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Elliot N. Dorff

**Assisted Suicide/Aid in Dying Reconsidered:
“God’s Compassion Embraces All God’s Creations” (Psalms 145:9)**

Approved on November 16, 2020, by a vote of 9-5-2. Voting in favor: Rabbis Jaymee Alpert, Aaron Alexander, Suzanne Brody, Nate Crane, Elliot Dorff, Judith Hauptman, Joshua Heller, Jan Kaufman, and Robert Scheinberg. Voting Against: Rabbis David Fine, Daniel Nevins, Micah Peltz, Avram Reisner, and Ariel Stofenmacher. Abstaining: Rabbis Steven Kane and Deborah Silver.

A. Why Reconsidered?

On March 11, 1997, the Committee on Jewish Law and Standards approved a rabbinic ruling that I wrote forbidding assisted suicide by a vote of 21 in favor, two opposed, and one abstaining.¹ Since then, however, eight American states and the District of Columbia have enacted laws that permit aid in dying, and Montana’s Supreme Court has ruled that nothing in its state’s statutes prohibits physicians from providing medical aid in dying (I will explain the differing terminology shortly). Specifically, in chronological order, the list includes the following, with the effective date followed by the date when the relevant law was enacted in parentheses, where that is different from the year the law took effect:

- Oregon since 1997 (the law had been passed in 1994)
- Washington since 2009 (2008)
- Montana (a Supreme Court ruling in 2009)
- Vermont since 2013
- California since 2016 (2015)
- Colorado since 2016
- District of Columbia since 2017 (2016)
- Hawaii since 2019 (2018)
- New Jersey as of August 1, 2019
- Maine, as of September, 2019

The Committee on Jewish Law and Standards of the Rabbinical Assembly provides guidance in matters of halakhah for the Conservative movement. The individual rabbi, however, is the authority for the interpretation and application of all matters of halakhah.

¹ Elliot N. Dorff, “Assisted Suicide,”

https://www.rabbinicalassembly.org/sites/default/files/assets/public/halakhah/teshuvot/19912000/dorff_suicide.pdf (accessed 7/16/19).

According to Death With Dignity, 21 other states are considering aid-in-dying bills in 2019.²

On June 17, 2016, Canada's Parliament passed Bill C-14 to legalize and regulate assisted dying throughout the country. It is also legal in Colombia (1997), the Netherlands (2002), Belgium (2002), Luxembourg (2008), and Switzerland.³ In addition, the Australian state of Victoria permits aid in dying (2017), and, as of this writing in November, 2020, it appears that the referendum in New Zealand to legalize aid in dying for those who have less than six months to live has been approved by the voters there; that law is set to come into effect in November, 2021. Switzerland is the only jurisdiction listed above that allows both residents and non-residents to receive aid in dying, which has led to a certain degree of "suicide tourism" there.⁴

These jurisdictions include areas with significant numbers of Jews, and so that alone suggests that we should at least review my responsum from 23 years ago. More importantly, the laws adopted by these jurisdictions governing aid in dying address at least some of my concerns that led to prohibiting it, and so a reassessment is in order to determine whether it should still be prohibited if the safeguards enacted by these jurisdictions make my objections moot.

In this responsum I will argue that in a limited number of cases that I will describe we should allow aid in dying. In other words, the aim of this responsum is to carve out some narrow exceptions to the general prohibition of seeking or offering aid in dying, for which I argued in 1997. It is definitely not to embrace the euthanasia movement, which, at its most extreme, would allow people to take their lives or assist others to do so for any reason and under any circumstance; this teshuvah will address only those who, according to their doctors, have six months or less to live because of their underlying, terminal disease, and then only those whose pain cannot be controlled.

² "While before 2015, only two or three states at the time considered physician-assisted dying bills, in the 2015 legislative session no fewer than 25 states considered such bills. In 2016, 20 jurisdictions, in 2017, 30 jurisdictions, in 2018, 25 jurisdictions, and in 2019, 21 jurisdictions considered such bills." <https://www.deathwithdignity.org/faqs/#laws> (accessed 4/7/20).

³ Although Wikipedia is not an academically reliable source, its summary of the law in Switzerland will do for our purposes: "The Swiss Criminal Code (1937) outlaws "incitement or assistance to suicide from selfish motives" (Art. 115). Any active role in voluntary euthanasia (manslaughter on request") is also outlawed, even if committed from "respectable motives" such as mercy killings (Art. 114). However, by omission, assisted suicide from non-selfish motives remains legal. For example, lethal drugs may be prescribed as long as the recipient takes an active role in the drug administration, but active euthanasia (such as the act of administering a lethal injection) is not legal. All forms of active euthanasia like administering lethal injection remain prohibited in Switzerland. Swiss law only allows providing means to commit suicide, and reasons for doing so must not be based on self-interest (such as monetary gain). Based on this legal situation, non-profit organizations administering life-ending medicine were first established in Switzerland in the 1980s.... most of the assisted suicides concerned elderly people suffering from a terminal disease" https://en.wikipedia.org/wiki/Euthanasia_in_Switzerland (accessed 10/8/20).

⁴ "Suicide Tourism," https://en.wikipedia.org/wiki/Suicide_tourism (accessed 7/18/19). The law in Switzerland prohibits aid in dying for selfish reasons but, by omission, permits it for non-selfish reasons under Paragraph 115 of the Swiss Criminal Code, and the Swiss government in 2006 rejected attempts to ban it for non-selfish reasons as well.

B. Definitions

Before we go any further, it will be helpful to define varying ways in which people die:

- 1) **Murder** (including what secular law defines as first degree, second degree, and manslaughter) occurs when one human being unlawfully kills another human being. This is clearly prohibited in both secular and Jewish law, but the punishments vary depending on the motives of the murderer and the circumstances. Declaring an act a murder presumes that the victim did not want to die, in contrast to the next category, where the victim does want to die.

- 2) **Active euthanasia** is one person taking the life of another in accordance with that person's will. Sometimes this is called "mercy killing," for the motive of the one bringing about the person's death is to relieve the other person's pain. Jewish law and civil law in most jurisdictions prohibit this as well and even declare such acts "murder," despite the difference in the victim's will. Because of the difference in the victim's will, however, courts have done everything from putting the offender on probation without jail time to sentencing the offender to years or even life in prison.⁵ The sources that I cite in my 1997 responsum and others that I will cite in this one make it clear that Jewish law prohibits active euthanasia. Because, however, Jewish courts have not had jurisdiction over cases of murder in most places for the last two thousand years (except, of course, in the modern State of Israel, where only the secular court system using Israeli law has the authority to rule on such matters, not the religious courts using Jewish law), there is no extensive record of how Jewish

⁵ A sentence of probation for mercy killing: Brian Skoloff, "Arizona man, 86, gets probation in mercy killing case," *The Christian Science Monitor*, March 30, 2013, <https://www.csmonitor.com/USA/Latest-News-Wires/2013/0330/Arizona-man-86-gets-probation-in-mercy-killing-case> (accessed 7/17/19). A sentence of four years in prison for involuntary manslaughter, followed by the suicide of the culprit before going to prison: George Houde, "Woman who killed disabled daughter found dead 2 days before prison sentence was to begin," *Chicago Tribune*, November 27, 2017, <https://www.chicagotribune.com/news/breaking/ct-met-bonnie-liltz-dead-killed-disabled-daughter-20171126-story.html> (accessed 7/17/19). A sentence of six years for aggravated murder with a firearm, but less than the minimum of 23 years the law requires for that crime: Crimesider Staff, "John Wise, Ohio man, gets 6 years in wife's 'mercy killing,'" CBS News, December 13, 2013, <https://www.cbsnews.com/news/john-wise-ohio-man-gets-6-years-in-wifes-mercy-killing/> (accessed 7/17/19); Gavin Drake, "Churchgoer is given a life sentence for 'mercy killing,'" *Church Times*, June 12, 2015, with a minimum of nine years to be served, <https://www.churchtimes.co.uk/articles/2015/12-june/news/uk/churchgoer-is-given-a-life-sentence-for-mercy-killing> (accessed 7/17/19); Michael Miller, "'I hope I can be forgiven': Man gets 100 years for 'mercy killings' of wife, sister," *The Washington Post*, August 11, 2016, https://www.washingtonpost.com/news/morning-mix/wp/2016/08/11/i-hope-i-can-be-forgiven-man-gets-100-years-for-mercy-killings-of-wife-sister/?noredirect=on&utm_term=.2bfd46dd5ce3 (accessed 7/17/19). See also Brooke Baitinger, "Caregivers who kill their spouses share traits, experts say," *Sun Sentinel*, April 21, 2017, <https://www.sun-sentinel.com/local/palm-beach/fl-pn-family-caregiver-homicide-20170418-story.html> (accessed 7/17/19).

courts would punish acts of active euthanasia, even if such acts are legally assimilated to acts of murder.

- 3) **Physician assisted suicide.** As will be discussed below, some jurisdictions (e.g., Canada) permit physicians but nobody else to engage in active euthanasia.
- 4) **Aid in dying (what I called “Assisted Suicide” in my 1997 responsum)** is helping a person bring about his or her own death. It differs from active euthanasia in that ultimately it is not someone else but rather the patient him/herself who causes his/her death, albeit with assistance from someone else who provides the means to do so. I will discuss the legal status of this below.
- 5) **Withholding or withdrawing life-support mechanisms** (sometimes called “passive euthanasia, but not truly passive). This type of intervention was thoroughly discussed in the responsa by Rabbis Avram Reisner and Elliot Dorff on the topic, approved by the CJLS in 1990.⁶ Both rabbis agreed that machines and medications may be withheld or withdrawn if that is in the best interests of the patient, but Rabbi Dorff would also allow withholding or withdrawing artificial nutrition and hydration.⁷
- 6) **Natural death.** This is death that happens on its own, whether within or outside of a medical setting, and despite any attempts to keep the patient alive.

⁶ Avram Israel Reisner, “A Halakhic Ethic of Care for the Terminally Ill,” https://www.rabbinicalassembly.org/sites/default/files/assets/public/halakhah/teshuvot/19861990/reisner_care.pdf (accessed 7/17/19); Elliot N. Dorff, “A Jewish Approach to End-Stage Medical Care,” https://www.rabbinicalassembly.org/sites/default/files/assets/public/halakhah/teshuvot/19861990/dorff_care.pdf (accessed 7/17/19); and Avram Israel Reisner, “Mai Beinaihu?” <https://www.rabbinicalassembly.org/sites/default/files/assets/public/halakhah/teshuvot/19861990/maibeinaihu.pdf> (accessed 7/17/19).

⁷ That same year, 1990, the U.S. Supreme Court ruled specifically included artificial nutrition and hydration in the medical interventions that may be withheld or withdrawn if the patient, while mentally competent, made that wish clear, and the Ethics Committee of the American Medical Association did so as well. *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990). For the relevant sections of the AMA’s Code of Ethics, see <https://www.ama-assn.org/delivering-care/ethics/withholding-or-withdrawing-life-sustaining-treatment> (accessed 7/17/19), which argues for no moral difference between withholding and withdrawing, and <https://www.ama-assn.org/delivering-care/ethics/advance-care-planning> (accessed 7/17/19), which specifically recommends that physicians ask patients about their preferences about artificial nutrition and hydration, thereby indicating that it is morally acceptable for physicians to withhold or remove it, unlike other patient requests that physicians deem futile or immoral. Artificial nutrition and hydration do indeed supply the nutrients and liquids that we all need in contrast to medications and machines, which we do not always need, as Rabbi Reisner maintains, but artificial nutrition and hydration lack many of the traits of what we call “food” (it enters the body through tubes rather than being inserted into the mouth, chewed if necessary, and swallowed; it lacks differences in taste, temperature, and texture; it must be done in a hospital; etc.). In the same way, a blood transfusion does not count as a violation of the Torah’s ban on eating blood (Leviticus 3:17; 17:10-12; Deuteronomy 12:16, 23) because it is not “eating” in the usual sense. Hence Rabbi Dorff, the U.S. Supreme Court, and the American Medical Association see artificial nutrition and hydration as medicine rather than food, with the result that it may be withheld or withdrawn, as other medicines may be.

C. Terminology: “Assisted Suicide” vs. “Aid (or Assistance) in Dying” vs. “End of Life Option” vs. “Death with Dignity”

What has become clear to me in the intervening years since I wrote my 1997 responsum is that those opposed to enabling a person to cause his or her own death describe it as “assisted suicide,” invoking the negative associations Western, monotheistic religions (Judaism, Christianity, and Islam) and Western secular, philosophical traditions have attached to suicide. (Some Asian traditions, especially Hinduism in India, see self-immolation as the proper and dignified way to end one’s life, and so there it has very positive connotations.) Those who want to discuss it without prejudice against it from the outset describe it instead as “aid in dying” or “assisted dying” in order to avoid such negative connotations. California’s legislation goes further in avoiding negative connotations, for its law on this is named the “End of Life Option Act,” thus emphasizing that what is being permitted by the act is based on the patient’s choice. That title of the California law also makes it clear that the moral burden for engaging in the procedure rests on the patient, who under the law is exercising an option, rather than the physician, who is assisting a suicide.⁸ On the other end of the emotional spectrum, “death with dignity” attributes a positive connotation to helping someone die.

I was unaware of these distinctions when I wrote my responsum in 1997, and, in hindsight, I now realize that titling it “Assisted Suicide” served to substantiate my ruling that this behavior should be prohibited. The neutral terminology of “aid in dying” or “assisted dying,” however, is much more appropriate if one is seeking to evaluate the practice fairly.

Moreover, my subsequent work on a curriculum on bioethics for the Florence Melton School of Adult Jewish Learning brought me in touch with another very cogent reason to use “aid in dying” rather than “assisted suicide” – namely, that most people seeking aid in dying have striven mightily for years to live, even with pain, and are thus not suicidal in intention; they are just now facing their inevitable demise, despite multiple attempts to fight it, and they want to do that with as little pain as possible. For example,

I’m not committing suicide, and I don’t want to die. I was upset by media reports that I intend to ‘kill’ myself. I’m not killing myself; bone cancer is taking care of that. I may take the option of shortening the agony of my final hours.

—JACK NEWBOLD

All I am asking for is to have some choice over how I die. Portraying me as suicidal is disrespectful and hurtful to me and my loved ones. It adds insult to injury by dismissing all that I have already endured; the failed attempts for a cure, the

⁸ I would like to thank Rabbi Stuart Kelman for pointing out to me this ramification of the differing terminology.

progressive decline of my physical state and the anguish that has involved exhaustive reflection and contemplation, leading me to this very personal and intimate decision about my own life and how I would like it to end.

—LOUISE SCHAEFER⁹

So from here on, I will use the term “aid in dying” to describe what is defined as such above.

D. The Trenchant Factors to Prohibit Aid in Dying

When we think of aid in dying, we usually have in mind the isolated case in which uncontrollable pain or the prospect thereof and the desire for control over one’s dying process are motivating the patient to ask for assistance in dying, but nothing else is prompting this decision. In the vast majority of cases, though, that is not true, for all of the following issues (some of which I mentioned in my 1997 responsum and some I am adding now) undermine the simple morality of helping to relieve someone’s pain:

- 1) Money. Money can and does complicate these situations in at least these three ways:
 - a) Mom is dying, and she does not want to “squander” (that is the term that is usually used) the family money on what she deems futile medical interventions to keep her alive because there is no reasonable hope for her to recover from her terminal illness.
 - b) Worse, from a moral point of view, are cases in which Mom’s children do not want her to squander the family money on what they deem to be futile medical interventions to keep her alive because they want to inherit it. That said, whether it is Mom or her children who want to stop the use of family funds for Mom’s medical expenses, we must recognize that dying can render individuals and families deeply in debt, and access to adequate insurance to pay for her care varies widely from family to family but usually is available, ironically, only to the more wealthy among us.
 - c) Much more pervasively than either of the two cases above, your insurance company, whether private or governmental, would be very happy to aid your dying process because it is much less costly to do that than to provide Mom with long-term care. So far insurance companies do not pay for medication to aid in dying, and in most jurisdictions aid in dying is illegal altogether; but one can understand why insurance companies would gladly pay for that rather than for long-term care.
- 2) Depression. People suffering from terminal illnesses understandably and normally feel depressed about the state of their health and its prognosis, leading to a more general dissatisfaction with every aspect of their current lives. That should lead us, though, not to assist them in dying but rather to take measures to counteract their depression, including the following:

⁹ Death with Dignity National Center, “Terminology of Assisted Dying,” <https://www.deathwithdignity.org/terminology> (accessed 7/18/19).

- a) Medications and other therapies. Medications to counteract depression are used by people at many ages, and there is no reason to refrain from using them in terminally ill patients to relieve at least this aspect of their suffering. The same is true for Cognitive-Behavioral Therapy and other psychological interventions.
 - b) Visits. All forms of illness isolate patients from their community, but people have a deep need to interact with others. As a result, often the most effective response to patients' depression is frequent interactions with others, especially those they know and love.
 - c) Alleviation of boredom. Illness often also deprives people of the activities that give meaning to their lives, so people visiting patients give them a double boost of enthusiasm for life when they not only show up, but also engage the ill in discussions or activities that interest them. Topics of conversation should be the same adult topics that patients used to discuss with those who visit them. Activities that visitors may use to engage patients' interest include helping them create an ethical will and/or a family history to leave to their children, grandchildren, other family members and/or friends. This can be done in writing or in the various recording media available to us now.
- 3) Psychological disorders, particularly narcissism, lead people to request aid in dying when their lives do not conform to their fantasies. Here again, treatment of those disorders is in order, not aid in dying. More prevalent and more disturbing are elderly people who are easily confused and manipulated into decisions that will benefit their heirs, doctors, medical institution (hospital, nursing home, etc.), or insurance companies rather than themselves, even if they are still mentally competent enough to use the law to ask for aid in dying; we clearly need to protect such people from this kind of exploitation.
 - 4) A sense of being useless and a burden and other forms of existential suffering. Terminally ill people often lose the abilities that enabled them to contribute to society and gave them self-respect in the process, and they are usually indeed a burden; pretending that those realities are not true does not help either patients or their caregivers. It is precisely here, though, when we need to remind people that their worth is not solely a function of what they can do for others (their utilitarian value), but rather of their inherent value as a person created in the image of God (their intrinsic value).¹⁰ This also speaks to

¹⁰ This is clearly also relevant to how what the disabled community calls "the temporarily abled" among us treat those who are disabled. For more on this as understood and practiced in the Conservative movement, see the United Synagogue sourcebook by Carl Astor, "...*Who Makes People Different*": *Jewish Perspectives on the Disabled* (New York: United Synagogue of America, Department of Youth Activities, 1985), and the following responsa of the Committee on Jewish Law and Standards: James Rosen, "Mental Retardation, Group Homes, and the Rabbi," https://www.rabbinicalassembly.org/sites/default/files/assets/public/halakhah/teshuvot/19912000/rosen_grouphomes.pdf (accessed 7/16/19); Daniel S. Nevins, "The Participation of Those Who Are Blind in the Torah Service," https://www.rabbinicalassembly.org/sites/default/files/assets/public/halakhah/teshuvot/20052010/nevins_blind.pdf (accessed 7/16/19); and Pamela Barmash, "Status of the Heresh and of Sign Language," <https://www.rabbinicalassembly.org/sites/default/files/assets/public/halakhah/teshuvot/2011-2020/Status%20of%20the%20Heresh6.2011.pdf> (accessed 7/16/19), together with its appendix on reading Torah in sign language and the varying concurring opinions by Rabbis Daniel Nevins and Avram Reisner, each with others.

other forms of existential suffering, in which the patient for some other reason thinks that his or her life is not worth living. This could include, for example, a profound sense of guilt for something they did and therefore they deserve to die, or a sense that nobody cares if they live or die. Patients in these emotional states should not be immediately accommodated in their stated wishes to die so as to cease being a burden or to end a life in which they see no value; they should instead be reassured that they are well worth the effort to help them live and live meaningfully, to the extent that that is possible. This is most effectively done through family and friends who interact with the person often and express in varying ways how much and why they value the person who is contemplating suicide. This will clearly be the case for patients who still have their mental faculties, but even for those who do not, for the sake of our own moral standing as well as theirs, we must not let utilitarian concerns determine how we treat them.

- 5) A need for control. For many people who request aid in dying this is the central issue: they need to feel that ultimately they will decide when and how to die. This can be rooted in a fear of death or the dying process, or simply a need to assert power over themselves when they are increasingly losing it. It is precisely this factor that explains why a significant number of people who obtain the drugs to help them die never use them.
- 6) Lack of sufficient pain medication. Especially with the recent epidemic of the use of opioids, together with the startling numbers of addictions, overdoses, and deaths they have caused, doctors are reluctant to use pain medications, even if they are clearly medically necessary to quell pain. American culture, with its approving attitude to those who “grin and bear it,” especially for men, makes this phenomenon even worse. We clearly need to avoid addiction to pain medication, but we also need to ensure that people who are in pain, especially the excruciating pain that some terminal illnesses entail, get whatever relief we can afford them. In cases such as the ones we are considering, where patients are “actively dying” and have less than six months to live (as per the California law that will be discussed below), the concern of addiction becomes irrelevant. Because of that and because of our general duty to relieve pain, the lack of sufficient pain medication should never be what prompts patients to ask for aid in dying. Moreover, it is preferable to use large doses of pain medication that will make the person unconscious than to provide aid in dying; as will be discussed below, however, the cases that I am trying to distinguish from these are the ones in which no amount of pain medication quiets the person’s pain, and the person remains conscious and screaming despite massive doses of morphine.
- 7) Access to health care. In the United States, probably the most trenchant objection in practice to offering aid in dying is the fact that some 40 million Americans lack health care insurance altogether, and millions more lack adequate health care insurance to

As of this writing, Rabbis Micah J. Peltz and Joel Seltzer are working on a responsum, “Intellectual Disabilities and Halakhah.”

provide what they need throughout life, including the time when they are in the process of dying. This clearly is different in countries that have socialized medicine (Canada, Israel, most of Europe, etc.), but even in such nations one must determine whether what is offered is adequate to treat the physical pain and other needs of the dying. We do not live in a world of complete abundance, and so all nations (or the insurers within them) will need to determine which medical interventions will be provided, which not, and to whom; but to the greatest extent possible health care plans should provide people with the medical interventions needed to enable them to live and, when the time comes, to die with as little pain as possible and other supportive services as well (“palliative care”) so that people do not need to ask for aid in dying for lack of such medical assistance. .

- 8) The role of doctors and their training to aid in dying. From the Hippocratic Oath to the current Code of Ethics of the American Medical Association,¹¹ doctors have understood helping someone die to violate the ethics of their profession, whose purpose is to prevent, cure, or at least ameliorate disease in order to sustain life, and, in the case of hospice and palliative care, to improve “a patient’s quality of life by managing pain and other distressing symptoms of a serious illness.”¹² To revise the mission of doctors to include giving people aid-in-dying therefore requires physicians to embrace a new understanding of their role and may, some doctors and associations of doctors believe, threaten patients’ trust in their doctors to try to heal them, not kill them. That said, it is not at all clear that the role of doctors prevents them from this compassionate response to suffering, as other doctors and medical associations have asserted, for their role is ultimately to care even if they cannot cure. This tension is evident in a statement on physician-assisted suicide of the American Medical Association.¹³ Another point to note, however, is that physicians are trained in therapeutic dosing, not lethal dosing, and so their facility in prescribing the right amount of pharmaceutical to aid in dying may be incomplete.
- 9) Theology. Underlying all these practical concerns that Jews and others have concerning assisting patients to die is the underlying Jewish theological conviction that our bodies, along with the rest of the world, belong to God, as articulated, for example, in these biblical verses:

הוּן לַהּ אֱלֹהֵינוּ הַשָּׁמַיִם וְהָאָרֶץ וְכָל-אֲשֶׁר-בָּהּ:

¹¹The Hippocratic Oath: https://www.nlm.nih.gov/hmd/greek/greek_oath.html (accessed 7/21/19). American Medical Association, Code of Medical Ethics, Opinion 5.7, <https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide> (accessed 7/21/19).

¹² American Academy of Hospice and Palliative Medicine, <http://aahpm.org/about/about> (accessed April 2, 2020).

¹³ American Medical Association, “Physician-Assisted Suicide,” <https://www.ama-assn.org/delivering-care/ethics/physician-assisted-suicide> (accessed April 2, 2020). . See also note 15 below and it accompanying text at G8 for some of the regions of the American Medical Association that have issued statements in opposition to their national organization’s stance, as well as the positions in favor of doctors providing medical aid-in-dying proclaimed by other organizations of physicians. I want to thank Dr. Toby Schonfeld for pointing out to me the importance of noting the level of debate among doctors about whether aid in dying is compatible with their role and that, even if it is, the remaining issue that most physicians are not trained in how to administer lethal doses of drugs appropriately.

Mark, the heavens to their uttermost reaches belong to the LORD your God, the earth and all that is on it! (Deuteronomy 10:14)

לְדָוִד מִזְמוֹר לְה' הָאָרֶץ וּמְלוֹאֶתָהּ תִּבְּלֵן וְיִשְׁבֵי בָהּ:

Of David. A psalm. The earth is the LORD's and all that it holds, the world and its inhabitants. (Psalms 24:1)

- 10) Law. Finally, and perhaps most importantly for a Jewish legal ruling such as this, Jewish law forbids taking one's own life or assisting someone else in doing so. In my 1997 responsum, "Assisted Suicide," I describe in detail the sources and nuances of this legal ban, and so I will not repeat them here.

Some of these considerations (I have added to them in the list above) led me in 1997 to write a responsum prohibiting aid-in-dying. It is important to understand that this did *not* entail that we must do everything possible to keep a person alive; exactly what we should, need not, or should not do toward that goal is governed by the two responsa by Rabbis Reisner and Dorff on end of life issues, cited in note 5 above.

E. The Aid-in-Dying Laws in California and Canada

As indicated earlier, aid-in-dying laws adopted by Canada and the American states that have them address some of the concerns that I raised in my 1997 responsum and some of the additional ones listed above. To see this, I will present the basic parameters of two of those laws from the two jurisdictions with the largest populations of Jews among the jurisdictions that have approved aid-in-dying legislation and have had at least several years of experience with it, namely, California and Canada.¹⁴ As will become clear, the level and type of safeguards against the kinds of abuses listed in the last section of this responsum varies from one jurisdiction to another (and, of course, none of the American or Canadian laws will deal with Jewish theological or legal concerns), and so those living in other jurisdictions must evaluate the aid-in-dying law in their own jurisdiction, if such legislation exists, to determine the degree to which it protects patients from such abuses.

¹⁴ According to a survey conducted by the University of Toronto in 2018, the Jewish population of Canada is approximately 392,000. See https://www.environicsinstitute.org/docs/default-source/project-documents/2018-survey-of-jews-in-canada/2018-survey-of-jews-in-canada---executive-summary.pdf?sfvrsn=77e82c2f_2 (accessed (10/9/2020)). The Jewish population of California is 1,182,900 according to the article in the *American Jewish Yearbook* for 2019; see <https://ejewishphilanthropy.com/us-jewish-population-approaches-7-million-implications-for-the-2020-us-presidential-election/> (accessed 10/9/2020).

I am including the current version of the aid-in-dying laws in California and Canada. They may, of course, be amended in the future, but I want readers to see how careful and precise they are to ensure that neither law permits large-scale use of these laws. (I will discuss the statistics that indicate the rarity with which these laws are being used in Section H below.) Those readers, however, who would like to see just a comparison of these laws can skip to Section F below.

1. California. The following paragraphs are selections from the California’s End of Life Option Act:

443.

This part shall be known and may be cited as the End of Life Option Act.

443.1.

As used in this part, the following definitions shall apply:

(a) “Adult” means an individual 18 years of age or older....

(e) “Capacity to make medical decisions” means that, in the opinion of an individual’s attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision to health care providers....

(i) “Informed decision” means a decision by an individual with a terminal disease to request and obtain a prescription for a drug that the individual may self-administer to end the individual’s life, that is based on an understanding and acknowledgment of the relevant facts, and that is made after being fully informed by the attending physician of all of the following:

(1) The individual’s medical diagnosis and prognosis.

(2) The potential risks associated with taking the drug to be prescribed.

(3) The probable result of taking the drug to be prescribed.

(4) The possibility that the individual may choose not to obtain the drug or may obtain the drug but may decide not to ingest it.

(5) The feasible alternatives or additional treatment opportunities, including, but not limited to, comfort care, hospice care, palliative care, and pain control....

(n) “Public place” means any street, alley, park, public building, any place of business or assembly open to or frequented by the public, and any other place that is open to the public view, or to which the public has access.

(o) “Qualified individual” means an adult who has the capacity to make medical decisions, is a resident of California, and has satisfied the requirements of this part in order to obtain a prescription for a drug to end his or her life.

(p) “Self-administer” means a qualified individual’s affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to bring about his or her own death.

(q) “Terminal disease” means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.

443.2.

(a) An individual who is an adult with the capacity to make medical decisions and with a terminal disease may make a request to receive a prescription for an aid-in-dying drug if all of the following conditions are satisfied:

(1) The individual’s attending physician has diagnosed the individual with a terminal disease.

(2) The individual has voluntarily expressed the wish to receive a prescription for an aid-in-dying drug.

(3) The individual is a resident of California and is able to establish residency through any of the following means:

(A) Possession of a California driver license or other identification issued by the State of California.

(B) Registration to vote in California.

(C) Evidence that the person owns or leases property in California.

(D) Filing of a California tax return for the most recent tax year.

(4) The individual documents his or her request pursuant to the requirements set forth in Section 443.3.

(5) The individual has the physical and mental ability to self-administer the aid-in-dying drug....

(c) A request for a prescription for an aid-in-dying drug under this part shall be made solely and directly by the individual diagnosed with the terminal disease and shall not be made on behalf of the patient, including, but not limited to, through a power of attorney, an advance health care directive, a conservator, health care agent, surrogate, or any other legally recognized health care decisionmaker.

443.3.

(a) An individual seeking to obtain a prescription for an aid-in-dying drug pursuant to this part shall submit two oral requests, a minimum of 15 days apart, and a written request to his or her attending physician. The attending physician shall directly, and not through a designee, receive all three requests required pursuant to this section.

(b) A valid written request for an aid-in-dying drug under subdivision (a) shall meet all of the following conditions:

(1) The request shall be in the form described in Section 443.11.

(2) The request shall be signed and dated, in the presence of two witnesses, by the individual seeking the aid-in-dying drug.

(3) The request shall be witnessed by at least two other adult persons who, in the presence of the individual, shall attest that to the best of their knowledge and belief the individual is all of the following:

(A) An individual who is personally known to them or has provided proof of identity.

(B) An individual who voluntarily signed this request in their presence.

(C) An individual whom they believe to be of sound mind and not under duress, fraud, or undue influence.

(D) Not an individual for whom either of them is the attending physician, consulting physician, or mental health specialist.

(c) Only one of the two witnesses at the time the written request is signed may:

(1) Be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the individual's estate upon death.

(2) Own, operate, or be employed at a health care facility where the individual is receiving medical treatment or resides.

(d) The attending physician, consulting physician, or mental health specialist of the individual shall not be one of the witnesses required pursuant to paragraph (3) of subdivision (b).

443.4.

(a) An individual may at any time withdraw or rescind his or her request for an aid-in-dying drug, or decide not to ingest an aid-in-dying drug, without regard to the individual's mental state.

(b) A prescription for an aid-in-dying drug provided under this part may not be written without the attending physician directly, and not through a designee, offering the individual an opportunity to withdraw or rescind the request.

443.5.

(a) Before prescribing an aid-in-dying drug, the attending physician shall do all of the following:

(1) Make the initial determination of all of the following:

(A) (i) Whether the requesting adult has the capacity to make medical decisions....

(B) Whether the requesting adult has a terminal disease.

(C) Whether the requesting adult has voluntarily made the request for an aid-in-dying drug pursuant to Sections 443.2 and 443.3.

(D) Whether the requesting adult is a qualified individual pursuant to subdivision (o) of Section 443.1.

(2) Confirm that the individual is making an informed decision by discussing with him or her all of the following:

(A) His or her medical diagnosis and prognosis.

(B) The potential risks associated with ingesting the requested aid-in-dying drug.

(C) The probable result of ingesting the aid-in-dying drug.

(D) The possibility that he or she may choose to obtain the aid-in-dying drug but not take it.

(E) The feasible alternatives or additional treatment options, including, but not limited to, comfort care, hospice care, palliative care, and pain control.

(3) Refer the individual to a consulting physician for medical confirmation of the diagnosis and prognosis, and for a determination that the individual has the capacity to make medical decisions and has complied with the provisions of this part.

(4) Confirm that the qualified individual's request does not arise from coercion or undue influence by another person by discussing with the qualified individual, outside of the presence of any other persons, except for an interpreter as required pursuant to this part, whether or not the qualified individual is feeling coerced or unduly influenced by another person....¹⁵

- 2. Canada.** What follows are selections from the official Canadian government website on assistance in dying. Note that it refers to the change in language discussed above from “assisted suicide” to “assistance in dying.”

¹⁵ https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520162AB15 (accessed 7/18/19).

Available options

There are 2 types of medical assistance in dying available to Canadians. They each must include a physician or nurse practitioner who:

- directly administers a substance that causes death, such as an injection of a drug
 - this is becoming known as clinician-administered medical assistance in dying
 - it was previously known as voluntary euthanasia

or

- provides or prescribes a drug that the eligible person takes themselves, in order to bring about their own death
 - this is becoming known as self-administered medical assistance in dying
 - it was previously known as medically assisted suicide or assisted suicide...

Eligibility criteria

Who is eligible for medical assistance in dying

In order to be eligible for medical assistance in dying, you must meet **all** of the following criteria. You must:

- be eligible for health services funded by the federal government, or a province or territory (or during the applicable minimum period of residence or waiting period for eligibility)
 - generally, visitors to Canada are not eligible for medical assistance in dying
- be at least 18 years old and mentally competent. This means being capable of making health care decisions for yourself.
- have a grievous and irremediable medical condition
- make a voluntary request for medical assistance in dying that is not the result of outside pressure or influence
- give informed consent to receive medical assistance in dying

Grievous and irremediable medical condition

To be considered as having a grievous and irremediable medical condition, you must meet **all** of the following criteria. You must:

- have a serious illness, disease or disability
- be in an advanced state of decline that **cannot** be reversed
- experience unbearable physical or mental suffering from your illness, disease, disability or state of decline that **cannot** be relieved under conditions that you consider acceptable
- be at a point where your natural death has become reasonably foreseeable
 - this takes into account all of your medical circumstances and does not require a specific prognosis as to how long you have left to live

You do **not** need to have a fatal or terminal condition to be eligible for medical assistance in dying.

Informed Consent

This means you have consented (given permission) to medical assistance in dying after you have received all of the information you need to make your decision, including:

- your medical diagnosis
- available forms of treatment
- available options to relieve suffering, including palliative care

You must be able to give informed consent both:

- at the time of your request
- immediately before medical assistance in dying is provided

You can withdraw your consent at any time and in any manner.

About mental illness and physical disability

If you have a mental illness or a physical disability and wish to seek medical assistance in dying, you may be eligible. Eligibility is assessed on an individual basis, looking at all of the relevant circumstances. However, you must meet all the criteria to be eligible for medical assistance in dying, which means:

- your natural death must be foreseeable in a period of time that is not too distant
- you must be mentally competent and capable of making decisions at the time of your request

- you must also be mentally competent and capable of making decisions immediately before medical assistance in dying is provided
 - the physician or nurse practitioner must ask you to confirm your choice before administering the service

You can withdraw your consent at any time and in any manner...

Process for requesting the service

The legislation contains safeguards to make sure those who ask for medical assistance in dying:

- request the service of their own free will
- are able to make health care decisions for themselves
- are eligible (this means they meet **all** of the listed criteria)
- can and do give informed consent, which includes being informed of all care options available to them to help relieve suffering

These safeguards will guide health care providers to carry out this service appropriately and in a way that protects people from abuse or misuse.

You can ask a health care provider for information about medical assistance in dying at any time. The process for requesting medical assistance in dying requires you to complete the following steps:

Talk to your physician or nurse practitioner about end-of-life care options in relation to your medical condition or circumstances.

Submit a written request.

You must make a written request that says you want to have a medically assisted death. Some provinces and territories may require that you complete a specific form. This form may be provided by your health care provider or available on a provincial or territorial website.

If you are unable to write, another adult can sign the request on your behalf under your clear direction. This adult must:

- be at least 18 years of age
- understand what it means to request medical assistance in dying
- not benefit from your death (for example, they must not be an heir to your estate)

You must sign and date your written request before two independent witnesses, who must also sign and date the request.

An independent witness must be 18 years of age and understand what it means to request medical assistance in dying.

To be considered independent means that the witnesses cannot:

- benefit from your death
- be an owner or operator of a health care facility where you live or are receiving care
- be directly involved in providing you with health or personal care

Undergo medical assessments.

Your physician or nurse practitioner must make sure that you are eligible to receive medical assistance in dying according to all of the listed criteria.

A second physician or nurse practitioner must also provide a written opinion confirming that you are eligible.

You must also be informed that you have the right to withdraw your request at **any** time.

The physician or nurse practitioner providing the original assessment and the one giving the second opinion **must** be independent.

To be considered independent means that neither of them:

- holds a position of authority over the other
- could knowingly benefit from your death
- is connected to the other or to you in a way that could affect their objectivity

Wait a 10-day reflection period to receive the service.

You must wait a period of at least 10 clear days after signing your written request before the service can be provided so that you have time to consider your request. If you do decide to proceed after the 10 days, your practitioner can have confidence in your true desire to receive the service.

An exception may be made to the 10 clear day reflection period if both your first and second medical or nurse practitioner agree that:

- your death is fast approaching OR
- you might soon lose your capacity to provide informed consent

Choosing to withdraw your request

You may choose to withdraw your request at **any** time in the process and in any manner.

You are **not** obligated to proceed with medical assistance in dying even if you are found eligible for the service.

Just before receiving medical assistance in dying, you will also be given a final opportunity to withdraw your request.¹⁶

F. Comparing These Laws

Both of these laws take pains to make sure that the following is true:

- 1) The patient is mentally competent to make a decision to use medications to bring about his or her death.
- 2) The patient is informed of the alternative forms of treatment available.
- 3) The patient is not being coerced in this decision.
- 4) The patient understands that even after obtaining the drugs he or she need not use them.
- 5) The patient's diagnosis and prognosis, as given by one physician, must be confirmed by another who is independent in specified ways from the first.
- 6) Those who may act as witnesses to a patient's request for these drugs must meet specified qualifications to avoid people with their own agendas (e.g., family members, hospital personnel) misrepresenting the patient's wishes.
- 7) Only citizens of the given jurisdiction (in these cases, California or Canada) are eligible to take advantage of this law to prevent the "suicide tourism" that is happening in Switzerland. Indeed, with the exception of Switzerland, all of the American states and nations that have adopted aid-in-dying laws, listed at the beginning of this responsum, have reserved application of the law to their own citizens as one step in ensuring that all of the restrictions of the law are met and that therefore the use of the law is rare.
- 8) Individual doctors and hospitals may choose not to aid patients in dying through medical aid-in-dying, but presumably doctors and hospitals retain their duty to engage in normal end-of-life care for such patients, including palliative measures.

¹⁶ Government of Canada, "Medical Assistance in Dying," <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html> (accessed 7/18/19).

California's law is considerably stricter than Canada's, though, in the following ways:

- 1) California requires three separate requests, two oral and one written, the oral requests at least 15 days apart, while Canada requires only one request and a 10-day waiting period.
- 2) California requires that the doctor who will be providing the drugs, and not any designee, to interact with the patient directly to ensure that all of the act's requirements are met, and the doctor must meet with the patient alone (except for an interpreter, when necessary) to make sure that the patient is not being pressured into making this decision. Canada does not require this.
- 3) California requires that for a patient to be eligible for aid-in-dying drugs, he or she must be diagnosed with a terminal illness that is expected to take the patient's life within six months; Canada specifically does not require that the patient have a terminal illness, although it must be "grievous and irremediable" to qualify, and "your natural death must be foreseeable in a period of time that is not too distant," however that is defined.
- 4) Canada allows for "clinician-administered medical assistance in dying," previously known as voluntary euthanasia, in which the physician administers the drugs, in addition to aid in dying, where the patient self-administers the drugs; California's law is restricted to cases in which the patient administers the drugs provided by the physician to him/herself.

G. To What Extent and How These Laws Address the Reasons to Prohibit Aid in Dying

As the above comparison of the laws in California and Canada indicates, aid-in-dying laws vary from one jurisdiction to another. Therefore, in evaluating whether a given jurisdiction protects patients from the concerns listed in Section D above, one must examine the particular law in force.

To aid in this process, here is an evaluation of the two laws described above in meeting the objections listed in Section D above:

- 1) Money. The laws in California and Canada include significant safeguards to ensure that the patient is not being coerced into making this decision by family members, a private insurance company, or a governmental insurance agency for reasons of saving money. Of

course, if Medicare or Canada's system of socialized medicine one day decides that it will no longer provide long-term health services – a possibility increased by the aging population in both countries—this concern may return. Furthermore, these laws cannot govern private decisions within families, and so they do not prevent a patient choosing to die now so as to be able to leave money for his or her children or grandchildren.

- 2) Depression. The California law provides safeguards to ensure that depression is not the cause of a request for aid in dying by denying eligibility to use the law to those with a diagnosis of depression, but it does not require supportive care for the depressed patient
- 3) Psychological disorders, especially narcissism; and
- 4) A sense of being useless or a burden or other forms of existential suffering.
The laws do not speak to concern (3) and (4) directly, but they both do require that patients be informed of alternative approaches to dealing with their needs so that they might choose to live rather than die. To what extent that includes emotional and psychological supports as well as medical ones is unclear in the laws of California and Canada. That said, as Rabbi Leonard Sharzer, M.D., has pointed out to me, the majority of patients who seek aid in dying are not alone, as many imagine them; they are much more often than not supported by close family and friends in the process of making their decisions about whether to seek the drugs needed to die and, if obtained, whether to use them, even though the patient him/herself must ultimately make these decisions.¹⁷
- 5) A need for control. This is the specific aim of these laws, to provide autonomous choices to patients at the end of life.
- 6) Lack of sufficient pain medication. The provisions in these laws that require that patients be informed of alternative approaches to responding to their needs. This presumably includes palliative care, which is routinely done in hospice settings but can also be done for anyone in pain and long before the person is about to die, as well as other interventions (physical therapy, occupational therapy, social support, etc.) to reduce their pain and/or suffering. In the context of the current opioid epidemic, however, the continued willingness of physicians to provide adequate pain medication for those who really need it is in some jeopardy.
- 7) Access to health care. This is universal in Canada, but not so in the United States. The aid-in-dying laws in both jurisdictions assume that the patients involved have access to whatever medical services they need to remain alive and nevertheless choose to die. As the next section will demonstrate, this probably is true for the vast majority of those who have taken advantage of these laws to date, even in the United States, but it may not be true in the future in the United States, depending upon what Congress does with the Affordable Care Act (“Obamacare”).
- 8) The role of doctors. Although the American Medical Association has reaffirmed its opposition to physicians assisting people to die, many of its members think that the

¹⁷ As Marieke Vervoort put it in the case that I will describe below, “Who can say that he had so many friends also in the bad days? It’s really amazing.” See note 27 below. The quotation appears on p. 28 in the printed edition.

doctor's role includes relieving pain and suffering, and for patients who are actively dying that may well include affording them such assistance as helping them to die. As a result, as of this writing, fourteen state chapters of the American Medical Association and that of the District of Columbia have rejected their national organization's statement and have instead taken a more neutral stance toward physicians participating in aid-in-dying, and the same is true for a number of other associations of doctors and specialists.¹⁸ The role of physicians in providing aid in dying is thus currently a major controversy among physicians and not obviously right or wrong to practicing physicians themselves, let alone to those outside the medical field who think about the role of medicine in society.

- 9) Theology. Both the United States and Canada have foundational laws that protect freedom of religion, and so the laws in those countries do not invoke religious views on this topic. They do, however, permit individual doctors and hospitals to refuse to participate in aid-in-dying protocols for any reason, including, presumably, reasons of conscience or religion.

H. The Use of Aid-in-Dying Laws¹⁹

The laws in most jurisdictions that allow aid in dying require tracking of the use of the law. California's results are typical, and so they will suffice for a sense of the extent of the use of its law, the identity of its users, and the circumstances under which it was used.

California's law went into effect on July 1, 2016. According to the California Department of Public Health,²⁰ in the first eighteen months that the law was in effect (that is, through 2017), 485 Californians used it to take their lives, and an additional 283 patients received a prescription from their physician for the drugs but have either not filled it or not ingested the medicines. This latter group illustrates that as many as a third of the people who request the drugs do so in order that they can determine how they will die; as I will note below, in Oregon, the first state to approve aid in dying, during the first years of the law close to half (46%) of the patients who received the medicine did not use it.²¹ Why do patients ask for the

¹⁸ "Medical Associations and Medical Aid in Dying," <https://compassionandchoices.org/resource/medical-associations-medical-aid-dying/> (accessed 7/22/19).

¹⁹ I want to thank Dr. Neil Wenger, M.D., Chair of the Ethics Committee of the UCLA Medical Center and Director of its Ethics Center, and Dr. Tanya Dorff, an oncologist at City of Hope Medical Center in Duarte, CA (and my daughter-in-law), for their help with this entire responsum, but especially this and the following sections.

²⁰ In this paragraph, I am combining the data on the website for the six months of 2016 that the law was in effect and 2017, <https://www.cdph.ca.gov/Programs/CHSI/Pages/End-of-Life-Option-Act-.aspx> (accessed 7/22/19).

²¹ As a matter of comparison, according to an *Annals of Internal Medicine* study of April 17, 2017, twenty to thirty percent of prescriptions written by physicians are not filled, and fifty percent of prescriptions for chronic illnesses are not taken properly. This lack of adherence causes 125,000 deaths in the United States each year and ten percent of hospitalizations, costing between \$100 billion and \$289 billion in health care costs each year. Jane E. Brody, "The Cost of Not Taking Your Medicines," *New York Times*, April 17, 2017, <https://www.nytimes.com/2017/04/17/well/the-cost-of-not-taking-your-medicine.html> (accessed 9/19/19). There

medicine if they do not use it? Overwhelmingly, patients say that they want to retain control over their lives when their conditions have taken most of that control away from them.

In the first eighteen months that the law was in effect, 89% of those who took advantage of the law were white, and the vast majority had college educations, so this law was primarily being used by educated, white people. From the standpoint of public policy, this may indicate an inappropriate inequality among racial and ethnic groups in information about the end of life option that the new law provides and/or access to using it, or it may reflect the unwillingness of people of African-American, Latino, and Asian descent to use it. It likely also reflects the mistrust of the medical establishment that minorities, especially African-Americans, have, as well as disparities to health care in general access to health care, disparate treatments once care is sought, and both unconscious and institutional discrimination. As a result, equalizing both knowledge of the legal option to ask for aid in dying (where it exists) and access to it will be very difficult to achieve.²²

Similar statistics occurred in 2019, the last year for which statistics are available. Here are the results, as reported on the website of the California Department of Public Health:

For the calendar year 2019, 736 individuals started the end-of-life option process, as set forth in the Act, by making two verbal requests to their physicians at least 15 days apart. A total of 246 physicians prescribed 618 individuals aid-in-dying drugs. The two most common drug categories prescribed were a combination of a cardiotoxic, opioid, and sedative at 78.8 percent followed by individuals who were only prescribed a sedative at two percent. Of the 618 individuals who were prescribed such drugs, 378, or 61.2 percent, were reported by their physician to have died following ingestion of aid-in-dying drugs prescribed under the Act; and 90 individuals, or 14.6 percent, died from the underlying illness or other causes. The ingestion status of the remaining 150 individuals is unknown. Of the remaining 150 individuals, 82, or 13.3 percent, have died, but their ingestion status is unknown because follow up information is not available yet. For the remaining 68 individuals, or 11.0 percent, both death and ingestion status are pending. Further, 27 individuals with prescriptions written in prior years ingested and died from the drugs during 2019. As a result, the report demographics include the 405 individuals who ingested and subsequently died during the 2019 calendar year from aid-in-dying drugs....In 2019, 405 individuals died from ingestion of aid-in-dying drugs, a rate of 15.0 per 10,000 deaths based on 270,492 deaths to California residents in 2019....

Of the 405 individuals who died pursuant to EOLA during 2019, 11.4 percent were under 60 years of age, 74.5 percent were 60-89 years of age, and 14.1 percent were 90 years

are, of course, multiple reasons why patients do not fill their prescriptions for non-lethal drugs; in the case of lethal drugs prescribed as part of a protocol for aid in dying, though, the primary reason that patients asked for the drugs but did not take them is to have control of how they were going to die, including letting nature take its course.

²² I would like to thank Dr. Toby Schonfeld for alerting me to the complexity of equalizing access to aid in dying.

of age and older. The median age was 76 years. The decedents were 87.2 percent white, 55.3 percent were male; 85.4 percent were receiving hospice and/or palliative care, and 74.4 percent had at least some level of college education. In addition, 84.0 percent informed their family of their decision to participate in EOLA. ...

Of the 405 individuals who died pursuant to EOLA during 2019, 67.9 percent were identified as having had malignant neoplasms (cancer). Neurological diseases such as amyotrophic lateral sclerosis and Parkinson's accounted for the second largest underlying illness grouping, totaling 10.1 percent. The remaining major categories of underlying illnesses were documented as: cardiovascular diseases (8.9 percent), respiratory diseases (non-cancer; 7.2 percent) and other diseases (5.8 percent). The other diseases were documented as; cerebrovascular disease (1.7 percent), kidney disease (1.2 percent), endocrine, nutritional and metabolic disease (1.0 percent), immune mediated disease (0.7 percent) and other (1.2 percent).²³

These statistics indicate that the law is working in permitting *some, but very few*, deaths through aid in dying relative to the total number of people who died in California in 2019, so there has not been a rush to die as a result of this act, as some feared. *Indeed, 405 deaths through aid-in-dying in California in 2019 out of 270,492 deaths in California that year amounts to 0.15% of the deaths in California that year.* The data also indicate that those who took advantage of the act had terminal, irreversible illnesses, as the law requires, and 85.4% of them were already on hospice care, which was clearly not working to quell their pain and hence their request for aid in dying.

These statistics are parallel to Oregon's first three years of activity under its 1997 aid-in-dying law. There physicians wrote prescriptions for only one in six patients who requested drugs to enable them to die, and only one in ten actually used the drugs to die. Forty-six percent of the patients who obtained the drugs changed their mind about using them.²⁴ This reflects that fact that for many patients the request is grounded in a desire to control their dying process, not necessarily to die with the aid of drugs.

California's population is 39.5 million; Canada's is 35 million. California's law became operational on July 1, 2016, Canada's on June 17, 2016. So the two jurisdictions are comparable in both population and years of experience with this law. It is interesting, then, to see the comparable figures in Canada. Health Canada, the official government website of Canada on health matters, issued a total of four interim reports on medical assistance in dying in Canada

²³California Department of Public Health, *California End of Life Option Act, 2019 Data Report*, <https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CDPHEndofLifeOptionActReport2019%20Final%20ADA.pdf> (accessed 10/9/2020).

²⁴Linda Ganzini, Heidi D. Nelson, Terri A Schmidt, Dale F. Kramer, Molly A. Delorit, and Melinda A. Lee, "Physicians' Experiences with the Oregon Death with Dignity Act," *The New England Journal of Medicine* 342:8 (February 24, 2000), 557-563, <https://www.nejm.org/doi/full/10.1056/NEJM200002243420806> (accessed 7/31/19).

covering various time periods before its first calendar year report, the one for 2019. It says the following about its Medical Aid in Dying (MAID) cases:

The number of medically assisted deaths is steadily increasing

- In 2019, there were 5,631 cases of MAID reported in Canada, accounting for 2.0% of all deaths in Canada.
- The number of cases of MAID in 2019 represents an increase of 26.1% over 2018 numbers, with all provinces experiencing a steady year over year growth in the number of cases of MAID since its introduction into law in 2016.
- When all data sources are considered, the total of number of medically assisted deaths reported in Canada since the enactment of federal legislation is 13,946.

Profile of MAID recipients

- In 2019, the proportion of men and women receiving MAID across Canada was nearly equal with only slightly more cases among men (50.9%) than women (49.1%).
- The average age of persons who received MAID in Canada was 75.2 years; this average age varied across jurisdictions ranging from a low of 70.4 in Newfoundland and Labrador to a high of 76.9 in British Columbia.
- Over 80% of MAID deaths occur at age 65 or older.
- Cancer (67.2%) was the most commonly cited underlying medical condition of persons who received MAID, followed by respiratory (10.8%) and neurological (10.4%) conditions.

The majority of MAID recipients also received supportive services

- The majority of persons receiving MAID (82.1%) were reported to have received palliative care services.
- Of those MAID recipients who **did not** access palliative care services prior to receiving MAID, the majority (89.6%) had access to these services but chose not to do so, according to the reporting practitioner.
- Among the 41.3% of patients requiring disability support services, 89.8% had received them....

One-quarter of written requests for MAID did not result in an assisted death

- There were 7,336 written requests for MAID reported through the MAID monitoring system in 2019. Of these requests, 26.5% (or 1,947) did not result in a MAID death, because the patients died before receiving MAID (57.2% or 1,113 cases), were deemed ineligible (29.3% or 571 cases), or they withdrew their request (13.5% or 263).
- The most frequently reported reasons why a person was deemed ineligible for MAID (7.8% of written requests) were: lack of capacity to make health care decisions (32.2%); the individual's natural death was not reasonably foreseeable (27.8%); and the individual was not in an advanced state of irreversible decline in capability (23.5%).

- Of those persons who were assessed as eligible for MAID, but did not receive it, the majority died of another cause prior to administration (15.2%), while a small number (3.6%) of persons withdrew their request after having been deemed eligible.²⁵

This a considerably higher number of people in Canada used aid-in-dying or active euthanasia than in California, undoubtedly because Canada allows active euthanasia administered by a physician or nurse while California requires the patient to be able to administer the drugs on his or her own; but even the Canadian numbers represent, according to the report, 2% of all deaths in Canada during the report period.²⁶ Notice also that in Canada, as in California, over 80% of the people asking for aid in dying were already receiving hospice care, but that was not enough, in the opinion of the patient, to respond to their condition.

What these statistics do not reflect are some of the advantages to the patients and their families when a family member begins this process. I am a member of the Ethics Committee of UCLA Medical Center. At the meeting of the Committee on July 23, 2019, the team of doctors, nurses, and social workers at UCLA Medical Center who interact with patients who request aid in dying reported that such a request often leads to deep and meaningful conversations between patients and their families about their lives together, the patient's fears about dying, and the patient's disclosure of how he or she wants to die. This then also leads to a much higher quality of grief after the patient's death, involving no trauma, self-doubts, or guilt on the part of survivors about what happened to their loved one in the dying process, for they knew that death was imminent and how their loved one wanted to die, and they did that. The same kinds of results can be produced through hospice care if it is done correctly, but the aid-in-dying process has provided this format for deep family discussions for a high percentage of patients who have engaged in it. At that meeting the team also mentioned that they are striving to educate non-white populations about this option, but they suggested that Hispanics, Armenians, and Asians, groups with large populations in the Los Angeles area, often live in very tightly knit families where decisions are made as a family, in contrast to the rugged individualism typically held by the large majority of white Americans and encouraged by American history, law, and ethos. That individualism mandates that one take charge of one's own dying process. This may be at least part of the explanation as to why a very high percentage of the people taking advantage of the law are white and educated.

The California statistics also do not reflect the need for aid in dying. My daughter-in-law, Dr. Tanya Dorff, is an oncologist, formerly at the University of Southern California and now at City of Hope Medical Center.²⁷ She confirmed what the statistics above reveal -- that in

²⁵ Health Canada, *First Annual Report on Medical Assistance in Dying in Canada, 2019*, "Highlights," <https://www.canada.ca/en/health-canada/services/medical-assistance-dying-annual-report-2019.html> (accessed 10/9/2020).

²⁶ *Ibid.*, Section 3.2. This section of the Canadian Government's report claims that 0.3% of deaths in U.S. states that allow aid in dying resulted from it, but, as noted above, the California statistics show a rate of half that.

²⁷ <https://www.cityofhope.org/tanya-dorff>

her experience, patients request aid in dying because they fear that as their disease progresses they could experience pain that cannot be relieved and/or they want autonomy and control in case of suffering. She told me that three specific cases that she witnessed before the California law came into effect overcame her reluctance to participate in what the California now allows. In all three cases the patients were given the best available medications for their pain, but *they literally screamed their way to death*. She assures me that pain can usually be controlled, even in advanced cancer, and that the established protocol in the medical community is to prefer pain relief, even to the point of unconsciousness and a possibility of overdose that leads to death unintentionally, over providing aid in dying. Furthermore, she told me, someone in pain is not eligible for inclusion in the California End of Life Option Act because it is assumed that their pain colors their feelings about the way they want to die. There are, however, some cases, the rare cases for which I want to carve out an exception in this responsum to our usual opposition to helping people die, in which maximal medication has failed to relieve distress sufficiently. To quote what she wrote me in an email about this,

The use of pain medications to relieve pain is a given... We accept the sedation and potential for overdose related death and prioritize pain relief at the end of life.

But there are cases (rare - to be clear; I've had 3 extreme experiences in my 15 years of caring for cancer patients) in which despite pouring morphine into a patient's veins, they are crying out or screaming in pain. They are still awake and cognizant.²⁸

As she explained to me, such patients are experiencing excruciating and uncontrollable pain and/or other forms of physical suffering, including, for example, chronic shortness of breath. It is this reality that those of us reading this responsum, who presumably are not in such distress, must recognize, along with Hillel's dictum,

הלל אומר, ... ואל תאמין בעצמך עד יום מותך, ואל תדין את חברך עד שתגיע למקומו

Hillel said: ...Do not be sure of yourself until the day of your death, do not judge your fellow human being until you have reached his place....²⁹

Rabbi Susan Grossman and others have asked whether such cases can be treated with a medically induced coma. As Dr. Toby Schonfeld has informed us, however, such treatment is generally used for brain injuries. It is not clinically indicated for alleviating pain, and so doctors will not induce a coma to alleviate pain, and insurance companies will not pay for it. A different procedure, terminal sedation, involves using an amount of morphine that completely suppresses respiration, causing death (hence “terminal”), but whether one accepts that morally and

²⁸ An email from Dr. Tanya Dorff to me, April 7, 2020, in response to my question of how, in practice, pain relief medication is used but that there are still patients who need aid in dying.

²⁹ M. Avot 2:4 (2:5 in some editions).

halakhically depends on whether one endorses the double effect argument, one issue on which Rabbi Reisner and I disagreed in our 1990 responsa. I will discuss more about that below.

Rabbi Amy Levin has asked whether there will be a conflict between state and federal law in the United States, such that physicians in states that permit aid in dying may either lose their licenses or be prosecuted by federal authorities. The answer to both questions is No. Licenses to practice medicine are governed by state law. Even though the Second Circuit and Ninth Circuit of the federal judiciary determined that there is a Constitutional right to assisted suicide, the Supreme Court ruled, 9-0, that there is no Constitutional right to aid in dying but that states do not violate the Constitution in permitting it, thus making it a matter for the states to determine.³⁰

As the subtitle of this responsum indicates, the underlying value of this responsum is that we imitate God in being compassionate, as the Psalmist (145:9) says:

טוֹב־יְהוָה לְכֹל יִרְחַמְיוּ עַל־כָּל־מַעֲשָׂיוֹ:

The LORD is good to all, and His mercy embraces all His works.

Jewish tradition has us recited this verse three times a day every day of the year, so our tradition clearly wants us to learn these attributes of God and imitate God in our own lives. As the *Sifre* interprets the Torah's demand that we "walk in all God's ways" (Deuteronomy 11:22):

ללכת בכל דרכיו - ... וכי היאך אפשר לו לאדם להיקרא בשמו של הקב"ה? אלא מה המקום נקרא רחום וחנון - אף אתה הוי רחום וחנון... מה הקב"ה נקרא צדיק, שנ' צדיק ה' בכל דרכיו וחסיד בכל מעשיו - אף אתה הוי צדיק. הקב"ה נקרא חסיד, שנאמ' חסיד בכל מעשיו - אף אתה הוי חסיד....

"To walk in God's ways" (Deuteronomy 11:22): ...Now how is it possible for a person to be called by the name of the Holy Blessed One? Just as the All Present is called "merciful and gracious," you, too, be merciful and gracious... Just as the Holy Blessed One is called "righteous," as the Bible (Psalms 145:17) says, "Righteous is Adonai in all His ways and loving in all His acts" — you, too, be righteous. Just as the Holy Blessed One is called "loving," — you, too, be loving....³¹

Rabbi Amy Levin has appropriately asked whether this concern for compassion should be limited to hospice care. Hospice care, approved by both Rabbi Reisner and me in our 1990 responsa, certainly is an expression of our compassion, for in allowing it, we are saying that, at some point, patients, their families, and their doctors need no longer aggressively try to cure a disease that physicians have tried to reverse but cannot, that comfort care is then sufficient to fulfill the mandate of Jewish law to preserve our lives. In some cases, though, even hospice care

³⁰ *Washington v. Glucksberg* 521 U.S. 702 (1997); *Vacco v. Quill* 521 U.S. 793 (1997).

³¹ *Sifre*, Ekev, on Deuteronomy 11:22.

is not enough to quell pain, and so then, I am arguing, imitating God requires us to allow aid in dying as well.

Another kind of case that leads people to request aid in dying is prolonged and only partially controlled pain. On December 8, 2019 *The New York Times* published a 42-page Special Report, “The Champion Who Picked a Date to Die.”³² It describes the case of Marieke Vervoort, a Belgian³³ who, since her teenage years, “had been battling a degenerative muscle disease that stole away the use of her legs, stripped her of her independence, and caused her agonizing, unrelenting pain.”³⁴ In her 20s

she had come to find some meaning in sports: wheelchair basketball, scuba diving, triathlons. But the constant pain and fear eventually plunged her into deep depression. At age 29, she determined her disease was too heavy to bear. She began hoarding pills at home. That was how she would end things, she thought.³⁵

A psychiatrist, though, suggested that she speak with a doctor who assisted people in dying, and that led her to choose life – a very active one at that – over death:

In Veervoort’s telling, the euthanasia papers allowed her to wrest back some control of her life. She no longer feared death because she could hold it in her hands at any time.

Newly empowered, she said she found herself approaching sports with a different level of focus. She reoriented her nascent wheelchair racing career from triathlons and marathons toward sprinting. She thrived.

The pain was still there, deepening. But she also imagined herself using it as fuel for competition. Her days were no longer consumed with dark thoughts of how her life would end. Mentally, she felt free.

“Because of those papers,” she said, “I started to live again.”³⁶

She ultimately won two medals -- a gold and silver -- at the 2012 Paralympics in London, three gold medals at the 2015 world championships in Doha, Qatar, and then two medals -- a silver and bronze -- at the 2016 Paralympics in Rio de Janeiro. She ultimately died, after a goodbye party, at age 40 when the pain became too great to bear any longer.

³² Andrew Keh, “The Champion Who Picked a Date to Die,” <https://www.nytimes.com/interactive/2019/12/05/sports/euthanasia-athlete.html> (accessed 10/6/20). References to page numbers in the following footnotes will be to the printed edition; unfortunately, the online edition lacks page numbers.

³³ Belgium allowed aid in dying beginning in 2002.

³⁴ *Ibid.*, p. 7.

³⁵ *Ibid.*, p. 11.

³⁶ *Ibid.* p. 17.

Not everyone who requests aid in dying will then go on to excel in sports, of course. Furthermore, the “papers” to which she refers are directions to give her aid in dying whenever she asks for it, and, in Belgium (but not in California or Canada), they can be completed years before the request, as she did. Her story, though, illustrates two common characteristics of those who request such aid: They are responding to prolonged and either uncontrolled or inadequately controlled pain, and the availability of aid in dying gives them reason to choose life for more time – in her case, for eleven years -- than they otherwise would.

Another class of cases in which people have advocated aid in dying beyond the protocols of either California or Canada is that of people with dementia. For example, Nicholas Goldberg wrote an opinion piece in the *Los Angeles Times* in which he made an emotionally compelling case for enabling people gradually losing their minds to be offered aid in dying, using his grandmother as the case in point.³⁷

These two kinds of cases also cry out to us for compassion, and, at some point, both civil law in many jurisdictions and our understanding of Jewish law may allow for extending aid in dying to such patients. In this responsum, however, I am arguing for a much more limited class of people to whom aid in dying should be offered – namely, those diagnosed with a terminal disease that makes it likely that they will die within six months and who are experiencing uncontrollable pain. I am limiting my responsum to such cases for two reasons: (1) The jurisdictions that allow aid in dying in both Canada and the United States have limited aid in dying to people whose death is near, and so prolonged pain from a disability or the prospect of becoming increasingly demented are not currently allowed as justifications for aid in dying in the civil law of those jurisdictions; (2) I am already stretching past Jewish law to respond to our new abilities to keep people alive, even when they are in great pain that cannot be controlled and so it is cruel to use our armamentarium to do that; to address other conditions,, such as disability and dementia, involve other considerations and should therefore be the subject of another responsum, perhaps some years from now so that we have more experience with applying aid in dying laws and can assure that these more complex cases can be done in a way that does not lead to abuse.

Even though I am arguing that in limited cases we should allow aid in dying, patients have no obligation to ask for such aid, and physicians and hospitals should not be forced to offer it. California law specifically permits physicians and hospitals to opt out of providing aid in dying. Indeed, only 39% of hospitals in California permit physicians to participate in aid-in-dying care, in line with the new law; 61% prohibit physicians to provide such care on their premises, although some of those allow physicians to refer patients desiring such care to other

³⁷ Nicholas Goldberg, “Dementia Patients Deserve Access to Aid-In-Dying Laws,” *Los Angeles Times*, July 15, 2020 in the print edition, p. A11, <https://www.latimes.com/opinion/story/2020-07-15/california-aid-in-dying-law-assisted-suicide-alzheimers-dementia> (accessed 10/8/20).

facilities. Of the hospitals that approve such care, their policies regulating such care vary widely.³⁸

In any case, we clearly must insist that physicians and hospitals may opt out of providing aid in dying, for at the very most this should be an option in civil and Jewish law and not a mandate on the medical community to provide it. The law in California and Canada specifically permits medical personnel to opt out of providing aid in dying.³⁹ From a Jewish perspective as well, I am arguing in this responsum that providing aid in dying is permitted (*muttar*) in the circumstances and under the conditions described in the remainder of this responsum and in its conclusion (*p'sak halakhah*), despite the many reasons rooted in the Jewish tradition that I provided in my 1997 responsum to oppose assisted suicide/aid in dying in most cases, reasons to which I added in Section D above; I am definitely not claiming here that there is a Jewish obligation (*hiyyuv*) to provide aid in dying, even under the circumstances and under the conditions that I would now allow it. That said, as I will explain below, I think that physicians opposed to providing aid-in-dying should refer patients who ask for it to other physicians, both as part of their duty to relieve the pain of their patients and also in recognition that reasonable, moral people disagree about the appropriateness of providing medical aid-in-dying, and so their own position should not prevent others from acting otherwise.

I. A Jewish Evaluation of Aid in Dying Under These Laws

How, then, should we respond to the old realities and the new ones concerning aid in dying? The fundamental principle noted above that God owns our bodies leads to the conclusions in Jewish law that we have the duties to take care of our body and health,⁴⁰ to avoid danger,⁴¹ and certainly not to commit suicide.⁴² As also noted above, however, the people who request aid in dying in the isolated case that I am discussing – that is, where all of the factors

³⁸ Cain CL, Koenig BA, Starks H, Thomas J, Forbes L, McCleskey S, Wenger NS. “Hospital and Health System Policies Concerning the California End of Life Option Act,” J Palliat Med. 2019 Jul 12, <https://www.liebertpub.com/doi/10.1089/jpm.2019.0169> (accessed 7/31/19). Cain CL, Koenig BA, Starks H, Thomas J, Forbes L, McCleskey S, Wenger NS., “Hospital Responses to the End of Life Option Act: Implementation of Aid in Dying in California,” JAMA Intern Med. 2019 Apr 8, available at <https://jamanetwork.com> (accessed 7/31/19). I want to thank Dr. Neil Wenger for the references in this and the following footnote.

³⁹ California: Section 443:14 of the End of Life Option Act, https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520162AB15 (accessed 4/2/20); Canada: <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html> (accessed 4/2/20) and the original text of the act at https://laws-lois.justice.gc.ca/eng/AnnualStatutes/2016_3/FullText.html, C3, s.3 (accessed 4/2/20).

⁴⁰ See, for example, M.T. Laws of Ethics (*Hilkhot De'ot*) 3:3.

⁴¹ B. *Hullin* 10a; S. A. *Orah Hayyim* 173:2; S.A. *Yoreh De'ah* 116:5 gloss.

⁴² Genesis 9:5; M. *Semahot* 2:2; B. *Bava Kamma* 91b; M.T. Laws of Murder 2:3; M.T. Laws of Injury and Damage 5:1; S.A. *Yoreh De'ah* 345:1-3. On all of these three duties see Elliot N. Dorff, *Matters of Life and Death: A Jewish Approach to Modern Medical Ethics* (Philadelphia: Jewish Publication Society, 1998), Chapter Two and pp. 176-198.

listed in Section D above do not apply and the patient is in uncontrollable pain or suffering despite the best efforts of medical personnel to diminish that pain and suffering – are not committing suicide; indeed, as the patients quoted in Section C indicate, they have done their very best to stay alive and have no desire to die, but their underlying lethal disease is killing them despite their prodigious efforts to stay alive. This, then, is not “suicide” in the sense that we normally mean it – that is, that a physically healthy person intentionally and willingly takes his or her own life; it is instead alleviating pain and suffering, and that we also have a duty to do.

Motivations for everything we do in life are multifactorial, even if a particular motive is prominent in our consciousness as we do something. I teach my classes, for example, for all of the following reasons: I love to teach; I signed a contract that I would teach these courses (I promised); I have a duty to the students who paid tuition for these courses; I want to be known as a responsible person; I am committed to the material I am teaching; I earn a living that way; etc. On any given day, any of those may be the most powerful impetus for showing up to class prepared.

Similarly, there are many factors that may lead a patient to ask for aid in dying. We clearly have a duty to make sure that none of the considerations described in Section D above are the primary factors motivating the person to ask for aid in dying, and those elements, as I wrote in my 1997 responsum and reiterated above, are all too often what in fact leads a person to ask for assistance in dying. That is why I took the position that I did in 1997, and still do today, that we must be concerned about those factors, for in many cases (the majority? the vast majority?) those factors are what are producing the patient’s stated desire to die, and then we must respond appropriately to the particular factor(s) involved rather than help the person die. The laws that have come into effect that permit aid in dying, however, do address some of those concerns – indeed the most common and troublesome ones – and so it is more possible today than it was in 1997 to identify the isolated cases in which uncontrollable pain and/or suffering, or the likely prospect thereof, is the primary, and possibly the only, factor motivating the request for aid in dying, in contrast to those motivated primarily by other reasons.

Furthermore, as more and more civil jurisdictions are considering and adopting aid-in-dying laws, we do need to make sure that our stance recognizes that fact and gives guidance to Jews living in those jurisdictions. A flat “No” does not do that in a way that acknowledges that some cases are about people who indeed have no desire for suicide – they would much rather live and have taken multiple steps to do that – but rather now need to alleviate the uncontrollable pain their underlying illness is causing them. We must, in other words, tailor our decision to the new facts that have emerged in light of the new civil laws that eliminate many of the abuses that I feared in my 1997 responsum and the others listed in Section D above, not because civil law determines Jewish law, but because the civil law that governs Jews as well as all other citizens under its jurisdiction creates the context to which Jewish law must respond for the Jews living in those jurisdictions. Each jurisdiction will have its own laws and its own set of protections, and the law in each jurisdiction must be examined and evaluated to determine how much it alleviates

our concerns. In the case of California and many other jurisdictions, though, it is the case that the civil law has succeeded in identifying the isolated cases and restricting the application of the law only to those, and in such contexts we must rule with this new reality in mind.

The legal issue involved in the case at hand, then – the isolated case -- is the same one that arose in the responsa about end-of-life issues that Rabbi Avram Reisner and I wrote in 1990, both of which were approved by the CJLS⁴³ – namely, the role of intention in determining the legal and moral status of an act. Intention clearly plays a role in Jewish law, for the Torah itself distinguishes between killing a person intentionally in contrast to cases where the perpetrator did not intend to do so.⁴⁴ The degree to which intention should play a role in determining Jewish law on end-of-life issues was, however, one of the few places where Rabbi Reisner and I disagreed. Morphine is titrated, first using the minimum necessary to relieve pain and then raising that amount as necessary. It works, however, by suppressing the respiratory system. Rabbi Reisner allows only as much morphine to quell pain that has no reasonable chance of suffocating the patient. In addition to outcome, I took (and continue to take) intention to be a critical part of estimating the morality and legality of an act, so if the intention in using the next amount of morphine is to kill the patient, it is prohibited, but if the intention is to quell the patient's pain and no lesser amount is adequate to doing so, one may use the next amount of morphine, even if it has the chance of suffocating the patient in the process (the “double effect argument”⁴⁵). Similarly here I am maintaining that the clear record of the patient's intent in the past to do even painful things to live as long as possible and/or his or her current intent not to die but to relieve pain is dominant, for it marks the patient's request for aid-in-dying as a request for pain relief, not a request to die.

In my 1990 responsum, however, dealing with cases where there was no intention to kill the patient but only to relieve pain, I could rely on the fact that *it was not clear* to doctors that increasing the amount of morphine to the next level in the name of relieving the patient's pain would cause the person's death, and so the double-effect argument could be used. In aid-in-dying cases, however, even in the isolated cases I have in mind in which aid in dying would be allowed, the patient and physician do consciously intend to help the person die, and there is little,

⁴³ See note 5 above.

⁴⁴ Exodus 21:12-13; Numbers 35:9-34; Deuteronomy 19:1-13.

⁴⁵ In his extensive notes to me on an earlier draft of this responsum, for which I thank him, Rabbi Nevins pointed out correctly that it was Thomas Aquinas who first formulated the double effect argument, but, as I noted above, that does not mean that intention is absent in Jewish law from the determination of how one who caused another's death should be treated; see the last note. In any case, in this responsum, the one who is providing aid in dying is not causing the person's death; the patient in excruciating pain is doing so. Rabbi Nevins also raised the possibility that failing to keep a person alive would violate our obligation to rescue people under Leviticus 19:16 and its Rabbinic extensions in B. *Sanhedrin* 73a, M.T. Laws of Murder and Preservation of the Body 1:14. We clearly do need to try to provide whatever is necessary to deter people from asking for aid in dying, as this responsum and my 1997 one on this topic make clear; but the duty to rescue people does not mean, as Rabbi Reisner and I point out in our 1990 responsa, that we must do everything possible to keep someone alive, for we also have the duty not to delay the dying process.

if any, doubt that the drugs that will be used in this effort will produce the intended result. In the terms of Jewish law, it is not even a case of not intending the result (*she'aino mitkaven*) but it is inevitable and therefore should have been known (*p'sik reishei v'al yamut?*)⁴⁶; it is a case of outright intention that the result be achieved (*mitkaven*), and the intended result, helping the patient to die, would seem to violate Jewish laws prohibiting both suicide and assisting a suicide.

It is here, though, that we should note that despite this clear legal precedent, the actual legal responses to people who commit suicide have historically been much more nuanced. So, for example, rabbis through the Middle Ages struggled to find warrant for the suicides of Saul,⁴⁷ the four hundred boys and girls abducted for sodomy or rape, as recorded in the Talmud,⁴⁸ and the Jews at Masada by distinguishing those cases from the general ban on suicide. One way rabbis did that was by saying that those people committed suicide as an act of martyrdom, that they died for the sanctification of God's Name (*al Kiddush ha-Shem*). Even without that justification, the general rule that people who commit suicide be buried outside the Jewish cemetery was rarely, if ever, enforced, using the presumption that the person was insane and therefore not responsible for his or her act of suicide to justify burial within the cemetery. Dr. Avraham Steinberg writes, on one hand, that "Even if a terminally ill patient is *suffering* terribly, and even if he *asks* in a clear and unambiguous manner that he be killed, *one may not acquiesce*. He who kills him is guilty of murder..." This disallows active euthanasia ("mercy killing"). On the other hand, though, "A terminally ill patient suffering terrible pains who *actively kills himself* is not considered as one who knowingly committed *suicide*, and none of the rites relating to burial and mourning are withheld from him."⁴⁹ Furthermore, the *Be'samim Rosh*, attributed to the Ro"sh (Rabbeinu Asher, 1250-1327) but not without controversy, allowed full burial rites without assumption of insanity to a person who committed suicide not because of physical pain, but because of psychological suffering caused by the fact that he could no longer endure the poverty and degradation of his life, for "in any case of suicide for a multiplicity of troubles, worries, pain, or utter poverty, there is not the slightest reason to deny mourning rites."⁵⁰ These compassionate responses to people who take their own lives do not constitute legal permission in Jewish law for people to kill themselves or to assist others in doing so ; they are rather similar to the widely varying ways in which civil jurisdictions have treated those engaged in active

⁴⁶ Rabbi Shimon's position – that one is not held liable for unintentional violations of the law – is the law: B. *Shabbat* 22a; B. *Beitzah* 23a. Rabbi Shimon admits, however, that if the unintended result is inevitable ("can you cut off a chicken's head and it not die?"), the person acting in such a way is liable: B. *Shabbat* 75a; B. *Sukkah* 33b; B. *Ketubbot* 6a.

⁴⁷ I Samuel 31:3-4.

⁴⁸ B. *Gittin* 47b.

⁴⁹ Avraham Steinberg, M.D., *Encyclopedia of Jewish Medical Ethics*, Fred Rosner, M.D., trans. (Jerusalem and Nanuet, NY: Feldheim, 2003), 3: 1056-1057. Italics in the original.

⁵⁰ All of these are discussed in Basil F. Herring, *Jewish Ethics and Halakhah for Our Time: Sources and Commentary* (New York: Ktav and Yeshiva University Press, 1984), pp. 74-78; the quotation is on p. 77. The note there is presumably to where this responsum is reported but opposed: *Responsa Hatam Sofer to Yoreh De'ah* 326; see also to *Yoreh De'ah* 328 and to *Even Ha-Ezer* 1:69.

euthanasia,⁵¹ recognizing through our response to such acts that they are not legally equivalent to murder done out of malice (first degree murder) or the heat of anger (second degree murder) or even through negligence; it is rather manslaughter, defined as “an unlawful killing that doesn't involve malice aforethought—intent to seriously harm or kill, or extreme, reckless disregard for life.”⁵²

Manslaughter, though, is also “unlawful.” Indeed, the many sources that I quoted in my 1997 responsum make it abundantly clear that one may not either take one's own life or assist someone else in doing so. One especially relevant and poignant source that needs to be added to that list is this from the *Arukh Ha-Shulhan*:

אף על פי שאנו רואים שמצטער הרבה... וטוב לו המות, מ"מ אסור לנו לעשות דבר ולקרר מיתנו

Even though we see that he is in great pain... and death would be good for him, nevertheless it is forbidden to us to do anything to advance his death.⁵³

Still, in the isolated case where pain is unbearable, whether as a result of a recently contracted disease (e.g., bone cancer) or a prolonged condition or degeneration, expression of compassion is just not enough; one must do what one needs to do to enable the patient to stop suffering. Yes, as noted above, we need to assure that the patient has been provided as much pain medication as necessary, even at the cost of losing consciousness, before offering aid in dying, but sometimes doctors know full well that either the amount necessary to quell the pain will simultaneously kill the patient or that no amount of pain medication will work in this case. Suffering is part of life, and some suffering is even beneficial, as when a toddler learns not to touch hot objects by doing so and feeling pain or when pain alerts a person to consult a doctor. That is different, though, from the excruciating pain that sometimes accompanies the dying process or the prolonged and insufficiently controlled pain due to a neurological condition or some other malady, and to those cases Hillel's dictum, quoted earlier, most relevantly and poignantly applies: “Do not judge your fellow until you come to his place in life.” What I am suggesting in this responsum, then, is a general ban on aid in dying but with rare exceptions in which we say, legally, *הלכה ואין מורין כן*, it is the law, but in these specific cases we do not rule

⁵¹ See note 4 above.

⁵² https://www.google.com/search?q=manslaughter&rlz=1C1LDJZ_enUS510US586&oq=manslaughter&aqs=chrome..69i57j0l5.2943j1j7&sourceid=chrome&ie=UTF-8 (accessed 9/26/19).

⁵³ *Arukh Ha-Shulhan*, Yoreh De'ah 339:1. I would like to thank Rabbi Avram Reisner for calling my attention to this source.

according to it,⁵⁴ or, alternatively, ולא מיהו בידם חכמים, the law is x, but the Sages did not object when the people did y.⁵⁵

It is important that we confront these cases not only pastorally, but legally. For to say that the law prohibits aid in dying but we should understand those who engage in it and comfort their families leaves the patient with tremendous guilt in asking for aid in dying and the family with shame. It is extremely difficult for families to deal with the suicide of one of their members, and so it is critical that rabbis make it clear that, legally as well as medically, aid in dying is not a suicide but rather a compassionate effort to alleviate pain caused by the underlying disease that is taking the person's life. Moreover, for Jewish doctors this clearly is a legal issue, for they will want to know that not only civil law, but also their own tradition, supports what they are doing when they provide aid in dying. Rabbis and others should certainly show empathy and support for all three of the following participants in the process: patients who are experiencing uncontrollable pain to the point of asking for aid in dying, their families who are witnessing that pain and their family member asking for and obtaining aid in dying, and the doctors who are taking steps to help end the patient's pain but also his or her life. Kindness in these cases, though, is not enough; we need to be able to say that the patient has a Jewish legal right to gain aid in dying and the doctor has legal permission in Jewish as well as civil law to provide it. The Talmud and later codes permit a sick patient to eat on Yom Kippur when he or she expresses the need to do so, even over the opinion of a hundred doctors who say that it is unnecessary for the patient to violate the laws of Yom Kippur in that way, for "The heart knows its own bitterness"⁵⁶; here we are talking about a case where both the patient and doctors agree that the pain is uncontrollable, and both want to stop the pain, even if it comes at the cost of the person's life, and so we certainly should declare it legally permissible for the patient to obtain the aid in dying that he or she needs despite the general ban on suicide and assisting a suicide in Jewish law (in these cases, הלכה ואין מורין כן) or at least not object legally to that happening (ולא (מיחו בידם חכמים).

In Israel and other jurisdictions that do not allow aid in dying, of course, rabbis can only provide pastoral care, and they certainly should do that, as difficult as it is in these cases. Deaths, as rabbis know full well, range the spectrum from tragic (e.g., a young person who dies of leukemia) to a blessing (someone who lived a full life but suffered greatly in the dying process

⁵⁴ *Sefaria* lists 123 examples of the use of this principle. Among them are these: B. *Shabbat* 12b; B. *Eruvin* 7a; B. *Beitzah* 28b; B. *Bava Kamma* 30b; B. *Avodah Zarah* 37b; B. *Menahot* 36b; Tur and Arukh Ha-Shulhan, *Orah Hayyim* 509:7; etc. *Sefaria's* list includes many Rishonim and Aharonim.

⁵⁵ *Sefaria* lists 122 examples. Among them are M. *Ketubbot* 1:5; M. *Menahot* 10:8; T. *Ketubbot* 1:1; B. *Eruvin* 96a; B. *Pesahim* 55b-56a; B. *Ketubbot* 3b; B. *Menahot* 71a and many Rishonim and Aharonim. The question is whether *halakhah v'ein morin ken* applies only to cases where the law is permissive but the Rabbis ruled stringently, or whether it also applies to cases where the law is stringent but the Rabbis ruled permissively. In any case, *v'lo mihu b'yadam hakhamim* would certainly apply to our case, where normally we would prohibit aid in dying but in the small group of cases that I am identifying we should not object to patients obtaining aid in dying. I would like to thank Rabbi Joshua Heller for pointing out to me the question of which Rabbinic category to use here.

⁵⁶ Proverbs 14:10; B. *Yoma* 83a; M.T. *Shevitat Assor* 2:8; S.A. *Orah Hayyim* 618:1.

until it finally ended). Even in the latter cases, the kind this responsum addresses, helping patients and family members find support and solace during a patient's excruciating pain requires keen pastoral skills. For that matter, even in those jurisdictions that allow for aid in dying, rabbis will be called upon to engage in pastoral support that test their abilities and skills. This is a legal responsum, not a course in pastoral counseling, but let me note here that rabbis need that kind of training to help the increasing numbers of our aging population and their families who will be facing these circumstances.

In what follows, I want to consider two aspects of the position I have described above that are hard even for me, namely, drawing the limits of where providing aid in dying is warranted, and defining the role of doctors in the process.

1. The conditions that warrant aid in dying. In her thoughtful response to an earlier draft of this responsum, Rabbi Judith Hauptman wants me to go further than this, both in theory and in practice. First, in theory, she wrote:

If statements made in the past by Orthodox rabbis/codists did not meet our approval today, because we espouse different ethical guidelines, then why are we limited to saying, "This is the law, but we will give a different answer in a specific case"? I cannot sanction saying to someone dying of cancer, who is screaming in pain, or someone suffering with Alzheimer's who can no longer swallow food or talk, and who is incontinent, that Jewish law stands in the way of permitting that person to choose dignity in death, or to avoid unbearable pain when dying, but that we can make exceptions and allow it in certain cases.

It seems to me that the CJLS is not in existence merely to rubber stamp what others have already decided. Rather, it is in existence to chart its own views of halakhic behavior. Allowing women to count in a minyan or serve as a rabbi is not consistent with what Orthodox rabbis have said in the past. And yet the CJLS approved these positions mainly as a product of ethical reasoning: women are as fully human as men and should therefore not be discriminated against because of their gender....I don't want to see מורין כן הלכה ואין כן as the basis for allowing aid in dying. We should be able to note that Jewish law has an ethical impulse coursing through it. Unlike deciding if rennet is kosher or not, a question that does not have easily observable ethical dimensions, this is a time when we must say that past views of aid in dying no longer speak to us today. We will rewrite this rule in light of our evolved ethical sensibilities. If we deem it wrong to let someone scream in pain as he or she approaches death, and if that person is asking for aid in dying, then we should allow that person to die peacefully by allowing someone to offer aid in dying, past Jewish law to the contrary notwithstanding.

As someone whose own theory of Jewish law sees ethical issues not as "extra-legal" but rather as part of the warp and woof of Jewish law, an organic weave of posited law, morality,

theology, science, economics, social issues, and everything else that does and should affect our understanding of Jewish law in our time,⁵⁷ I am very sympathetic to the methodological concerns that Rabbi Hauptman is raising. In this case, though, all of the worries that I stated in my 1997 responsum and summarized and expanded upon in Section D above about the abuses that can occur in allowing aid in dying lead me to say that we need to reaffirm our stance that in general helping someone to die should be seen as prohibited but that we should carve out a narrow exception in cases in which a person is suffering from uncontrollable pain. That is, the ethical concern that Rabbi Hauptman and I both share – along with, I know, many other rabbis and lay members of the Conservative Movement -- should not annul past law on this topic but rather lead us to include in our statement of the law a narrow exception to it.

The really hard issue for me is knowing where to draw the line. Here is what Rabbi Hauptman writes on the matter of practice:

I will go one step further than the author of this teshuvah. I agree with him that aid in dying cannot be offered in a case in which someone stands to benefit, such as an insurance company. But I would give more leeway to the one who wishes to end his or her life. If that person faces a horrible end, for instance losing all control of bodily function, and if that person does not want to see a lifetime of savings squandered on keeping him or her alive when he or she would be little more than a physical presence without mental capacity, and if that person wants a lifetime of savings to be passed to children or grandchildren and not to a nursing home or insurance company, I would also allow that person to choose to die sooner rather than later. Depression is not a reason to choose death since there are cures for depression. But irreversible, significant deterioration, or irreversible, uncontrollable pain, I submit, is sufficient reason for someone to say let me die sooner, with my life savings intact, rather than later, when I will be essentially penniless. ...

This is the approach in Canada but not in California. In California eligibility for aid in dying requires the expectation of death, despite available medical interventions, within six months. In Canada the person must have “a grievous and irremediable medical condition” with natural death “reasonably foreseeable” but does not require that one have a terminal condition to be eligible for aid in dying. Specifically, as the reader may remember from its description above, eligibility is defined as follows:

Grievous and irremediable medical condition

To be considered as having a grievous and irremediable medical condition, you must meet **all** of the following criteria. You must:

⁵⁷ Elliot N. Dorff, *For the Love of God and People: A Philosophy of Jewish Law* (Philadelphia: Jewish Publication Society, 1998), especially chapters 2, 3, and 6.

- have a serious illness, disease or disability
- be in an advanced state of decline that **cannot** be reversed
- experience unbearable physical or mental suffering from your illness, disease, disability or state of decline that **cannot** be relieved under conditions that you consider acceptable
- be at a point where your natural death has become reasonably foreseeable
 - this takes into account all of your medical circumstances and does not require a specific prognosis as to how long you have left to live

You do **not** need to have a fatal or terminal condition to be eligible for medical assistance in dying.⁵⁸

Especially because I am arguing that our usual laws prohibiting taking or aiding the taking of a life may be set aside when suffering cannot be controlled, a part of me would want to extend this permission to anyone in that condition, regardless of the person's life expectancy, and perhaps even to some of the conditions that Rabbi Hauptman describes. That would certainly flow consistently from my prime concern with responding to pain and suffering. At the same time, though, I am worried, as the legislators in California clearly were, that that can too easily be extended to people who should be provided other kinds of interventions, along the lines that I suggested in Section D above, rather than aid in dying. Moreover, I also worry that permitting aid in dying without requiring that the person be expected to die soon would undermine our care for disabled people, for it is much easier and much less expensive to help them die than to provide the kinds of physical, educational, social, and psychological assistance that enable them to live lives meaningful to them and to society at large, despite the suffering involved in coping with their disability. For these reasons, in this responsum I am preferring California's definition of who is eligible for aid in dying to Canada's as a matter of public policy (how I would state Jewish law *ab initio*), but, like Rabbi Avraham Steinberg, after the fact (*post facto*) I would not condemn or deny normal Jewish burial rites to Jews in Canada or in other jurisdictions who are allowed by civil law to seek medical aid-in-dying when they are subject to "a grievous and irremediable medical condition" that causes them uncontrollable pain who take advantage of that option, even though their condition does not involve a prognosis of death soon.

Specifically, then, in light of the clear ban on helping someone die in the Jewish legal tradition and yet the nuanced response after the fact to people who take their lives, and in light of the new civil laws that have been passed on aid in dying in a number of jurisdictions that speak to many of our concerns about abuse of assisting people in dying, I would recommend this:

- 1) Jewish law requires Jews to visit the sick, to aid in healing both physical and mental illness, to treat people with disabilities and the sick with respect, and to assure that everyone has access to the health care they need, short of aiding them in dying.

⁵⁸ Government of Canada, "Medical Assistance in Dying," <https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html#grievous> (accessed 4/3/20).

- 2) Jewish law prohibits active euthanasia (“mercy killing”), where people other than the patient administers the drugs to bring about death, even though the patient expressly wants that and even in jurisdictions that allow that.
- 3) Jewish law also prohibits taking one’s own life or assisting others in doing so. Therefore families, medical personnel, and rabbis should not suggest, let alone encourage, patients to seek aid in dying.
- 4) However, if, despite the fact that all the factors in Section D above have been addressed, a patient persists in wanting aid in dying by being provided drugs that the patient him/herself will administer to alleviate uncontrollable pain in jurisdictions that allow the provision of lethal drugs in such circumstances, rabbis should not object. As a matter of law, we should rather express understanding for both the patient and his or her family as they engage in an act that is an exception to the usual prohibitions of suicide and assisting a suicide because of the uncontrollable pain involved. In such cases, following Hillel, we who are healthy should shrink from judging others who are in pain we have never had.
- 5) In accordance with Rabbi Kassel Abelson’s responsum, “Suicide,” overwhelmingly approved by the CJLS in 2005,⁵⁹ full burial rites should be accorded to someone who uses medical aid-in-dying, not only for the reasons he gives in cases of suicide, but also because in these cases the patients involved tried to live, often with great difficulty and for an extended period of time, and are now just trying to alleviate their pain.

The Role of Doctors in Providing Aid in Dying. I recognize, as the Canadian law does, that some people are too feeble to administer the medication to themselves, and so Canada allows “clinician-administered medical assistance in dying” in addition to permitting patients to take the drugs provided by doctors on their own. Indeed, there is a certain unfairness and maybe even cruelty in permitting aid in dying to patients who are mentally and physically competent to administer the drugs to themselves to relieve uncontrollable pain but not to permit patients in the same situation who cannot administer the drugs themselves to get help in doing so. Such cases may be the very hardest cases for us emotionally. Indeed, as Rabbi Pamela Barmash, Rabbi Daniel Nevins, Dr. Toby Schonfeld, and Professor Neil Netanel have pointed out to me, Jewish law as it stands, like California law, may induce people to die earlier than they really want their lives to end for fear that if they wait too long, they will not meet the requirements of the law and therefore be ineligible to use it. One way around this, as Rabbi Amy Levin pointed out, would be to allow patients to write into their advance directive for health care a provision that if I am in

⁵⁹ Kassel Abelson, “Suicide,” https://www.rabbinicalassembly.org/sites/default/files/assets/public/halakhah/teshuvot/20052010/abelson_suicide.pdf (accessed 9/19/19).

uncontrollable pain, I want aid in dying, whether administered by myself or by my physician, even if at the time I am not in a mental state to ask for it or a physical state to administer it, but neither California nor Canada allows for that; in both jurisdictions the patient must be mentally competent at the time of asking for aid in dying and make the requisite requests shortly before it is provided, and in California the person must be able to take the drugs him/herself.

Although I see the strength of these arguments for permitting physicians to administer the drugs, like the California law I would stop short of permitting medical personnel to administer drugs intended to bring about a person's death. First, as noted above, even though one could construe injecting lethal drugs into a patient suffering from uncontrollable pain to be an acceptable goal of medicine, the medical community is anything but united in seeing it that way; in fact, as the conflicting statements of the American Medical Association noted above demonstrate, whether that is appropriate for doctors to do is itself a major debate in the medical community. Furthermore, although Jewish law prohibits both taking one's own life and enabling others to do so, it invokes much harsher penalties on those who aid in dying than those who take their own lives. This is not only because the one who helps someone die is still alive and subject to the full jurisdiction of the law while the one who takes his or her own life can be punished retroactively only in ways that he or she will not suffer (burial outside the cemetery wall, shame experienced by the person's family, and also possibly denial of inheritance rights; the last of those is not part of American, Canadian, or Jewish law, but what life insurance companies will pay for is another matter). It is also because there is more culpability in assisting someone to die than in seeking to die oneself due to excruciating pain. The person in pain, after all, has that pain as a justification for seeking to die, while the person assisting that process is presumably healthy and intentionally, even if compassionately, deciding to bring about a person's death. Furthermore, allowing active euthanasia immediately raises the question of the motive of the person administering it. These may seem like thin lines separating active euthanasia from aid in dying, especially to patients too feeble to take the drugs themselves and who therefore want and need a doctor's help to bring about their death, but significant moral and Jewish legal boundaries do distinguish the one from the other.⁶⁰

Consequently, as a matter of public policy, I would favor the California law on this over the Canadian one. Specifically, I would interpret Jewish law to allow physicians to provide aid in dying to patients in uncontrollable pain who can administer the drugs to themselves but ban

⁶⁰ This distinction between aid in dying, where the patient administers the drugs him/herself, in contrast to active euthanasia, where someone else administers the drugs, is different from, and, in my view, stronger than the distinction between active and passive euthanasia, which many in the bioethics world see as a distinction without a difference, for in both active and passive euthanasia people other than the patient are making the decision about the patient's treatment. For an early and oft-cited challenge to distinction between active and passive euthanasia, see James Rachels, "Active and Passive Euthanasia," *The New England Journal of Medicine* 292:2 (9 January, 1975), 79-80, reprinted in many books on bioethics and ethics generally including, for example, Jeffrey Olen and Vincent Barry, eds., *Applying Ethics: A Text with Readings* (Belmont, CA: Wadsworth Publishing Company, 1996), fifth edition, 235-238; James E. White, ed., *Contemporary Moral Problems* (Minneapolis/St. Paul: West Publishing Company, 1997), fifth edition, 197-201.

active euthanasia. At the same time, I would stand aside without judgment of either the patient or the physician in cases of people in uncontrollable pain seeking aid to end their own lives and who need a physician to administer it in jurisdictions that allow that.⁶¹ Rabbis need to offer solace and understanding to patients and their families in all these cases, whether the patient dies through a protocol of aid in dying or active euthanasia.

Although, for the reasons described in the last paragraph, I would not *ab initio* allow physicians to administer the lethal drugs to assist a person in dying, I want to assert, conversely, that, like the laws in California and Canada, Jewish law permits doctors and hospitals to refuse to provide aid in dying. After all, as I describe in detail in my 1997 responsum, Jewish law forbids both suicide and assisting one. At the very most, then, providing such aid should be *permitted*, I am claiming, in the rare cases where patients experience uncontrollable pain; it is certainly *not mandatory* for physicians to provide such aid.

That said, out of compassion for the patient and/or recognition that people have differing moral evaluations of aid in dying, doctors who refuse to participate in aid-in-dying protocols should refer such cases to another doctor to provide the medications. Alternatively, to remove the doctor who refuses to provide aid in dying yet further from responsibility for the procedure, he or she may follow the procedure prescribed by the government of Alberta, Canada, in which the first doctor refers the case to another doctor for evaluation and then, if that doctor sees it appropriate, he or she refers the patient to yet a third doctor for providing the medications for aid in dying. Either of these procedures preserves the right of doctors to refuse to provide aid in dying but nevertheless responds to the patient's uncontrollable pain.

J. P'sak Halakhah

1. Jewish law prohibits murder; active euthanasia ("mercy killing"), whether by a physician or a family member; suicide; and assisting a suicide.⁶²
2. As demonstrated, however, by the responsa on end-of-life care by Rabbis Avram Israel Reisner and Elliot N. Dorff, previously approved by the Committee on Jewish Law and Standards,⁶³ machines and medications may be withheld or withdrawn from patients who do not benefit from them, as indicated by the patient's own expressed evaluation personally now, through his or her advance directive, or through a proxy appointed in his or her advance directive for health care. According to Rabbi Dorff's responsum but not Rabbi Reisner's, artificial nutrition and hydration may also be withheld or withdrawn.

⁶¹ I am not here including "at the hands of a close family member" because that even more deeply raises the question of motive. Here I share the perplexity of how to respond to such cases indicated by the range of legal responses to them noted in note 4 above.

⁶² See note 30 above and my 1997 responsum, "Assisted Suicide," at note 1 above.

⁶³ See note 6 above.

3. Those confronted with a request for aid in dying by being provided drugs that the patient him/herself will administer in those civil jurisdictions that permit this should first determine that:

a. The patient has a terminal, incurable disease, which, despite available treatments, will, in the opinion of at least two independent physicians, bring about the person's death within six months or shortly thereafter (depending on the statute in the jurisdiction) and that involves pain or suffering that cannot be quelled.

b. Monetary pressure is not the motivation for the request, whether that pressure is internal to the patient him/herself ("I do not want to squander the family's resources on my futile care"), comes from family members who do not want to spend the family's money on what they regard as futile medical interventions for a parent or other relative, or is applied by public or private insurance companies that will provide for medical aid-in-dying but not long-term care, which is much more expensive. Especially in the United States, which does not have universal health care, money is often part of the deliberations of a patient, family, doctors, and hospitals in deciding what medical interventions to use and for how long, but even countries with socialized medicine set limits as to what their health care coverage will provide, based in part on how much money the government is willing to spend on health care. To the greatest extent possible, however, money should not be the dominant factor motivating a person to seek aid in dying; uncontrollable pain, despite the availability and use of medical interventions, is the motive that justifies providing aid in dying.

c. If the patient is depressed or suffers from other psychological maladies, appropriate social, psychological, behavioral, and medical interventions to treat these conditions are employed rather than aid in dying.

d. Similarly, adequate pain medication to quell pain, to the extent that that is possible, is in use, and other necessary medical services have been and are being provided to alleviate the patient's other symptoms or suffering.

e. While still conscious, the patient asks for aid in dying of his or her own free will, as determined in a private conversation between the patient and doctor with nobody other than an interpreter, if necessary, in the room.

f. The patient is mentally competent to ask for aid in dying, as demonstrated according to the requirements specified for mental competence for such decisions in the civil law of the relevant jurisdiction. This includes age restrictions.

4. In cases where all the requirements of (3) are met, patients who nevertheless ask for drugs that they themselves will administer to aid them in dying and are doing so despite taking all steps possible to live and are currently subject to, or are likely soon to be subject to, uncontrollable pain or suffering may be provided with medications that will aid them in dying. This is not "suicide" in the usual understanding of the term because their underlying disease is taking their

lives, accompanied by uncontrollable pain. This is the isolated case in which I am arguing that aid in dying should be allowed. These are rare cases, as demonstrated by the experience of jurisdictions with experience in administering aid-in-dying laws, where only a very small percentage of deaths occur as a result of aid in dying (in 2019, 0.15% in California, 2% in Canada, for example). Therefore, although family members, physicians, and rabbis should not suggest aid in dying, let alone encourage it, they should not object to it either if the patient perseveres with the request. They should rather show understanding for such a decision by the person enduring such suffering. In these rare cases, we should recognize that Jewish law bans aid in dying but not rule according to it (הלכה ואין מורין כן) or recognize that Jewish law bans aid in dying but not interfere with it in these cases (לא מיהו בידם חכמים).

5. A person who chooses aid in dying under the circumstances detailed in (3) above may be buried in a Jewish cemetery without prejudice because they are not committing suicide in the usual sense; in fact, most people in this condition have fought to stay alive for a long time and often with considerable discomfort. It is their underlying disease or condition that is the ultimate, even if not the proximate, cause of their death.
6. This responsum allows patients to request drugs to bring about their death when they suffer from uncontrollable pain and can administer the drugs themselves; it also permits physicians to provide the drugs needed for this purpose. It does not authorize physicians to administer the drugs themselves. Nevertheless, after the fact, if physicians have done so, rabbis and others should stand aside without judgment. Rabbis and others should provide support and comfort for patients and their families facing this condition, no matter how the patient dies.
7. This responsum declares that as we are interpreting Jewish law, physicians and hospitals in civil jurisdictions that allow aid in dying may provide it under the conditions described above in accordance with Jewish law as well. At the same time, they are under no obligation in Jewish law to provide aid in dying, even to patients in uncontrollable pain. Out of compassion for such patients and/or recognition that people have differing moral evaluations of aid dying in such cases, however, those doctors who refuse to provide aid in dying should refer the care of such patients to other physicians who will provide aid in dying, either directly or by transferring the case to another physician who will evaluate the case and make the referral to a third physician to provide the necessary medications to bring about death.
8. All of these provisions apply only in those civil jurisdictions that permit aid in dying.⁶⁴

⁶⁴ Without asserting their agreement with what I have written here or with my conclusions, I would like to thank the following for their help in my thinking about the issues addressed in this responsum: Tanya Dorff, M.D., oncologist at City of Hope Medical Center; Neil Wenger, M.D., Chair of the Ethics Committee at UCLA Medical Center; Professor Neil Netanel of UCLA School of Law; Arielle Friedtanzer, M.A. and M.S.W.; Rabbi Stuart Kelman; and the members of the Ethics Subcommittee of the Committee on Jewish Law and Standards, namely, Rabbi Avram Israel Reisner, Chair, Dr. Toby Schonfeld, Mr. Ed Rudofsky, and Rabbis Pamela Barmash, Baruch Frydman-Kohl, Daniel Nevins, Micah Peltz, David Schuck, and Ellen-Wolintz-Fields. I would especially like to thank Dr. Toby

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