.2d at 661 (dissenting opinion); Huffman v. Lindquist, 37 Cal.2d 465, 234 P.2d 34, 46 (1951) (dissenting opinion); Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396, 1405-06 (1967); Note, 75 Harv.L.Rev. 1445, 1447 (1962).
[198] *fn125 D.C.Code § 12-301(4) (1967).
[199] *fn126 D.C.Code § 12-301(8), specifying a three-year limitation for all actions not otherwise provided for. Suits seeking damages for negligent personal injury or property damage are in this category. Finegan v. Lumbermens Mut. Cas. Co., 117 U.S.App.D.C. 276, 329 F.2d 231 (1963); Keleket X-Ray Corp. v. United States, 107 U.S.App.D.C. 138, 275 F.2d 167 (1960); Hanna v. Fletcher, 97 U.S.App.D.C. 310, 313, 231 F.2d 469, 472, 58 A.L.R.2d 847, cert. denied, Gichner Iron Works, Inc. v. Hanna, 351 U.S. 989, 76 S. Ct. 1051, 100 L. Ed. 1501 (1956).
[200] *fn127 D.C.Code § 12-302(a)(1) (1967). See also Carson v. Jackson, supra note 119, 52 App.D.C. at 53, 281 F. at 413.
[201] *fn128 See cases cited supra note 126.
[202] *fn129 See text supra at notes 32-36.

[203] *fn130 For discussions of the differences between battery and negligence actions, see, McCoid, A Reappraisal of Liability for Unauthorized Medical Treatment, 41 Minn.L.Rev. 381, 423-25 (1957); Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396, 1399-1400 n. 18 (1967); Note 75 Harv.L.Rev. 1445, 1446 (1962).
[204] *fn131 See Natanson v. Kline, supra note 12, 350 P.2d at 1100; Restatement (Second) of Torts §§ 13, 15 (1965).
[205] *fn132 The obligation to disclose, as we have said, is but a part of the physician's general duty to exercise reasonable care for the benefit of his patient. See Part III (supra).
[206] *fn133 Thus we may distinguish Morfessis v. Baum, 108 U.S.App.D.C. 303, 305, 281 F.2d 938, 940 (1960), where an action labeled one for abuse of process was, on analysis, found to be really one for malicious prosecution.
[207] *fn134 See Maercklein v. Smith, 129 Colo. 72, 266 P.2d 1095, 1097-1098 (en banc 1954); Hershey v. Peake, 115 Kan. 562, 223 P. 1113 (1924); Mayor v. Dowsett, 240 Or. 196, 400 P.2d 234, 250-251 (en banc 1965); McCoid, A Reappraisal of Liability for Unauthorized Medical Treatment, 41 Minn.L.Rev. 381, 424-25, 434 (1957); McCoid, The Care Required of Medical Practitioners, 12 Vand.L.Rev. 586-87 (1959); Plante, An Analysis of "Informed Consent," 36 Fordham L.Rev. 639, 669-71 (1968); Comment, Informed Consent in Medical Malpractice, 55 Calif.L.Rev. 1396, 1399-4100 n. 18 (1967); Note, 75 Harv.L.Rev. 1445, 1446 (1962).
[208] *fn135 See Mellon v. Seymoure, 56 App.D.C. 301, 303, 12 F.2d 836, 837 (1926); Pedesky v. Bleiberg, 251 Cal.App.2d 119, 59 Cal.Rptr. 294 (1967).
[209] *fn136 See text supra at notes 81-90.
[210] *fn137 See text supra at notes 91-92.
[211] *fn138 See Part VI (supra). With appellant's prima facie case of violation of duty to disclose, the burden of introducing evidence showing a privilege was on Dr. Spence. See text supra at notes 114-115. Dr. Spence's opinion -- that disclosure is medically unwise -- was expressed as to patients generally, and not with reference to traits possessed by appellant. His explanation was:
[212] I think that I always explain to patients the operations are serious, and I feel that any operation is serious. I think that I would not tell patients that they might be paralyzed because of the small percentage, one per cent, that exists. There would be a tremendous percentage of people that would not have surgery and would not therefore be benefited by it, the tremendous percentage that get along very well, 99 per cent.
[213] *fn139 See Part VI (supra). Since appellant's evidence was that neither he nor his mother was informed by Dr. Spence of the risk of paralysis from the laminectomy, we need not decide whether a parent's consent to an operation on a nineteen-year-old is ordinarily required. Compare Bonner v. Moran, supra note 32, 75 U.S.App.D.C. at 157-158, 126 F.2d at 122-123.
[214] *fn140 See Part V (supra).
[215] *fn141 Bourne v. Washburn, 142 U.S.App.D.C. 332, 336, 441 F.2d 1022, 1026 (1971); Clark v. Associated Retail Credit Men, 70 App.D.C. 183, 187, 105 F.2d 62, 66 (1939); Baltimore & O.R.R. v. Morgan, 35 App.D.C. 195, 200-201 (1910); Washington A. & M. V. Ry. v. Lukens, 32 App.D.C. 442, 453-454 (1909).
[216] *fn142 361 U.S. 107, 80 S. Ct. 173, 4 L. Ed. 2d 142 (1959).
[217] *fn143 Id. at 109-110, 80 S. Ct. at (footnote omitted).

[218] *fn144 Even if Dr. Spence himself made the change, the result would not vary as to the hospital. It was or should have been known by hospital personnel that appellant had just undergone a serious operation. A jury might fairly conclude that at the time of the fall he was in no condition to be left to fend for himself. Compare Washington Hosp. Center v. Butler, supra note 48, 127 U.S.App.D.C. at 385, 384 F.2d at 337.
[219] *fn145 Compare id. See also cases cited supra note 121.
[220] *fn146 See id. at 383-385, 384 F.2d at 335-337.
[221] *fn147 See id.
[222] *fn148 Bowman v. Redding & Co., 145 U.S.App.D.C. 294, 305, 449 F.2d 956, 967 (1971).
[223] *fn149 Appellant's remaining points on appeal require no elaboration. He contends that his counsel, not the trial judge, should have conducted the voir dire examination of prospective jurors, but that matter lay within the discretion of the judge, Fed.R.Civ.P. 47(a). He argues that Mrs. Canterbury, a rebuttal witness, should not have been excluded from the courtroom during other stages of the trial. That also was within the trial judge's discretion and, in any event, no prejudice from the exclusion appears. He complains of the trial judge's refusal to admit into evidence bylaws of the hospital pertaining to written consent for surgery, and the judge's refusal to permit two physicians to testify as to medical custom and practice on the same general subject. What we have already said makes it unnecessary for us to deal further with those complaints.

***** END FOOTNOTE(S) HERE *****

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Appendix K – *Cruzan v. Director,* DMH 497 U.S. 261 (1990)

Selection from Opinion

Cruzan v. Director, DMH 497 U.S. 261 (1990)
881503 OPINION *v.* DIRECTOR, MISSOURI DEPT. OF HEALTH
(http://supct.law.cornell.edu/test/hermes/88-1503.ZO.html)

Before the turn of the century, this Court observed that "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." Union Pacific R. Co. v. Botsford, 141 U.S. 250, 251 (1891). This notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment. Justice Cardozo, while on the Court of Appeals of New York, aptly described this doctrine: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 12930, 105 N.E. 92, 93 (1914). The informed consent doctrine has become firmly entrenched in American tort law. See Dobbs, Keeton, & Owen, supra, 32, pp.189192; F.Rozovsky, Consent to Treatment, A Practical Guide 198 (2d ed. 1990).

Dissenting Opinion

Cruzan v. Director, DMH 497 U.S. 261 (1990)
At http://supct.law.cornell.edu/supct/html/88-1503.ZD1.html

881503 DISSENT *v.* DIRECTOR, MISSOURI DEPT. OF HEALTH
No. 881503
[June 25, 1990]
Justice Brennan, with whom *Justice Marshall* and *Justice Blackmun* join, dissenting.
Nancy Cruzan has dwelt in that twilight zone for six years. She is oblivious to her surroundings and will remain so. Cruzan v. Harmon, 760 S.W. 2d 408, 411 (Mo. 1988). Her body twitches only reflexively, without consciousness. Ibid. The areas of her brain that once thought, felt, and experienced sensations have degenerated badly and are continuing to do so. The cavities remaining are filling with cerebro- spinal fluid. The "`cerebral cortical atrophy is irreversible, permanent, progressive and ongoing.'" Ibid. "Nancy will never interact meaningfully with her environment again. She will remain in a persistent vegetative state until her death." Id., at 422. [n.2] Because she cannot swallow, her nutrition and hydration are delivered through a tube surgically implanted in her stomach.
A grown woman at the time of the accident, Nancy had previously expressed her wish to forgo continuing medical care under circumstances such as these. Her family and her friends are convinced that this is what she would want. See n.20, infra. A guardian ad

litem appointed by the trial court is also convinced that this is what Nancy would want. See 760 S.W. 2d, at 444 (Higgins, J., dissenting from denial of rehearing). Yet the Missouri Supreme Court, alone among state courts deciding such a question, has determined that an irreversibly vegetative patient will remain a passive prisoner of medical technologyfor Nancy, perhaps for the next 30 years. See id., at 424, 427.

Today the Court, while tentatively accepting that there is some degree of constitutionally protected liberty interest in avoiding unwanted medical treatment, including life- sustaining medical treatment such as artificial nutrition and hydration, affirms the decision of the Missouri Supreme Court. The majority opinion, as I read it, would affirm that decision on the ground that a State may require "clear and convincing" evidence of Nancy Cruzan's prior decision to forgo life-sustaining treatment under circumstances such as hers in order to ensure that her actual wishes are honored. See ante, at 1719, 22. Because I believe that Nancy Cruzan has a fundamental right to be free of unwanted artificial nutrition and hydration, which right is not outweighed by any interests of the State, and because I find that the improperly biased procedural obstacles imposed by the Missouri Supreme Court impermissibly burden that right, I respectfully dissent. Nancy Cruzan is entitled to choose to die with dignity.

□I

A "[T]he timing of deathonce a matter of fateis now a matter of human choice." Office of Technology Assessment Task Force, Life Sustaining Technologies and the Elderly 41 (1988). Of the approximately two million people who die each year, 80" die in hospitals and long-term care institutions, [n.3] and perhaps 70" of those after a decision to forgo life-sustaining treatment has been made. [n.4] Nearly every death involves a decision whether to undertake some medical procedure that could prolong the process of dying. Such decisions are difficult and personal. They must be made on the basis of individual values, informed by medical realities, yet within a framework governed by law. The role of the courts is confined to defining that framework, delineating the ways in which government may and may not participate in such decisions.

The question before this Court is a relatively narrow one: whether the Due Process Clause allows Missouri to require a now-incompetent patient in an irreversible persistent vegetative state to remain on life-support absent rigorously clear and convincing evidence that avoiding the treatment represents the patient's prior, express choice. See ante, at 13. If a fundamental right is at issue, Missouri's rule of decision must be scrutinized under the standards this Court has always applied in such circumstances. As we said in Zablocki v. Redhail, 434 U.S. 374, 388 (1978), if a requirement imposed by a State "significantly interferes with the exercise of a fundamental right, it cannot be upheld unless it is supported by sufficiently important state interests and is closely tailored to effectuate only those interests." The Constitution imposes on this Court the obligation to "examine carefully ... the extent to which [the legitimate government interests advanced] are served by the challenged regulation." Moore v. East Cleveland, 431 U.S. 494, 499 (1977). See also Carey v. Population Services International, 431 U.S. 678, 690 (1977) (invalidating a requirement that bore "no relation to the State's interest"). An evidentiary rule, just as a substantive prohibition, must meet these standards if it significantly burdens a fundamental liberty interest. Fundamental rights "are protected not only against heavy-handed frontal

attack, but also from being stifled by more subtle governmental interference." Bates v. Little Rock, 361 U.S. 516, 523 (1960).

□B The starting point for our legal analysis must be whether a competent person has a constitutional right to avoid unwanted medical care. Earlier this Term, this Court held that the Due Process Clause of the Fourteenth Amendment confers a significant liberty interest in avoiding unwanted medical treatment. Washington v. Harper, 494 U.S. , (1990). Today, the Court concedes that our prior decisions "support the recognition of a general liberty interest in refusing medical treatment." See ante, at 14. The Court, however, avoids discussing either the measure of that liberty interest or its application by assuming, for purposes of this case only, that a competent person has a constitutionally protected liberty interest in being free of unwanted artificial nutrition and hydration. See ante, at 15. *Justice* O'Co*nnor*'s opinion is less parsimonious. She openly affirms that "the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause," that there is a liberty interest in avoiding unwanted medical treatment and that it encompasses the right to be free of "artificially delivered food and water." See ante, at 1.

But if a competent person has a liberty interest to be free of unwanted medical treatment, as both the majority and *Justice* O'*connor* concede, it must be fundamental. "We are dealing here with [a decision] which involves one of the basic civil rights of man." Skinner v. Oklahoma ex rel. Williamson, 316 U.S. 535, 541 (1942) (invalidating a statute authorizing sterilization of certain felons). Whatever other liberties protected by the Due Process Clause are fundamental, "those liberties that are `deeply rooted in this Nation's history and tradition'" are among them. Bowers v. Hardwick, 478 U.S. 186, 192 (1986) (quoting Moore v. East Cleveland, supra, at 503 (plurality opinion). "Such a tradition commands respect in part because the Constitution carries the gloss of history." Richmond Newspapers, Inc. v. Virginia, 448 U.S. 555, 589 (1980) (*Brennan*, J., concurring in judgment).

The right to be free from medical attention without consent, to determine what shall be done with one's own body, is deeply rooted in this Nation's traditions, as the majority acknowledges. See ante, at 5. This right has long been "firmly entrenched in American tort law" and is securely grounded in the earliest common law. Ibid. See also Mills v. Rogers, 457 U.S. 291, 294, n.4 (1982) ("the right to refuse any medical treatment emerged from the doctrines of trespass and battery, which were applied to unauthorized touchings by a physician"). "`Anglo-American law starts with the premise of thorough-going self determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of lifesaving surgery, or other medical treatment.'" Natanson v. Kline, 186 Kan. 393, 406407, 350 P. 2d 1093, 1104 (1960). "The inviolability of the person" has been held as "sacred" and "carefully guarded" as any common law right. Union Pacific R. Co. v. Botsford, 141 U.S. 250, 251252 (1891). Thus, freedom from unwanted medical attention is unquestionably among those principles "so rooted in the traditions and conscience of our people as to be ranked as fundamental." Snyder v. Massachusetts, 291 U.S. 97, 105 (1934). [n.5]

That there may be serious consequences involved in refusal of the medical treatment at issue here does not vitiate the right under our common law tradition of medical self-determination. It is "a well-established rule of general law ... that it is the patient, not the

physician, who ultimately decides if treatmentany treatmentis to be given at all. ... The rule has never been qualified in its application by either the nature or purpose of the treatment, or the gravity of the consequences of acceding to or foregoing it." Tune v. Walter Reed Army Medical Hospital, 602 F. Supp. 1452, 1455 (DC 1985). See also Downer v. Veilleux, 322 A. 2d 82, 91 (Me. 1974) ("The rationale of this rule lies in the fact that every competent adult has the right to forego treatment, or even cure, if it entails what for him are intolerable consequences or risks, however unwise his sense of values may be to others"). [n.6]

No material distinction can be drawn between the treatment to which Nancy Cruzan continues to be subjectartificial nutrition and hydrationand any other medical treatment. See ante, at 2 (O'C*onnor*, J., concurring). The artificial delivery of nutrition and hydration is undoubtedly medical treatment. The technique to which Nancy Cruzan is subjectartificial feeding through a gastrostomy tubeinvolves a tube implanted surgically into her stomach through incisions in her abdominal wall. It may obstruct the intestinal tract, erode and pierce the stomach wall or cause leakage of the stomach's contents into the abdominal cavity. See Page, Andrassy, & Sandler, Techniques in Delivery of Liquid Diets, in Nutrition in Clinical Surgery 6667 (M. Deitel 2d ed. 1985). The tube can cause pneumonia from reflux of the stomach's contents into the lung. See Bernard & Forlaw, Complications and Their Prevention, in Enteral and Tube Feeding 553 (J. Rombeau & M. Caldwell eds. 1984). Typically, and in this case (see Tr. 377), commercially prepared formulas are used, rather than fresh food. See Matarese, Enteral Alimentation, in Surgical Nutrition 726 (J. Fischer ed. 1983). The type of formula and method of administration must be experimented with to avoid gastrointestinal problems. Id., at 748. The patient must be monitored daily by medical personnel as to weight, fluid intake and fluid output; blood tests must be done weekly. Id., at 749, 751.

Artificial delivery of food and water is regarded as medical treatment by the medical profession and the Federal Government. [n.7] According to the American Academy of Neurology, "[t]he artificial provision of nutrition and hydration is a form of medical treatment ... analogous to other forms of life- sustaining treatment, such as the use of the respirator. When a patient is unconscious, both a respirator and an artificial feeding device serve to support or replace normal bodily functions that are compromised as a result of the patient's illness." Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient, 39 Neurology 125 (Jan. 1989). See also Council on Ethical and Judicial Affairs of the American Medical Association, Current Opinions, Opinion 2.20 (1989) ("Life-prolonging medical treatment includes medication and artifically or technologically supplied respiration, nutrition or hydration"); President's Commission 88 (life- sustaining treatment includes respirators, kidney dialysis machines, special feeding procedures). The Federal Government permits the cost of the medical devices and formulas used in enteral feeding to be reimbursed under Medicare. See Pub. L. 99509, 9340, note following 42 U.S.C. 1395u p.592 (1982 ed., Supp. V). The formulas are regulated by the Federal Drug Administration as "medical foods," see 21 U.S.C. 360ee and the feeding tubes are regulated as medical devices, 21 CFR 876.5980 (1989).

Nor does the fact that Nancy Cruzan is now incompetent deprive her of her fundamental rights. See Youngberg v. Romeo, 457 U.S. 307, 315316, 319 (1982) (holding that

severely retarded man's liberty interests in safety, freedom from bodily restraint and reasonable training survive involuntary commitment); Parham v. J.R., 442 U.S. 584, 600 (1979) (recognizing a child's substantial liberty interest in not being confined unnecessarily for medical treatment); Jackson v. Indiana, 406 U.S. 715, 730, 738 (1972) (holding that Indiana could not violate the due process and equal protection rights of a mentally retarded deaf mute by committing him for an indefinite amount of time simply because he was incompetent to stand trial on the criminal charges filed against him). As the majority recognizes, ante, at 16, the question is not whether an incompetent has constitutional rights, but how such rights may be exercised. As we explained in Thompson v. Oklahoma, 487 U.S. 815 (1988), "[t]he law must often adjust the manner in which it affords rights to those whose status renders them unable to exercise choice freely and rationally. Children, the insane, and those who are irreversibly ill with loss of brain function, for instance, all retain `rights,' to be sure, but often such rights are only meaningful as they are exercised by agents acting with the best interests of their principals in mind." Id., at 825, n.23 (emphasis added). "To deny [its] exercise because the patient is unconscious or incompetent would be to deny the right." Foody v. Manchester Memorial Hospital, 40 Conn. Super. 127, 133, 482 A. 2d 713, 718 (1984).

II

A The right to be free from unwanted medical attention is a right to evaluate the potential benefit of treatment and its possible consequences according to one's own values and to make a personal decision whether to subject oneself to the intrusion. For a patient like Nancy Cruzan, the sole benefit of medical treatment is being kept metabolically alive. Neither artificial nutrition nor any other form of medical treatment available today can cure or in any way ameliorate her condition. [n.8] Irreversibly vegetative patients are devoid of thought, emotion and sensation; they are permanently and completely unconscious. See n.2, supra. [n.9] As the President's Commission concluded in approving the withdrawal of life support equipment from irreversibly vegetative patients:

"[T]reatment ordinarily aims to benefit a patient through preserving life, relieving pain and suffering, protecting against disability, and returning maximally effective functioning. If a prognosis of permanent unconsciousness is correct, however, continued treatment cannot confer such benefits. Pain and suffering are absent, as are joy, satisfaction, and pleasure. Disability is total and no return to an even minimal level of social or human functioning is possible." President's Commission 181 182.

There are also affirmative reasons why someone like Nancy might choose to forgo artificial nutrition and hydration under these circumstances. Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence. "In certain, thankfully rare, circumstances the burden of maintaining the corporeal existence degrades the very humanity it was meant to serve." Brophy v. New England Sinai Hospital, Inc., 398 Mass. 417, 434, 497 N.E. 2d 626, 635636 (1986) (finding the subject of the proceeding "in a condition which [he] has indicated he would consider to be degrading and without human dignity" and holding that "[t]he duty of the State to preserve life must encompass a recognition of an individual's right to avoid circumstances in which the individual himself would feel that efforts to sustain life demean or degrade his humanity"). Another court, hearing a similar case, noted:

"It is apparent from the testimony that what was on [the patient's] mind was not only the invasiveness of life- sustaining systems, such as the [nasogastric] tube, upon the integrity of his body. It was also the utter helplessness of the permanently comatose person, the wasting of a once strong body, and the submission of the most private bodily functions to the attention of others." In re Gardner, 534 A. 2d 947, 953 (Me. 1987).

Such conditions are, for many, humiliating to contemplate, [n.10] as is visiting a prolonged and anguished vigil on one's parents, spouse, and children. A long, drawn-out death can have a debilitating effect on family members. See Carnwath & Johnson, Psychiatric Morbidity Among Spouses of Patients With Stroke, 294 Brit. Med. J. 409 (1987); Livingston, Families Who Care, 291 Brit. Med. J. 919 (1985). For some, the idea of being remembered in their persistent vegetative states rather than as they were before their illness or accident may be very disturbing. [n.11]

B Although the right to be free of unwanted medical intervention, like other constitutionally protected interests, may not be absolute, [n.12] no State interest could outweigh the rights of an individual in Nancy Cruzan's position. Whatever a State's possible interests in mandating life-support treatment under other circumstances, there is no good to be obtained here by Missouri's insistence that Nancy Cruzan remain on life-support systems if it is indeed her wish not to do so. Missouri does not claim, nor could it, that society as a whole will be benefited by Nancy's receiving medical treatment. No third party's situation will be improved and no harm to others will be averted. Cf. nn.6 and 8, supra. [n.13]

The only state interest asserted here is a general interest in the preservation of life. [n.14] But the State has no legitimate general interest in someone's life, completely abstracted from the interest of the person living that life, that could outweigh the person's choice to avoid medical treatment. "[T]he regulation of constitutionally protected decisions ... must be predicated on legitimate state concerns other than disagreement with the choice the individual has made.... Otherwise, the interest in liberty protected by the Due Process Clause would be a nullity." Hodgson v. Minnesota, U.S. , (1990) (Opinion of *Stevens, J.*) (slip op., at 14) (emphasis added). Thus, the State's general interest in life must accede to Nancy Cruzan's particularized and intense interest in self-determination in her choice of medical treatment. There is simply nothing legitimately within the State's purview to be gained by superseding her decision.

Moreover, there may be considerable danger that Missouri's rule of decision would impair rather than serve any interest the State does have in sustaining life. Current medical practice recommends use of heroic measures if there is a scintilla of a chance that the patient will recover, on the assumption that the measures will be discontinued should the patient improve. When the President's Commission in 1982 approved the withdrawal of life support equipment from irreversibly vegetative patients, it explained that "[a]n even more troubling wrong occurs when a treatment that might save life or improve health is not started because the health care personnel are afraid that they will find it very difficult to stop the treatment if, as is fairly likely, it proves to be of little benefit and greatly burdens the patient." President's Commission 75. A New Jersey court recognized that families as well as doctors might be discouraged by an inability to stop life-support measures from "even attempting certain types of care [which] could thereby force them into hasty and premature decisions to allow a patient to die." In re Conroy, 98 N.J. 321,

370, 486 A. 2d 1209, 1234, (1985). See also Brief for American Academy of Neurology as Amicus Cruae 9 (expressing same concern). [n.15]

III This is not to say that the State has no legitimate interests to assert here. As the majority recognizes, ante, at 17, Missouri has a parens patriae interest in providing Nancy Cruzan, now incompetent, with as accurate as possible a determination of how she would exercise her rights under these circumstances. Second, if and when it is determined that Nancy Cruzan would want to continue treatment, the State may legitimately assert an interest in providing that treatment. But until Nancy's wishes have been determined, the only state interest that may be asserted is an interest in safeguarding the accuracy of that determination.

Accuracy, therefore, must be our touchstone. Missouri may constitutionally impose only those procedural requirements that serve to enhance the accuracy of a determination of Nancy Cruzan's wishes or are at least consistent with an accurate determination. The Missouri "safeguard" that the Court upholds today does not meet that standard. The determination needed in this context is whether the incompetent person would choose to live in a persistent vegetative state on life-support or to avoid this medical treatment. Missouri's rule of decision imposes a markedly asymmetrical evidentiary burden. Only evidence of specific statements of treatment choice made by the patient when competent is admissible to support a finding that the patient, now in a persistent vegetative state, would wish to avoid further medical treatment. Moreover, this evidence must be clear and convincing. No proof is required to support a finding that the incompetent person would wish to continue treatment.

A The majority offers several justifications for Missouri's heightened evidentiary standard. First, the majority explains that the State may constitutionally adopt this rule to govern determinations of an incompetent's wishes in order to advance the State's substantive interests, including its unqualified interest in the preservation of human life. See ante, at 1718, and n.10. Missouri's evidentiary standard, however, cannot rest on the State's own interest in a particular substantive result. To be sure, courts have long erected clear and convincing evidence standards to place the greater risk of erroneous decisions on those bringing disfavored claims. [n.16] In such cases, however, the choice to discourage certain claims was a legitimate, constitutional policy choice. In contrast, Missouri has no such power to disfavor a choice by Nancy Cruzan to avoid medical treatment, because Missouri has no legitimate interest in providing Nancy with treatment until it is established that this represents her choice. See supra, at 1314. Just as a State may not override Nancy's choice directly, it may not do so indirectly through the imposition of a procedural rule.

Second, the majority offers two explanations for why Missouri's clear and convincing evidence standard is a means of enhancing accuracy, but neither is persuasive. The majority initially argues that a clear and convincing evidence standard is necessary to compensate for the possibility that such proceedings will lack the "guarantee of accurate factfinding that the adversary process brings with it," citing Ohio v. Akron Center for Reproductive Health, U.S. , (1990) (upholding a clear and convincing evidence standard for an ex parte proceeding). Ante, at 17. Without supporting the Court's decision in that case, I note that the proceeding to determine an incompetent's wishes is quite different from a proceeding to determine whether a minor may bypass notifying her parents before

undergoing an abortion on the ground that she is mature enough to make the decision or that the abortion is in her best interests.

An adversarial proceeding is of particular importance when one side has a strong personal interest which needs to be counterbalanced to assure the court that the questions will be fully explored. A minor who has a strong interest in obtaining permission for an abortion without notifying her parents may come forward whether or not society would be satisfied that she has made the decision with the seasoned judgment of an adult. The proceeding here is of a different nature. Barring venal motives, which a trial court has the means of fer reting out, the decision to come forward to request a judicial order to stop treatment represents a slowly and carefully considered resolution by at least one adult and more frequently several adults that discontinuation of treatment is the patient's wish.

In addition, the bypass procedure at issue in Akron, supra, is ex parte and secret. The court may not notify the minor's parents, siblings or friends. No one may be present to submit evidence unless brought forward by the minor herself. In contrast, the proceeding to determine Nancy Cruzan's wishes was neither ex parte nor secret. In a hearing to determine the treatment preferences of an incompetent person, a court is not limited to adjusting burdens of proof as its only means of protecting against a possible imbalance. Indeed, any concern that those who come forward will present a one- sided view would be better addressed by appointing a guardian ad litem, who could use the State's powers of discovery to gather and present evidence regarding the patient's wishes. A guardian ad litem's task is to uncover any conflicts of interest and ensure that each party likely to have relevant evidence is consulted and brought forwardfor example, other members of the family, friends, clergy, and doctors. See, e.g., In re Colyer, 99 Wash. 2d 114, 133, 660 P. 2d 738, 748749 (1983). Missouri's heightened evidentiary standard attempts to achieve balance by discounting evidence; the guardian ad litem technique achieves balance by probing for additional evidence. Where, as here, the family members, friends, doctors and guardian ad litem agree, it is not because the process has failed, as the majority suggests. See ante, at 17, n.9. It is because there is no genuine dispute as to Nancy's preference.

The majority next argues that where, as here, important individual rights are at stake, a clear and convincing evidence standard has long been held to be an appropriate means of enhancing accuracy, citing decisions concerning what process an individual is due before he can be deprived of a liberty interest. See ante, at 1819. In those cases, however, this Court imposed a clear and convincing standard as a constitutional minimum on the basis of its evaluation that one side's interests clearly outweighed the second side's interests and therefore the second side should bear the risk of error. See Santosky v. Kramer, 455 U.S. 745, 753, 766767 (1982) (requiring a clear and convincing evidence standard for termination of parental rights because the parent's interest is fundamental but the State has no legitimate interest in termination unless the parent is unfit, and finding that the State's interest in finding the best home for the child does not arise until the parent has been found unfit); Addington v. Texas, 441 U.S. 418, 426427 (1979) (requiring clear and convincing evidence in an involuntary commitment hearing because the interest of the individual far outweighs that of a State, which has no legitimate interest in confining individuals who are not mentally ill and do not pose a danger to themselves or others). Moreover, we have always recognized that shifting the risk of error reduces the likelihood of errors in one direction at the cost of increasing the likelihood of errors in the other. See Addington,

supra, at 423 (contrasting heightened standards of proof to a preponderance standard in which the two sides "share the risk of error in roughly equal fashion" because society does not favor one outcome over the other). In the cases cited by the majority, the imbalance imposed by a heightened evidentiary standard was not only acceptable but required because the standard was deployed to protect an individual's exercise of a fundamental right, as the majority admits, ante, at 18, n.10. In contrast, the Missouri court imposed a clear and convincing standard as an obstacle to the exercise of a fundamental right.

The majority claims that the allocation of the risk of error is justified because it is more important not to terminate life- support for someone who would wish it continued than to honor the wishes of someone who would not. An erroneous decision to terminate life-support is irrevocable, says the majority, while an erroneous decision not to terminate "results in a maintenance of the status quo." See ante, at 19. [n.17] But, from the point of view of the patient, an erroneous decision in either direction is irrevocable. An erroneous decision to terminate artificial nutrition and hydration, to be sure, will lead to failure of that last remnant of physiological life, the brain stem, and result in complete brain death. An erroneous decision not to terminate life-support, however, robs a patient of the very qualities protected by the right to avoid unwanted medical treatment. His own degraded existence is perpetuated; his family's suffering is protracted; the memory he leaves behind becomes more and more distorted.

Even a later decision to grant him his wish cannot undo the intervening harm. But a later decision is unlikely in any event. "[T]he discovery of new evidence," to which the majority refers, ibid., is more hypothetical than plausible. The majority also misconceives the relevance of the possibility of "advancements in medical science," ibid., by treating it as a reason to force someone to continue medical treatment against his will. The possibility of a medical miracle is indeed part of the calculus, but it is a part of the patient's calculus. If current research suggests that some hope for cure or even moderate improvement is possible within the life-span projected, this is a factor that should be and would be accorded significant weight in assessing what the patient himself would choose. [n.18]

□B Even more than its heightened evidentiary standard, the Missouri court's categorical exclusion of relevant evidence dispenses with any semblence of accurate factfinding. The court adverted to no evidence supporting its decision, but held that no clear and convincing, inherently reliable evidence had been presented to show that Nancy would want to avoid further treatment. In doing so, the court failed to consider statements Nancy had made to family members and a close friend. [n.19] The court also failed to consider testimony from Nancy's mother and sister that they were certain that Nancy would want to discontinue to artificial nutrition and hydration, [n.20] even after the court found that Nancy's family was loving and without malignant motive. See 760 S.W. 2d, at 412. The court also failed to consider the conclusions of the guardian ad litem, appointed by the trial court, that there was clear and convincing evidence that Nancy would want to discontinue medical treatment and that this was in her best interests. Id., at 444 (Higgins, J., dissenting from denial of rehearing); Brief for Respondent Guardian Ad Litem 23. The court did not specifically define what kind of evidence it would consider clear and convincing, but its general discussion suggests that only a living will or equivalently formal directive from the patient when competent would meet this standard. See 760 S.W. 2d, at 424425.

Too few people execute living wills or equivalently formal directives for such an evidentiary rule to ensure adequately that the wishes of incompetent persons will be honored. [n.21] While it might be a wise social policy to encourage people to furnish such instructions, no general conclusion about a patient's choice can be drawn from the absence of formalities. The probability of becoming irreversibly vegetative is so low that many people may not feel an urgency to marshal formal evidence of their preferences. Some may not wish to dwell on their own physical deterioration and mortality. Even someone with a resolute determination to avoid life-support under circumstances such as Nancy's would still need to know that such things as living wills exist and how to execute one. Often legal help would be necessary, especially given the majority's apparent willingness to permit States to insist that a person's wishes are not truly known unless the particular medical treatment is specified. See ante, at 21.

As a California appellate court observed: "The lack of generalized public awareness of the statutory scheme and the typically human characteristics of procrastination and reluctance to contemplate the need for such arrangements however makes this a tool which will all too often go unused by those who might desire it." Barber v. Superior Court, 147 Cal. App. 3d 1006, 1015, 194 Cal. Rptr. 484, 489 (1983). When a person tells family or close friends that she does not want her life sustained artificially, she is "express[ing] her wishes in the only terms familiar to her, and ... as clearly as a lay person should be asked to express them. To require more is unrealistic, and for all practical purposes, it precludes the rights of patients to forego life-sustaining treatment." In re O'Connor, 72 N.Y. 2d 517, 551, 531 N.E. 2d 607, 626 (1988) (Simons, J., dissenting). [n.22] When Missouri enacted a living will statute, it specifically provided that the absence of a living will does not warrant a presumption that a patient wishes continued medical treatment. See n.15, supra. Thus, apparently not even Missouri's own legislature believes that a person who does not execute a living will fails to do so because he wishes continuous medical treatment under all circumstances.

The testimony of close friends and family members, on the other hand, may often be the best evidence available of what the patient's choice would be. It is they with whom the patient most likely will have discussed such questions and they who know the patient best. "Family members have a unique knowledge of the patient which is vital to any decision on his or her behalf." Newman, Treatment Refusals for the Critically and Terminally Ill: Proposed Rules for the Family, the Physician, and the State, 3 N.Y.L.S. Human Rights Annual 35, 46 (1985). The Missouri court's decision to ignore this whole category of testimony is also at odds with the practices of other States. See, e.g., In re Peter, 108 N.J. 365, 529 A. 2d 419 (1987), Brophy v. New England Sinai Hospital, Inc., 398 Mass. 417, 497 N.E. 2d 626 (1986); In re Severns, 425 A. 2d 156 (Del. Ch. 1980).

The Missouri court's disdain for Nancy's statements in serious conversations not long before her accident, for the opinions of Nancy's family and friends as to her values, beliefs and certain choice, and even for the opinion of an outside objective factfinder appointed by the State evinces a disdain for Nancy Cruzan's own right to choose. The rules by which an incompetent person's wishes are determined must represent every effort to determine those wishes. The rule that the Missouri court adopted and that this Court upholds, however, skews the result away from a determination that as accurately as possible

reflects the individual's own preferences and beliefs. It is a rule that transforms human beings into passive subjects of medical technology.

"[M]edical care decisions must be guided by the individual patient's interests and values. Allowing persons to determine their own medical treatment is an important way in which society respects persons as individuals. Moreover, the respect due to persons as individuals does not diminish simply because they have become incapable of participating in treatment decisions.... [I]t is still possible for others to make a decision that reflects [the patient's] interests more closely than would a purely technological decision to do whatever is possible. Lacking the ability to decide, [a patient] has a right to a decision that takes his interests into account." In re Drabick, 200 Cal. App. 3d 185, 208; 245 Cal. Rptr. 840, 854855 (1988).

□C I do not suggest that States must sit by helplessly if the choices of incompetent patients are in danger of being ignored. See ante, at 17. Even if the Court had ruled that Missouri's rule of decision is unconstitutional, as I believe it should have, States would nevertheless remain free to fashion procedural protections to safeguard the interests of incompetents under these circumstances. The Constitution provides merely a framework here: protections must be genuinely aimed at ensuring decisions commensurate with the will of the patient, and must be reliable as instruments to that end. Of the many States which have instituted such protections, Missouri is virtually the only one to have fashioned a rule that lessens the likelihood of accurate determinations. In contrast, nothing in the Constitution prevents States from reviewing the advisability of a family decision, by requiring a court proceeding or by appointing an impartial guardian ad litem.

There are various approaches to determining an incompetent patient's treatment choice in use by the several States today and there may be advantages and disadvantages to each and other approaches not yet envisioned. The choice, in largest part, is and should be left to the States, so long as each State is seeking, in a reliable manner, to discover what the patient would want. But with such momentous interests in the balance, States must avoid procedures that will prejudice the decision. "To err either wayto keep a person alive under circumstances under which he would rather have been allowed to die, or to allow that person to die when he would have chosen to cling to lifewould be deeply unfortunate." In re Conroy, 98 N.J., at 343, 486 A. 2d, at 1220.

D Finally, I cannot agree with the majority that where it is not possible to determine what choice an incompetent patient would make, a State's role as parens patriae permits the State automatically to make that choice itself. See ante, at 22 (explaining that the Due Process Clause does not require a State to confide the decision to "anyone but the patient herself"). Under fair rules of evidence, it is improbable that a court could not determine what the patient's choice would be. Under the rule of decision adopted by Missouri and upheld today by this Court, such occasions might be numerous. But in neither case does it follow that it is constitutionally acceptable for the State invariably to assume the role of deciding for the patient. A State's legitimate interest in safeguarding a patient's choice cannot be furthered by simply appropriating it.

The majority justifies its position by arguing that, while close family members may have a strong feeling about the question, "there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had she been confronted with the prospect of her situation while competent." Ibid. I cannot quarrel with

this observation. But it leads only to another question: Is there any reason to suppose that a State is more likely to make the choice that the patient would have made than someone who knew the patient intimately? To ask this is to answer it. As the New Jersey Supreme Court observed: "Family members are best qualified to make substituted judgments for incompetent patients not only because of their peculiar grasp of the patient's approach to life, but also because of their special bonds with him or her.... It is ... they who treat the patient as a person, rather than a symbol of a cause." In re Jobes, 108 N.J. 394, 416, 529 A. 2d 434, 445 (1987). The State, in contrast, is a stranger to the patient.

A State's inability to discern an incompetent patient's choice still need not mean that a State is rendered powerless to protect that choice. But I would find that the Due Process Clause prohibits a State from doing more than that. A State may ensure that the person who makes the decision on the patient's behalf is the one whom the patient himself would have selected to make that choice for him. And a State may exclude from consideration anyone having improper motives. But a State generally must either repose the choice with the person whom the patient himself would most likely have chosen as proxy or leave the decision to the patient's family. [n.23]

□IV As many as 10,000 patients are being maintained in persistent vegetative states in the United States, and the number is expected to increase significantly in the near future. See Cranford, supra n.2, at 27, 31. Medical technology, developed over the past 20 or so years, is often capable of resuscitating people after they have stopped breathing or their hearts have stopped beating. Some of those people are brought fully back to life. Two decades ago, those who were not and could not swallow and digest food, died. Intravenous solutions could not provide sufficient calories to maintain people for more than a short time. Today, various forms of artificial feeding have been developed that are able to keep people metabolically alive for years, even decades. See Spencer & Palmisano, Specialized Nutritional Support of PatientsA Hospital's Legal Duty?, 11 Quality Rev. Bull. 160, 160161 (1985). In addition, in this century, chronic or degenerative ailments have replaced communicable diseases as the primary causes of death. See R. Weir, Abating Treatment with Critically Ill Patients 1213 (1989); President's Commission 1516. The 80" of Americans who die in hospitals are "likely to meet their end ... `in a sedated or comatose state; betubed nasally, abdominally and intravenously; and far more like manipulated objects than like moral subjects.'" [n.24] A fifth of all adults surviving to age 80 will suffer a progressive dementing disorder prior to death. See Cohen & Eisdorfer, Dementing Disorders, in The Practice of Geriatrics 194 (E. Calkins, P. Davis, & A, Ford eds. 1986).

"[L]aw, equity and justice must not themselves quail and be helpless in the face of modern technological marvels presenting questions hitherto unthought of." In re Quinlan, 70 N.J. 10, 44, 355 A. 2d 647, 665, cert. denied, 429 U.S. 922 (1976). The new medical technology can reclaim those who would have been irretrievably lost a few decades ago and restore them to active lives. For Nancy Cruzan, it failed, and for others with wasting incurable disease it may be doomed to failure. In these unfortunate situations, the bodies and preferences and memories of the victims do not escheat to the State; nor does our Constitution permit the State or any other government to commandeer them. No singularity of feeling exists upon which such a government might confidently rely as parens patriae. The President's Commission, after years of research, concluded:

"In few areas of health care are people's evaluations of their experiences so varied and uniquely personal as in their assessments of the nature and value of the processes associated with dying. For some, every moment of life is of inestimable value; for others, life without some desired level of mental or physical ability is worthless or burdensome. A moderate degree of suffering may be an important means of personal growth and religious experience to one person, but only frightening or despicable to another." President's Commission 276.

Yet Missouri and this Court have displaced Nancy's own assessment of the processes associated with dying. They have discarded evidence of her will, ignored her values, and deprived her of the right to a decision as closely approximating her own choice as humanly possible. They have done so disingenuously in her name, and openly in Missouri's own. That Missouri and this Court may truly be motivated only by concern for incompetent patients makes no matter. As one of our most prominent jurists warned us decades ago: "Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent.... The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well meaning but without understanding." Olmstead v. United States, 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting).

I respectfully dissent.

Notes

2 Vegetative state patients may react reflexively to sounds, movements and normally painful stimuli, but they do not feel any pain or sense anybody or anything. Vegetative state patients may appear awake but are completely unaware. See Cranford, The Persistent Vegetative State: The Medical Reality, 18 Hastings Ctr. Rep. 27, 28, 31 (1988).

3 See President's Commission for the Study of Ethical Problems in Med icine and Biomedical and Behavioral Research, Deciding to Forego Life Sustaining Treatment 15, n.1, and 1718 (1983) (hereafter President's Commission).

4 See Lipton, Do-Not-Resuscitate Decisions in a Community Hospital: Incidence, Implications and Outcomes, 256 JAMA 1164, 1168 (1986).

5 See, e.g., Canterbury v. Spence, 150 U.S. App. D.C. 263, 271, 464 F. 2d 772, 780, cert. denied, 409 U.S. 1064 (1972) ("The root premise" of informed consent "is the concept, fundamental in American jurisprudence, that `[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body'") (quoting Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 129130, 105 N.E. 92, 93 (1914) (Cardozo, J.)). See generally Washington v. Harper, 494 U.S. , (1990) (*Stevens*, J., dissenting) (slip op., at 5) ("There is no doubt ... that a competent individual's right to refuse [psychotropic] medication is a fundamental liberty interest deserving the highest order of protection").

6 Under traditional tort law, exceptions have been found only to protect dependent children. See Cruzan v. Harmon, 760 S.W. 2d 408, 422, n.17 (Mo. 1988) (citing cases where Missouri courts have ordered blood transfusions for children over the religious objection of parents); see also Winthrop University Hospital v. Hess, 128 Misc. 2d 804, 490 N.Y.S. 2d 996 (Sup. Ct. Nassau Co. 1985) (court ordered blood transfusion for religious objector because she was the mother of an infant and had explained that her objection was to the signing of the consent, not the transfusion itself); Application of President & Directors of Georgetown College, Inc., 118 U.S. App. D.C. 80, 88, 331 F. 2d

1000, 1008, cert. denied, 377 U.S. 978 (1964) (blood transfusion ordered for mother of infant). Cf. In re Estate of Brooks, 32 Ill. 2d 361, 373, 205 N.E. 2d 435, 441442 (1965) (finding that lower court erred in ordering a blood transfusion for a womanwhose children were grownand concluding: "Even though we may consider apellant's beliefs unwise, foolish or ridiculous, in the absence of an overriding danger to society we may not permit interference therewith in the form of a conservatorship established in the waning hours of her life for the sole purpose of compelling her to accept medical treatment forbidden by her religious principles, and previously refused by her with full knowledge of the probable consequences").

7 The Missouri court appears to be alone among state courts to suggest otherwise, 760 S.W. 2d, at 419 and 423, although the court did not rely on a distinction between artificial feeding and other forms of medical treatment. Id., at 423. See, e.g., Delio v. Westchester County Medical Center, 129 App. Div. 2d 1, 19, 516 N.Y.S. 2d 677, 689 (1987) ("review of the decisions in other jurisdictions ... failed to uncover a single case in which a court confronted with an application to discontinue feeding by artificial means has evaluated medical procedures to provide nutrition and hydration differently from other types of life-sustaining procedures").

8 While brain stem cells can survive 15 to 20 minutes without oxygen, cells in the cerebral hemispheres are destroyed if they are deprived of oxygen for as few as 4 to 6 minutes. See Cranford & Smith, Some Critical Distinctions Between Brain Death and the Persistent Vegetative State, 6 Ethics Sci. & Med. 199, 203 (1979). It is estimated that Nancy's brain was deprived of oxygen from 12 to 14 minutes. See ante, at 2. Out of the 100,000 patients who, like Nancy, have fallen into persistive vegetative states in the past 20 years due to loss of oxygen to the brain, there have been only three even partial recoveries documented in the medical literature. Brief for American Medical Association et al. as Amici Curiae 1112. The longest any person has ever been in a persistent vegetative state and recovered was 22 months. See Snyder, Cranford, Rubens, Bundlie, & Rockswold, Delayed Recovery from Postanoxic Persistent Vegetative State, 14 Annals Neurol. 156 (1983). Nancy has been in this state for seven years.

9 The American Academy of Neurology offers three independent bases on which the medical profession rests these neurological conclusions:

"First, direct clinical experience with these patients demonstrates that there is no behavioral indication of any awareness of pain or suffering.

"Second, in all persistent vegetative state patients studied to date, postmortem examination reveals overwhelming bilateral damage to the cerebral hemispheres to a degree incompatible with consciousness ....

"Third, recent data utilizing positron emission tomography indicates that the metabolic rate for glucose in the cerebral cortex is greatly reduced in persistent vegetative state patients, to a degree incompatible with consciousness." Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient, 39 Neurology 125 (Jan. 1989).

10 Nancy Cruzan, for instance, is totally and permanently disabled. All four of her limbs are severely contracted; her fingernails cut into her wrists. App. to Pet. for Cert. A93. She is incontinent of bowel and bladder. The most intimate aspects of her existence are

exposed to and controlled by strangers. Brief for Respondent Guardian Ad Litem 2. Her family is convinced that Nancy would find this state degrading. See n.20, infra.

11 What general information exists about what most people would choose or would prefer to have chosen for them under these circumstances also indicates the importance of ensuring a means for now-incompetent patients to exercise their right to avoid unwanted medical treatment. A 1988 poll conducted by the American Medical Association found that 80" of those surveyed favored withdrawal of life support systems from hopelessly ill or irreversibly comatose patients if they or their families requested it. New York Times, June 5, 1988, p.14, col. 4 (citing American Medical News, June 3, 1988, p.9, col. 1). Another 1988 poll conducted by the Colorado University Graduate School of Public Affairs showed that 85" of those questioned would not want to have their own lives maintained with artificial nutrition and hydration if they became permanently unconscious. The Coloradoan, Sept. 29, 1988, p.1.

Such attitudes have been translated into considerable political action. Since 1976, 40 States and the District of Columbia have enacted natural death acts, expressly providing for self-determination under some or all of these situations. See Brief for Society for the Right to Die, Inc. as Amicus Curiae 8; Weiner, Privacy, Family, and Medical Decision Making for Persistent Vegetative Patients, 11 Cardozo L. Rev. 713, 720 (1990). Thirteen States and the District of Columbia have enacted statutes authorizing the appointment of proxies for making health care decisions. See ante, at 4, n.2 (*O'Connor, J.*, concurring).

12 See Jacobson v. Massachusetts, 197 U.S. 11, 2627 (1905) (upholding a Massachusetts law imposing fines or imprisonment on those refusing to be vaccinated as "of paramount necessity" to that State's fight against a smallpox epidemic).

13 Were such interests at stake, however, I would find that the Due Process Clause places limits on what invasive medical procedures could be forced on an unwilling comatose patient in pursuit of the interests of a third party. If Missouri were correct that its interests outweigh Nancy's interest in avoiding medical procedures as long as she is free of pain and physical discomfort, see 760 S.W. 2d, at 424, it is not apparent why a State could not choose to remove one of her kidneys without consent on the ground that society would be better off if the recipient of that kidney were saved from renal poisoning. Nancy cannot feel surgical pain. See n.2, supra. Nor would removal of one kidney be expected to shorten her life expectancy. See The American Medical Association Family Medical Guide 506 (J. Kunz ed. 1982). Patches of her skin could also be removed to provide grafts for burn victims, and scrapings of bone marrow to provide grafts for someone with leukemia. Perhaps the State could lawfully remove more vital organs for transplanting into others who would then be cured of their ailments, provided the State placed Nancy on some other life-support equipment to replace the lost function. Indeed, why could the State not perform medical experiments on her body, experiments that might save countless lives, and would cause her no greater burden than she already bears by being fed through the gastrostomy tube? This would be too brave a new world for me and, I submit, for our Constitution.

14 The Missouri Supreme Court reviewed the state interests that had been identified by other courts as potentially relevantprevention of homicide and suicide, protection of interests of innocent third parties, maintenance of the ethical integrity of the medical

profession, and preservation of lifeand concluded that: "In this case, only the state's interest in the preservation of life is implicated." 760 S.W. 2d, at 419.

15 In any event, the State interest identified by the Missouri Supreme Courta comprehensive and "unqualified" interest in preserving life, id., at 420, 424is not even well supported by that State's own enactments. In the first place, Missouri has no law requiring every person to procure any needed medical care nor a state health insurance program to underwrite such care. Id., at 429 (Blackmar, J., dissenting). Second, as the state court admitted, Missouri has a living will statute which specifically "allows and encourages the pre-planned termination of life." Ibid.; see Mo. Rev. Stat. 459.015(1) (1986). The fact that Missouri actively provides for its citizens to choose a natural death under certain circumstances suggests that the State's interest in life is not so unqualified as the court below suggests. It is true that this particular statute does not apply to nonterminal patients and does not include artificial nutrition and hydration as one of the measures that may be declined. Nonetheless, Missouri has also not chosen to require court review of every decision to withhold or withdraw life-support made on behalf of an incompetent patient. Such decisions are made every day, without state participation. See 760 S.W. 2d, at 428 (Blackmar, J., dissenting).

In addition, precisely what implication can be drawn from the statute's limitations is unclear given the inclusion of a series of "interpretive" provisions in the Act. The first such provision explains that the Act is to be interpreted consistently with the following: "Each person has the primary right to request or refuse medical treatment subject to the state's interest in protecting innocent third parties, preventing homicide and suicide and preserving good ethical standards in the medical profession." Mo. Rev. Stat. 459.055(1) (1986). The second of these subsections explains that the Act's provisions are cumulative and not intended to increase or decrease the right of a patient to make decisions or lawfully effect the withholding or withdrawal of medical care. 459.055(2). The third subsection provides that "no presumption concerning the intention of an individual who has not executed a declaration to consent to the use or withholding of medical procedures" shall be created. 459.055(3).

Thus, even if it were conceivable that a State could assert an interest sufficiently compelling to overcome Nancy Cruzan's constitutional right, Missouri law demonstrates a more modest interest at best. See generally Capital Cities Cable, Inc. v. Crisp, 467 U.S. 691, 715 (1984) (finding that state regulations narrow in scope indicated that State had only a moderate interest in its professed goal).

16 See Colorado v. New Mexico, 467 U.S. 310 (1984) (requiring clear and convincing evidence before one State is permitted to divert water from another to accommodate society's interests in stabile property rights and efficient use of resources); New York v. New Jersey, 256 U.S. 296 (1921) (promoting federalism by requiring clear and convincing evidence before using Court's power to control the conduct of one State at the behest of another); Maxwell Land-Grant Case, 121 U.S. 325 (1887) (requiring clear, unequivocal, and convincing evidence to set aside, annul or correct a patent or other title to property issued by the Government in order to secure settled expectations concerning property rights); Marcum v. Zaring, 406 P. 2d 970 (Okla. 1965) (promoting stability of marriage by requiring clear and convincing evidence to prove its invalidity); Stevenson v. Stein, 412

Pa. 478, 195 A. 2d 268 (1963) (promoting settled expectations concerning property rights by requiring clear and convincing evidence to prove adverse possession).

17 The majority's definition of the "status quo," of course, begs the question. Artificial delivery of nutrition and hydration represents the "status quo" only if the State has chosen to permit doctors and hospitals to keep a patient on life-support systems over the protests of his family or guardian. The "status quo" absent that state interference would be the natural result of his accident or illness (and the family's decision). The majority's definition of status quo, however, is "to a large extent a predictable, yet accidental confluence of technology, psyche, and inertia. The general citizenry ... never said that it favored the creation of coma wards where permanently unconscious patients would be tended for years and years. Nor did the populace as a whole authorize the preeminence of doctors over families in making treatment decisions for incompetent patients." Rhoden, Litigating Life and Death, 102 Harv. L. Rev. 375, 433434 (1988).

18 For Nancy Cruzan, no such cure or improvement is in view. So much of her brain has deteriorated and been replaced by fluid, see App. to Pet. for Cert. A94, that apparently the only medical advance that could restore consciousness to her body would be a brain transplant. Cf. n.22, infra. 19 The trial court had relied on the testimony of Athena Comer, a long- time friend, co-worker and a housemate for several months, as sufficient to show that Nancy Cruzan would wish to be free of medical treatment under her present circumstances. App. to Pet. for Cert. A94. Ms. Comer described a conversation she and Nancy had while living together, concerning Ms. Comer's sister who had become ill suddenly and died during the night. The Comer family had been told that if she had lived through the night, she would have been in a vegetative state. Nancy had lost a grandmother a few months before. Ms. Comer testified that: "Nancy said she would never want to live [as a vegetative state] because if she couldn't be normal or even, you know, like half way, and do things for yourself, because Nancy always did, that she didn't want to live ... and we talked about it a lot." Tr. 388389. She said "several times" that "she wouldn't want to live that way because if she was going to live, she wanted to be able to live, not to just lay in a bed and not be able to move because you can't do anything for yourself." Id., at 390, 396. "[S]he said that she hoped that [all the] people in her family knew that she wouldn't want to live [as a vegetable] because she knew it was usually up to the family whether you lived that way or not." Id., at 399.

The conversation took place approximately a year before Nancy's accident and was described by Ms. Comer as a "very serious" conversation that continued for approximately half an hour without interruption. Id., at 390. The Missouri Supreme Court dismissed Nancy's statement as "unreliable" on the ground that it was an informally expressed reaction to other people's medical conditions. 760 S.W. 2d, at 424.

The Missouri Supreme Court did not refer to other evidence of Nancy's wishes or explain why it was rejected. Nancy's sister Christy, to whom she was very close, testified that she and Nancy had had two very serious conversations about a year and a half before the accident. A day or two after their niece was stillborn (but would have been badly damaged if she had lived), Nancy had said that maybe it was part of a "greater plan" that the baby had been stillborn and did not have to face "the possible life of mere existence." Tr. 537. A month later, after their grandmother had died after a long battle with heart problems, Nancy said that "it was better for my grandmother not to be kind of brought back and

forth [by] medical [treatment], brought back from a critical near point of death .... Id., at 541.

20 Nancy's sister Christy, Nancy's mother, and another of Nancy's friends testified that Nancy would want to discontinue the hydration and nutrition. Christy said that "Nancy would be horrified at the state she is in." Id., at 535. She would also "want to take that burden away from [her family]. Id., at 544. Based on "a lifetime of experience [I know Nancy's wishes] are to discontinue the hydration and the nutrition." Id., at 542. Nancy's mother testified: "Nancy would not want to be like she is now. [I]f it were me up there or Christy or any of us, she would be doing for us what we are trying to do for her. I know she would,... as her mother." Id., at 526.

21 Surveys show that the overwhelming majority of Americans have not executed such written instructions. See Emmanuel & Emmanuel, The Medical Directive: A New Comprehensive Advance Care Document, 261 JAMA 3288 (1989) (only 9" of Americans execute advance directives about how they would wish treatment decisions to be handled if they became incompetent); American Medical Association Surveys of Physician and Public Opinion on Health Care Issues 2930 (1988) (only 15" of those surveyed had executed living wills); 2 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions 241242 (1982) (23" of those surveyed said that they had put treatment instructions in writing).

22 New York is the only State besides Missouri to deny a request to terminate life support on the ground that clear and convincing evidence of prior, expressed intent was absent, although New York did so in the context of very different situations. Mrs. O'Connor, the subject of In re O'Connor, had several times expressed her desire not to be placed on life-support if she were not going to be able to care for herself. However, both of her daughters testified that they did not know whether their mother would want to decline artificial nutrition and hydration under her present circumstances. Cf. n.13, supra. Moreover, despite damage from several strokes, Mrs. O'Connor was conscious and capable of responding to simple questions and requests and the medical testimony suggested she might improve to some extent. Cf. supra, at 1. The New York Court of Appeals also denied permission to terminate blood transfusions for a severely retarded man with terminal cancer because there was no evidence of a treatment choice made by the man when competent, as he had never been competent. See In re Storar, 52 N.Y. 2d 363, 420 N.E. 2d 64, cert. denied, 454 U.S. 858 (1981). Again, the court relied on evidence that the man was conscious, functioning in the way he always had, and that the transfusions did not cause him substantial pain (although it was clear he did not like them).

23 Only in the exceedingly rare case where the State cannot find any family member or friend who can be trusted to endeavor genuinely to make the treatment choice the patient would have made does the State become the legitimate surrogate decisionmaker.

24 Fadiman, The Liberation of Lolly and Gronky, Life Magazine, Dec. 1986, p.72 (quoting medical ethicist Joseph Fletcher).

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