

“Who Shall Live ...”

A Report from the CCAR Task Force on Assisted Suicide

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There are some studies of Jewish law whose modern applications are more theoretical than practical. But in the field of Jewish bioethics—particularly those dealing with issues at the beginning or end of life—these discussions have applications that are real and are usually applied when people are at their most vulnerable. Societal norms are often inadequate and insufficiently articulate. As Jews, we look to our tradition to offer guidance at these moments of intense decision-making. As rabbis, we are often called upon to give direction. The answer to the question “What do Jews believe about ...?” is rarely a simple one, especially when people are in pain, both physical and emotional. We balance our pastoral duties and compassion with our knowledge and discretion. As members of a rabbinic body, we also have the obligation to influence civil legislation that can potentially weaken the fabric of our society by devaluing our tradition’s deeply held reverence for life. The purpose of this task force is to craft language and a position for the body’s approval on the controversial subject of physician-assisted suicide.

1. There Is Nothing New...

Although the terminology “physician-assisted suicide” is relatively new,¹ the controversy surrounding the role of the physician at the end of life is not. Some have argued that a phrase in the Hippocratic Oath was inserted as a political statement by those who opposed euthanasia, indicating a rift that was supposedly settled in the fifth century B.C.E.² The phrase is instructive: “Never will I give a deadly drug, not even if I am asked for one, nor will I give any advice tending in that direction.”³ This phrase points to two arenas that are under the physician’s purview: (1) the active role of the doctor in directly prescribing medications to assist the dying, and (2) the more

passive role of providing information or advice to enable a patient to end his or her life prematurely.

To understand the issues surrounding assisted suicide, we must also address euthanasia, although they are different in practice. Euthanasia has been continuously discussed both from a societal-needs perspective and within the context of human suffering. The Church, for example, has regularly and vigorously opposed euthanasia as simple murder, articulated from the writings of Augustine in the fourth century to Aquinas in the thirteenth.⁴ Even in the twentieth century, as the discussion of euthanasia assumed political meaning, in 1940 the Roman Holy Office condemned all direct euthanasia as a breach of the "natural and divine positive law."⁵ Suffering as a virtue to be endured, which at least in part underlies the Christian position, is not generally articulated in Jewish writings. But the halakhic prohibitions against suicide are clear,⁶ as is the commandment to break the Shabbat laws even for the *possibility* of saving a life. The classic case is of the victim buried under a collapsed building for whom every effort is to be made on Shabbat, even if the victim can not survive for long.⁷ Less well known is the perspective that life in pain is preferable to no life at all, evidenced by the horrific experience of the *soṭah* made to drink the "bitter waters."⁸ The Gemara and Rambam indicate that the victim did not always die immediately, but if she "possessed other merit," although still guilty of the crime of adultery, the waters would produce a debilitating condition that was only eventually fatal. Although accompanied by lingering pain and suffering, this circumstance was seen as preferable to death.⁹

2. What Is New

Although these religious and cultural perspectives on Euthanasia have been around for a long time, the specific circumstance that has pushed this agenda to the fore centers around modern medical technology and issues of autonomy.

Medical technology has made great strides in modern times. Even those diseases still seen as "incurable" are very often "manageable." Death itself, while never overcome, is forestalled. This is not so much a new development as an evolving one. A poignant expression of this state of affairs was written by an anonymous woman in an article in the *Atlantic Monthly* in 1957:

There is a new way of dying today. It is the slow passage via modern medicine. If you are very ill modern medicine can save you. If you are going to die it can prevent you from so doing for a very long time.¹⁰

This article, detailing the suffering endured by her husband, which she felt was needlessly prolonged by doctors dedicated to maintaining life at all costs, resonated throughout the medical profession and the public during the late 1950s and 1960s. The phrase “death with dignity” was articulated here and has become something of a rallying cry. A movement took hold in the 1970s through the publication of books such as Paul Ramsey’s *The Patient as a Person*, a hugely popular work in which he held that “the patient has entered a covenant with the physician for his complete *care*, not for continuing useless efforts to *cure*.” Elisabeth Kubler-Ross’ highly influential *On Death and Dying* gave a name to an emerging movement that stressed better communication, sensitivity, and palliative care for the dying. The Karen Ann Quinlin case (1976) extended the “right of refusal” idea to patients in comas. A less well-known case, Claire C. Conroy (1985), dealt with such rights for a patient who was mentally and physically impaired but neither brain dead nor in a chronic vegetative state, and not even terminally ill. Her proxies advocated for the removal of artificial feeding tubes. Case law now upholds the right of refusal by both competent and mentally impaired patients. The reasoning is that “their rights of free choice, self-determination, and privacy outweigh medicine’s and the state’s interests in prolonging life, preventing suicide or manslaughter, and protecting the goals and practices of modern medicine.”¹¹

The “death and dying” movement began to take on new meaning in the 1990s with the introduction of “assisted suicide.” The discussion began earlier with the publication in 1978 of *Jean’s Way*, “the true story of one woman’s plans to end her own life toward the end of a terminal [bone cancer] illness.” The article was written by Jean’s husband, then *Los Angeles Times* reporter Derek Humphry. Humphry went on to write *Let Me Die before I Wake*, a regularly revised book that included personal narratives of persons with advanced illnesses who carried out “rational suicides” with the aid of friends and physicians. In the 1980s Humphry and his new wife founded the Hemlock Society, which championed “self-deliverance through dying.” His 1991 self-help book *Final Exit* remains a best-seller. The

movement's most visible advocate, of course, was Dr. Jack Kevorkian, whose highly publicized assistance in Janet Adkin's death in 1990 began a career that eventually led to his imprisonment following the televised death of Thomas Youk, a 52-year-old ALS sufferer. Dr. Timothy E. Quill's moving personal account of a physician providing life-ending medication to his patient was printed in the pages of the prestigious *New England Journal of Medicine* in 1991. Dr. Quill and others have maintained that this has been a long-standing but quiet practice among physicians.

These popular movements led to legislative actions. Washington state and California both sought to decriminalize euthanasia and physician-assisted suicide under the rubric "Aid in Dying." Both initiatives failed. But in 1994, Oregon passed the "Death with Dignity Act," a citizen-led initiative that advanced the right of adults "to request and obtain prescriptions from doctors to end their life." A second referendum was passed in 1997 and the law cleared all court appeals. The federal government immediately issued a ban from the Drug Enforcement Administration (DEA) that was overturned in 1998 by Attorney-General Janet Reno. In 2001 Attorney-General John Ashcroft sought to overturn this ruling but was overruled by the courts. The U.S. Supreme Court had earlier ruled that states could permit doctors to assist in the suicide of terminally ill patients. In 1999, Representative Henry Hyde introduced legislation to the House to "amend the Controlled Substances Act to promote pain management and palliative care without permitting assisted suicide and euthanasia, and for other purposes."¹² This legislation is still pending.

The Oregon legislation gained national attention and debate. Some of the more striking predictions, i.e., that large numbers of people would flock to Oregon to take advantage of this law, have not come true. During 2002, physicians in Oregon gave fatal prescriptions to about 75 terminally ill patients; 38 of the recipients used them to commit suicide. The total number of physician-assisted suicide cases in Oregon since the *Death with Dignity* law came into effect in 1997 is 129.¹³

The experience in Holland, where the practice of euthanasia and physician-assisted suicide is firmly established, is more striking. A government study estimated that during 1995 alone there were 3,200 cases of euthanasia performed and 400 cases of assisted suicide, out of a population of some 15 million. An analysis of both

categories shows that 22.5 percent of those deaths involved patients who did not give their explicit consent to be killed.¹⁴ Examples of abuse and failure to appropriately report these deaths abound. Further, the fear remains that the law will lead to more involuntary deaths. A 1996 survey of Dutch psychiatrists found 64 percent of those responding “thought physician-assisted suicide for psychiatric patients could be acceptable.”¹⁵

In the United States popular opinion continues to support the practice both inside and outside the state of Oregon. In January 2002, a Harris poll found “2–1 support for both euthanasia and doctor-assisted suicide.”¹⁶

3. The Issue

Physician-assisted suicide is distinct from euthanasia in both motivation and practice. The goal of the latter is often societal, whereas the former is advocated as a means to express the will of the patient. In addition, the physician is generally active in practicing euthanasia—the lethal medication is administered directly. The practice of physician-assisted suicide, as legalized in Oregon and Holland,¹⁷ has the doctor prescribe lethal medication that the patient then self-administers. The same practice, it should be noted, allowed Dr. Jack Kevorkian’s “patients” to activate the machinery that would cause their death. It should also be noted that many other topics such as terminal sedation, withholding or withdrawal of life-sustaining treatments, and pain medication that hastens death are adjunct issues. We will focus here on the specific issue of physician-assisted suicide. The ethical arguments will thus relate not only to suicide in the face of real or potential pain and suffering, but to the role of the physician in hastening death.

One paper has laid out the arguments for and against physician-assisted suicide (PAS) in the following manner:¹⁸

Arguments in favor of PAS

1. **Respect for autonomy:** Decisions about time and circumstances of death are very personal. Competent person should have right to choose death.

Arguments against PAS

1. **Sanctity of life:** This argument points out strong religious and secular traditions against taking human life. It is argued that assisted suicide is morally wrong because it contradicts these beliefs.

2. **Justice:** Justice requires that we "treat like cases alike." Competent, terminally ill patients are allowed to hasten death by treatment refusal. For some patients, treatment refusal will not suffice to hasten death; the only option is suicide. Justice requires that we should allow assisted death for these patients.
3. **Compassion:** Suffering means more than pain; there are other physical and psychological burdens. It is not always possible to relieve suffering. Thus PAS may be a compassionate response to unbearable suffering.
4. **Individual liberty vs. state interest:** Though society has a strong interest in preserving life, that interest lessens when a person is terminally ill and has a strong desire to end life. A complete prohibition on assisted death excessively limits personal liberty. Therefore PAS should be allowed in certain cases.
5. **Openness of discussion:** Some would argue that assisted death already occurs, albeit in secret. For example, morphine drips ostensibly used for pain relief may be a covert form of assisted death or euthanasia. That PAS is illegal prevents open discussion in which patients and physicians could engage. Legalization of PAS would promote open discussion.
2. **Passive vs. Active distinction:** The argument here holds that there is an important difference between passively "letting die" and actively "killing." It is argued that treatment refusal or withholding treatment equates to letting die (passive) and is justifiable, whereas PAS equates to killing (active) and is not justifiable.
3. **Potential for abuse:** Here the argument is that certain groups of people, lacking access to care and support, may be pushed into assisted death. Furthermore, assisted death may become a cost-containment strategy. Burdened family members and health care providers may encourage the option of assisted death. To protect against these abuses, it is argued, PAS should remain illegal.
4. **Professional integrity:** Here opponents point to the historical ethical traditions of medicine, strongly opposed to taking life. For instance, the Hippocratic oath states, "I will not administer poison to anyone where asked," and "Be of benefit, or at least do no harm." Furthermore, major professional groups (AMA, AGS) oppose assisted death. The overall concern is that linking PAS to the practice of medicine could harm the public's image of the profession.
5. **Fallibility of the profession:** The concern raised here is that physicians will make mistakes. For instance, there may be uncertainty in diagnosis and prognosis. There may be errors in diagnosis and treatment of depression, or inadequate treatment of pain. Thus the State has an obligation to protect lives from these inevitable mistakes.

4. Traditional Jewish Perspectives

Numerous articles have appeared in recent years on the Jewish response to physician-assisted suicide. While many have expressed human sympathy for the pain and suffering, and express the Jewish quality of mercy,¹⁹ those writing from the perspective of *halakhah* have shown remarkable unanimity in opposing the practice.²⁰ Immanuel Jakobovits, whose work *Jewish Medical Ethics* helped define the field, is typical in his condemnation: "It is clear, then, that, even when the patient is already known to be on his deathbed and close to the end, any form of *active euthanasia* is strictly prohibited."²¹ These authors generally note that there are aggadic references to suicide, i.e., Saul falling on his sword rather than facing a degrading death at the hands of his enemy,²² and even examples of those who took an active role in the death of one in pain, i.e., Rav Yehuda HaNasi's handmaiden who prayed for his death and dropped a pitcher to stop the prayers of those who prayed for his life.²³ Nonetheless, these authors have almost universally insisted that these stories, while demonstrating a sensitivity to pain and suffering, are misinterpreted as being permissive of active euthanasia and do not stand up to the long-held antipathy of Jewish law to suicide and murder.²⁴ Often mentioned as well is the moving story of Rabbi Ḥaninah ben Teradyon, who, upon his painful, fiery execution by the Romans, refused suicide, but eventually allowed the impediments to his death, water-soaked sponges on his chest placed there to lengthen the torture, to be removed. Although this story shows an act of mercy, the authors generally place it in the category of removing impediments to death and not as advocating euthanasia. Most often quoted is Ḥaninah's answer to his disciples who begged him to inhale the flames so that he might perish: "Let Him who gave me [my soul] take it away, but no one should injure oneself."²⁵ Corollary discussions, such as the right to refuse treatment or the right to have life-sustaining medications and machinery removed, have been argued in some detail, and on these subjects there are divergent opinions. But the active introduction of death-inducing medications to relieve pain and suffering, prescribed by physicians or induced by physicians, has few, if any, advocates in these writings. The arguments generally break down as follows:

1. Jewish law, unlike American civil law, prohibits suicide. The theological background to this *halakhah* contends that life is a gift from God and that to destroy it is to reject God. In fact, it is

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pointed out, the traditional perspective is that God owns our bodies, not us. Thus we are enjoined to take care of ourselves and to keep ourselves from harm.²⁶

2. Jewish law prohibits murder. We cannot kill another person, even to save our own lives,²⁷ even if the person is terminally ill.²⁸ A great deal of discussion is found in the literature about the special case of the *goses* (one who will be dead in 72 hours) and the *treifah* (one who is internally terminally defective). While there is wide-ranging opinion on the permissibility of withholding treatment or even withdrawing life-support, it is generally assumed that one may not actively euthanise even in these extreme cases.
3. Jewish law prohibits giving improper advice or enabling someone to violate Jewish law. This prohibition, referred to as *lifnei iver*, stems from the interpretation of Leviticus 19:14 “...put not a stumbling block before the blind.” This has been applied to the physician who prescribes medication that will induce death, even if he does not administer the medication directly.²⁹

Several *responsa* have been published on this subject as well. Over a century ago Rav Yaakov Zvi Mecklenburg interpreted the biblical verse “even at the hand of every man’s brother, will I require the life of man” (Gen 9:5) as “regarding the killing of a willing victim, performed with his good in mind, where even a person of elevated stature and a true friend of the victim might believe that he actually performs a mitzvah by killing him and relieving him of his pain.”³⁰ Even with such noble motives, he writes, the killer is guilty of murder. Rabbi Moshe Feinstein argues that the story of Rav’s maid-servant showed that one may pray for the death of someone in pain, and he goes even further by permitting the rejection of life-sustaining treatment for terminally ill patients who can live no longer than a few weeks and who are in excruciating pain. However, he reiterates that no affirmative action is permitted to terminate the patient’s life.³¹ Rabbi Aaron Soloveichik in a 1996 letter wrote against even this permissive reading: “It is my unmitigated, convinced opinion that a doctor must do his utmost to treat terminally ill patients. This is true whether doctors believe that the patient can survive for even an extremely brief period of time, or even if they believe that the patient is brain dead.”³² It would, of course, follow that active euthanasia would be out of the question.

In March 1997 the Conservative movement's Committee on Jewish Law and Standards adopted the responsum of Rabbi Elliot Dorff on assisted suicide.³³ Although Rabbi Dorff takes a liberal position on the permissibility of withdrawing all life-support mechanisms, including artificially induced food and hydration,³⁴ he is clear in the conclusion that: "A Jew may not commit suicide, ask others to help in committing suicide, or assist in the suicide of someone else." But he goes beyond simply forbidding certain actions, adding a dimension of life-affirming positive actions. The responsum and the accompanying statement from the Committee stress two additional points to help obviate the desire on the part of patients to end their lives: (1) the responsibility of physicians to provide sufficient pain medication "as mandated in Jewish law" and (2) the mitzvah of *biququr ḥolim*. This latter point is rarely mentioned in other literature on the topic and bears noting.

Requests for assistance in suicide are often an expression of the patient's extreme suffering, despair, psychiatric depression, and loneliness. The Jewish tradition bids us to express our compassion in ways that effectively respond to the patient's suffering while adhering to our mandate to respect the divine trust of life. Among such options is final care at home, with the help of palliative ministrations, including hospice care, to provide the social and emotional support severely sick people need. The approach of death can provide an opportunity for the patient, family, and friends to have meaningful closure and final reconciliation.³⁵

5. Reform Perspectives

Although discussions have ranged widely, as for example the articles collected in the Spring 1997 edition of the *CCAR Journal*, officially the Reform movement and the CCAR have consistently taken a stand against euthanasia and physician-assisted suicide. In 1948, at the convention in Kansas City, Missouri, the Conference adopted a resolution setting in place a special committee to "study this important question [of Euthanasia] in the light of Jewish teaching and to bring in a report at the next meeting." The report, authored by Rabbi Israel Bettan, notes the halakhic prohibition, and then goes on to state:

Of course, we liberal rabbis have always claimed the right, in the interest of a progressive faith, to modify Rabbinic law and to

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remove what we regard as an obstacle in the advance of the spirit. And, indeed, we have eliminated many an old restriction that, though meant to safeguard Judaism, proved to obscure its essential nature. But we have never sought to nullify an effective Rabbinic implementation of a vital spiritual principle.

The Jewish ideal of the sanctity of human life and the supreme value of the individual soul would suffer incalculable harm if, contrary to the moral law, men were at liberty to determine the conditions under which they might put an end to their own lives and the lives of other men.³⁶

A spirited floor debate followed in which a variety of opinions were expressed and recorded. The Conference did not vote to endorse the report but received it and referred it to the Executive Committee, which gave it the effect not of a resolution of the Conference but of a standing report of the Responsa Committee.³⁷

Rabbi Solomon B. Freehof, in a 1975 responsum,³⁸ notes that while even requesting suicide is forbidden by Jewish law, "if in his agony he does so, it is pardonable." Freehof is applying here the distinction between *l'hatehila*, an action done to begin with, and *b'diavad*, an action that has already occurred. Nonetheless, the action he is referring to is the *request* for death. The administration of a "lethal medicine, the direct effect of which would be to put an end to the patient's life, the use of such medicine would be absolutely forbidden."³⁹ This position is confirmed in later Reform responsa from 1980, 1985, and 1990.⁴⁰

The most cogent and exhaustive Reform responsum on the subject is the 1994 "On the Treatment of the Terminally Ill."⁴¹ Although assisted suicide is not the primary subject of the *sh'elah*, the authors examine the question at some length. In an excursus, the authors categorically reject the readings of the deaths of King Saul, R. Haninah ben Teradyon, and R. Yehudah HaNasi, mentioned earlier, as proof of a permissive stance toward mercy killing. While acknowledging that such readings are "plausible," they maintain:

we find that the very *tradition* of learning which created these passages and which has studied them for fifteen centuries and more as sources of moral meaning declares consistently and unequivocally *against* euthanasia. Indeed, the message which emerges from traditional halakhic thought on this subject is quite clear and uniform: we do almost anything to relieve the suffering

of the terminally-ill, but we do not kill them and we do not help them kill themselves.

The responsum goes on to reject the idea that “the existence of pain and suffering constitutes a sufficient Jewish justification for killing a human being in the name of compassion.” Similarly the “quality of life” argument is found to be unhelpful because it is too subjective. Any person, for whatever reason, may judge his life not worth living. Not only the terminally or chronically ill, but those suffering from psychological or emotional distress may equally deem themselves devoid of “quality of life.” Indeed, the reasoning continues, the subjectivity inherent in a competent person saying “I do not want to live like this” leads to the application of such a principle to those who cannot make such a judgment for themselves: the psychotic, the senile, the defective newborn, for whom we might confidently say “no one should have to live like this.” Thus, they conclude, “the move from voluntary to involuntary euthanasia is a natural one.” The responsum goes on:

Our duty to the sick is to heal them or, when this is no longer possible, to care for them; it is not to kill them. The sick, the terminally-ill, have a right to expect compassion from us, for such flows from the respect we ought to display to ourselves and to others as children of God. But they are not entitled to ask that we take their lives, and should they make that request, we are not entitled to grant it. For when we define “compassion” so as to include the killing of human beings, we have transgressed the most elemental of Jewish moral standards and the most basic teachings of Jewish tradition as we understand it. We believe that compassion toward the dying is a moral responsibility. But we also believe that this responsibility can and must be discharged without resort to assisted suicide and active euthanasia.

6. The Work of This Committee

In December of 1996, Neil Kominsky, the first chair of the CCAR Task Force on Physician-Assisted Suicide, wrote a letter to the committee members in which he outlined his view of the committee’s goals. These were to “explore the thorny issue of physician-assisted suicide, taking into account issues of *halakhah*, contemporary ethics, and the current situation as it is developing in our society, and, if possible, to bring to the full CCAR a proposed state-

ment." Simultaneously, the UAHC Committee on Bioethics, chaired by Dr. Harvey Gordon, in cooperation with the Commission on Social Action, was developing a pamphlet on the subject. Rabbi Richard Address staffed this group and served as well on the CCAR Task Force. The UAHC pamphlet "When it Hurts Too Much to Live—Questions and Answers about the Jewish Tradition and the Issues of Assisted Death" was published in the Fall of 1997 following the CCAR Task Force's review and approval.⁴² Similarly, as noted above, the Spring 1997 edition of the *CCAR Journal* was devoted to a symposium on physician-assisted suicide and included an article from the chair of the task force. Meetings of the task force were held in Miami and the UAHC Biennial in Dallas. These meetings were sparsely attended. In February of 1998, Neil Kominisky resigned as chair of the task force and the author accepted the position.

The task force, in its creation, was organized in a non-standard fashion. Rather than appointing a seven-member panel, the CCAR placed a notice in the *CCAR Newsletter* soliciting interest. All who responded were appointed to the task force. Because of the enlarged size of the group, there were not opportunities to meet outside of the convention structure. Members of the committee were diverse in their experience and outlook. Many were drawn from the ranks of health-care chaplains who could bring both a theoretical and practical consideration to the task.

In 1998, a meeting was held in Anaheim that was open to the convention and that attracted a diverse showing. Many divergent voices were heard. In 1999 the committee met several times at the Pittsburgh convention and began to finalize the text for a resolution. Rabbi Daniel Schiff was the original author of the text and he agreed to modify it as requested. Revisions were solicited by mail and e-mail over the year and incorporated into a final text. Major contributions were made by Rabbis Terry Bard and Irwin Zeplovitz. A smaller group met in Monterey in 2001. Discussions ensued about the need for greater education for physicians on the availability of appropriate palliative care. Particularly vocal on the issues of palliative care and potential abuse were Rabbis Stephan Roberts and Louis Feldman, both chaplains. New language was incorporated into the document and the text was approved. This was confirmed to all committee members not present.

The CCAR Convention of 2002 was held in Jerusalem. As no resolutions were presented at that convention, the task force's document

was held. In 2003, the resolution was submitted to the CCAR Board for discussion. The Board was unable to review the text and a recommendation was given to present the resolution at the 2004 convention in Toronto.

The resolution, as proposed, endorses the work of the Responsa Committees as reflected in a series of published works. It rejects suicide as an appropriate response to pain and suffering, calling instead for increased education on, and application of, and research into, the use of pain management techniques. It calls on governmental bodies to reject legislation endorsing physician-assisted suicide and endorses palliative-care organizations such as Hospice. It finally calls on the membership of the CCAR to “continually refine their skills in order to provide the best and most spiritually appropriate support during these times of life-transition.”

The task force was swayed by the following arguments:

1. The respect for life and the universal rejection in halakhic text of suicide as an appropriate response to pain and suffering;
2. The recognition that disabled people, including those disabled by pain, are full human beings and deserving of the full protections of life;
3. The concern that voluntary euthanasia could become involuntary, that a “right to die” could become a “duty to die,” especially as the costs of long-term health care increase. Those elements of society least well protected, i.e., the elderly, minorities and the poor, would have the least ability to counter the resulting pressure;
4. The recognition that palliative care exists to a greater and more effective extent than is generally used and is growing ever more sophisticated. The belief is that when pain and suffering is appropriately managed, the desire to end one’s life diminishes;
5. Organizations such as Hospice provide palliative care as well as aid to families of terminally ill patients. While often under-used, such organizations help the dying remain connected to family and community, again decreasing the desire for death as a release;
6. Physician-assisted suicide breaks down the very nature of the doctor-patient relationship.

It is the feeling of the group that these arguments outweighed subjective “quality of life” issues or even the argument of auton-

omy. Although compassion rules us, we believe that death is not the only response to suffering. At a certain point the role of the physician turns from curing to caring. Tremendous amounts for money and research have been devoted to the former. There is much more to do on the latter.

Some of the most important work we do as rabbis is as pastoral leaders. It is our hope that the body of Reform rabbis would offer to those we touch guidance on the role of God's presence that offers hope and values life.

Notes

1. Dating, perhaps, from the publication of Derek Humphry's how-to-end-your-life best-seller, *Final Exit* (1991). See Harold Y. Vanderpool, "Doctors and the Dying of Patients in American History," in Robert F. Weir, ed., *Physician Assisted Suicide* (Bloomington and Indianapolis: Indiana University Press, 1997), pp. 33–66. See below.
2. See, for example, Immanuel Jakobovits, *Jewish Medical Ethics* (New York: Bloch Publishing, 1959), p. 124 and Robert F. Weir in the preface to his book *Physician Assisted Suicide*, p. vii.
3. Some scholars see this as a reference not to euthanasia but to murder by poison. However, as Jakobovits points out, references to euthanasia exist in Plato, who argued that invalids ought not be kept alive. The third-century B.C.E. Alexandrian pioneer in anatomy, Erasistratos, is reported to have taken poison to end his suffering from cancer. His final words are recorded as "It is well that I should remember my country," which may well reflect a popular utilitarian sentiment. The pressures on those knowledgeable in the means of achieving a "good death" could not be ignored.
4. See, however, Darrell W. Amundsen "The Significance of Inaccurate History in Legal Considerations of Physician-Assisted Suicide," in Weir, pp. 3–32. Note in particular p. 26, in which he argues that these discussions are separate from the desire to commit suicide because of chronic illness or physical suffering. "So foundational are the goodness of God and his sovereignty in patristic theology and patient endurance of affliction so regularly and consistently stressed as an essential Christian virtue that it is not in the least surprising that *patristic texts are void of any reference to suicide by the ill.*"
5. Quoted in Jakobovits, p. 125.
6. TB. *Baba Kama* 91b and *Yad, Hilkhhot Rozeah* 2:2–3.
7. *Shulhan Arukh, Orakh Hayyim* 329:4; see J. David Bleich, "Treatment of the Terminally Ill," in *Bioethical Dilemmas, a Jewish Perspective* (Jersey City, N.J.: Ktav, 1998), p. 62.
8. Numbers 6:11–31.
9. TB. *Soṭah* 22a and *Hilkhhot Soṭah* 3:20. See Bleich, p. 63.

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10. Anonymous, "A Way of Dying," *Atlantic Monthly*, January 1957, pp. 53–55. Quoted in Vanderpool, p. 46.
11. *Ibid.*, p. 51.
12. H.R.2260—introduced 6/17/1999—Senate preparation for floor: 5/23/2000 under the short title: "Pain Relief Promotion Act of 2000." Status: Placed on Senate Legislative Calendar under General Orders. Calendar No. 566.
13. "New law paved way for 38 to commit suicide in Oregon," Quick Hits, *Toronto Star*, March 6, 2003.
14. P.J. van der Maas, G. van der Wal, I. Haverkate, C.L.M et al. (1996). "Euthanasia, physician-assisted suicide, and other medical practices involving the end of life in the Netherlands, 1990–1995," *New England Journal of Medicine* 335, pp. 1700–1.
15. H. Groenewoud, P.J. van der Maas, G. van der Wal, et al., "Physician-assisted death in psychiatric practice in the Netherlands," *New England Journal of Medicine* 336, p. 1796.
16. Harris poll, January 9, 2002. http://www.harrisinteractive.com/harris_poll/index.asp?PID=278.
17. See David Lilienthal, "Physician-Assisted Suicide—the Dutch Situation," in *CCAR Journal* (Spring 1997) for a fascinating account of the experience in the Netherlands.
18. Clarence H. Braddock III and Mark R. Tonelli, "Physician-Assisted Suicide," *Ethics in Medicine*, University of Washington School of Medicine, <http://eduserv.hscer.washington.edu/bioethics/topics/pas.html>.
19. See, for example, Samuel Klagsbrun "Physician-assisted Suicide," *Sh'ma*, September 20, 1996, and movingly, Leon W. Wells "Suicide during the Shoah," *Midstream* 43/3 (April 1997).
20. For a notable exception, see essays by Rabbis Leonard Kravitz and Peter Knobel in Walter Jacob and Moshe Zemer, eds., *Death and Euthanasia in Jewish Law* (Pittsburgh and Tel Aviv, 1995).
21. *Jewish Medical Ethics*, p. 123.
22. I Samuel 31:4.
23. TB, *Ketubot* 104a.
24. Discussed below.
25. *Avodah Zarah* 18a; see also *Shulḥan Arukh*, *Yoreh De'ah* 339:1.
26. So, for example, a person's testimony is not acceptable against himself in a capital case. Maimonides, *Mishneh Torah*, Laws of Wounding and Damaging 5:1, *Shulḥan Arukh*, *Hoshen Mishpat* 420:31.
27. Maimonides, *Mishneh Torah*, Foundations of the Torah 5:1.
28. Maimonides, *Mishneh Torah*, Laws of Murder, 2:7 "There is no difference between a person who kills either a healthy person or one who is ill and dying or even a *goses*. In all these cases, the murderer is put to death."

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29. See, for example, Elliot Dorff, *Matters of Life and Death, A Jewish Approach to Modern Medical Ethics* (JPS: Philadelphia and Jerusalem, 1998), p. 183.
30. *HaKsav V'HaKabbalah*, 9:4 s.v. *u-miyad*. Quoted in *Crosscurrents – A Journal of Torah and Current Affairs*, vol. 1, issue 2, and J. David Bleich, “Treatment of the Terminally Ill” in *Bioethical Dilemmas, A Jewish Perspective* (Jersey City, N.J.: Ktav, 1998), pp. 63–64.
31. *Iggerot Moshe*, *Yoreh De'ah* II:174(3).
32. Published in Bleich, “Treatment of the Terminally Ill.”
33. “Teshuvah on Assisted Suicide” printed in *Conservative Judaism* (Summer 1998).
34. As opposed to the dissenting opinion of Rabbi Avram Israel Reisner, *ibid.* See also Reisner, “A Halakhic Ethic of Care for the Terminally Ill,” *Conservative Judaism* 43:3 (Spring 1991).
35. “Statement on Assisted Suicide,” Committee on Jewish Law and Standards, March 12, 1997.
36. *American Reform Responsa* (New York: CCAR, 1983), p. 263.
37. “Hospital Patient beyond Recovery” 5750.5 *Teshuvot for the Nineties* (New York: CCAR).
38. “Relieving Pain of a Dying Patient” *American Reform Responsa*, pp. 83–85.
39. *Ibid.* Freehof does here permit the administration of pain medication that *might* have the effect of shortening the patient’s life, since the purpose is pain relief not death. Here he joins Dorff’s later responsum.
40. “Euthanasia,” *American Reform Responsa*, no. 79, pp. 271–74; “Quality of Life and Euthanasia,” *Contemporary American Reform Responsa*, no. 83, and “Hospital Patient beyond Recovery,” *Teshuvah for the Nineties*, no. 5750.5, pp. 365–69, respectively.
41. *Teshuvah for the Nineties* 5754.14, pp. 337–64.
42. A note of thanks to Rabbi Neil Kominsky and the task force is contained in the introduction, p. 2.

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