

# Is There Patient Autonomy in Halacha?

**Rabbi Zev Schostak**

Patient autonomy, the right of a patient to determine his or her mode of medical treatment or to reject it, is a *sine qua non* of modern medical ethics. Indeed, many of our most fundamental and universally accepted medical practices are rooted in patient autonomy: informed consent, truth telling, risking or rejecting hazardous (and even some basic) procedures or surgery, and advance directives, such as living wills or health care proxies. Patient autonomy is actually another aspect of individual autonomy, a doctrine central to our constitutional tradition. In 1914, Judge Cardozo articulated this concept:

“Every human being of adult years and sound mind has a right to determine what shall be done with his body and a surgeon who performs an operation without his patient’s consent commits an assault for which he is liable in damage.”<sup>1</sup>

Since a patient must be able to determine what medical procedure may (or may not) be performed on his body, he must be fully informed in advance of the available treatment options and he must consent to any procedure. In fact, “unless a physician discloses certain information to a patient before performing a procedure, the patient is entitled to damages even if the procedure was performed correctly. The exact scope of disclosure demanded of the doctor is not clear, but most courts require that the patient be told the diagnosis, the nature of the proposed procedure, the risks and benefits of the procedure, the available alternative procedures and their risks and benefits, and the consequences of not having the procedure.”<sup>2</sup>

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1. Scholendorf v. Society of New York Hospital, 211 N.Y. 125, 129-30, 105 N.E. 2nd 92, 93 (1914).
  2. Sprung C.L., Winick, B.J.: “Informed consent in theory and practice: legal and medical perspectives on the informed consent doctrine and a proposed reconceptualization.” *Critical Care Medicine* 1989; (12)1347.

Disclosure to the patient and his subsequent consent forms the basis of what is commonly referred to as “informed consent,” a term first used in 1957.<sup>3</sup> It is, of course, axiomatic that when the patient is informed of his diagnosis, he be told his “true” condition – clearly and candidly; otherwise, he could not possibly make a proper determination regarding the future course of his treatment. But his disclosure also raises some ethical concerns of truth telling, such as when the patient’s diagnosis is terminal and his mental/emotional state is so fragile that this bad news might overwhelm him, seriously affecting his physical or psychological well-being. Finally, patient autonomy recognized the right of an individual to request certain medical treatments or withhold them should he become incapacitated if he expresses them in an advance directive. For example, an individual may direct, in a living will, that he refuses cardiac resuscitation and mechanical respiration should he become incapacitated (i.e., incapable of making his own decisions) and is suffering from an “incurable or irreversible mental or physical condition with no reasonable expectation of recovery.”<sup>4</sup> Clearly, then, the concept of patient autonomy is pivotal to contemporary medical ethics and practice.

### **A Halachic Perspective**

At first glance, one might conclude that there is no patient autonomy in halacha. Since this doctrine is predicated on the “right to determine what shall be done with (one’s) body,” it is understood that one has some sort of proprietary interest in his body: it belongs to him to do as he pleases. Yet, no less an authority than Maimonides declares, “the soul of this murder victim is not the property of the avenging relative but rather that of the Holy One, blessed be He...”<sup>5</sup> Man does not “own” his body; it belongs to God. Indeed, while our society recognizes personal autonomy as a cardinal principle, it is not absolute. As Rabbi J. David Bleich so eloquently observes:

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3. *Salgo v. Leland Stanford Jr. University Board of Trustees*, 154 Cal. App. 2d 560, 317 P. 2d 170 (1957).
  4. From the generic text of the living will, prepared by the Society for the Right to Die, New York, 1990
  5. *Mishneh Torah, Rotzeach* 1:4. See also *Radbaz on Mishneh Torah, Sanhedrin* 18:6; *Sefer Chasidim* 723; *Shulchan Aruch Harav, Nizkei Haguf V’Nefesh* 4; *Responsa of Rivash* 484; *Chazon Ish, Nizikin*, 19:5; and *Igrot Moshe, Yoreh De’ah*, Volume 2, 174:3

Despite our society's commitment to individual liberty as an ideal, it recognizes that this liberty is not entirely sacrosanct. Although there are those who wish it to be so, self-determination is not universally recognized as the paramount human value. There is a long judicial history of recognition of the State's compelling interest in the preservation of life of each and every one of its citizens, an interest which carries with it the right to curb personal freedom. What the jurist calls a 'compelling state interest' the theologian terms 'sanctity of life'. It is precisely this concept of the sanctity of life which, as a transcendental value, supersedes considerations of personal freedom... Were autonomy recognized as the paramount value, society would not shrink from sanctioning suicide, mercy killing, or indeed consensual homicide under any or all conditions.<sup>6</sup>

There are halachic authorities, however, who maintain that man has some autonomy to make personal medical decisions. One of their most compelling sources is found in the Talmud (*Sanhedrin* 73a) concerning the obligation to restore a lost article to its rightful owner. The Talmud reasons that if one is obliged to return lost property to its owner, then he must certainly restore that "owner's" life and health,<sup>7</sup> wherever possible. Based on this passage, these authorities conclude that if the rightful owner chooses to abandon his property and not seek its return, the seriously ill patient, too, may forego the restoration of his health, under certain circumstances.<sup>8</sup>

While the sources for patient autonomy may be a subject of debate, the rights of Jewish patients to determine the course of their medical treatment are well documented in Talmud, codes, and responsa. Our sages recognized long ago that one has an obligation to protect his health, based on the Torah imperative —“Only watch

6. Bleich, J.D. "The moral obligations of the physician in rabbinic tradition" *Doctor's Decisions: Ethical Conflicts in Medical Practice*, Oxford University Press, 1989:219

7. Maimonides' Commentary to the Mishna *Nedarim* 6:8. Also, *Teshuvot Atzei Ha-Levanon*, 61, who extends this passage to include restoring health in non-life-threatening situations. See also *Halacha Urefuah*, Volume 2, pp. 133-134.

8. *Hakometz Mincha* on *Minchat Chinuch*, *Mitzvah* 237 and *Hochmat Shlomo* to *Choshen Mishpat* 426. See also article by Rabbi Hershel Schechter, appearing in the *Beit-Yitzchak Journal*, 5746 issue.

yourself, surely watch your soul...” (Deut. 4:9) which Maimonides<sup>9</sup> and others say refers to safeguarding one’s health. Indeed, it has been suggested that one who “watches” his health is treated in halacha as a bailee<sup>10</sup> (*shomer*), who must make every effort to protect the article he is given from loss or damage. Since the Torah enjoins one to safeguard his body and physicians have been granted the authority to heal,<sup>11</sup> it follows that one may seek medical treatment from a recognized physician and, of course, pray for his health. Carrying the analogy further, when the obligation of watching the article becomes onerous, in cases where the burden far exceeds the benefit, where the costs of sophisticated life support systems or experimental treatments are almost prohibitive, the patient may not be required to avail himself of these measures.<sup>12</sup>

Patient autonomy in halacha goes beyond the right to seek standard medical care when necessary; it allows a seriously ill patient to request a high-risk procedure (i.e., where he may die immediately as a result of that procedure) when there is a

9. *Mishneh Torah, Rotzeach* 11:4

10. As heard from Rabbi Dr. J.D. Bleich, interpreting the Ran to *Nedarim* 40a, at a lecture on 4/19/90.

11. *Yoreh De’ah* 336:1, based on *Baba Metziah* 31a

12. Rabbi Shlomo Zalman Auerbach rules that a terminal cancer patient whose disease has metastasized may refuse extraordinary treatment, such as radiation or chemotherapy. Similarly, a diabetic whose leg was amputated as a result of his illness may refuse the amputation of his other leg, even though gangrene has set in and he will die imminently without the operation. In both these instances, the medical procedure will not reverse the underlying condition, and the patient may therefore refuse it. (Cited by Dr. A.S. Abraham in *Halacha Urefuah* 2:189.) See also *Igrot Moshe, Choshen Mishpat*, 2:74.

The *Shvut Yaakov* (*Orach Chayim* 1:13) declares that when a physician is unable to reverse a patient’s terminal condition and cure him, he no longer has the Torah’s sanction to practice medicine on that patient (*reshut l’rapot, Baba Kama* 85a), and his treatment does not fulfill the mitzvah of saving lives. Since the mitzvah of expending money to save another’s life is derived from the verse, “do not stand idly by the blood of your neighbor” (Leviticus 19:16, as interpreted in *Sanhedrin* 73a), and this verse applies only where one is saved from certain death or, as a minimum, has his health restored (i.e., curative, not merely palliative), then we suggest that a terminal patient need not impoverish himself, or spend excessive monies to avail himself of experimental drugs, high-tech treatments and the like. However, if there is a reasonable possibility that this treatment will save his life, he may borrow money and pay interest (*Yoreh De’ah* 160:22); indeed, according to the Rivash (387), he must expend his entire wealth since he wishes to avoid transgressing a negative commandment thereby. The *Chavot Yair* (139), however, opines that in the case of a negative commandment of a passive nature (*lav she’ayn bo maaseh*, i.e., where no overt act is required to transgress), one need not expend more than he normally would to avoid violating a positive commandment (Cited in the *Novellae* of Rabbi Akiva Eiger to *Yoreh De’ah*, 157:1).

possibility of long-term survival. Recent responsa find talmudic precedent to this notion of one risking his immediate life (literally, “hourly life”) when there is a possibility of long term (literally, “enduring indefinitely” or “perpetual”) survival.<sup>13</sup> The Talmud (*Avodah Zarah* 27b) raises the issue of whether an individual may risk his life by receiving potentially lifesaving treatment from a heathen physician who may kill him. May he risk his certain short-term life of a day or two<sup>14</sup> against the possibility of a long-term cure? The Talmud rules that he may risk his short-term survival because “we are not concerned about hourly life” when there is a possibility of long-term survival. While the general halachic principle is that one may not risk a “certainty” in favor of a “doubtful” possibility (*eyn safek motzi midei vaday*), “in this case, we disregard the certainty (of the patient’s short-term life) in favor of the doubtful (long-term survival).”<sup>15</sup>

The right to refuse medical treatment clearly demonstrates patient autonomy; it, too, is recognized in halacha. The source of this concept is also found in the Talmud, (*Ketubbot* 104a) which describes the fatal illness of the great Rabbi Juda the Prince, known simply as “Rebbe.” Rebbe’s pious maidservant, upon seeing her master’s suffering, prayed for his demise, and even interrupted his students from praying for his life. Since the Talmud does not criticize her conduct, or in any way reject it, Rabbenu Nissim, a major Talmudic commentator, concludes “There are times when one should pray for the sick to die, such as when the sick one is suffering greatly from his malady and his condition is terminal...”<sup>16</sup> Contemporary authorities have applied this passage to the treatment of the critically ill in extreme pain, by allowing them to refuse “extraordinary” lifesaving measures, and to receive intensive

13. *Ahiezer*, 2:16; *Binyan Tzion* 1:111; *Beit Meir (Yoreh De’ah)* 339:1; *Tzitz Eliezer*, 4:13 and 10:25 and *Igrot Moshe, Choshen Mishpat* Volume 7, 74:5. However, note the *Shvut Yaakov* 3:75, who qualifies the decision by requiring a majority of expert medical opinion with the approbation of the leading halachic authority in the city.

14. *Rashi, ad loc.*

15. *Tosafot, ad loc.* See also *Ritva* on this passage who notes “that we are not concerned about this (short-term life), since there is a possibility of a complete cure we must do what is best for him.” This case, according to the Vilna Gaon, is accepted as the source for the halachic norm (*Biur Hagrah* to *Yoreh De’ah*, 155:1, note 5) For a comprehensive review of hazardous medical procedures in halacha, see Rabbi Bleich’s *Contemporary Halachic Problems*, Volume 2, pp. 80-84.

16. *Nedarim* 40a.

doses of pain-killers.<sup>17</sup> Indeed, the great Rabbi Chaim Ozer Grodzinski, the leading halachic authority of pre-war Europe, determined that a patient who is critically ill may refuse surgery. Rabbi Chaim Ozer reckoned with the patient's wishes.<sup>18</sup>

The ability of a live donor to donate non-vital organs or parts of his body, such as bone marrow or kidneys, clearly demonstrates that he has a proprietary interest in his body since one may not donate what does not belong to him. Of course, organ transplants are a relatively recent development, and one would think it virtually impossible to find a precedent or sources in halacha. Yet, contemporary authorities have found a source in a responsum of the *Radbaz*.<sup>19</sup> The *Radbaz* was posed this most poignant question: a gentile authority requests that a Jew allow him to amputate one of his non-vital limbs or he will execute one of his friends. May he permit this amputation in order to save his friend's life? The *Radbaz* ruled that he is not required to allow the amputation, unless he is motivated out of piety; however, if any way he may be risking his life by allowing the amputation, he is regarded as a "pious fool" if he permits it. The *Radbaz* summarizes his position most succinctly: "his doubtful (risking of his life) supersedes the certain (saving) of his friend's life."<sup>20</sup> Contemporary authorities derive from this ruling that bone marrow transplants and, according to

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17. *Halacha Urefuah*, Volume 2, p. 189, in an article entitled, "Treatment of a Moribund Patient and Establishing the Time of Death" by Dr. A.S. Abraham. Also, *Igrot Moshe, Choshen Mishpat*, Volume 7, 73:2.

18. From a communication by the late Rabbi Yisroel Gustman, a member of Vilna's Rabbinical Court, to Rabbi Dovid Cohen.

19. Responsa 3:625 cited in *Pitchei Teshuva* to *Yoreh De'ah* 157:15.

20. See the *S'ma* on *Choshen Mishpat* 426:1 who cites a Yerushalmi which requires one to place himself in doubtful danger to save his friend who is in certain danger. The *Beit Yosef* also quotes this source and explains it in accordance with the general principle – his friend who is in "certain" danger takes precedence over his own "doubtful" risk – *ayn safek motzi midei vaday*. Yet, surprisingly, in normative *halacha*, this source is rejected: Rabbi Yosef Caro does not refer to it in the *Shulchan Aruch*, and it is not mentioned in any of the major, primary sources (*i.e.*, *Rif*, *Rambam*, *Rash* or *Tur*). The *Pitchei Teshuva* (*ad loc*, note 2), citing the *Agudat Ezov*, echoes the *Radbaz*: "his doubtful risking of his life supersedes the certain (saving) of his friend's life." In other words, one should not risk his own life (*safek pikuach nefesh*) to save his friend's life because to do so would be tantamount to declaring that his "friend's blood is redder than his"; thus one's own life takes precedence (*chayecha kodmin*, *Baba Metziah* 62a).

most opinions, kidney transplants are permissible in instances where there are no substantial risks to the donor.<sup>21</sup>

The advance directive is the document of patient autonomy. In situations where the patient has become incapacitated and is no longer competent to make medical decisions, two types of advance directives were developed to enable the patient to direct his medical treatment in advance: living wills and health care proxies.

A living will is essentially a document prepared by a competent adult which instructs medical personnel regarding utilization of various procedures in the event that the adult becomes incapacitated. Generally, the “will” is utilized as a directive to withhold or withdraw treatment in advance of an “incurable or irreversible mental or physical condition with no reasonable expectation or recovery.”<sup>22</sup> In this document, individuals may specify forms of treatment that they would refuse such as cardiac resuscitation, mechanical respiration, tube feeding, antibiotics, and maximum pain relief. While the “living will” could be used to request that these and other treatments be utilized, in practice, this is rarely the case. By contrast, the health care proxy does not necessarily relate to various types of anticipated medical treatments. It is simply a legal form to appoint a trusted individual to serve as a proxy or health care agent to make medical treatment decisions on behalf of the principal who signs the form. The proxy operates with a power of attorney to make these decisions in the event that the principal becomes incapacitated. It is best that the principal discuss his feelings with his proxy about which treatments should be taken or withheld, so that the latter will decide in accordance with the wishes of the former.

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21. Both the *Igrot Moshe, Yoreh De'ah*, Volume 2, 174:4 and *Tzitz Eliezer*, 10:25 permit kidney transplants to save a Jewish life, providing that there is no substantial risk to the life of the donor. According to the latter in another opinion (9:45), a team of expert physicians must carefully determine that there is no life-threatening risk to the donor. The *Yechaveh Daat* 3:84, of Rabbi Ovadiah Yosef, concurs. (See also his article in *Halacha Urefuah*, Volume 3, pp. 61-63). However, the *Minchat Yitzchak*, 6:103, prohibits kidney donations because of the immediate danger to the donor (transplant surgery) and possible long-term risks (failure of the donor's remaining kidney).

In the case of a bone marrow transplant, where there is almost no risk to the donor, all authorities agree that such surgery is permissible. Indeed, according to Rabbi Shlomo Zalman Auerbach, “it is a mitzvah for a relative to donate in this situation to save the life of a fellow Jew” (*Nishmat Avraham, Yoreh De'ah*, p. 264.)

22. From the generic text of the living will, prepared by the “Society for the Right to Die,” New York, 1990.

Upon careful analysis, neither of these advance directives is ideal. The living will, precisely because it is so specific, tends to be somewhat rigid. No one can possibly anticipate with certainty every medical contingency; in fact, one's specific directives may later prove to be inapplicable or inappropriate. As a result, the principal is "locked in" to an irrevocable treatment mode which may be medically contraindicated once he has become incapacitated; indeed, if he could talk, he might well reconsider his decision. Another consideration: in the fast-paced world of medical technology, new drugs and treatments might appear that would have impacted on his original directives. The inflexibility of his living will might not allow for these developments.

By contrast, the great advantage of the health care proxy is its flexibility, which better allows for changing diagnoses and medical breakthroughs. This flexibility is created by giving great latitude to the proxy – and this broad power (of attorney) also poses its greatest danger. To wit: Agudath Israel, a major advocacy group for Orthodox Jewry, objects to the NY health care proxy bill primarily because it accords too much authority to agents to decide the fate of the patient.

In the context of advance directives, the recent release of a health care proxy prepared by the RCA Medical Bio-Ethics Commission is a source of much anguish to this writer. It is objectionable for practical reasons and on halachic/medical grounds.

The RCA details four paradigmatic scenarios, defined by the prognosis and disability of incompetent patients. In each scenario, patients are asked to indicate their preference regarding specific life-sustaining interventions. The Medical Directive also provides for the designation of a proxy to make decisions in circumstances where the patient's preferences are uncertain. Finally, there is a section for a statement of wishes regarding organ donation."<sup>23</sup> The RCA Proxy, as noted, is taken from a directive published two years ago in *JAMA*, the Journal of the American Medical Association. Indeed it suffers from the same criticism leveled against the *JAMA* directive. There are medical decisions that cannot prudently be made in advance since one cannot always anticipate later develop-

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23. Emanuel L.L., Emanuel E.J. "The Medical Directive: a New Comprehensive Health Care Document", *JAMA*. 1989;261:3288



ments in the progress of the disease. In a strongly-worded letter to *JAMA* concerning this Medical Directive, two University of Chicago physicians charge:

How then can we expect them (patients) to make decisions about several specific treatments, such as antibiotics or invasive tests, in four different hypothetical clinical scenarios? Even a physician would have to ask many questions, such as “What kind of an infection is it? What kind of test?” It seems to us that seeking this kind of specificity is misleading at best, and at worst is an abrogation of the most central aspect of the physician-patient relationship, in which the physician, as the expert in medicine, explains the risks and benefits of different options and recommends a course of action to the patient or surrogate(s). It will never be possible to specify all eventualities in sufficient detail, and to seek such certainty is to deny the fundamental ambiguities at the heart of clinical medicine, something with which physicians should be better able to cope.<sup>24</sup>

Another cause for concern is the fact that the RCA Proxy is predicated upon the brain death criterion, which has spurred much controversy in halachic circles. It is beyond the scope of this article to review the brain death *vs.* cardiac death debate. Suffice it to say that the Chief Rabbinate of Israel, which accepts the brain death criterion, requires strict safeguards to prevent abuse: transplant surgeons must follow a detailed protocol before declaring the donor’s death. Among the conditions of the protocol: an additional test (BAER) to verify the destruction of the brain stem and participation of a representative of the Chief Rabbinate as a full member of the committee which establishes donor death.<sup>25</sup> Regrettably, the RCA document does not contain these safeguards which are essential to prevent neurologists and transplant surgeons from prematurely declaring a prospective donor’s brain death. These physicians are under intense pressure from long-suffering organ candidates to perform transplant surgery; in fact, as recently as June 1991, 23,276 people were on the waiting list of the United

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24. Sachs, G.A., Cassel C.K. *JAMA* 1990; 263:1070

25. Jakobovits, Y. Brain Death and Heart Transplants: the Israeli Chief Rabbinate Directive. *Tradition* 1989; 24(4):1-14

Network for Organ Sharing, a national registry and tracking service.<sup>26</sup> Finally, it is unrealistic to expect most rabbis to be sufficiently versed in these live-and-death issues to advise their congregates on the use of this most detailed medical directive. Rabbis who research these matters for their congregates will not find a consensus on most major issues. The sad fact is that there is almost no issue in medical halacha where there is a consensus of *Poskim*. Thus, for example, the RCA Proxy omits the option of withholding nutrition and hydration (tube-feeding) because of “the consensus of most ‘*poskim*’ that water and food are not medical treatments that can be withheld in certain circumstances.”<sup>27</sup> Indeed, there are circumstances where even Rabbi Moshe Feinstein, who generally opposed withholding “tube feeding,” permits it.<sup>28</sup> Thus, we may conclude that since there is generally no consensus on directives which are universally applicable, every case should be judged on its own merits. Consequently, the best course for patients wishing to prepare a health care proxy is to appoint a halachic authority of their choice to rule on medical issues as they arise in the event they become incapacitated.<sup>29</sup>

Jewish law has been accused by ethicists and reform-minded secularists of being paternalistic. In their opinion, patient autonomy in halacha is non-existent. As a result, “patients are treated as if they are not capable of making decisions about medical problems: they are too ignorant medically speaking, and such knowledge as they have, is too partial in both senses of the word.” Thus, they are unlikely to understand the situation even if it is explained to them and so are likely to make worse decisions than the doctor would.<sup>30</sup> These critics claim that Jewish law substitutes the judgment of the rabbi and/or the doctor for that of the patient, thus violating his right of self-determination.

As we have seen, halacha generally recognizes and supports the concept of patient autonomy. A patient may seek certain hazardous

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26. *Time*, 6/17/91, p.56

27. The RCA Health Care Proxy: Background Material, p.2

28. *Igrot Moshe, Choshen Mishpat*, Volume 7, 74:3 and 73:5.

29. RCA Health Care Proxy – A(2). Also, note Chaim Dovid Zwiebel, Esq., “The Halachic Health Care Proxy: An Insurance Policy with Unique Benefits,” *The Jewish Observer*, September 1990.

30. R. Gilon, *Philosophical Medical Ethics*, 69, (1986). While this citation does not refer to paternalism in Judaism *per se*, it provides a philosophical justification for paternalism in general.

medical treatments, even where he may be risking his life in the hope of achieving a long-term cure. In some cases, he may even reject life-support systems, surgery, and radiation or chemotherapy. He may execute an advance directive. Finally, according to many authorities, he may donate a non-vital organ or body part when he does not jeopardize his own health in the process.

In conclusion, we must remember that the Jewish patient is no different than any other Jew: he, too, is governed by halacha. To the extent that the Torah-observant Jew submits to halacha as an expression of God's will, he relinquishes a degree of autonomy.

However, within the parameters of halacha, his feelings and wishes must be honored. Rabbis and doctors should not dictate to him. Rather, the patient is duty-bound to the first consult expert medical opinion regarding his diagnosis and treatment alternatives and then seek authoritative halachic guidance, as he would in any other critical matter. Then, and only then, will he be able to exercise his free will to choose or refuse medical treatments and to provide truly informed consent in full accordance with his religious commitments.

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