Court File No.:
CV-17-585553

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N :

SHALOM OUANOUNOU, BY HIS SUBSTITUTE DECISION-MAKER AND LITIGATION GUARDIAN, MAXIME OUANOUNOU

Applicant

- and -

HUMBER RIVER HOSPITAL, ALI GHAFOURI, GARRET PULLE, SANJAY MANOCHA, DR. DAVID GIDDONS, CORONER and OFFICE OF THE CHIEF CORONER

Respondents

APPLICATION RECORD
(returnable Wednesday, November 1, 2017)

October 31, 2017

SCHER LAW PROFESSIONAL CORPORATION
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175 Bloor Street East
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LSUC No.: 36906T

Lawyers for the Applicant

TO: **Humber River Hospital**
1235 Wilson Avenue
Toronto, ON M3M 0B2

AND TO **Ali Ghafouri**
Humber River Hospital
1235 Wilson Avenue
Toronto, ON M3M 0B2

AND TO **Garret Pulle**
Humber River Hospital
1235 Wilson Avenue
Toronto, ON M3M 0B2

AND TO **Sanjay Manocha**
Humber River Hospital
1235 Wilson Avenue
Toronto, ON M3M 0B2

AND TO **David Giddons**
Office of the Chief Coroner
25 Morton Shulman Avenue
Toronto, ON M3M 0B1

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Respondents

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Court File No.:
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ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

SHALOM OUANOUNOU, BY HIS SUBSTITUTE DECISION-MAKER AND LITIGATION GUARDIAN, MAXIME OUANOUNOU

Applicant

- and -

HUMBER RIVER HOSPITAL, ALI GHAFOURI, GARRET PULLE, SANJAY MANOCHA, DAVID GIDDONS, CORONER, REPRESENTATIVE OF THE OFFICE OF THE CHIEF CORONER

Respondents

NOTICE OF APPLICATION

TO THE RESPONDENTS:

A LEGAL PROCEEDING HAS BEEN COMMENCED by the applicant. The relief claimed by the applicant appears on the following page.

THIS APPLICATION will come on for a hearing on Wednesday, November 1, 2017 at 9:30 a.m. or soon after that time as the application can be heard, at 393 University Avenue, Toronto, Ontario.

IF YOU WISH TO OPPOSE THIS APPLICATION, to receive notice of any step in the application or to be served with any documents in the application, you or an Ontario lawyer acting for you must forthwith prepare a notice of appearance in Form 38A prescribed by the *Rules of Civil Procedure*, serve it on the applicant's lawyer or, where the applicant does not have a lawyer, serve it on the applicant, and file it, with proof of service, in this court office, and you or your lawyer must appear at the hearing.

IF YOU WISH TO PRESENT AFFIDAVIT OR OTHER DOCUMENTARY EVIDENCE TO THE COURT OR TO EXAMINE OR CROSS-EXAMINE WITNESSES ON THE APPLICATION, you or your lawyer must, in addition to serving your notice of appearance, serve a copy of the evidence on the applicant's lawyer or, where the applicant does not have a lawyer, serve it on the applicant, and file it, with proof of service, in the court office where the application is to be heard as soon as possible, but at least two days before the hearing.

IF YOU FAIL TO APPEAR AT THE HEARING, JUDGMENT MAY BE GIVEN IN YOUR ABSENCE AND WITHOUT FURTHER NOTICE TO YOU. IF YOU WISH TO OPPOSE THIS APPLICATION BUT ARE UNABLE TO PAY LEGAL FEES, LEGAL AID MAY BE AVAILABLE TO YOU BY CONTACTING A LOCAL LEGAL AID OFFICE.

Dated: October 31, 2017

Issued by: _____
(Local Registrar)

Address of court office: 393 University Avenue
Toronto, ON M5G 1E6

TO: **Humber River Hospital**
1235 Wilson Avenue
Toronto, ON M3M 0B2

AND
TO: **Ali Ghafouri**
Humber River Hospital
1235 Wilson Avenue
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AND
TO: **David Giddons**
Office of the Chief Coroner
25 Morton Shulman Avenue
Toronto, ON M3M 0B1

APPLICATION

1. **The Applicant makes application for:**

(a) an Order for an Interlocutory Injunction pursuant to Rule 40.02(2) of the *Rules of Civil Procedure* restraining the Respondents from withdrawing life support measures including mechanical ventilation, food and fluids, from Shalom Ouanounou, son of Maxime Ouanounou, who is a patient in the intensive care unit of Humber River Hospital, pending a determination on the main Application or until a decision is rendered by the Consent and Capacity Board pursuant to the *Health Care Consent Act*;

(b) an Order to rescind the death certificate of Shalom , improperly issued by the Respondent Coroner based on a medical determination of death wrongly made by the Respondents without consideration of or legal accommodation of Shalom's individual religious beliefs, and made in a manner contrary to Shalom's specific religious beliefs;

(c) an Order requiring the Respondents to facilitate the orderly transfer of Shalom either to another health care facility or to his home and providing for ongoing mechanical ventilation and life support measures to be maintained;

(d) an Order that Shalom is not dead because he is alive according to Jewish law;

(e) an Order that the *Consent and Capacity Board* shall have jurisdiction to adjudicate and determine all disputes arising from treatment of the Applicant and others who have been certified as brain dead but who challenge that determination and claim to be alive based

upon their own religious beliefs or related considerations, whether or not a death certificate has been issued.

(f) an Order that doctors shall be required to apply before the *Consent and Capacity Board* in respect of this or any such dispute of this nature per the Supreme Court of Canada's ruling in *Cuthbertson v. Rasouli*, 2013 SCC 53.

(g) an order to abridge service;

(h) Costs of this motion, if opposed; and

(i) Such further and other relief as this Honourable Court may deem just.

2. **The grounds for the application are:**

(a) Shalom is a 25 year old devout Orthodox Jew. He is a member of the Orthodox *Agudath Israel* congregation in Toronto and the Keter Torah Learning Centre under the spiritual leadership of Rabbi Eliyahu Zrihen, where Shalom has studied, taught and practiced his Jewish faith at the Centre for the past 10 years.

(b) On September 27, 2017, Shalom experienced an asthma attack at home. He was taken by ambulance to Humber River Hospital. He was intubated and placed on ventilator support with consent of his mother and the Applicant father, his substitute decision-maker.

(c) On September 30, 2017, Shalom was determined to meet the guidelines for death by neurological criteria (NDD)("brain death") by Doctor Ali Ghafouri and Doctor Garret Pulle, critical care physicians at the hospital.

(d) In coming to that determination, no consideration was given to Shalom's expressed religious beliefs which clearly reject determination of death by neurological criteria.

(e) Death was subsequently certified by the Respondent, David Giddons, Coroner at the request of the Respondents and a death certificate was issued.

(f) In coming to that determination, no consideration or accommodation was given for Shalom's religious beliefs which expressly reject determination of death by neurological criteria.

(g) Jewish law recognizes death as the cessation of breathing and heartbeat.

(h) Shalom's religious principles, values, beliefs and conception of death stem from his strict *Halachic* Jewish study and lifestyle.

(i) Based on Shalom's religious beliefs and traditional Jewish orthodoxy as practiced by Shalom, the removal of life support measures before death occurs under Jewish law, is tantamount to murder.

(j) The province of Ontario provides no statutory legal definition of death. This is distinct from the province of Manitoba and most states in the United States which do provide for a statutory definition of death.

(k) In the absence of a uniform or any statutory legal definition of death in Ontario, the Canadian secular definition of death is applied in Ontario as reflected in Canadian Guidelines with respect to the neurological determination of death. This secular definition of death based upon the irreversible cessation of consciousness and the capacity to breathe conflicts with the definition of death by Jewish law as the irreversible cessation of respiration and cardiac function.

(l) The Jewish law definition of death accords with Shalom's individual religious values and beliefs, and the teachings and determinations about death made by Shalom's spiritual advisor.

(m) Shalom's religious beliefs prohibit the determination of death by neurological criteria and require that any determination of death be done by cardio-respiratory failure, which has yet to occur. As such, Shalom is not dead by Jewish *Halachic law*, according to his specific religious beliefs.

(n) The conflict between the secular definition of death under the Canadian guidelines and the definition of death under Jewish law and as endorsed by Shalom's religious beliefs,

discriminates against Shalom as an Orthodox Jew on the basis of religion and creed and deprives him of life, liberty and security of the person, contrary to the terms of ss. 2(a), 7, and 15 of the *Charter of Rights and Freedoms* and section 1 of the *Human Rights Code.*

(o) Shalom seeks a legal accommodation to the definition of death, by way of a religious exemption that is respectful of his equality, religious beliefs and his right to human dignity and privacy in accord with his rights under sections 2(a), 7, and 15 of the *Charter of Rights and Freedoms* and section 1 of the *Human Rights Code.*

(p) Such a religious accommodation is included in the statutory definition of death in the states of New York and New Jersey. Not only does the religious exception provide comfort to families in sad and serious times, but the exception accords with Constitutional religious freedom, and privacy rights.

STRONG PRIMA FACIE CASE – SERIOUS ISSUE TO BE TRIED

(q) The absence of religious accommodation as part of the legal process and definition to determine and certify death in Ontario represents discrimination and a breach of religious freedom of Shalom and the Applicant on his behalf. Such issues are fundamental to the identity and very existence of Shalom as a human being and Orthodox Jew.

(r) Disregard of a person's religious beliefs at the time of sickness and death when they would most expect to take comfort from those beliefs represents a serious assault on human dignity, equality, and religious liberty which raises a fundamental and serious constitutional issue to be tried.

(s) The absence of any accommodation for religious beliefs as part of the definition and criteria for determining death casts a cloud over the constitutional validity of the requirements for determining death for Orthodox Jews such as Shalom in Ontario.

(t) The strength of the *prima facie* case in this matter is bolstered by the fact that such religious exemptions to the legal definition of death were either disregarded or ignored in constructing the practices for determining death in Ontario.

(u) The strength of the case is further bolstered by the fact that neighbouring jurisdictions sharing similar values, beliefs, and cultural norms in the states of New York and New Jersey provide for religious accommodation in the legal statutory definitions of death in those states, to allow for death by cardio-respiratory cessation in the case of Orthodox Jews, sharing similar beliefs and values as Shalom.

(v) The Plaintiff's claim raises a serious constitutional issue and is not frivolous or vexatious.

IRREPARABLE HARM

(w) Shalom would suffer the ultimate irreparable harm in the event that this Application is not granted. He would be declared dead in a manner contrary to his religious values and beliefs and would be deprived of accommodation of his most fundamental constitutional and human rights, when he is most dependent upon them.

BALANCE OF CONVENIENCE

(x) The balance of convenience favours granting the requested relief as the irreversible harm to the Applicant outweighs the relative cost and inconvenience to the Respondents in all of the circumstances.

(y) The Applicant does not seek an unlimited period of ICU hospitalization from the Respondents which further renders the balance of convenience in favour of the Applicant in this case. However, holidays over the past month have made it impossible for the Applicant to explore other options.

(z) The questions at issue are of profound and fundamental public concern to the Applicant and to a discrete and identifiable minority group that has been subject to prejudice, disadvantage, and discrimination throughout history.

(aa) Section 9 of the *Human Rights Code.*

(bb) Sections 2, 7 and 15 of the Charter of Rights and Freedom.

(cc) *Health Care Consent Act, 1996,* SO 1996, c 2, Sch A, s.37(1)

(dd) *Courts of Justice Act*, R.S.O. 1990, c.C-43, s.101;

(ee) *Rules of Civil Procedure*, R.R.O. 1990, Reg 194, Rules 1.05 and 40.01;

(ff) Disputes arising with respect to treatment, including the withdrawal of life support, are properly the subject of a Form G application brought by a doctor before the *Consent and Capacity Board* under the *Health Care Consent Act,* including in circumstances where a person has been declared brain dead but that determination is disputed, and including in circumstances where a death certificate has been issued.

(gg) Such further and other grounds as counsel may advise and this Honourable court may permit.

3. **The following documentary evidence will be used at the hearing of the application:**

(a) The following Affidavits:

a. the Affidavit of Maxime Ouanounou, sworn October 30 , 2017;

b. the Affidavit of Eliyahu Zhrien, sworn October 30,2017; and

c. the Afffidavit of Tomer Malca, sworn October 30, 2017.

(b) Such further and other material as counsel may advise and this Honourable Court may permit.

Date: October 31, 2017

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Court File No.: CV-17-585553

SHALOM OUANOUNOU, BY HIS SUBSTITUTE DECISION MAKER v. **HUMBER RIVER HOSPITAL ET AL**
Applicant Respondents

ONTARIO
SUPERIOR COURT OF JUSTICE

Proceedings commenced at Toronto

NOTICE OF APPLICATION

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Respondents

AFFIDAVIT OF MAXIME OUANOUNOU

AKA. MAX WARNER

I, Maxime Ouanounou, of the City of Toronto, make oath and say as follows:

Introduction

1. I am making this Application to maintain ongoing life support measures for my son Shalom. I am advised that his medical treatment team intends to withdraw life support on November 2, 2017. This action is contrary to the express wishes, values and religious beliefs of my son Shalom. Withdrawing Shalom's life support fails to make any accommodation for his religious beliefs.

2. I am the father of Shalom and have personal knowledge of these matters, except where I have indicated that my knowledge comes from other sources.

3. Shalom's mother is Rebecca Azulelos. We understand that because Shalom is not married and incapable to make his own treatment decisions, we together, are his substitute decision-makers ("SDMs") in accordance with the laws of the Province of Ontario.

4. Rebecca is not a party to this Application. However, I have discussed it with her. She fully supports this Application, has reviewed the draft materials and agrees it is necessary to ensure respect for our son's wishes and religious beliefs. Attached to my Affidavit as **Exhibit "1"** is her consent to this Application.

5. My lawyers have explained to me that the legal obligation of an SDM is to make treatment decisions for an incapable person according to his previously expressed capable wishes applicable to the circumstances. They have also explained that if an SDM is not aware of such wishes, that our obligation is to make decisions according to his "best interests," a primary factor of which is respect for his values and beliefs, including his religious beliefs.

Who is Shalom?

6. My son Shalom is a devout Orthodox Jew who lives his life in accordance with the Torah or Jewish Bible, as those Holy words have been explained by Talmudic scholars for centuries and interpreted by his Rabbi.

7. Throughout his life, Shalom has adhered to the tenets of Jewish Law. He has always strictly observed the Sabbath, the Jewish Holidays, the laws of Kashruth and the other commandments of the Torah. Shalom prays daily, as Jewish law requires. In the morning, except on certain Jewish Holidays when it is not required, Shalom puts on Tefillin as part of his morning prayers. At all times when awake, he wears a kippah, in keeping with the Jewish requirement that he cover his head out of respect for G-d. He also always wears an "undervest" with "tzitzes" [special fringes] tied at each corner, which have religious meaning and significance.

8. Shalom does not work on the Sabbath or on Jewish Holidays for which work is proscribed. His interpretation of Jewish law in this regard is in accord with that of Orthodox Judaism and his own Rabbi and therefore prohibits him from being in an automobile, turning lights on or off, and even writing or using a computer on the Sabbath and holidays.

9. Shalom's identity is defined by his strict adherence to his religious beliefs.

10. My personal knowledge of Shalom's values and beliefs is based not only upon the fact that he is my son, but upon my observation of him daily and upon his religious education.

11. Shalom spent two years at a Yeshiva in Israel, where he was taught the lessons of the Torah and had the opportunity to develop and define his Jewish faith, values and beliefs with teachers and other students at the Yeshiva.

12. Shalom's experience at the Yeshiva, along with his experience in our family, synagogue and as a member of our Toronto Orthodox Jewish community, have informed and defined his spiritual values and beliefs over time. They have contributed to his advanced understanding and appreciation of the lessons of the Torah and its role in his daily life.

13. Shalom lived with me until the start of his recent hospitalization. My personal knowledge of his values and beliefs is also based on our regular discussions about life, the Jewish faith and study of the nuances of Jewish laws and customs, both between ourselves and together with other members of our family, synagogue and Orthodox community.

14. I am also an observant Orthodox Jew. I instilled Jewish values in my son and am proud of his acceptance of them. I am aware of my legal obligation to make his treatment decisions based upon *his* wishes, values and beliefs and that is why I oppose

the withdrawal of life support as in these circumstances doing so would be contrary to his expressed wishes, values and deeply held religious beliefs.

15. My family immigrated to Canada from Morocco precisely so we could live in a multicultural community that respects and welcomes our Orthodox Jewish heritage, and enables us to practice Judaism in accordance with our Orthodox values and beliefs.

16. Shalom worked as an installer of doors and windows. At the same time he attended Seneca College, intending to study business management with plans to work in property management.

17. He is also a student of Judaic ethics, philosophy and law, both here in Toronto and as noted above at a Yeshiva in Jerusalem.

18. Shalom is a model son, conscientious, sensitive and committed to our family. He has one older and one younger sister and a younger brother. Our whole family is devoutly Orthodox. Shalom has a wide range of friends. He plays basketball in a house league and was developing an interest in baseball.

19. He has also served as a mentor to younger children in our Orthodox Jewish community. Shalom organized Jewish education programs in our community to teach Jewish philosophy, ethics and practices to help younger community members refine

their character and become active and contributing members to our Orthodox Jewish community.

20. When Shalom was 10 years old, we made a pilgrimage to the grave of Rabbi Nachman of Breslov. He is buried in Uman, Ukraine, which is about three hours south of Kiev. For the last two years, Shalom and I have made the same pilgrimage. The purpose of our pilgrimages on Rosh Hashonnah, one of the holiest days of the year, is to reaffirm our commitment to the study of and adherence to strict observance of the Jewish Code of Law as set out in the *Shulchan Aruch*, which is the comprehensive code of Jewish law.

Shalom's Medical Condition

21. Shalom's doctors advise me that they have concluded that he is "brain dead." Attached to this Affidavit as **Exhibit "2"** is the letter dated October 26, 2017 in which they formally did so, after prior statements to that same effect. Nonetheless, a ventilator assists his breathing and his heart and respiratory functions continue. Therefore, based upon the principles of Jewish Halachic law to which Shalom subscribes, he is alive and not dead.

22. These principles of Jewish Halachic law represent the principles, values and beliefs shared by Shalom, myself and our Rabbi. They reflect the teachings and lessons from the Torah that we received and practice as the foundation for our Jewish life and identity in Toronto. Shalom's express religious beliefs were made known to his doctors and hospital staff. Indeed, the hospital sought to accommodate him in terms of receiving kosher food and in other aspects of his religion.

23. Shalom has demonstrated throughout his life that he accepts the tenets of Jewish law as set out in the Torah, commented upon by Jewish scholars throughout the centuries and interpreted by our Rabbi.

24. These tenets include the principle that brain death is not death.

25. Shalom's values and beliefs do not accept "brain death" as the equivalent of death. Rather, his view is that he is alive for as long as his heart beats and he breathes.

26. Consequently, Shalom's belief is that discontinuing life support in these circumstances is murder and therefore contrary to his fundamental belief in the sanctity of human life, a belief that is the foundation of Judaism.

27. Shalom explained in our discussions that there are differing opinions among Jews and Jewish scholars regarding whether "brain death" is the same as "death." However, he made clear that his beliefs in this regard are that "brain death" is not the same as death, which he explained during prior discussions with me, occurs when breathing and heart function stop.

28. Shalom's beliefs are consistent with a large body of Jewish legal and medical opinion and with those of his spiritual advisor, Rabbi Zrihen.

29. I know all this because we have talked about this on several occasions over the years, including specific discussions about life, death and family, particularly when Shalom's grandfather became ill and came to live with us.

30. We cared for Shalom's grandfather throughout this time and provided comfort and support during his illness and the decline that ultimately resulted in his death.

31. Although Shalom's grandfather died at our home and he did not require ventilator support, we did discuss this prospect and what would be his grandfather's wishes in that event, and in the event that the ventilator would subsequently have to be removed.

32. This naturally provoked a discussion about Shalom's own wishes, values and beliefs and what he would want in similar circumstances.

33. Shalom was clear on that occasion as on others that his view of Halachic Jewish law prevented removal of a ventilator where doing so would hasten or cause death. He also believes that as long as the heart beats, a person is alive.

34. Shalom explained that this is based upon his learning of Halachic Jewish law at the Yeshiva, as well as from his review of multiple sources on this and other subjects of Jewish law, including Rabbi Nachman, Maimonides, and the Talmud. Shalom was also a regular student of Rabbi Zrihen, whom he viewed as his spiritual advisor and with whom he studied weekly in Toronto.

35. In the face of differing interpretations of Jewish law with regard to any topic, including the Jewish definition of "death," Shalom has a simple way of deciding what, for him, is the correct course of action: he asks his Rabbi and accepts the Rabbi's interpretation. This is his "rule of Law," consistent with our Jewish tradition.

Shalom's Previously Expressed Capable Wishes Applicable to His Current Circumstances

36. As noted in the preceding paragraphs, Shalom makes his personal decisions based upon Jewish law. Where there are differing opinions among Jewish scholars as to interpretation or application of Jewish law, or as to what an observant Jew should do in any circumstances, Shalom has a time-tested and time-honoured method of resolving them: he asks his Rabbi and accepts his Rabbi's interpretation of Jewish law as final and binding.

37. On Shalom's behalf, I have asked his Rabbi, Rabbi Zrihen, whether or not Shalom's mechanical ventilation can be discontinued. Rabbi Zrihen was definitive in his response. He told me that according to Jewish Law, Shalom is not dead and that to remove mechanical ventilation prior to cessation of all cardiac function is the equivalent of murder.

38. Shalom accepts such determinations as authoritative and binding rulings relative to his Jewish practices and beliefs.

39. Respect for Shalom's wishes, which are based upon his devout belief and faith in Orthodox Judaism therefore require that mechanical ventilation not be withdrawn prior to his cardiac death. Anything less than continuing Shalom's life support is a failure to accommodate his lifelong, firmly held religious beliefs.

40. Failure to allow for an accommodation of Shalom's religious beliefs as part of the Canadian guidelines on the determination of death and as part of the legal standard by which death is determined in Ontario would require that Shalom be transferred to either New York State, New Jersey, or Israel, or be brought home, in order to ensure that he is able to live and die according to his lifelong deeply held religious beliefs.

41. I attach as **Exhibit "3"** an article that addresses and supports the need for religious accommodation as part of the definition of death.

42. I attach as **Exhibit "4"** another article that addresses and supports the need for religious accommodation as part of the definition of death.

43. I am asking that Shalom's medical team and the hospital respect Shalom's profoundly held and expressed religious beliefs.

I swear this Affidavit in support of the Applicant's Application and for no other improper purpose.

Sworn before me at the City of Toronto, in the Province of Ontario, on the 30th day of October, 2017.

A Commissioner, etc.

NATALIA KROUKOVA, B.A., J.D.,
Barrister & Solicitor, Notary Public
519 Marlee Avenue
Toronto, Ontario M6B 3J3

MAXIME OUANOUNOU

Court File No.:

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MAXIME OUANOUNOU

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Solicitor for the Applicant

This is Exhibit "1" referred to in the Affidavit of Maxime Ouanounou sworn before me, this 30th day of October, 2017.

A Commissioner of taking Affidavits

NATALIA KROUKOVA, B.A., J.D.,
Barrister & Solicitor, Notary Public
519 Marlee Avenue
Toronto, Ontario M6B 3J3

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Respondents

CONSENT

I, Ms. Rebecca Azulelos, mother and Substitute Decision Maker of Shalom Ouanounou, have discussed and understand the issues being advanced in this Application with Mr. Maxime Ouanounou, Shalom's father and my former husband. I have reviewed the materials and affidavits being filed in support of this Application and I agree to the orders requested.

Rebecca Azulelos
Oct 29 2017

Date: October 29, 2017

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Solicitor for the Applicant

This is Exhibit "2" referred to in the Affidavit of Maxime Ouanounou sworn before me, this 30th day of October, 2017.

A Commissioner of taking Affidavits

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Barrister & Solicitor, Notary Public
519 Marlee Avenue
Toronto, Ontario M6B 3J3

HUMBER RIVER HOSPITAL

1235 Wilson Avenue
Toronto, Ontario
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416. 242.1000

October 26, 2017

Hand-delivered

Dear Rebecca Azulelos and Maxime Ouanounou

Re: Shalom Ouanounou

We are providing you with this letter as the representative of the family of Shalom Ouanounou, and trust that you will share it with the family. We again express our sympathies for you at this very difficult time.

Over the past weeks, there have been multiple discussions between you and members of the hospital staff regarding your son who was determined to meet the criteria for death by neurologic criteria on September 30, 2017 by Dr. Ali Ghafouri and Dr. Garret Pulle, critical care physicians. The Medical Certificate of Death was completed by the Coroner.

The determination of death was made based on a standard medically accepted Canadian guideline which is routinely applied to assess the function of the brain and to determine whether there has been a death by neurologic criteria. The findings of those tests were unequivocal and on the basis of the results, your son was determined to be dead. There is no medical evidence to the contrary. All appropriate treatments for your son's condition were exhausted prior to determining he had died and there is nothing available to restore him to life.

We understand from our discussions that you accept the assessments that have been conducted and that you recognize that Shalom Ouanounou has suffered death by neurologic criteria. However, you advised that you do not believe that a death by neurologic criteria is truly death, and it is your wish that mechanical ventilator support be continued. The medical team has followed standard accepted practice in declaring that your son has died. The team may lawfully, at any time, stop the mechanical ventilation. As your son has died, this intervention is no longer "treatment" and as such, it can be discontinued without the family's consent.

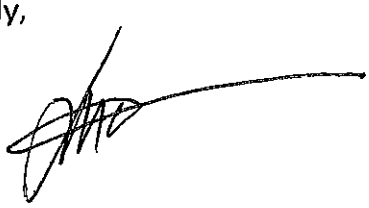
Please be advised that the mechanical ventilation will be removed on ~~October 30, 2017~~ November 2, 2017.

Out of compassion, the team would like to give the family a final opportunity to come to terms with Shalom's death, and we would like to work with you so that, if you wish, family members

can be at the bedside when the mechanical ventilation is turned off. You can also consider whether there is any other support or guidance you require in order to come to terms with this difficult situation. If you require supports that you think we can help with, please let us know and we will aim to facilitate that for you.

We are profoundly sorry for your loss. Please be in touch with us if you have questions, or if there is anything else we can do to support you through this difficult time.

Sincerely,



Sanjay Manocha, MD, FRCPC
Medical Director, Intensive Care Unit

This is Exhibit "3" referred to in the Affidavit of Maxime Ouanounou sworn before me, this 30th day of October , 2017.

A Commissioner of taking Affidavits

NATALIA KROUKOVA, B.A., J.D.,
Barrister & Solicitor, Notary Public
519 Marlee Avenue
Toronto, Ontario M6B 3J3

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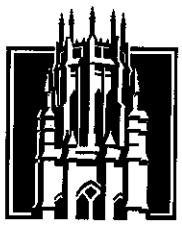

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DEFINING DEATH: WHY ALL FIFTY STATES SHOULD ADOPT THE UNIFORM DEFINITION OF DEATH ACT WITH A RELIGIOUS EXCEPTION

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(Student Paper – April 2010)

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Defining Death: Why All Fifty States Should Adopt the Uniform Definition of Death Act with a Religious Exception

Rachel Delaney*

Abstract

This article addresses the tension between the secular, American definition of death and the Jewish law definition of death. While the definition of death has been debated separately in both Jewish and American legal scholarship, the secular and Jewish law definitions of death have not been thoroughly analyzed in relation to one another. The secular definition of death—irreversible cessation of all functions of the entire brain—conflicts with the Jewish law definition of death—irreversible cessation of respiration. The conflict presents a First Amendment Free Exercise Clause challenge because state laws with strict secular definitions of death preclude Orthodox Jews from practicing Judaism in their final stages of life. This article argues that each state should adopt a definition of death statute that acknowledges the competing goals at issue in the legal definition of death—the recognition of the personal and private nature of death versus the accomplishment of secular and state objectives. New York State offers such a law by including a religious exception to the secular definition of death. Not only does the religious exception provide comfort to families in sad and serious times, but the exception is required by the First Amendment Free Exercise Clause and the right to privacy, and the exception does not significantly interfere with state interests.

Table of Contents

* Marquette University Law School J.D. candidate 2010. I am grateful for comments on earlier drafts from Professor Michael M. O'Hear and Professor Keith Sharfman.

I. Introduction

On March 1, 1994, a horrifying act of anti-Semitism left fifteen-year-old Aaron Halbertstam mortally wounded:

> [That morning], a blue 1978 Chevrolet Impala pulled next to a van as it began to cross the Brooklyn Bridge. The van was carrying fifteen students from the Lubavitch Hasidic Jewish sect returning from a prayer vigil in Manhattan. As the car neared the van, a lone gunman fired at least five rounds of bullets from two separate semiautomatic weapons into the side of the van while reportedly yelling, "Kill the Jews." Four students were injured, two critically.[1]

[1] Robert M. Veatch, *The Conscience Clause: How Much Individual Choice in Defining Death Can Our Society Tolerate?, in* THE DEFINITION OF DEATH 137, 137 (Stuart J. Youngner et al. eds, 1999).

Following the incident, Mr. Halberstam, who was inside the van, was rushed to a New York City hospital where he was declared brain dead, but at the request of his parents and rabbis he was placed on a ventilator for as long as his heart could potentially beat independently.[2] Generally, Mr. Halberstam's condition, "irreversible cessation of all functions of the entire brain,"[3] would fulfill the criteria for a legal determination of death in New York State. However, the Jewish law definition of death sought by Mr. Halberstam's family, "irreversible cessation of respiration,"[4] was substituted by way of the religious exception to the New York determination of death regulation.[5]

If not for the religious exception to the New York law, Mr. Halberstam would have been declared dead and removed from life support, an event that no doubt would have greatly troubled his family as it would have denied Mr. Halberstam the ability to die in accordance with his religious beliefs. This article will address the tension between the secular definition of death and the Jewish law definition of death that arises in situations like Mr. Halbertstam's. While the definition of death has been debated separately in both Jewish and American legal scholarship, the Jewish law and secular definitions of death have not been thoroughly analyzed in relation to one another. This article will argue that New York's definition of death law embodies fairness by acknowledging the competing goals at issue in the legal definition of death—the recognition of the personal and private nature of death that a religious exception would provide versus the accomplishment of secular and state objectives such as uniformity and accuracy. This article will demonstrate that because the New York law permits use of the Jewish law standard without undermining important secular and state objectives, every state should adopt a similar provision.

The balance of this article will proceed as follows. Part II will provide background on the significance of Jewish law and the Orthodox, Conservative, and Reform viewpoints on the Jewish law definition of death. Part III will

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[2] *Id.* at 137-38.

[3] 10 N.Y. A.D.C. 400.16(a)(2) (2009).

[4] Alan Mayor Sokobin, *Shaken Baby Syndrome: A Comparative Study: Anglo-American Law and Jewish Law – Legal, Moral, and Ethical Issues*, 29 U. TOL. L. REV. 513, 521 (1998).

[5] 10 N.Y. A.D.C. 400.16(e) (2009) ("Each hospital shall establish and implement a written policy regarding determinations of death in accordance with paragraph (a)(2) of this section. Such policy shall include . . . a procedure for the reasonable accommodation of the individual's religious or moral objection to the determination as expressed by the individual, or by the next of kin or other person closest to the individual.").

outline the American, secular definition of "brain death" promulgated in the Uniform Determination of Death Act (UDDA).[6] Part IV will compare the UDDA brain death standard to the Jewish law cardiac death standard and argue that because both standards accomplish similar societal goals a religious exception to the UDDA would not upset the purpose of the UDDA. Finally, Part V will explain that it is necessary, based on the Free Exercise Clause in the First Amendment[7] and the right to privacy,[8] that states adopt a UDDA approach modified as the New York law is to include an exception to brain death for those whose religious beliefs call for cardiac death. Such an exception will not burden secular justifications or state interests in the use of the brain death standard.

II. Jewish law and the Jewish law definition of death

A. The significance of Jewish law

Judaism is a religion comprised of its laws. Jewish law, or "halakhah", is not simply a legal code separate from the Jewish religion.[9] Rather, halakhah "has a religious connotation, [it is] a statement of faith, a commitment to one's Creator."[10] Jewish law is significant to Jews because the practice of halakhah stems from God's words in the Torah.[11] The word "halakhah" comes from the Hebrew root word "halokh," meaning "to walk," which indicates that halakhah is the path of life for Jewish people.[12] Jews believe that following halakhah gives humans a sense of purpose and fosters rational decision making.[13] Halakhah

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[6] UNIF. DETERMINATION OF DEATH ACT § 1 (1981) ("An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.").

[7] "Congress shall make no law respecting an establishment of religion, or prohibiting a free exercise thereof." U.S. CONST. amend. I.

[8] Tom Stacy, *Death, Privacy, and the Free Exercise of Religion*, 77 CORNELL L. REV. 490, 562-63 (1992) (noting that the free exercise of religion supports aspects of the right to privacy, such as the right to define the "terms upon which . . . death will be decided").

[9] MENDELL LEWITTES, PRINCIPLES AND DEVELOPMENT OF JEWISH LAW 3 (1987).

[10] *Id.*

[11] *Id.* at 4.

[12] *Id.* at 54.

[13] *Id.*

guides all aspects of Jewish life, including civil, criminal, and religious inquiries.[14]

In contrast to American law and secular culture, which revolves around ideals of liberty, privacy, and personal autonomy, Jewish law and culture centers largely on the idea of human duty and responsibility.[15] Halakhah is intertwined with the faith-based aspects of Judaism to the extent that the *Mishneh Torah* of Maimonides, one of the most comprehensive codes of Jewish law, begins not with Jewish legal obligations, but with the fundamental principles of Jewish faith and belief.[16] Other authoritative sources of halakhah are the main works used to guide Jewish practitioners in their observance of the Jewish religion: the Torah, the Talmud, and the "responsa".[17]

The fundamental duties of halakhah are codified in the Torah,[18] which is the written Jewish law.[19] The oral Jewish law is found in the Talmud, which is comprised of sixty-three tractates of interpretation and analysis crafted by rabbis and Jewish scholars beginning in the second century with Rabbi Judah the Prince through the *Shulchan Aruch* created by Rabbi Joseph Karo in the fifteenth century.[20] The Talmud is considered necessary for Jewish society to operate because it provides essential elaboration on the Torah.[21] Finally, rabbinic literature dating back to the sixth century, called "responsa," complement the Talmud.[22] The responsa consist of formal replies to legal questions addressed to

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[14] Michael A. Grodin, *Religious Exemptions: Brain Death and Jewish Law*, 36 J. CHURCH & STATE 357 (1994). Grodin expounds on the Conservative and Orthodox Jewish law definitions of death and concludes that future availability of the Orthodox Jewish law definition of death is uncertain due how advances in medical technology have shaped definition of death laws.

[15] Fred Rosner, *The Definition of Death in Jewish Law, in* THE DEFINITION OF DEATH 210, 214 (Stuart J. Youngner et al., 1999).

[16] LEWITTES, *supra* note 9, at 3.

[17] Rosner, *supra* note 15, at 212-23.

[18] The Torah is also called the Pentateuch or the Five Books of Moses.

[19] Rosner, *supra* note 15, at 212.

[20] *Id.* at 212-13.

[21] LEWITTES, *supra* note 9, at 50-51.

[22] Gideon Libson, *The Age of the Geonim, in* AN INTRODUCTION TO THE HISTORY AND SOURCES OF JEWISH LAW, 197, 197, 207 (N.S. Hecht et al., eds., 1996).

rabbinic scholars.[23] The responsa are considered Jewish case law and speak to social, political, and economic issues.[24]

In the sixth century, the responsa were collected in booklets by the Gaonim, or the presidents of rabbinical colleges in Babylonia, and disseminated in Jewish communities.[25] Over the centuries to come, responsa on Jewish law were composed by famous Jewish scholars and looked to as authoritative interpretations of halakhah.[26] Today, many collections of responsa have been republished and are still considered authoritative interpretations of Jewish law.[27] Responsa is still being written by modern experts in Jewish law in response to current questions of halakhah.[28]

A key aspect of responsa is debate.[29] There is no one central authority in halakhah, nor is there a universal answer to all questions of halakhah.[30] Instead, questions are answered through an intricate method of discussion and deliberation over Jewish legal resources.[31] Jewish law precedent—consisting of majority and minority opinions on legal questions—has developed through this method of question and debate.[32]

Today, the responsa are often split on how advances in modern technology affect Jewish obligations.[33] Splits in the responsa commonly occur between the different sects of Judaism: Orthodox, Conservative, and Reform. For instance, Orthodox Judaism follows a strict halakhic interpretation of the Jewish laws and

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[23] *Id.*

[24] *Id.*

[25] Libson, *supra* note 22, at 208.

[26] Rosner, *supra* note 15, at 212.

[27] Libson, *supra* note 22, at 208-09 (The most famous collection of responsa that currently exists was published by A. Harkavy in 1887 and it "preserves the original forms of some of the booklets.").

[28] ROBERT GORDIS, THE DYNAMICS OF JUDAISM: A STUDY IN JEWISH LAW 88 (1990).

[29] Grodin, *supra* note 14, at 362.

[30] *Id.*

[31] *Id.*

[32] *Id.*

[33] LEWITTES, *supra* note 9, at 207.

rejects modern ideas and ways of life other than modern economic opportunities.[34] Conservative Jews consider themselves bound by Jewish law but they allow for modern changes to the laws to be intertwined with the traditional interpretations.[35] Reform Jews do not consider themselves bound by Jewish law; instead of following halakhic interpretations set by rabbis, Reform Jews interpret the laws for themselves individually.[36]

In relation to how modern medicine impacts Jewish law, there has been a surge in responsa literature from all of the Jewish sects.[37] The question of the definition of death is one that has been answered with both Orthodox and Reform/Conservative voices.

B. The Jewish law definition of death

The Jewish law definition of death is divided into two schools—the traditional, or Orthodox, cardiac death standard and the more modern, or Conservative and Reform, brain death standard.

1. Cardiac death: The Orthodox viewpoint

The traditional, or Orthodox, view of death in Jewish law is that death occurs upon the departure of the soul from the body.[38] Since the instance of the soul departing from the body cannot be observed, death is said to coincide with the absence or cessation of breathing and heartbeat.[39]

The idea that life is held in the breath stems from a passage in Genesis: "The Lord God formed man from the dust of the earth. He blew into his nostrils the breath of life, and man became a living being."[40] The twelfth-century legal scholar and philosopher Moses Maimonides explained that "[i]f upon examination, no sign of breathing can be detected at the nose, the victim must be left where he is [until after the Sabbath] because he is already dead."[41] In

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[34] GORDIS, *supra* note 28, at 93.

[35] Grodin, *supra* note 14, at 366-67.

[36] *Id.*

[37] LEWITTES, supra note 9, at 213.

[38] Rosner, *supra* note 15, at 215.

[39] *Id.*

[40] *Genesis* (2:7).

[41] Moses Maimonides, *Mishnah Torah, Hilchot Shabbat* 2:19 (Simon Glaser trans., 1927).

addition to checking for signs of breath, Rashi, the renowned Talmudic commentator, added the criteria of listening for a heartbeat, as finding a heartbeat is a telltale sign of life.[42] Finally, in other commentary, Rabbi Moses Schreiber and Rabbi Sholom Mordechai Schwadron, respectively, stated that in addition to checking for breath and heartbeat, one must ensure there are no signs of life in the limbs, or that a person must be "motionless like an inanimate stone" to be considered dead.[43]

It is not surprising then, that when the statements in the responsa and other commentary are pooled, the resulting three-part Orthodox Jewish law test for death, which aligns with the idea of cardiac death, is: (1) absence of spontaneous respiration; (2) absence of heartbeat; and (3) absence of signs of life.[44] This standard is confirmed by Orthodox Jewish legal scholars who favor the cardiac death standard over the brain death standard.[45] Rabbi J. David Bleich, professor of Talmud at Yeshiva University, offers the position that Jewish law rejects brain

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[42] FRED ROSNER, MODERN MEDICINE AND JEWISH ETHICS 245 (1986) [hereinafter ROSNER, MODERN MEDICINE].

[43] *Id.* at 247.

[44] Sokobin, *supra* note 4, at 524.

[45] Orthodox Rabbis Shlomo Zalman Auerbach and Yosef Sholom Elyashiv offered the following perspective on brain death in response to a letter asking for guidance with respect to the removal of organs for transplantation from a brain dead patient:

> We have been requested to declare our views [according to Jewish law] with respect to the transplantation of a heart or other organs for the benefit of a sick person whose life is in danger, at a time when the heart of the donor is beating, and its entire brain, including the brain stem, is not functioning at all, which is known as "brain death": It is our view that it is absolutely not permissible to remove any of his organs; and to do so would involve the taking of a life.

Letter from Israel Rabbi Shlomo Zalman Auerbach and Rabbi Yosef Sholom Elyashiv, (Aug. 28, 1991), *in A Matter of Life and Death—Revisited*, JEWISH OBSERVER (1991), *cited in* Grodin, *supra* note 14, at 357 n.2. But see the position of Rabbi Moshe Tendler and Dr. Fred Rosner:

> [T]otal and irreversible cessation of brain (stem) function . . . is equivalent to total destruction of the brain and, hence, tantamount to functional or psychological decapitation [which in Judaism is equated with death].

ROSNER, MODERN MEDICINE, *supra* note 42, at 250-51.

death and irreversible comas as the end of life, and accepts only the total cessation of both cardiac and respiratory activity as death.[46] The late Rabbi Moshe Feinstein, a rabbinic authority on Orthodox Judaism, affirmed the cardiac death position, noting that signs of life are in the breath rather than the brain,[47] and that only total, irreversible cessation of independent respiration can establish death.[48]

2. Practical support for the cardiac definition of death in Jewish law

The Orthodox Jewish law definition of death finds practical support in two main rationales: (1) accuracy in death determinations, and (2) the extreme importance Judaism and Jewish law places upon upholding the value of life.

i. Accuracy

Jewish law strives for accuracy, defined here as validity in determining the point at which a person can no longer recover, in determining death. For instance, before the advent of medical technology, checking for the absence of breath was the most accurate method of ascertaining whether a person was dead. As explained by the Talmudic scholar Rashi, to thoroughly determine whether a person is dead, one must check for both a heartbeat and evidence of respiration.[49] Rashi considered respiration, however, to be a more accurate indication of life than a heartbeat because a heartbeat may be difficult to hear through the body's layers of tissue, fat, and ribs.[50] Thus, the absence of a heartbeat alone cannot be interpreted as a sign of death in Jewish law, as without other signs it is not a dependable indicator.[51]

The concern for accuracy in determining death under Jewish law goes beyond the requirement to check for breath. For example, it is not permitted to perform a caesarean section on a pregnant woman who is believed to be dead in

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[46] ROSNER, MODERN MEDICINE, *supra* note 42, at 249.

[47] *Id.* at 248.

[48] J. David Bleich, *Neurological Criteria of Death and Times of Death Statutes, in* JEWISH BIOETHICS 303, 304 (Fred Rosner & J. David Bleich, eds., 1987).

[49] *Id.* at 310.

[50] *Id.*

[51] *Id.*

an attempt to save her baby.[52] This is because people may not be able to determine with certainty whether the mother is dead; and thus, the caesarean could be the cause of the mother's death.[53] In addition, to preserve accuracy, Jewish law cautions against mistaking a person who has fainted for a person who has died.[54]

Finally, Jewish law implies that if the pronouncement of death is not accurate, grave consequences may result. For instance, Rabbi Feinstein recounts the case of a person found to be alive three days after he was interred inside a crypt.[55] Although the man went on to live a normal life and father many children, the message of the story is that the effect of a hasty determination of death can be serious.

ii. The value of life

In Judaism, human life is of infinite worth, and taking or shortening human life constitutes murder.[56] Jews believe in the "supreme sanctity of human life and of the dignity of man created in the image of God."[57] Moreover, the Bible emphasizes a continuing obligation to heal or save the life of an endangered person, predicated upon a verse from Leviticus that instructs "nor shall you stand idly by the blood of your fellow."[58] It is from this passage that the Jewish law duty for a physician to do everything within reason to save the patient arises.[59] Other examples of the extremely high value placed on human life in Jewish law include mandatory abortion or the use of contraception if pregnancy endangers a

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[52] J. David Bleich, *Establishing Criteria of Death, in* JEWISH BIOETHICS 277, 282 (Fred Rosner & J. David Bleich, eds., 1987) [hereinafter Bleich, *Establishing Criteria of Death*].

[53] *Id.*

[54] ROSNER, MODERN MEDICINE, *supra* note 42, at 246, *quoting* Maimonides, *Mishneh Torah, Hilchot Sabbatt* 4:5 ("[W]hosoever closes the eyes of the dying while the soul is about to depart is shedding blood. One should wait a while, perhaps until he is only in a swoon.").

[55] Bleich, *supra* note 48, at 311.

[56] ROSNER, MODERN MEDICINE, *supra* note 42, at 251.

[57] Rosner, *supra* note 15, at 211.

[58] *Leviticus* (19:16).

[59] ROSNER, MODERN MEDICINE, *supra* note 42, at 249.

woman's life, organ transplant for those who can be saved, and autopsy if the results would yield information that could save another life.[60]

Moreover, the importance placed on life in Jewish law is exemplified by the fact that there is an affirmative obligation for a physician to do everything within his power to try to resuscitate the patient.[61] Most Jewish legal scholars would not require a doctor to go to superhuman lengths to prolong the life of a hopelessly ill individual, but once life-saving measures are instituted, it is forbidden to stop the measures before the patient naturally ceases automatic respiration and heartbeat.[62] Under Jewish law, it is not appropriate to declare a person dead until all reasonable life-saving measures have been exhausted.[63] Orthodox Jewish law disallows the removal of a brain dead person from life support until the person's heart has independently stopped beating.[64] This position is supported by Agudath Israel of America, a leading traditionalist organization of Orthodox Jews,[65] that offered the halakhik interpretation that removing organs from brain dead patients for transplant is tantamount to murder.[66]

In sum, the significance of the cardiac standard of death is supported by two practical justifications—accuracy and maintaining the value of life—that arise from halakhic interpretation of Jewish texts. In contrast, the Conservative and Reform viewpoint that the brain death standard fulfills Jewish law criteria for the definition of death is influenced by medical advances and modern ethics.

3. Brain death: The Conservative and Reform viewpoint

The Conservative and Reform movements in Judaism are associated with the brain death standard as stated in the UDDA.[67] For a determination of death, the

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[60] Rosner, *supra* note 15, at 211.

[61] ROSNER, MODERN MEDICINE, *supra* note 42, at 249.

[62] *Id.* at 219.

[63] *Id.* at 218.

[64] *See id.* at 250 ("[T]o take vital organs or to otherwise treat people as though they were dead already on the basis of [the brain death standard alone] is morally unacceptable to most Orthodox Jews . . . .").

[65] Joseph Berber & Robin Shulman, *American Jews Sharing Pain Of Gaza Pullout*, N.Y. TIMES, Aug. 14, 2005, at Metropolitan Desk 29.

[66] Grodin, *supra* note 14, at 366.

[67] *See infra* § III.

brain death standard requires "irreversible cessation of all functioning of the brain, including the brain stem."[68] The Conservative and Reform viewpoint is not based on established Orthodox methods of halakhic interpretation of religious texts.[69] Other examples of where Conservative and Reform interpretation of Jewish law differs from Orthodox interpretation of Jewish law include that Reform or Conservative rabbis may permit the use of electricity on specific holidays while Orthodox rabbis would not.[70] Likewise, Reform and Conservative rabbis may permit Passover matzah to be baked by using modern technology—such as a mechanized oven—while Orthodox rabbis would permit the matzah to be baked only in the traditional way—by hand.[71]

The Jewish law argument for brain death has been made by Rabbi Moses David Tendler, professor of Biology and Medical Ethics at Yeshiva University, in commentary and responsa that conflicts with that of the Orthodox movement. Rabbi Tendler accepts destruction of the entire brain as the biblical definition of death, even if cardiac function has not yet stopped.[72] Rabbi Tendler equates complete destruction of the brain with decapitation and concludes that if the brain has been completely destroyed death has occurred because even under biblical standards, "the death throes of a decapitated man were never considered residual life but simply manifestations of cellular life that continued after death of the entire organism."[73]

Further support for the brain death standard outside of halakhic interpretation but rooted in Jewish principles is evidenced by the fact that "[r]espect for the dead is mandated. Jewish law requires the physician to do everything in his power to prolong life, but prohibits the use of measures that prolong the act of

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[68] UNIF. DETERMINATION OF DEATH ACT § 1. "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards." Entire brain death does not include neocortical death or a persistent vegetative state. *Id.* at Prefatory Note.

[69] *See* Grodin, *supra* note 14, at 366-67.

[70] LEWITTES, *supra* note 9, at 208 (noting that Sephardic rabbis permit the use of electric light on Yom Tov while Ashkenazi rabbis do not).

[71] *Id.* at 209-10.

[72] Sokobin, *supra* note 4, at 523.

[73] Frank J. Veith et al., *Brain Death: A Status Report of Medical and Ethical Considerations*, 238 JAMA 1651, 1653 (1977).

dying."[74] The use of technology to keep brain dead patients alive can be viewed as an extension of the death process. In this way, the brain death standard comports with the Jewish law rationale that death should not be prolonged as well as spares families the agony of watching a loved one "experience a protracted death."[75]

Finally, in Jewish law there is no obligation to attempt to revive the dead.[76] When a patient shows irreversible cessation of cardiac and respiratory activity accompanied by the appearance that the patient is dead, the Jewish law criteria for death are fulfilled and the doctor is relieved of his obligation to try to revive the patient.[77] Brain death fulfills these same criteria, and similarly recognizes the point at which it is futile to try to revive a person.

In sum, based on modern medical advances combined with traditional ideals, the Conservative and Reform sects of Judaism consider brain death to be the point at which the Jewish law criteria for death are fulfilled. However, brain death does not fulfill the Orthodox definition of death because the above arguments are not rooted in the halakhic method of debate; rather, they are rooted in Jewish principles and the convenience provided by modern technological advances. Like the Conservative and Reform movements in Judaism, the UDDA supports the brain death standard.

III. Overview of the UDDA

The UDDA, promulgated by the National Conference of Commissioners on Uniform State Laws in conjunction with the American Medical Association and the American Bar Association, was created in 1981, about the time when interest in definition of death statutes arose due to advances in modern medicine that altered the death process. Today, thirty-four states have codified the UDDA.[78] Every other state has adopted, through statutory law or through the decision of the state's highest court, a version of the brain death standard.[79]

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[74] ROSNER, MODERN MEDICINE, *supra* note 42, at 218.

[75] Rabbi Yitzchok A. Breitowitz, *The Brain Death Controversy in Jewish Law*, http://www.jlaw.com/Articles/brain.html (last visited Feb. 28, 2010).

[76] Bleich, *Establishing Criteria of Death*, *supra* note 52, at 290.

[77] *Id.*

[78] UNIF. DETERMINATION OF DEATH ACT REFS. & ANNOS.

[79] Sokobin, *supra* note 4, at 520.

Death statutes provide a standardized definition of death which is necessary for the smooth operation of a host of legal and family-related issues. For instance, while the UDDA notes that alone it does not establish affirmative law or policy regarding "living wills, death with dignity, euthanasia, rules on death certificates, maintaining life support beyond brain death in cases of pregnant women or of organ donors, and protection for the dead body,"[80] the definition of death found in the UDDA can be adopted by any state and inserted into a variety of statutory provisions regarding these very matters. Moreover, the UDDA can be incorporated into definition of death statutes that in turn have implications for insurance policies, tax law, probate, and criminal law in the homicide context. Thus, in addition to the personal and private meaning attached to the definition of death, there is significant meaning for, and impact on, many processes in the American legal system.

Before the UDDA and before the development of machines that could artificially maintain cardiorespiratory functions, the common law definition of death was similar to the Jewish law definition of death; it included absence of traditional vital signs—such as breathing and heartbeat—indicative of life.[81] Formerly, termination of breathing and heartbeat always resulted in destruction of the brain, and in the reverse, destruction of the brain always resulted in termination of breathing and heartbeat.[82] With the advent of artificial circulation and respiration machines, it is now possible to maintain breathing and circulation when a person's brain has been destroyed.[83] Thus, the UDDA was created to provide a "comprehensive basis for determining death in all situations."[84] The UDDA advocates the position that "irreversible cessation of all functioning of the brain, including the brain stem, is death" because without artificial support, brain death would eventually result in cessation of heartbeat and breathing, or cardiac death.[85]

The UDDA definition of death is controversial, especially for those who follow the Orthodox Jewish law definition of death, because the UDDA

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[80] UNIF. DETERMINATION OF DEATH ACT at Prefatory Note.

[81] Sokobin, *supra* note 4, at 519.

[82] Veith et al., *supra* note 73, at 1651.

[83] *Id.*

[84] UNIF. DETERMINATION OF DEATH ACT at Prefatory Note.

[85] *Id.* § 1.

definition allows physicians to remove a patient from life support if the patient's brain no longer functions but the patient's heart and lungs still function due to life support. In such a scenario, the secular brain death standard would be fulfilled but the Jewish law cardiac death standard would not be fulfilled.

IV. Arguments that provide practical support for cardiac death also support UDDA arguments for brain death

Although there is tension between the secular and religious definitions of death, after deeper analysis it becomes clear that the practical arguments that support each standard are the same. The rationales behind cardiac death—accuracy and maintaining the value of life—also support brain death.

The commonalities between the arguments supporting the two standards demonstrate that since biblical times people have held relatively unchanging feelings about the definition of death; we want to be sure about who is dead and who is alive because we value life. However, despite that the justifications for both standards stem from the same arguments, brain death is not the appropriate standard for Orthodox Judaism because it is not rooted in halakhic interpretation and the word of God as the cardiac death standard is. The fact that the cardiac death standard also promotes accuracy and preserves the high value placed on life in Jewish culture is simply incidental to the halakhic interpretation.

The Jewish legal rules are binding on Orthodox Jews despite advances in modern technology that have made the brain death standard possible and despite that brain death may accomplish the same practical ends as the cardiac death standard. While "American law clings to medical solutions, Jewish law clings to verities that have sustained it through the centuries."[86] Because religious concerns are not adequately addressed under the brain death standard exclusively, brain death with a religious exception is the most appropriate standard for American society today.

What follows is an exploration—with an eye towards why the brain death standard is not appropriate under the Orthodox view of death—of the commonalities in the rationales behind the two standards. The commonalities demonstrate that fifty state adoption of the UDDA definition of death with a religious exception would not greatly impede the secular goals of death statutes because the Jewish law standard seeks to accomplish the same goals of accuracy and preservation of the value of life.

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[86] Sokobin, *supra* note 4, at 552.

A. Accuracy

Accuracy concerns govern the brain death definition of death just as accuracy concerns are present in the Jewish law definition of death. For instance, whole brain death was selected as the brain death standard over other losses of brain function, such as loss of consciousness, because medical science can accurately determine whole brain death but cannot yet accurately "establish whether an unconscious patient, who has suffered only partial loss of brain function, has permanently lost consciousness."[87] Destruction of the whole brain, including the brain stem, guarantees that critical nerve centers that make it possible for the brain to function are destroyed.[88] With the destruction of the brain stem comes death of the entire cerebrum, at which point the brain is unable to regain functionality.[89] Numerous studies document the accuracy of brain death; clinically, it is currently considered to be the most exact criterion for measuring death.[90]

The practical concern surrounding accuracy common to both secular and Jewish law illustrates a shared desire to avoid false positives in death determinations. In 1977, when Rabbi Bleich offered his opinion in favor of cardiac death as the Jewish law standard, he did not believe medical technology was sufficiently advanced to determine with certainty whether total brain death had occurred and the brain was completely destroyed unless the person had been decapitated, which clearly destroys brain function.[91] Today, science has proven brain death to be a good measure of death,[92] which supports the proposition that like the early followers of Jewish law who were highly concerned with accuracy, it is still imperative today that secular society strive to embrace an accurate method for determining death.

Predictability goes hand in hand with accuracy. The UDDA provides predictability because it offers a single standard by which all states may abide.

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[87] Stacy, *supra* note 8, at 521.

[88] Fred Plum, *Clinical Standards and Technological Confirmatory Tests in Diagnosing Brain Death, in* THE DEFINITION OF DEATH 34, 37-38 (Stuart J. Youngner et al., 1999).

[89] *Id.* at 61.

[90] *See* Veith et al., *supra* note 73, at 1652.

[91] *See* Bleich, *supra* note 48, at 308.

[92] *See* Plum, *supra* note 88, at 40-50 (describing the different clinical criteria for a diagnosis of brain death and the accuracy of each).

Imagine the chaos that would result if one could simply cross state lines with a loved one so as to avoid a declaration of death in one state to find a proclamation of life in another. In addition, a consistent definition of death can lessen the chances of liability for doctors and hospitals, and can give patients and families peace of mind by providing closure. Moreover, predictability in death declarations is valued today because it facilitates commencement of the mourning process, probate procedures, life insurance distributions, and a general wrapping up of the deceased person's affairs.

Accuracy in the death declaration today, as in biblical times, helps avoid harsh consequences. In biblical times, the harsh consequence at issue was generally an unintended death resulting from a false death declaration. Today, while a false positive is still a risk, other risks include avoidance of death declarations by moving between states, liability for the medical profession, and a delay of the probate and mourning process.

B. The value of life

American law, represented by the UDDA in this article, is similar to Jewish law in that it places a high value on human life. For instance, one of the values of the UDDA brain death standard is that it promotes organ donation by promoting the transfer of organs while they are more viable, thus avoiding the fast deterioration of organs in patients whose blood has stopped pumping.[93] By improving the organ donation process, more people in need of functioning organs who have a chance of recovery are able to receive organs they would otherwise have to go without. Therefore, the UDDA's promotion of organ donation demonstrates the American concern for the value of life by aiding those in need and increasing their chances of survival.

Moreover, organ donation promotes resource efficiency, which in turn supports the American value of life ideal by ensuring that those who can benefit most from a hospital bed and professional medical care receive the needed resources.

Jewish law echoes the American law perspective by pointing us back to biblical times before organ donation was feasible, but when people still recognized the importance of saving a life if at all possible. Jewish law permits

[93] Yitzchok, *supra* note 75.

doctors to abandon those without hope, and focus on those with hope,[94] which is precisely what the process of organ donation accomplishes today. Thus, the UDDA brain death standard comports with both the Jewish and American reverence for human life by helping organ donation become a more widely used practice and thereby allowing more people to benefit from life saving organ transplants.

With arguments to prove that the cardiac death rationale in Jewish law supports the brain death rationale based on shared concerns for accuracy and the value of life, in addition to the Conservative and Reform viewpoints that Jewish law supports brain death,[95] it seems logical to conclude that brain death is the appropriate standard by which secular, American law should establish death today. The trouble with this conclusion is that should the brain death standard reign supreme, it would preclude people like Mr. Halberstam—the fifteen-year old who was fatally shot in 1994 while inside a van driving across the Brooklyn Bridge—from dying in accordance with their religious beliefs because followers of Orthodox Judaism abide by the cardiac death standard. Thus, the brain death definition of death would not be complete without a religious exception. In addition, allowing an exception to the brain death standard for followers of cardiac death would not substantially disturb the secular goals of maintaining of accuracy and the value of life in death determinations.

V. Religious exception to the brain death standard

A religious exception to the brain death standard is appropriate because without a religious exception a brain death statute would burden the free exercise of religion. To allow a religious exception meets the constitutional standard for free exercise of religion and does not usurp the justifications offered in support of brain death.[96]

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[94] ROSNER, MODERN MEDICINE, *supra* note 42, at 218. Jewish law does not require a doctor to continue trying to save a patient who is past the point of saving, nor does Jewish law require patients to go to every length possible to prolong life. *Id.*

[95] *See supra* § II(B)(ii).

[96] While this article supports the view that the fairest definition of death statute is one that contains a religious exception, such an exception would raise questions not fully addressed in this article. Other issues implicated by adopting a religious exception to the definition of death include determinations of liability for doctors and hospitals should they be regarded as state actors, issues of taxation, the question of when Social Security and life insurance distributions should be made, and the proper procedure for resolving a family dispute over the definition of death for a family member.

A. The constitutional standard for the free exercise of religion

The First Amendment, which has been incorporated into the Fourteenth Amendment and made applicable to the states, houses the Free Exercise Clause which provides: "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof."[97] The United States Supreme Court first interpreted the Free Exercise Clause in *Reynolds v. United States*, reasoning that "Congress cannot pass a law . . . which shall prohibit the free exercise of religion."[98] The Supreme Court found in *Reynolds* that outlawing polygamy was appropriate because the law did not impermissibly "interfere with mere religious belief and opinions"; rather, the law appropriately outlawed a religious practice that the Court deemed harmful to society.[99] The Supreme Court reasoned that it would permit government interference with religion when religious "principles break out into overt acts against peace and good order."[100] Thus, in its most basic form, the Free Exercise Clause guarantees the idea of religious freedom unless the religious practice at issue harms society at large. The Court developed the parameters of this idea in later cases.

Following *Reynolds*, the Supreme Court and Congress have had a rocky relationship with the Free Exercise Clause as each branch has tried to overturn the other to bring competing definitions of religious freedom to American citizens. Almost a century after *Reynolds*, the Supreme Court addressed the Free Exercise Clause again in *Sherbert v. Verner*.[101] In *Sherbert*, the Court found that a law denying unemployment compensation to a woman whose job conflicted with the practice of her religion was unconstitutional because the law was not supported by a compelling state interest.[102] The Court determined that laws that burden the practice of religion must be analyzed under strict scrutiny; there must be a compelling state interest supporting any such regulations.[103] The Court established a four-factor test to determine if an individual's right to free exercise of religion has been violated by the government. The *Sherbert* Test asks

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[97] U.S. CONST. amend. I.

[98] Reynolds v. United States, 98 U.S. 145, 162 (1878).

[99] *Id.* at 166.

[100] *Id.* at 163.

[101] *See* Sherbert v. Verner, 374 U.S. 398 (1963).

[102] *Id.* at 409.

[103] *Id.*

whether: (1) the individual's religious belief is sincere,[104] (2) the government action is a substantial burden on the individual's ability to act on that valid religious belief,[105] (3) the government's action is in furtherance of a compelling state interest,[106] and (4) whether the government pursued the compelling state interest in the least restrictive manner.[107]

The Court reaffirmed the ruling in *Sherbert* nine years later in *Wisconsin v. Yoder*.[108] In *Yoder*, the Court found that the state could not compel the parents of Amish children to send their children to school past the eighth grade when to do so conflicted with religious ideals held by the Amish and thus violated the Amish parents' freedom of religion.[109] The Court applied the *Sherbert* Test, first finding that the respondents' religious beliefs were sincere.[110] The Court then balanced the burden of the Wisconsin law requiring children to attend school until the age of sixteen against the Amish belief that children should not obtain high school education beyond eighth grade.[111] The Court found that although the state had an important interest in providing public education through the age of sixteen, the state's interest was not compelling enough to trump parents' fundamental rights to raise their children according to the requirements of their religion.[112]

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[104] *See id.* at 402 n.1.

[105] *Id.* at 403 ("[I]f the purpose or effect of a law is to impede the observance of one or all religions or is to discriminate invidiously between religions, that law is constitutionally invalid even though the burden may be characterized as being only indirect.").

[106] *Id.* at 406 ("[O]nly the gravest abuses, endangering paramount interest, give occasion for possible limitation.").

[107] *Id.* at 407-08 ("[It is] incumbent upon [the government] to demonstrate that no alternative forms of regulation would combat such abuses without infringing on First Amendment rights.").

[108] 406 U.S. 205 (1972).

[109] *Id.* at 207.

[110] *Id.* at 208.

[111] *Id.* at 213-14.

[112] *Id.* ("[A] State's interest in universal education, however highly we rank it, is not totally free from a balancing process when it impinges on fundamental rights and interests, such as those specifically protected by the Free Exercise Clause. . . . [The Religion Clauses] have been zealously protected, sometimes even at the expense of other interests of admittedly high social importance."). *See also id.* at 221-22.

Eighteen years after *Yoder*, in *Employment Division v. Smith*, the Supreme Court moved away from the *Sherbert* Test and narrowed the applicability of the Free Exercise Clause.[113] In *Smith*, the Court refused to use strict scrutiny to analyze Oregon's prohibition on the use of peyote in a religious ceremony.[114] Rather, the Court determined that the legislation outlawing peyote incidentally prohibited a religiously mandated activity but that this was constitutional because the peyote ban was generally applicable to all citizens.[115] The Court noted that while states have the power to allow otherwise illegal activities done pursuant to religious beliefs, states are not required to allow such activities.[116]

After *Smith*, the *Sherbert* Test no longer applies to claims that the government violated an individual's right to free exercise. The result of the holding in *Smith* was that for a court to find a law to be in violation of the Free Exercise Clause the petitioner had to show that the law was one of general applicability, that the law burdened free exercise and also burdened another fundamental right, and that the law did not withstand strict scrutiny.[117] For instance, the situation in *Yoder* fulfills the *Smith* criteria because in *Yoder* the Wisconsin law of requiring students to attend high school was one of general applicability, the law burdened the Amish practice of religion at the same time it burdened Amish parents' fundamental right to direct the education of their children, and the law did not withstand strict scrutiny because it did not further a compelling state interest.[118]

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[113] Employment Division v. Smith, 494 U.S. 872 (1990).

[114] *Id.* at 886-88 (noting that using strict scrutiny in the situation in *Smith* would "produce a constitutional anomaly" because it would create "a private right to ignore generally applicable laws").

[115] *Id.* at 879-82 (explaining that the right of free exercise does not relieve an individual of the obligation to comply with a valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes)") (internal citations omitted).

[116] *Id.* at 882.

[117] *Id.* at 881.

[118] *Id.* at 881 n.1 ("[W]hen the interests of parenthood are combined with a free exercise claim of the nature revealed [in *Yoder*], more than merely a reasonable relation to some purpose within the competency of the State is required to sustain the validity of the State's requirement under the First Amendment") (internal citations omitted).

In response to the narrowing of the Free Exercise Clause in *Smith*, Congress passed the Religious Freedom Restoration Act (RFRA).[119] RFRA was intended to protect the free exercise of religion and it reinstated the *Sherbert* Test.[120] However, the Supreme Court overturned RFRA shortly after its creation in *City of Bourne v. Flores*, finding that RFRA unconstitutionally attempted to usurp the Supreme Court's power to interpret the Constitution.[121] Thus, the test set out in *Smith*—state infringement on freedom of religion plus infringement an additional fundamental right—is the constitutional standard by which to bring a Freedom of Religion claim today.

B. An exception to brain death statutes for the Jewish law cardiac death standard is warranted under Smith

The UDDA brain death definition of death is appropriate for a Free Exercise Clause exception from state determination of death statutes under *Smith* because without an exception the brain death standard burdens those who follow Orthodox Judaism by not allowing the cardiac standard of death to be used. Per the requirements of *Smith* that in order to challenge a law for violating the Free Exercise Clause both free exercise and a fundamental right must be burdened by the law, the fundamental right at issue is privacy—an individual's privacy to die within the parameters set by that individual's religion. Finally, a definition of death statute that disallows cardiac death does not withstand strict scrutiny because it does not fulfill a compelling state interest.

1. Burden on the free exercise of religion

Free exercise is burdened because a statute that allows only brain death would deny Jews, such as Mr. Halbertstam—the Jewish teenager who was fatally shot while crossing the Brooklyn Bridge—the opportunity to die in accordance with the Jewish law cardiac definition of death. This is significant because if Mr. Halbertstam were to be declared dead under the brain death standard he could potentially still be alive under the cardiac standard and thus Jewish law would consider the premature death declaration tantamount to murder. In addition, to

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[119] Religious Freedom Restoration Act, H.R. 1308, 103rd Cong. (1993) (enacted).

[120] *Id.* § (b)(1).

[121] 521 U.S. 507, 519 (1997) ("Legislation which alters the meaning of the Free Exercise Clause cannot be said to be enforcing the Clause. Congress does not enforce a constitutional right by changing what the right is. It has been given the power 'to enforce,' not the power to determine what constitutes a constitutional violation.").

prohibit the Jewish law definition of death would fly in the face of "our Nation's fundamental commitment to individual religious liberty."[122]

2. Burden on the fundamental right to privacy

In addition to a burden on the free exercise of religion, disallowing the cardiac death standard violates Orthodox Jews' fundamental right to privacy. Death is a private matter because "[a]fter birth, death is the most significant event for the living. The dividing event between life and death focuses on profound practical metaphysical and theological questions regarding the nature and meaning of life and the 'hereafter'."[123]

The United States Supreme Court declared privacy a fundamental right protected by the Constitution in *Griswold v. Connecticut.*[124] In *Griswold*, the majority found that while the right to privacy is not express in the Constitution, it is protected in the "penumbras" of other constitutional safeguards.[125] In concurrence, Justice Goldberg found the right to privacy in the Ninth Amendment.[126] Also in concurrence, Justice Harlan found the right to privacy in the Due Process Clause of the Fourteenth Amendment.[127]

The Supreme Court has reinforced the right to privacy in subsequent decisions, such as *Roe v. Wade*, wherein the Court based its holding that a woman may abort her pregnancy for any reason, up until the point at which the fetus becomes viable, on the Constitutional right to privacy found in the Due Process Clause of the Fourteenth Amendment.[128] *Roe* restricts the government's ability to define the beginning of life in a way that burden's a woman's right to

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[122] Employment Division v. Smith, 494 U.S. 872, 891 (1990) (O'Connor, J., concurring).

[123] Grodin, *supra* note 14, at 357.

[124] 381 U.S. 479 (1965).

[125] *Id.* at 484 ("Various guarantees [in the Constitution] create zones of privacy.").

[126] *Id.* at 487 (Goldberg, J., concurring).

[127] *Id.* at 500 (Harlan, J., concurring).

[128] 410 U.S. 113, 152-53 (1973) ("[T]he Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution.").

privacy.[129] Similarly, the government should be restricted from defining the end of life in a way that would burden a Jewish person's right to the privacy.[130]

Further, in *Lawrence v. Texas*, the Court found that a Texas anti-sodomy statute was unconstitutional because it attempted to control private, sexual behavior in violation of the Due Process Clause of the Fourteenth Amendment.[131] In other cases, the Supreme Court has found privacy interests relating to marriage,[132] procreation,[133] contraception,[134] family relationships and child rearing, [135] and education.[136]

The above-noted privacy interests all relate to serious, personal, and family-orientated matters that the Court refrains from intruding on. The definition of death is a similarly serious, personal, and family-related matter because it triggers other interpersonal processes, such as grieving, the probate and will process, commencement of life insurance payments, transfer of estates, organ donation, and autopsies.[137] It cannot be denied that each of these issues is a solemn, personal decision that deeply impacts the deceased person's family.

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[129] *See id.*

[130] Chaim Dovid Zwiebel, *Accommodating Religious Objections to Brain Death: Legal Considerations*, XVII J. HALACHA AND CONTEMPORARY SOCIETY 49 (1989).

[131] 539 U.S. 558, 578-79 (2003).

[132] Loving v. Virginia, 388 U.S. 1, 12 (1967) (holding that restricting the freedom to marry on racial grounds violates the Equal Protection Clause and deprives appellants of liberty without due process of law in violation of the Due Process Clause).

[133] Skinner v. Oklahoma, 316 U.S. 535, 541-42 (1942) (finding that Oklahoma violated the Equal Protection Clause when it enacted a law mandating sterilization for those who committed more than two felonies).

[134] Eisenstadt v. Baird, 405 U.S. 438, 453-54 (1972) (reasoning that right of privacy to be free of unwanted intrusions into the fundamental decision of whether to have children is the same for married and unmarried people alike).

[135] Prince v. Massachusetts, 321 U.S. 158, 166 (1944) (holding that parents have the right to rear their own children but the state has the power to restrict religious preaching by children as directed by their parents if the preaching occurs on public highways).

[136] Pierce v. Society of Sisters, 268 U.S. 510, 535 (1925) (finding that the Compulsory Education Act unreasonably interfered with the liberty of parents and guardians to direct the upbringing and education of their children).

[137] Grodin, *supra* note 14, at 359.

Moreover, the Court explained in *Planned Parenthood of Southeastern Pa. v. Casey*, that the fundamental right to privacy protects:

> [M]atters [] involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy . . . . At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and the mystery of human life.[138]

Thus, privacy in death determinations should be considered a fundamental liberty necessary for accomplishing the American ideal of allowing the free exercise of religion.

Lower courts have protected privacy interests in medical and death-related situations. For instance, in *In the Matter of Quinlan*, the Supreme Court of New Jersey recognized that a patient's constitutional right to privacy includes the right to terminate medical treatment.[139] The court reasoned: "the State's interest [] weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest."[140] Determination of death is a similarly invasive process—it can perhaps be considered the ultimate and final invasion—and a person's death decision should be afforded the same privacy right as a person's decision to refuse medical treatment.

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[138] 505 U.S. 833, 851 (1992).

[139] In the Matter of Quinlan, 355 A.2d. 647, 664 (N.J. 1976) (allowing a patient's guardian to consent to the withdrawal of life support to protect the privacy interest of a patient in a persistent vegetative state). The Supreme Court has yet to find a privacy interest in right to die cases, but has commented on how the Due Process Clause impacts death-related issues. In *Washington v. Glucksburg* the Court held that assisted suicide is not a fundamental liberty protected by the Due Process Clause. 521 U.S. 702, 728 (1997). However, in *Golzones v. Oregon*, the Court held that the United States Attorney General did not have the power to prohibit the prescription of controlled substances that could be used for euthanasia. 546 U.S. 243, 275 (2006). Moreover, the Supreme Court has stated that unwanted lifesaving treatment may be refused if the refusal is supported by "clear and convincing evidence." *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 280 (1990). The Court did not base this decision in the right to privacy; rather, the Court grounded its holding in the Due Process Clause. "[T]he Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment." *Id.* at 281. The Court was concerned with avoiding an "erroneous decision to withdraw life-sustaining treatment." *Id.* at 283.

[140] *Quinlan*, 355 A.2d at 664.

The Supreme Judicial Court of Massachusetts made a similar finding in *Brophy v. New England Sinai Hospital.*[141] In that case, the court recognized "fundamental principles of individual autonomy" and reasoned that:

> [I]t does not advance the interest of the State or the ward to treat the ward as a person of lesser status or dignity than others. To protect the incompetent person within its power, the State must recognize the dignity and worth of such a person and afford to that person the same panoply of rights and choices it recognizes in competent persons.[142]

Likewise, the idea of dignity extends to the definition of death in that allowing a person to die in accordance with specific religious beliefs affords that person dignity, and respects that person's privacy interest in their final and most vulnerable moments.

In sum, the definition of death deserves constitutional privacy protection.[143] A brain dead patient's right to privacy in her death decision stems from her religion-based death preference expressed in life,[144] which is protected by the "penumbras" of fundamental rights couched in various sections of the Constitution, including the Ninth Amendment and the Due Process Clause.[145] Moreover, protecting the Jewish law definition of death under the right to privacy does not counteract secular justifications for the brain death standard because

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[141] Brophy v. New England Sinai Hospital, 497 N.E.2d 626, 637-38 (Mass. 1986) (holding that, based on the right to privacy, a patient's guardian has the right to refuse medical treatment on behalf of the patient when treatment involves intrusive procedures).

[142] *Id.* at 634.

[143] *See* Brett Kingsbury, *A Line Already Drawn: The Case for Voluntary Euthanasia After the Withdrawal of Life-Sustaining Hydration and Nutrition*, 38 COLUM. J.L. & SOC. PROBS. 201 (2004) (argues that state constitutional law provides for a privacy interest in suicide); John A. Brennan, Note, *A State Based Right to Physician Assisted Suicide*, 79 B.U. L. REV. 231, 248-254 (1999) (suggests that the right to physician assisted suicide may be protected by broad interpretations of state constitutions); Steven J. Wolhandler, Note, *Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, 69 CORNELL L. REV. 363 (1984) (reasons that the right to privacy allows competent, terminally ill patients to end their lives and that privacy protection extends to those who assist with the suicide).

[144] *See* Stacy, *supra* note 8, at 534.

[145] *Id.* at 541.

both standards harbor the same concerns—accuracy and preservation of the value of life. Finally, as the next section explains, protecting the Jewish law definition of death does not substantially burden typical state interests such as uniformity in application of the law, preservation of life, and maintaining hospital efficiency. Thus, there is no compelling state interest that would prevent implementation of the cardiac death standard.

3. No compelling state interests are burdened by the Jewish law cardiac death standard

In 1987, the New York Department of Health adopted a determination of death regulation that follows the UDDA brain death model but also protects those who abide by the cardiac standard of death. The regulation requires hospitals to establish "a procedure for the reasonable accommodation of the individual's religious or moral objection to the determination [of death] . . . ."[146] The section

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[146] 10 N.Y. A.D.C. 400.16(e)(3) (2009). The full statutes reads as follows:

> Determination of death:
>
> (a) An individual who has sustained either:
>
> (1) Irreversible cessation of circulatory or respiratory functions; or
>
> (2) Irreversible cessation of all functions of the entire brain, including the brain stem, is dead
>
> (b) A determination of death must be made in accordance with accepted medical standards.
>
> (c) Death, as determined in accordance with paragraph (a)(2) of this section, shall be deemed to have occurred as of the time of the completion of the determination of death.
>
> (d) Prior to the completion of a determination of death of an individual in accordance with paragraph (a)(2) of this section, the hospital shall make reasonable efforts to notify the individual's next of kin or other person closest to the individual that such determination will soon be completed.
>
> (e) Each hospital shall establish and implement a written policy regarding determinations of death in accordance with paragraph (a)(2) of this section. Such policy shall include:
>
> (1) a description of the tests to be employed in making the determination;

applies specifically to those who reject the brain death standard of death.[147] The New York regulation accommodates both the brain death and cardiac death standards without disrupting state interests in uniformity, preservation of life, or hospital efficiency.

i. State interest in uniformity

The UDDA promotes government interest in uniformity in determining death because adoption of the UDDA by every state would standardize the definition of death across the United States. As a result, citizens would not be able to be declared dead in one state but cross state lines to be found alive in another. This is an important state interest because it fosters uniformity in death-related procedures such as life insurance, pension, and Social Security distribution, as well as probate and taxation.

Because only a select few—the Orthodox Jewish community—stand to raise the religious exception for cardiac death, uniformity in determining death will not be significantly disrupted by allowing an exception for cardiac death. The exception will apply in a small number of cases; only those who have "strong convictions are likely to make the necessary effort to invoke the exemption."[148] Further, it is arguable that uniformity is not a state interest compelling enough in all situations to stand in the way of privacy concerns and the free exercise of religion, especially if, as the New York regulation demonstrates, the laws can be crafted to accommodate both uniformity and free exercise of religion.[149]

> (2) a procedure for the notification of the individual's next of kin or other person closest to the individual in accordance with subdivision (d) of this section; and
>
> (3) a procedure for the reasonable accommodation of the individual's religious or moral objection to the determination as expressed by the individual, or by the next of kin or other person closest to the individual.

Id.

[147] Grodin, *supra* note 14, at 368.

[148] Robert S. Olick, *Brain Death, Religious Freedom, and Public Policy: New Jersey's Landmark Legislative Initiative*, 1 KENNEDY INST. ETHICS J. 278, 279 (1991).

[149] Zwiebel, *supra* note 130 at 65-66 (noting that the state interest at stake is clarity, not uniformity). "So long as government prescribes clear guidelines upon which a health care provider can safely rely without being concerned about running afoul of the law, it has achieved the main purpose of creating uniform laws." *Id.* at 65.

The New York regulation achieves uniformity in that it requires hospitals to make reasonable efforts to contact the patient's next of kin before a determination of death is made according to the brain death standard.[150] Notice of the religious accommodation must occur before death has been declared thereby ensuring application of the law occurs in a uniform way; the law is applied to each patient while he is still technically alive.[151] The law does not permit the religious standard to reverse the secular standard once the secular standard has been followed.[152]

In sum, by specifying the timing of the application of the law and by virtue of the fact that a cardiac death exception will not pertain to those choosing idiosyncratic definitions of death, the religious exception will operate only for those whose deeply held religious convictions reject the brain death standard. Thus, the religious exception will not disrupt state interest in uniform application of the laws.[153]

ii. State interest in preservation of life

Government interest in the preservation of life is articulated by the Supreme Court of New Jersey in *In the Matter of Quinlan*.[154] The court notes that "[t]he importance of the preservation of life is memorialized in various organic documents" such as the Declaration of Independence, the Constitution of the United States, and the New Jersey Constitution, which all give men certain unalienable rights, "among which of those are of enjoying and defending life."[155]

The New York law promotes the state's interest in preserving life because the law does not require absolute accommodation of the cardiac death standard under all circumstances. Instead, the law requires hospitals to make a "reasonable" effort to contact the next of kin so that the cardiac death standard

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[150] *Id.* at 56.

[151] *Id.* at 57. The delay of a declaration of death until after the family has been notified of the patient's condition allows health coverage to continue until the cardiac death standard is fulfilled because despite possible brain death the official death declaration has not been made yet; thus, the patient is still considered alive for the purposes of insurance coverage. Grodin, *supra* note 14, at 368.

[152] Grodin, *supra* note 14, at 368.

[153] Olick, *supra* note 148, at 278.

[154] In the Matter of Quinlan, 355 A.2d 647, 652 n.1 (N.J. 1976).

[155] *Id.*

can be implemented if so desired.[156] The Regulatory Impact Statement that accompanies the New York regulation suggests that the religious exception would not apply in emergency situations where "maintenance of a brain dead person would result in harm to another patient for whom meaningful life could be saved."[157] This viewpoint comports with the Jewish law interest in preserving life and makes sense in cases where organ donation could save the life of another. Thus, in triage cases it would be possible, under New York's law, for the state's interest in preserving life to override the religious interest in applying the cardiac death standard.

iii. State interest in hospital efficiency

The government has an interest in allowing hospitals to run efficiently, and has an obligation to avoid encumbering hospitals with unduly burdensome regulations that would require hospitals to go to great lengths to accommodate religious exceptions to the brain death standard. The New York law is not unduly burdensome because it requires only that hospitals alert the patient's next of kin to the patient's condition.[158] Hospitals do not have an affirmative duty to inform next of kin of the religious exception, nor do hospitals have to obtain consent to use of the brain death standard.[159] After the hospital provides notice, it is the responsibility of the next of kin to invoke the exception if desired. Thus, the law does not saddle hospitals with an unmanageable standard; rather, it clearly sets out the notice obligation and leaves the patient's family to determine the rest.

Moreover, the New York law does not burden hospitals with the excessive costs of maintaining patients who meet the standard for brain death but do not meet the standard for cardiac death. Because the law will apply in only a small number of cases—only those with deeply held religious convictions—any increase in cost will be negligible and cannot be considered a compelling state interest such that it would override the constitutionally protected right to freedom of religion.

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[156] 10 N.Y. A.D.C. 400.16(d) (2009).

[157] Zwiebel, *supra* note 130, at 49, *quoting* N.Y.S. Task Force on Life and the Law, *The Determination of Death* 4 (1986).

[158] *See generally* 10 N.Y. A.D.C. 400.16 (2009).

[159] *Id.*

The New York law exemplifies the balance between state interest and freedom of religion. The law respectfully accommodates the religious interest in having the exception available as well as preserves the state's interests in uniformity, preservation of life, and maintaining hospital efficiency. There are no competing state interests that would be damaged by use of the cardiac death standard.

VI. Conclusion

The ancient tenets of Jewish law show us that we should strive for the most accurate and life-respecting standard available when making declarations of death. Today, that standard is brain death, as it appears in the UDDA. However, the problem with implementing a strict brain death standard lies in that it would preclude followers of Orthodox Judaism from dying under their religiously-mandated standard of cardiac death. Excluding Orthodox Jews from the standard is troublesome because in most states physicians alone have the power to disconnect a patient from life support once the legal criteria for death are fulfilled.[160] Most states do not mandate that the physician defer to the wishes of the patient or family.[161]

New York offers a regulation that falls in line with the provisions argued for in this article because the New York law includes a religious exception, thereby avoiding a free exercise violation, and the law also promotes other important secular and state interests.[162] The New York regulation proved useful for Mr. Halberstam's family when he was declared brain dead and thus fulfilled the brain death standard, but because his heart could still beat independently he did not fulfill the cardiac death standard preferred by his family.

It is probable that there are others across the United States who may encounter the same unfortunate situation as Mr. Halberstam. Therefore, all states should adopt the UDDA definition of death with a religious exception as New York has. Not only would an exception provide religious comfort to families in sad times, but the exception is permitted under the First Amendment Free Exercise Clause and the right to privacy. Furthermore, the exception does not negate the secular justifications offered in support of brain death, as the Jewish law cardiac death standard promotes the same rationales of accuracy and the

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[160] Yitzchok, *supra* note 75.

[161] *Id.*

[162] 10 N.Y. A.D.C. 400.16(a)(2) (2009).

value of life. The exception also does not interfere with state interests in uniformity, preservation of life, and hospital efficiency.

In conclusion, adoption of the UDDA brain death standard with a religious exception for cardiac death not only permits freedom to practice the Jewish religion in matters as serious, private, and personal as death, but also accomplishes secular goals and preserves state interests.

This is Exhibit "4" referred to in the Affidavit of Maxime Ouanounou sworn before me, this 30th *day of* October, *2017.*

A Commissioner of taking Affidavits

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Brain Death Rejected

Expanding Legal Duties to Accommodate Religious Objections

Thaddeus Mason Pope

The determination of death by neurological criteria (DDNC or "brain death") has been legally established, for decades, as death in all U.S. jurisdictions and in most other developed countries.[1] It is supported by a "durable worldwide consensus."[2] Moreover, the consequences of DDNC are clear. Once a patient is determined dead, clinicians typically discontinue physiological support. In short, DDNC is a "hard clinical endpoint" where technological interventions reach the limits of required or accepted medical practice.[3]

Despite this legal consensus, hospitals continue to grapple with a significant (and growing) number of conflicts. Some families do not accept DDNC as death and want clinicians to continue physiological support. While some of these disputes are due to misunderstanding or diagnostic mistrust, many are religiously based.[4] Today, only four U.S. states legally require hospitals to "accommodate" families with religious objections to DDNC. In this chapter, I argue that other states should enact similar accommodation requirements.

Given the legal status of DDNC, clinicians typically have no duty to continue physiological support after DDNC. But this rule presents a profound problem for patients with religious objections to DDNC. For these individuals, the denial of physiological support after DDNC violates fundamental values. Indeed, hospitals

[1] J.L. Bernat, *The Whole-Brain Concept of Death Remains Optimum Public Policy*, 34 J. L. Med. & Ethics 35–43 (2006); E.F.M. Wijdicks, *Brain Death Worldwide: Accepted Fact but No Global Consensus*, 58 Neurology 20–5 (2002); D. Gardiner et al., *International Perspective on the Diagnosis of Death*, 108 British J. Anaesthesia i14–i28 (2012).

[2] J.L. Bernat, *The Definition and Criterion of Death*, 118 Handbook Clinical Neurology 419–35 (2013).

[3] M.J. Clarke, M.S. Remtema, & K.M. Swetz, *Beyond Transplantation: Considering Brain Death as a Hard Clinical Endpoint*, 14 Am. J. Bioethics 43–5 (2014).

[4] See generally Thaddeus M. Pope, *Brain Death Forsaken: Growing Conflict and New Legal Challenges*, 37 J. Leg. Med. (forthcoming 2017); Thaddeus M. Pope, *Legal Briefing: Brain Death and Total Brain Failure*, 25 J. Clinical Ethics 245–57 (2014); Christopher M. Burkle & Thaddeus M. Pope, *Brain Death: Legal Obligations and the Courts*, 35 Seminars Clinical Neurology 174–9 (2015).

often refuse to accommodate religious objections to DDNC. I concede that granting a complete exemption to DDNC may be problematic. Instead, I argue that all states should enact "reasonable accommodation" laws, requiring a brief period of continued ventilator support.

1. LEGAL STATUS OF DETERMINING DEATH BY NEUROLOGICAL CRITERIA (DDNC)

Every U.S. state has enacted the Uniform Determination of Death Act, or a nearly identical statute.[5] The UDDA provides that death may be determined by the application of either of two alternative standards: (1) "irreversible cessation of circulatory and respiratory function" or (2) "irreversible cessation of all functions of the entire brain, including the brain stem."[6]

The latter standard is also known as the determination of death by neurological criteria (DDNC). The satisfaction of *either* standard is sufficient to determine death. So, if cessation of all brain function is confirmed, then the patient may be declared dead, despite ongoing cardiopulmonary functions maintained by artificial ventilation or pharmacological support.

2. CLINICIAN DUTIES TO "TREAT" END AFTER DDNC

Once a patient is determined dead, clinicians typically discontinue physiological support. Once death is determined, there is no longer a duty to treat. This is well established both in appellate case law[7] and in medical practice.[8] Once dead, the patient is no longer a patient.[9] The hospital is no longer in a treatment relationship with a patient; it is instead the custodian of a corpse.[10] Indeed, to continue "treatment" could constitute abuse of the newly dead.[11]

But there are three situations in which hospitals continue physiological support after DDNC. First, if the patient is an organ donor, support is continued until the transplant. Second, if the patient is pregnant, support may be continued until delivery. Sometimes this is at the family's request, and sometimes it is legally required.[12]

[5] See Pope, supra note 4.
[6] 12 U.L.A. 589 (1980).
[7] See Pope, supra note 4 (collecting citations).
[8] Id.
[9] Id.
[10] R.D. Miller, *Problems in Health Care Law* 765–75 (2006).
[11] See, e.g., *Range v. Douglas*, 763 F.3d 573 (6th Cir. 2014); J.A. Anderson, L.W. Vernaglia, & S.P. Morrigan, *Refusal of Brain Death Diagnosis: The Health Lawyer's Perspective*, 9 JONAS Health Care L., Ethics & Reg. 90–2 (2007).
[12] See, e.g., Pope, supra note 4.

Third, organ-sustaining measures might be continued to accommodate religious objections.[13] Below, I focus on this third exception.[14]

3. MILLIONS OF AMERICANS HAVE RELIGIOUS OBJECTIONS TO DDNC

While most major religions in the world accept DDNC as death, several religions (or at least certain sects of these religions) object to DDNC.[15] These include Japanese Shinto as well as some (but not all) Orthodox Jews, Native Americans, Buddhists, and Muslims.[16] Approximately six million Americans are affiliated with one of these religions.[17]

For the adherents of these religions, the imposition of a "brain death" standard violates strongly held beliefs about the meaning of death.[18] These individuals believe that death can be determined only by the total cessation of cardiac and respiratory activity (regardless of whether such activity is artificially sustained). Even Teneille Brown, who argues against accommodating "miracles" in the next chapter of this volume, concedes that denial of life support can occur in "life and death situations of tremendous spiritual and religious significance."

Drafters of the UDDA and analogous state laws were careful to address only the "determination" of death and not the "definition" of death.[19] That is, the law limits itself to identifying the physiological standards that should be used by the medical

[13] Hospitals also accommodate nonreligious objections. See infra note 21.

[14] Families object not only to discontinuing physiological support but also to the performance of the brain death exam itself. See, e.g., *VCU Health System Authority v. Lawson*, No. 160968 (Va. June 27, 2016) (petition for review from Richmond City No. CL162358); *Pierce v. Loma Linda University Medical Center*, No. DS1609831 (Bernardino County Sup. Ct., Cal. June 7, 2016) (petition for TRO).

[15] See generally Eelco Wijdicks, Brain Death 69–79 (2d ed. 2011); E.F.M. Wijdicks, *Brain Death*, 118 Handbook Clinical Neurology 191–203 (2013); A. Earl Walker, *Cerebral Death* 139–42 (3d ed. 1985).

[16] See generally Robert M. Veatch & Lainie F. Ross, *Transplantation Ethics* 105–106 (2d ed. 2015); Jeffrey M. Singh & Mark Bernstein, *Brain Death, Neurosurgical Ethics in Practice: Value-based Medicine* 109, 115 (A. Ammar, M. Bernstein eds., 2015). See also Andrew C. Miller, *Opinions on the Legitimacy of Brain Death amongst Sunni and Shi'a Scholars*, 55 J. Religion & Health 394 (2016); R.S. Olick et al., *Accommodating Religious and Moral Objections to Neurological Death*, 20 J. Clinical Ethics 183–90 (2009). R.S. Olick, *Brain Death, Religious Freedom, and Public Policy: New Jersey's Landmark Legislative Initiative*, 1 Kennedy Institute Ethics J. 275–88 (1991); Kenneth Shuster, *"When Has the Grim Reaper Finished Reaping?" How Embracing One Religion's View of Death Can Influence Acceptance of the Uniform Determination of Death Act*, 30 Touro L. Rev. 655 (2014); N. Berlinger, B. Jennings & S.M. Wolf, *The Hastings Center Guidelines for Decisions on Life-Sustaining Treatment and Care Near the End of Life* 107 (2013).

[17] Pew Forum on Religion and Public Life, *U.S. Religious Landscape Survey Religious Affiliation: Diverse and Dynamic* (2008).

[18] I do not distinguish deeply held moral beliefs from religious beliefs regarding DDNC.

[19] Cf. Uniform Law Commission, Determination of Death Act Summary, available at uniformlaws.org/ActSummary.aspx?title=Determination of Death Act.

profession to ascertain when an individual has died. The law does not try to say what death actually "is." It does not attempt to answer the bigger philosophical and theological question of what is so essential to human life that, when it is lost, the individual should be considered dead.[20] But since DDNC results in stopping physiological support, the law still implicates these philosophical and theological questions.

4. LEGAL REQUIREMENTS TO ACCOMMODATE RELIGIOUS OBJECTIONS

Many health care facilities across the country *voluntarily* offer a short-term accommodation as a compassionate measure to help the family cope with the patient's death.[21] But in only four states is the duty to accommodate *mandated* by law.[22] Statutes and regulations in California, Illinois, New Jersey, and New York explicitly and specifically require hospitals to "accommodate" families asserting religious objections on the patient's behalf after a patient is declared dead by neurological criteria.[23] New Jersey's accommodation mandate is the broadest (and is effectively an exemption). New York and California have less expansive requirements. Illinois' requirement is the weakest.

[20] New York State Department of Health and New York State Task Force on Life and the Law, The Determination of Death 11 (1986).

[21] See generally D.D. Ayeh et al., *Physicians' Opinions About Accommodating Religiously Based Requests for Continued Life Sustaining Treatment*, 52 J. Pain & Symptom Mgmt. 972 (2016); Anne L. Flamm et al., *Family Members' Requests to Extend Physiologic Support after Declaration of Brain Death: A Case Series Analysis and Proposed Guidelines for Clinical Management*, 25 J. Clinical Ethics 222–37 (2014); *Dority v. Superior Court of San Bernardino County*, 193 Cal. Rptr. 288, 289 (Cal. Ct. App. 1983); L.R. Frankel & C.J. Randle Jr., "Complexities in the Management of a Brain-Dead Child," in *Ethical Dilemmas in Pediatrics: Cases and Commentaries* 135, 137 (L.R. Frankel et al. eds. 2005); M.J. Edens *et al.*, *Neonatal Ethics: Development of a Consultative Group*, 86 Pediatrics 944–9 (1990); R. Custaitis, *Right to Refuse Life-Sustaining Treatment*, 81 Pediatrics 317–21 (1988). Some have persuasively argued for such accommodation. See R.A. Burt, *The Medical Futility Debate: Patient Choice, Physician Obligation, and End-of-Life Care*, 5 J. Palliative Med. 249–54 (2004).

[22] As explained by Teneille Brown in this volume, accommodation may also be required under state religious freedom restoration acts. While no state RFRA has yet been applied to the DDNC context, the federal RFRA was applied in an analogous context. A federal court interpreted RFRA to require the state to accommodate a religious objection to an otherwise required autopsy. *Yang v. Sturner*, 728 F. Supp. 845 (D.R.I. 1990).

[23] The primary means of accommodation is through continued ventilator support. Other accommodations include the opportunity to transfer. See, e.g., *Winkfield v. Children's Hospital & Research Center at Oakland*, No. 13-CV-05993-SBA (N.D. Cal. January 6, 2014) (status report reporting settlement and transfer); *In re Koochin*, No. 043900708 (3rd Jud. Dist. Ct., Salt Lake Cty., Utah October 27, 2004) (six-year-old boy transferred home); *Brain-Dead Florida Girl Will Be Sent Home on Life Support*, N.Y. Times (February 19, 1994) (13-year-old girl transferred home); Flamm et al., supra note 21.

A. *New Jersey: Indefinite Accommodation*

In 1991, New Jersey enacted the New Jersey Declaration of Death Act.[24] As in every other state, this statute provides that an individual who has "sustained irreversible cessation of all functions of the entire brain, including the brain stem, shall be declared dead."[25] But in contrast to every other state, the statute includes a unique categorical exception.[26] When triggered, this exception amounts to an indefinite duty to accommodate a religious objection to DDNC.

Specifically, the New Jersey Declaration of Death Act provides that the death of an individual shall *not* be declared upon the basis of neurological criteria "when the licensed physician authorized to declare death, has reason to believe ... that such a declaration would violate the personal religious beliefs of the individual."[27]

While the statute does not define what qualifies as a legitimate religious belief, statutory interpretation would likely be guided by extensive constitutional analysis of this question. The threshold under the First Amendment is low.[28] Therefore, the New Jersey statute probably also includes "moral" objections, nontheistic beliefs which are sincerely held. This interpretation is implied by the broad definition of "religion" under Title VII of the Civil Rights Act of 1964.[29]

Consequently, it seems that upon the assertion of any plausible religious claim, in New Jersey death shall be declared "solely upon the basis of cardio-respiratory criteria." On the other hand, New Jersey providers and courts have rejected accommodation requirements without evidence that the patient herself held the religious beliefs.[30]

In short, if the patient has religious objections to DDNC and those objections are made known to clinicians, then the patient may not be declared dead until the complete irreversible cessation of her circulatory and respiratory functions. If the family does not consent to stop ventilator support, then under New Jersey law the patient may not be legally dead for a significant period of time after the determination of total brain failure.

[24] P.W. Armstrong & R.S. Olick, *Innovative Legislative Initiatives: The New Jersey Declaration of Death Act and Advance Directives for Health Care Acts*, 16(1) Seton Hall Legislative J. 177–97 (1992); Olick, supra note 16.

[25] N.J. Rev. Stat. § 26:6A-3.

[26] This is due in part because New Jersey has a large Jewish population. M.A. Grodin, *Religious Exemptions: Brain Death and Jewish Law*, 36 J. Church & State 357–72 (1994); Olick et al., supra note 16.

[27] N.J. Rev. Stat. § 26:6A-5; N.J. Admin. Code § 13:35-6A.6.

[28] *Employment Division v. Smith*, 494 E.S. 872, 887 (1990); *United States v. Meyers*, 906 F. Supp. 1494, 1499 (D. Wyo. 1995).

[29] 29 C.F.R. § 1605.1.

[30] *Life Support Is Removed After a Court Order*, N.Y. Times (February 20, 1998).

In other words, the New Jersey statute grants objecting individuals an "exemption" or "loophole" from the generally accepted standards for determining death. The New Jersey statute requires "indefinite accommodation" of religious objections by health care providers.[31] This law is unique in changing the patient's life/death status. One consequence is that the same person could be legally dead in Pennsylvania, yet, by merely crossing the Delaware River, still be legally alive in New Jersey.

B. *New York: Reasonable Accommodation*

New York judicially recognized DDNC in 1984.[32] In 1986, the New York State Task Force on Life and the Law recommended that the Department of Health recognize this standard.[33] And in 1987, the NYDOH adopted the Task Force's recommendation in administrative regulations.[34] But the NYDOH did more than formally recognize DDNC. It also required hospitals to accommodate religious or moral objections to DDNC.

In 2011, the NYDOH clarified its regulation. Specifically, the NYDOH confirmed that the New York accommodation requirement is not a categorical exception like the New Jersey accommodation requirement. Religious or moral objections to DDNC cannot change one's life/death status. Instead, New York hospitals must merely "establish written procedures for the reasonable accommodation of the individual's religious or moral objections to use of the brain death standard" when such an objection has been expressed by the patient or surrogate.[35]

In New York, the duty of accommodation is far less demanding than in New Jersey. The NYDOH leaves hospitals substantial discretion in designing their accommodation policies. Under the regulation, policies "may" include specific accommodations, such as "the continuation of artificial respiration under certain circumstances, as well as guidance on limits to the duration of the accommodation."[36] One major New York hospital provides up to 72 hours.[37] Policies "may" also provide guidance on "the use of other resources, such as clergy members, ethics committees, palliative care clinicians, bereavement counselors, and conflict mediators to address objections or concerns."[38]

[31] See Flamm et al., supra note 21.
[32] *People v. Eulo*, 63 N.Y.2d 341 (N.Y. Ct. App. 1984).
[33] New York State Task Force on Life & the Law, supra note 20.
[34] 10 N.Y.C.R.R. § 400.16 (1987).
[35] New York State Department of Health and New York State Task Force on Life & the Law, *Guidelines for Determining Brain Death* (November 2011), available at www.health.ny.gov/professionals/hospital_administrator/letters/2011/brain_death_guidelines.pdf [https://perma.cc/MUE4-V6WH].
[36] Id., at 4.
[37] New York City Health and Hospital Corporation, *Corporate Brain Death Policy*, available at http://thaddeuspope.com/braindeath.html [https://perma.cc/V2P2-3BE5].
[38] NY Guidelines, supra note 35, at 4.

C. *California: Reasonable Accommodation*

California recognized DDNC when it adopted the Uniform Determination of Death Act in 1982.[39] But, in 2009, a new California statute expanded the obligations of hospitals with respect to patients declared dead on the basis of neurological criteria.[40] California does not carve out a categorical exception like New Jersey. But, in two respects, the California duty of accommodation is broader and more expansive.

First, both New Jersey and New York require accommodation of *only* religious or moral objections. Indeed, the NYDOH specifically addresses objections to the DDNC based either upon psychological denial that death has occurred or upon an alleged inadequacy of the brain death determination. The NYDOH confirms that since such objections are not based upon the individual's moral or religious beliefs, reasonable accommodation is not required in such circumstances.[41]

In contrast, California requires accommodation of ***all types*** of objections. The California statute requires that general acute care hospitals adopt a policy for providing family with a "reasonably brief period of accommodation" after DDNC.

But while broad in the types of objections covered (e.g., religious, moral, psychological), the California duty of accommodation is limited in several material respects. It requires maintenance of only one type physiological support and only for one specific and objectively attainable purpose. First, during the "reasonably brief period of accommodation," a hospital is required to continue only previously ordered cardiopulmonary support. No other medical interventions are required. Second, the "brief period" is narrowly defined as only "an amount of time afforded to gather family or next of kin at the patient's bedside."[42] This usually entails an accommodation under 24 hours in duration.[43] Some hospitals permit up to 36 hours.[44]

The second respect in which the California duty of accommodation is broader (at least than that in New York) concerns religious objections. If the patient's legally

[39] Cal. Health & Safety Code §§ 7180–1.

[40] Cal. Health & Safety Code § 1254.4(a).

[41] However, hospital staff should demonstrate sensitivity to these concerns and consider using similar resources to help family members accept the determination and fact of death. Among other interventions, family presence during DDNC improves understanding without an adverse impact on psychological wellbeing. I. Tawil et al., *Family Presence during Brain Death Evaluation: A Randomized Controlled Trial*, 42(4) Critical Care Med. 934–42 (2014).

[42] Cal. Health & Safety Code § 1254.4(b).

[43] See, e.g., Flamm et al., supra note 21; New York City Health and Hospital Corporation, supra note 37; Southern California Bioethics Committee Consortium, Survey (2015).

[44] Cedars Sinai Medical Center, FAQs: AB2565: *The Accommodation of Brain Death Act*, available at www.cedars-sinai.edu/Patients/Programs-and-Services/Healthcare-Ethics-/Documents/2565-FAQs-NEW-PDF-158326.pdf [https://perma.cc/39GF-U93V]; *Winkfield v. Children's Hospital Oakland*, No. 4:13-CV-05993-SBA (N.D. Cal. 20 December 2013) (Opposition to Proposed TRO and Injunctive Relief) (noting that CHO has considered 2–3 days a reasonable accommodation in DDNC cases over the past 10 years).

recognized health care decision maker, family, or next-of-kin voices any special religious or cultural practices and concerns, the hospital must make "reasonable efforts to accommodate those religious and cultural practices and concerns." The legislative history suggests that the intended accommodations include permitting rituals such as herbal applications and washings.[45]

This duty of religious/cultural accommodation is broader than California's general duty of accommodation.[46] And it is broader than the NYDOH duty of moral or religious accommodation. For example, the hospital must accommodate not only the patient's, but also the family's, objections. But it is unclear exactly how much is required. The only guidance in the statute states, "in determining what is reasonable, a hospital shall consider the needs of other patients and prospective patients in urgent need of care."[47]

D. *Illinois: Take into Account*

Illinois recognized DDNC in 1983.[48] In 2007, Illinois amended its hospital-licensing act to include an accommodation requirement.[49] The statute provides: "Every hospital must adopt policies and procedures to allow health care professionals, in documenting a patient's time of death at the hospital, to take into account the patient's religious beliefs concerning the patient's time of death."[50]

While prima facie similar to accommodation requirements in other states, the Illinois language is distinctly weaker. Like California and New York, the statute delegates to hospitals discretion in defining the accommodation by directing that they "adopt policies and procedures." But the Illinois statute imposes no specific accommodation requirement. It uses permissive instead of mandatory language. The hospital's policies and procedures need only "allow" health care professionals to "take into account" the patient's religious beliefs concerning the patient's time of death.

Take, for example, the policy at the University of Illinois-Chicago. It provides: "After the patient is declared dead, life support mechanisms ***should*** be

[45] Wijdicks, supra note 15, at 209–10.

[46] *Dix v. Superior Court*, 53 Cal.3d 442, 459 (1991) ("[W]e avoid statutory constructions that render particular provisions superfluous or unnecessary.").

[47] Cal. Health & Safety Code § 1254.4(d). In both the McMath and Lopez cases the hospitals argued that accommodating dead patients would adversely impact the ability to serve other patients with a better prospect for benefit. Relatedly, justice arguments are increasingly common in the futility context. See, e.g., T.N. Huynh et al., *The Opportunity Cost of Futile Treatment in the ICU*, 42 Critical Care Med. 1977–82 (2014).

[48] In re Haymer, 450 N.E.2d 940 (Ill. App. 1983).

[49] Ill. Pub. Act No. 095-0181.

[50] 210 ILCS 85/6.23.

removed . . ."[51] This seems to appropriately "allow" a physician to "take into account" the patient's religion and continue physiological support after DDNC. This leaves accommodation to the discretion of individual clinicians.

On the other hand, by permitting a deviation in "documenting" a patient's time of death, the statute may actually operate more like the law in New Jersey than the laws in New York or California. In other words, instead of mandating certain duties after DDNC, it may permit clinicians to declare death later than the time of DDNC.

5. HOSPITALS DO NOT ALWAYS ACCOMMODATE RELIGIOUS OBJECTIONS TO DDNC

California, Illinois, New Jersey, and New York have significant populations of objecting religions.[52] But these are not the only states in which individuals have asserted religious objections to DDNC. Without a legal mandate, requests for accommodation are more commonly denied.[53] Here are just three examples.

Shahida Virk was declared dead in Michigan. Her husband and his religious leader asked for accommodation, explaining that removal of physiological support "would constitute murder in the Islamic faith."[54] But the hospital denied the request. An appellate court later affirmed the dismissal of the family's tort and contract claims because the hospital had "no duty to accommodate or give preferential treatment."[55]

Similarly, Motl Brody was declared dead in Washington, D.C. His Orthodox Jewish parents objected to DDNC and asked for continued physiological support, but the hospital refused. The parents were unable to obtain a court order.[56]

Finally, in Massachusetts, Cho Fook Cheng was declared dead. But Cheng's family refused to let doctors stop physiological support. They said that their belief as Buddhists was that Cheng's beating heart meant his spirit and consciousness were

[51] University of Illinois Medical Center, *Determination of Neurologic Death in Adults and Children* (April 2010), available at http://thaddeuspope.com/images/U_Illinois_Chicago_neurodeath.pdf [https://perma.cc/3SQJ-FL5F] (emphasis added).

[52] See Olick, supra note 16.

[53] Ariane Lewis et al., *Prolonging Support after Brain Death when Families Ask for More*, 24 Neurocritical Care 481 (2016). See also Chaim David Zwiebel, *Accommodating Religious Objections to Brain Death: Legal Considerations*, 17 J. Halacha & Contemp. Soc'y 49, 50 (1989) ("[I]nformal accommodation is by no means universal."). On the other hand, courts usually grant temporary restraining orders preserving the status quo until more evidence can be gathered and presented to adjudicate the claims. T.M. Pope, *Involuntary Passive Euthanasia in U.S. Courts: Reassessing the Judicial Treatment of Medical Futility Cases*, 9 Marquette Elder's Advisor 229–68 (2008).

[54] *Virk v. Detroit Receiving Hosp.*, No. 180621, 1996 WL 33348748, at *1 (Mich. Ct. App. October 25, 1996) (unpublished).

[55] Id.

[56] In re Motl Brody, No. 1:08-CV-01898 (HHK) (D.D.C. 2008).

not ready to move on.[57] But the hospital went to court to get an order allowing its clinicians to stop physiological support.

6. HOSPITALS SHOULD BE REQUIRED TO ACCOMMODATE RELIGIOUS OBJECTIONS TO DDNC

States have a significant interest in a uniform standard for the determination of death.[58] But this interest is not weighty enough to justify not accommodating those with religious objections. Opponents argue that practical considerations make accommodation "unworkable."[59] But their arguments are not compelling. Even Teneille Brown concedes, in her chapter herein, that a short accommodation period would not materially impede compelling state interests.

A. Five Reasons to Accommodate Religious Objections

For five reasons, uniformity will not be undone by a brief period of reasonable accommodation. First, accommodation already works in four populous states. Second, it affects very few cases. Third, because of its limited duration and scope, accommodation would work equally well in other states. Fourth, accommodation is not analogous to wholesale exemption. Fifth, DDNC is a more fragmented and contested concept today than it was when other states enacted their religious accommodation requirements.

1. **Accommodation already works in four populous states.** Perhaps the best evidence in support of accommodating religious objections to DDNC is the positive track record in the four states that already require it. New York has required accommodation of religious objections since 1986. New Jersey has required accommodation since 1991. And Illinois and California have required it for nearly ten years. In none of these four states have any deleterious consequences (material or otherwise) been reported.
2. **Expanding accommodation impacts very few cases.** Accommodation requirements affect a very small population. Only 30 percent of U.S. deaths occur in

[57] Megan Tench, After Buddhist Dies, Legal Battle Continues, Boston Globe, December 3, 2006.

[58] See, e.g., President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Defining Death: Medical, Legal, and Ethical Issues in the Determination of Death* (1981); New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care, *The New Jersey Advance Directives for Health Care and Declaration of Death Acts Statutes, Commentaries and Analyses* 86–9 (1991).

[59] New York State Task Force, supra note 20, at 12; Veatch and Ross, supra note 16 at 112 (referring to "policy chaos").

a hospital.[60] Less than 1 percent of these hospital deaths are by DDNC.[61] Since those with religious objections comprise only 2 percent of the U.S. population, only 0.006 percent of deaths might involve an accommodation.[62] Since there are 2.5 million annual deaths, that is just 150 cases nationwide in a year. Most of those are in the four states that already legally mandate accommodation. These four states comprise one-fourth of the U.S. population and an even higher percentage of the objecting religions. Therefore, the net marginal impact of expanding accommodation would be minimal.

3. **Accommodation is limited in duration and type.** Furthermore, even for this small subset of cases, accommodation is not disruptive. It is limited in both duration and type.[63] As implemented in California, Illinois, and New York, the accommodation is for only a limited time; hospitals usually continue physiological support for just 24 hours,[64] and that physiological support is normally limited to mechanical ventilation. It does not include vasopressors, hormones, or antibiotics. Moreover, not even mechanical ventilation is required if the hospital resources are needed for a living patient.

4. **Accommodation is not exemption.** Some have argued that accommodation would be unworkable because people's objections "range on a spectrum."[65] Indeed, some prominent scholars have argued for permitting people to "opt in" to being determined dead on a "higher brain death" standard.[66] But no state has actually done that. New Jersey permits an "opt out," and even that retains a single standard (cardiopulmonary) that is already universally accepted.

The unworkability objection applies only to the type of expansive accommodation seen in New Jersey. Only New Jersey grants a complete exemption from DDNC, and only New Jersey requires insurance coverage after DDNC. In contrast, accommodation laws in California, Illinois, and New York do not change the individual's life/death status. Unlike New Jersey, these laws preserve

[60] CDC National Center for Health Statistics, *Trends in Inpatient Hospital Deaths: National Hospital Discharge Survey, 2000–10*, NCHS Data Brief No. 118 (March 2013), available at www.cdc.gov/nchs/data/databriefs/db118.htm [https://perma.cc/NH9-8HWE].

[61] L.A. Siminoff, *Families' Understanding of Brain Death*, 13 Progress Transplantation 218–24 (2003) (estimating only 50 DDNC per million).

[62] Pew Forum on Religion and Public Life, *U.S. Religious Landscape Survey Religious Affiliation: Diverse and Dynamic* (2008).

[63] Cf. Martin L. Smith & Anne L. Flamm, *Accommodating Religious Beliefs in the ICU: A Narrative Account of a Disputed Death*, 1 Narrative Inquiries Bioethics 55–64 (2011).

[64] See Lewis et al., supra note 53.

[65] New York State Task Force, supra note 20, at 12.

[66] See Veatch & Ross, supra note 16.

the uniformity of the determination of death, and instead only change hospital duties after DDNC, recognizing plurality and diversity by allowing a brief period of accommodation.[67]

5. **Value-laden nature of brain death.** While DDNC is widely accepted, it has never been universally supported. It has been described as "at once well settled and persistently unresolved."[68] For decades, DDNC has been subjected to persuasive criticisms and serious concerns.[69] Central to these criticisms and concerns is the fact that the bodies of individuals determined dead by neurological criteria still do many of the things done by living organisms. For example, these "brain dead" bodies can still heal wounds, fight infections, mount a stress response to surgical incisions, and even gestate a fetus.[70] In 2008, these theoretical and practical problems were acknowledged but ultimately dismissed by the President's Council on Bioethics.[71]

But more recently, these long-standing disagreements over DDNC's validity have been reignited. Controversies over DDNC have "taken on new life in medical, ethical, and public debate."[72] For example, the Supreme Court of Nevada seriously questioned whether standard medical assessments of DDNC satisfy the legal standard for death.[73] As currently implemented, DDNC does not literally measure the cessation of "all" functions of the "entire" brain. Instead, the medical profession has decided that the cessation of only some functions is sufficient. Other lawsuits even more directly attack generally accepted medical criteria for DDNC.[74]

In short, DDNC is increasingly seen as a contested value judgment rather than as a scientific, objective truth. Since there is no way to adjudicate the "correctness" of competing moral or religious judgments, the case for accommodating those with alternative values becomes more compelling.[75]

[67] Geoffrey Miller, *Reexamining the Origins and Application of DDNC*, 13 J. Bioethics Inquiry 27 (2016).

[68] Alexander M. Capron, *Brain Death: Well Settled, Yet Still Unresolved*, 344 New Eng. J. Med 1244 (2001).

[69] See Pope, supra note 1.

[70] D.A. Shewmon, *Constructing the Death Elephant: A Synthetic Paradigm Shift for the Definition, Criteria, and Tests for Death*, 35 J. Med & Phil. 223 (2010).

[71] President's Council on Bioethics, *Controversies in the Determination of Death* 6 (2008).

[72] S.H. Johnson, *Death, State by State*, 44 Hastings Center Rep. 9–10 (2014).

[73] Thaddeus M. Pope, *Legal Standards for Brain Death*, 13 J. Bioethical Inquiry 173 (2016).

[74] See, e.g., *Winkfield v. Rosen*, No. RG15760730 (Alameda County Sup. Ct., Cal. 2016); *Fonseca v. Kaiser Permanente*, No. 2:16-cv-00889-KJM-EFB (E.D. Cal. 2016).

[75] Veatch & Ross, supra note 16, at 42, 105, 119.

B. *Accommodation vs. Exemption*

Some commentators have argued that these five reasons justify more than just a limited accommodation. They contend that these considerations support a wholesale exemption from DDNC, as in New Jersey. While this argument has significant weight, it is not clearly dispositive.

First, expanding exemption would impede state interests in uniformity far more than mere accommodation. Second, we must more carefully assess prior experience with exemption before making such a drastic move. While New Jersey has served as the laboratory, its outcomes have not been reported or assessed. We need more evidence before copying that model.

Third, it would be anomalous to require clinicians to indefinitely accommodate religious objections to DDNC when we do not require them to indefinitely accommodate religious objections in more common, less-drastic medical situations when the family's claims are stronger (such as family-clinician conflicts over continuing dialysis for patients in a persistent vegetative state). For the sake of consistency, if we permit a religious opt-out for brain death, then we should also allow a religious opt-out from medical futility rules and policies. But the consequences of extending clinician duties this far are uncertain.

In short, although the case for accommodation is clear, the case for exemption requires more empirical substantiation. Proponents may be correct that the ethical case for exemption may be just as strong as the case for reasonable accommodation. But the legal case must also consider the practical consequences. These still remain unknown and potentially hazardous.

CONCLUSION

The state's interests in the uniform legal recognition of DDNC are not sufficiently weighty to justify compelling those with contrary religious beliefs to accept determinations of death on these grounds. But only four states strike a minimally appropriate balance in requiring hospitals to accommodate religious objections to DDNC. Other states should follow their lead and enact laws mandating hospitals to *reasonably* accommodate such objections without necessarily fully exempting them.

Court File No.:

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N :

SHALOM OUANOUNOU, BY HIS SUBSTITUTE DECISION-MAKER AND LITIGATION GUARDIAN, MAXIME OUANOUNOU

Applicant

- and -

HUMBER RIVER HOSPITAL, ALI GHAFOURI, GARRET PULLE, SANJAY MANOCHA, DAVID GIDDONS, CORONER, REPRESENTATIVE OF THE OFFICE OF THE CHIEF CORONER

Respondents

AFFIDAVIT OF ELIYAHU ZRIHEN

I, Eliyahu Zrihen, of the City of Vaughan, in the Province of Ontario make oath and say as follows:

1. I am a Rabbi and Teacher of Jewish Law Philosophy and Ethics at the Keter Torah Learning Centre in Thornhill, Ontario.

2. From 2010 to present, I have served in this role.

3. My duties include organizing and teaching programs on Jewish Law, Ethics and Philosophy, conducting family and marriage counselling and assisting families with

bereavement and the rituals of shiva following death. I regularly lead shiva sessions at various times throughout the week for families who have lost loved ones. This involves directing families in prayer relative to Jewish tradition.

4. I also visit with people regularly in hospital and with their families. I have extensive experience working with younger people and visit younger people at hospitals 1-2 days per week.

5. My teaching duties are usually done daily for 5 hours per day between 9:30 and 1:00 pm. I also am engaged in discussion groups throughout the week with members of our centre and the community.

6. My classes include the teaching of Jewish Codified Law including Talmud, Jewish Philosophy and Ethics.

7. From 2002 through 2010, I attended Kollel Yasmach Moshe in Toronto. This is a Biblical and Talmudic College, where Rabbis and individuals seeking advanced knowledge and understanding of Jewish Theology, Law, Philosophy and Ethics attend after completing time at a Jewish Yesheva.

8. Upon completion of my program at Kollel, I was ordained by the Chief Rabbi of Israel.

9. This program comprised 10 years of study of Judaic Ethics, Philosophy and Codified Law.

10. The program is akin to a PHD program in a Canadian University system. The Kollel is an Institute of Advanced Judaic Studies.

11. Throughout this program, I would be engaged in regular, often nightly discussions and study sessions with members of the community, I would teach Codified Jewish Law, Philosophy and Ethics.

12. In around 2006, I met Shalom at Kollel.

13. Shalom has been a student of mine in Judaic studies including in the subjects of Jewish law, philosophy and ethics since he was approximately 14 years old.

14. From 2006 to present, Shalom would attend for classes once per week for approximately 1.5 hours per week.

15. As part of our classes and discussions over the course of time, we would periodically address issues of life and death, including such matters as euthanasia, assisted suicide, withdrawal of medical treatment, brain death and death under Jewish Law. We also addressed the subject of organ donation.

16. I recall detailed discussion approximately 3 years ago with Shalom in which we discussed the question of organ donation and its complexity under Jewish Law.

17. We also discussed the question of death under Jewish Law and how that required the heart to stop beating and breathing to stop.

18. We particularly discussed the question of withdrawal of life support and how this can be considered murder legally and ethically under Jewish Law according to our beliefs.

19. Shalom is a strict adherent to Orthodox Jewish legal tenets.

20. Shalom strictly believes that under Jewish Law, brain death was not death and that death does not occur until the heart stops beating and a person stops breathing.

21. These Halachic laws and beliefs are supported by many Jewish texts and codified laws.

22. While there is no question that there is debate within the broader Jewish community, strict and traditional Jewish Halachic Law, which Shalom follows, does not endorse brain death. The attached article by Rabbi Breitowitz at Exhibit "1" highlights the nature of the debate regarding brain death, Halachic Jewish Law, and the need for a religious exemption from brain death determination.

23. Under the Talmud, as part of tractate Yoma, it discusses when a wall falls on top of a person, it may be unclear if the person is alive or dead.

24. Jewish Law requires that even on Yom Kippur or the Sabbath, we must take all steps possible to save a life, even if we are uncertain if that person is alive or dead.

25. Maimonides speaks of the Laws of Shabat.

26. He notes that it is acceptable to desecrate the Sabbath to save a life. He speaks of the method by which one determines life by checking for breath and a heartbeat.

27. These principles are reflected at various places in Jewish Law, including in the Code of Jewish Law, Chapter 329.

28. Even as part of contemporary Halachic Law, Moses Feinstein in his responsa in the Igot Moshe Journal, and in the Yoreh Deah at Volume 3 speaks of how where a person is in a coma and on a ventilator, that it is not permissible to turn off the machine as to do so would be to hasten or cause death.

29. Such actions are strictly forbidden under Jewish Law and are considered tantamount to murder. Feinstein notes that the ventilator should be maintained so long as it is assisting the person to breathe regardless of whether the person would be able to

breathe on their own without the machine. These are also my beliefs and Shalom's beliefs based on traditional orthodox Jewish teachings.

30. Shalom spoke of the notion of complete death. His specific belief was that for a person to be dead, they must die complete. He also believes that a person should go to the grave complete, that is physically intact.

31. He expressed the belief during our discussion about organ donation about how it is best to bury the body complete. These were his express religious beliefs held for many years.

32. In the circumstances, to remove the ventilator and life support from Shalom would be impermissible based on his beliefs until his heart had stopped and he was incapable to breathe. At that time, he would be considered dead under Jewish Law.

33. For these reasons, it is clear to me that Shalom's express religious beliefs and values would support maintaining the ventilator and to withdraw it would represent fundamental disrespect for Shalom's religious beliefs and Jewish identity.

I swear this Affidavit in support of the Applicant's Application and for no other improper purpose.

Sworn before me at the City of Toronto, in the Province of Ontario, on the 25th day of October, 2017.

A Commissioner, etc.

NATALIA KROUKOVA, B.A., J.D.,
Barrister & Solicitor, Notary Public
519 Marlee Avenue
Toronto, Ontario M6B 3J3

ELIYAHU ZRIHEN

Court File No.:

SHALOM OUANOUNOU, BY HIS SUBSTITUTE DECISION MAKER **v.** **HUMBER RIVER HOSPITAL ET AL**
Applicant Respondents

ONTARIO
SUPERIOR COURT OF JUSTICE

Proceedings commenced at Toronto

AFFIDAVIT OF
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Solicitor for the Applicant

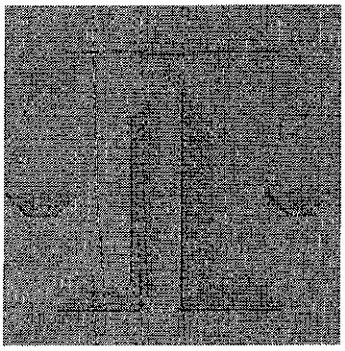
This is Exhibit "1" referred to in the Affidavit of

Eliyahu Zrihen sworn before me, this 30th *day of* October

, 2017.

A Commissioner of taking Affidavits

NATALIA KROUKOVA, B.A., J.D.,
Barrister & Solicitor, Notary Public
519 Marlee Avenue
Toronto, Ontario M6B 3J3



The Brain Death Controversy in Jewish Law
Rabbi Yitzchok A. Breitowitz

The Brain Death Controversy in Jewish Law

Rabbi Yitzchok A. Breitowitz

Historically, death was not particularly difficult to define from either a legal or halachic standpoint. Generally, all vital systems of the body-respiratory, neurological, and circulatory-would fail at the same time and none of these functions could be prolonged without the maintenance of the others. Today, with major technological advances in life support, particularly the development of respirators and heart-lung machines, it is entirely possible to keep some bodily systems "functioning" long after others have ceased. Since we no longer face the inevitable simultaneity of systemic failures, it has become necessary to define with greater precision and specificity which physiological systems are indicators of life and which (if any) are not, especially in light of the scarcity of medical resources and the pressing need for organs for transplantation purposes. Over the past 20 or so years, the concept of "neurological death" commonly called "brain death," "whole brain death" or "brain-stem death" (and, sometimes, inaccurately-termed "cerebral death") has gained increasing acceptance within the medical profession and among the vast majority of state legislatures and courts in the United States. Whether this standard comports with halacha is a matter of great controversy among rabbinic authorities. The purpose of this article is not to take sides nor in any way resolve the halachic debate. Its purpose is more modest. This article will attempt to explain to the general reader: (1) what is "brain death" and how is it clinically determined; (2) some (not all) of the major sources on whether it is an acceptable criterion of death from the standpoint of halacha; (3) a "scorecard" on how contemporary authorities line up; and (4) the halachic and legal ramifications of one view or the other.

I. WHAT IS "BRAIN DEATH" AND HOW IS IT DIAGNOSED?

The concept of total "brain death" as an alternative to the older definition of irreversible circulatory-respiratory failure was first introduced in a 1968 report authored by a special committee of the Harvard Medical School[2] and was later adopted, with some modifications, by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research, as a

recommendation for state legislatures and courts.[3] The "brain death" standard was also employed in the model legislation known as the Uniform Determination of Death Act which has been enacted by a large number of jurisdictions and the standard has been endorsed by the influential American Bar Association. While New York is one of the few jurisdictions that does not have a "brain death" statute, it has adopted the identical rule through the binding decisions of its highest court.[4]

The rapid, and near universal, acceptance of neurological criteria of death is probably attributable to three factors. First, moving the time of death to an earlier point facilitates organ transplants, and indeed makes such transplants possible. Organs, especially hearts and livers, are suitable for transplantation only if they are removed at a time when blood is still circulating. Once cardiac arrest stops circulation, rapid tissue degeneration makes the organ unsuitable for such use. Given the increasing success of these operations and the relative uselessness (from a secular standpoint!) of sustaining "brain dead" patients on respirators, there is a natural temptation to redefine death so that organs become available to serve higher ends. It is no coincidence that the movement towards acceptance of "brain death" coincided with the development of cyclosporine and other anti-rejection drugs.

Additional considerations involve triage and allocation of scarce medical resource. It is extraordinarily expensive (in terms of equipment and labor) to maintain patients on respirators and other life support and using these resources for "brain dead" patients prevents their deployment for those who stand a better chance of recovery. Yet a third impetus towards redefinition is an understandable desire to spare families the agony and anguish of watching a loved one experience a protracted death.

For whatever the reason, the current definition of "death" is now a composite one: death is deemed to occur when there is either irreversible cessation of circulatory and respiratory functions (the "old" definition) or irreversible cessation of all functions of the entire brain including the brain stem.[5] The principal utility of this second standard permits declaring as dead a comatose, ventilator-dependent patient incapable of spontaneous respiration but whose heart is still beating due to the provision of oxygen via an artificial breathing apparatus.

At the outset, two points must be made absolutely clear. First, contrary to the misperceptions of many lay people, "brain death" is not synonymous with merely being comatose or unresponsive to stimuli. Indeed, even a flat EEG (electro-encephalogram) does not indicate brain stem destruction.[6] The human brain consists of three basic anatomic regions: (1) the cerebrum; (2) the cerebellum; and (3)

the brain stem consisting of the midbrain, the pons, and the medulla, which extends downwards to become the spinal chord. The cerebrum controls memory, consciousness, and higher mental functioning. The cerebellum controls various muscle functions while the brain stem controls respiration and various reflexes (e.g., swallow and gag). A patient may be in a deep coma and nonresponsive to most external stimuli but still very much alive. At most, such patients may have a dysfunctional cerebrum but, by virtue of the brain stem remaining intact, are capable of spontaneous respiration and heartbeat. Indeed, the most famous of these cases, Karen Ann Quinlan, was able to live off a respirator for almost a decade. While such persons may be popularly referred to as brain dead, they are more accurately described as being in persistent vegetative state [PVS] and are very much alive under both secular and Jewish law. Removal of organs such a donor would indisputably be homicide. This is even more true for the phenomenon known as being "locked-in" where the patient is fully conscious but unable to respond.

A second point to keep in mind is the relationship among respiration, circulation, and the brain. The heart, like any organ, or indeed cell, needs oxygen to survive and without oxygen will simply stop beating. Respiration, in turn, is controlled by the vagus nerve whose nucleus is located in the medulla of the brain-stem. The primary stimulant for the operation of the nerve is the presence of excess carbon dioxide in the blood. When stimulated, the nerve causes the diaphragm and chest muscles expand, allowing the lungs to fill with air. Spontaneous respiratory activity can therefore not continue once there is brain stem destruction or dysfunction. The heart, on the other hand, is not controlled by the brain but it is autonomous. It is obvious, of course, that the brainstem will inevitably lead to cardiac cessation not because of any direct control the brain stem exercises over the heart but simply because the heart muscle is deprived of oxygen. Where, however, the patient's intake of oxygen is being artificially maintained, the heart may continue to beat blood and circulate for a considerable amount of time after the total brain-stem destruction. The time lag between brain death and circulatory death is on the average only two to ten days, though there is at least one case on record where a woman's heart continued to beat for 63 days after a diagnosis of brain death.[7] (Indeed, she delivered a live baby through Caesarean section.) It is this crucial gap between cessation of spontaneous respiration and cessation of the heart beat that defines the parameters of the phenomenon called "brain-stem death."

The steps taken in a clinical diagnosis of "brain-death" vary from medical center to medical center and those differences may have significant halachic repercussions but will typically involve the following:[8] (1) a determination that the patient is in a deep coma and is profoundly unresponsive to external stimuli; (2) absences of elicitable brain-stem reflexes such as swallowing, gag, cough, sigh, hiccup, corneal, and vestibulo-ocular (ear); (3) absence of

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spontaneous respiration as determined by an apnea test;[9] and (4) performance of tests for evoked potentials testing the brain-stem's responsiveness to a variety of external stimuli. These tests are to be repeated between 6-24 hours later to insure irreversibility - with life support supplied for the interim - and a specific cause for brain dysfunction must be identified before the patient will be declared dead.[10]

An additional test that is sometimes employed (when other clinical tests are deemed inconclusive) is radionuclide cerebral angiography [nuclide or radioisotope scanning]. A harmless radioactive dye is injected into the patient's blood-stem, typically through the intravenous tubing already in place. In brain-dead patients, scanning will reveal an abrupt cutoff of circulation below the base of the brain with no visible fluid draining away. While many observers have described this test as nearly 100% accurate, others have claimed the brain-stem circulation, especially in the medulla, is not well visualized and absolute absence of blood flow to this region cannot be diagnosed with certainty.[11]

Note that a patient who is brain dead may theoretically continue to have muscle spasms or twitchings or even sit up. Whether this so-called Lazarus Reflex is an indicator of life will be discussed in due course; what is undisputed is that such movements are coordinated from the brain from the brain but solely from the spinal cord. It should also be noted that there are several instances of clinically brain dead patients carrying live babies to term.[12] Again, this may or may not be significant.

II. IS BRAIN DEATH AN ACCEPTABLE HALACHIC CRITERION OF DEATH?

The question breaks down into distinct issues. First, is irreversible dysfunction of the entire brain a valid criterion of death? Second, even if the answer is yes, are the medical test currently utilized in establishing such a condition halachically valid indicators of its presence? One could easily subscribe to "whole brain" death as a concept and yet reject the particular diagnostic tools employed.

There are a number of halachic sources that are relevant to the question of "brain death", the most important being the *Mishnah* in *Oholot* 1:6, the Talmud in *Yoma 85a*, passages in *Teshuvot Chatam Sofer* and *Teshuvot Chacham Tzvi*, and various pronouncement of R. Moshe Feinstein in his *Iggrot Moshe*.[13] This is not the forum for a detailed examination of these sources other than to note that a number of them are equivocal and subject to a variety of interpretations.

Briefly stated, the Mishnah in Oholot establishes the dual propositions that, first, physical decapitation of an animal is a conclusive indicator

of death and second, some degree of subsequent movement is nit incompatible with a finding of death provided that such movement qualifies as spastic in nature (*pirchis be'alma*) like the twitching of the "severed tail of a lizard." The Talmud in *Yoma 85a*, detailing with a person trapped under a building, rules that a determination of respiratory failure establishes death without the need to continue to uncover the debris to check heartbeat. Proponents of "brain death" argue that a dysfunctional brain-stem is equivalent to a decapitated one (physiological decapitation), that destruction of the brain-stem inevitably means inability to spontaneously respire (meeting the criterion in *Yoma*) and that subsequent "movement," whether the Lazarus Reflex or the heartbeat, falls into category of *pirchus* since such movement is not coordinated from a "central root and point of origin,"[14] ie., the brain.

The counter-arguments are: first, physiological dysfunction is not the equivalent of anatomical decapitation. The only phenomenon short of actual decapitation that might similarly qualify is total liquefaction (lysis) of the brain, something that probably does not occur until well after cardiac arrest. Second, according to Rashi in *Yoma*, cessation of respiration is a conclusive indicator of death only when the person is "comparable to a dead man who does not move his limbs." While certain forms of postmortem movement may be characterized as merely spastic and would not qualify as "movement," the rhythmic coordinated beating of the heart and the maintenance of a circulatory system can hardly be characterized as *pirchus* since such a heartbeat is life-sustaining and identical to that in a normally functioning individual. Reference is also made to the *teshuvot* of *Chatam Sofer* and *Chacham Tzvi* who both write that it is only the cessation of respiration and pulse (heartbeat) that allows for a determination of death and the *Gemara* in *Yoma* merely creates a presumption that upon cessation of respiration and an appropriate waiting time, one is permitted to assume that heartbeat has stopped as well. Since this assumption is obviously not true in the case of "brain dead" patients hooked up to respirators whose heartbeats are monitored, such patients may not be declared as dead.

The position of R. Moshe Feinstein, whose psak could well have been definitive at least in the United States, is unfortunately a matter of some controversy. His son-in-law, Rabbi Dr. Moshe Tendler, a Rosh Yeshiva in RIETS and Professor of Biology, Yeshiva College, has vigorously argued the concept of decapitation in *Mishnah Oholot*.[15] His position finds strong support in *Iggrot Moshe, Yoreh Deah III* no. 132 which seems to validate nuclide scanning as a valid determinant of death. This is also the understanding of the Israeli Chief Rabbinate, R. David Feinstein (who admits, however, to having no inside information on the topic), and R. Shabtai Rappaport, the editor of R. Moshe responsa.[16]

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Others, however, have interpreted his *teshuvot* very differently,

pointing out that R. Moshe reiterated twice (indeed, in one instance two years after the "nuclide scanning" reference) that removal of an organ for a transplantation was murder of the donor.[17] (R. Tendler's response: Both of those *teshuvot* refer to comatose patients in a persistent vegetative state who are capable of spontaneous respiration and are very much alive and not to those who are respirator-dependent.) They also cite R. Moshe's express opposition to proposed "brain death" legislation in New York unless it contained a "religious exemption."[18] (R. Tendler's response: Although R. Moshe accepted the concept of "brain death," his support of an exemption was simply to accommodate the view of other religious Jews who disagree.) Finally, they note that in the very *teshuvah* upholding the use of angiographic scanning, R. Moshe approvingly cites *Teshuvot Chatam Sofer*, Y.D. no. 338, who insists on absence of *dofeik* to breathe, and no other sign of life is recognizable with them (*Vegam lo nikarim behem inynei chiyut achairim*). Their conclusion: R. Moshe merely validated nuclide scanning as a criterion to verify one determination of death, i.e., absence of respiration, but did not maintain that it alone was sufficient.[19] This author certainly lacks both the competence and the authority ro resolve this dispute but presents it to the reader so that he may see why this area has been so fraught with unresolved controversy.

III. CONTEMPORARY VIEWS

The following is a cataloging of the major schools of thought among contemporary *poskim* and *rabanim* on the brain death issue and some of the recent events connected with this question.

1. As noted, Rabbi Dr. Moshe Tendler has been the most vigorous advocate for the halachic acceptability of brain death criteria. In his capacity as chairman of the RCA's Biomedical Ethics Committee, Rabbi Tendler spearheaded the preparation of a health-care proxy form that, among other innovations, would authorize the removal of vital organs from a respirator dependent, brain death patient for transplantation purposes. Although the form was approved by the RCA's central administration, its provisions on brain death were opposed by a majority of the RCA's own *Vaad Halacha* (Rabbis Rivkin, Schachter, Wagner and Willig).[20]

2. The Israeli Chief Rabbinate Council, in an order dated Cheshvan 5747, has also approved the utilization of "brain death" criteria in authorizing Hadassah Hospital to perform heart transplants but on a somewhat different theory than Rabbi Tendler. Positing that cessation of independent respiration was the only criterion of death (based on *Yoma* 85 but somewhat inexplicably also citing *Chatam Sofer*, Y.D. no. 338), the Rabbinate ruled that

brain death was confirmatory of irreversible cessation of respiration. Theoretically, this would allow for a standard far less exacting than clinical brain death, perhaps nothing more than a failure of an apnea test. Indeed, Dr. Steinberg, the principal medical consultant to the Rabbinate, dismissed any requirement of nuclide scanning since destruction of the brain's respiratory center may be conclusively verified without such a test.[21] Since defining "death" exclusively in terms of inability to spontaneously respire would lead to the absurdity that even a fully conscious, functioning polio patient in an iron lung is dead, a subsequent communication from R. Shaul Yisraeli, a member of the Chief Rabbinate Council, qualified the Rabbinate's ruling by imposing, as an additional requirement, that the "patient be like a stone without movement"[22] (but apparently maintaining that heartbeat does not qualify as such movement). It is probable, though not certain, that R. Tendler's test of "physiological decapitation" and the Rabbinate's newly formulated test of "respiratory failure coupled with profound nonresponsiveness" amount to the same thing though the Rabbinate has not retracted from its non-insistence on nuclide scanning.

3. Rabbi J. David Bleich, Rosh Kollel at Yeshiva University and author of many papers and a recently published book on the subject, has stated that anything short of total liquefaction (lysis) of the brain cannot constitute the equivalent of decapitation. He further maintains, relying on Rashi in *Yoma*, the *Chatam Sofer*, and the *Chacham Tzvi*, that even total lysis would be insufficient in the presence of cardiac activity but dismissed the matter as being only of theoretical importance since cessation of heartbeat inevitably occurs prior to total lysis. He also asserts that his position is not based on stringency in case of doubt but rather on the certainty that the brain death patient is still alive, a certainty that could be relied upon even to be lenient, e.g., a Cohen may enter a "brain dead" patient's room without violating the prohibition of *tumat meit*.

4. Rabbi Aaron Soloveitchik, Rosh Yeshiva of Brisk and RIETS, has done slightly further than Rabbi Bleich. Even if the heart has stopped and the patient is no longer breathing, the patients is alive if there is some detectable electrical activity in the brain.[23] It has been noted, however, that there is no recorded instance of this phenomenon occurring.

5. Rabbi Hershel Schachter, Rosh Yeshiva and Rosh

Kollel of RIETS, has taken a more cautious view. Conceding that the concept of "brain death" may find support in the decisions of R. Moshe, he concludes that such a patient should be in the category of *safeik chai, safeik met* (doubtful life). While removal of organs would be prohibited as possible murder, one would also have to be stringent in treating the patients as *met*, e.g., a Cohen would not be allowed to enter the patient's room.[24]

6. Most contemporary *poskim* in Eretz Yisroel (other than the Chief Rabbinate) have unequivocally repudiated the concept of death based on neurological or respiratory criteria.[25] Of special significance are letters[26] signed by R. Shlolmo Zalman Auerbach and R. Yosef Elyashiv, widely acknowledged as the leading *poskim* in Eretz Yisroel (if not the world), stating that removal of organs from a donor whose heart is beating and whose entire brain including the brain-stem is not functioning at all is prohibited and involves the taking of life. Unfortunately, these very brief communications do not indicate if the *psak* is based on *vadei* (certainty) or *safeik* (doubt) nor do they address what the decision would be in case of total lysis.

IV. HALACHIC AND LEGAL RAMIFICATIONS

Obviously, in a matter so fraught with controversy, every family confronted with the tragic situation of a brain death patient must follow the ruling of its *posek*. To the extent the patient is halachically alive, removal of an organ even for *pikuach nefesh* would be tantamount to murder. The principle of *ain dochin nefesh mipnei nefesh*- that one life may not set aside to ensure another life - applies with full force even where the life to be terminated is of short duration and seems to lack the meaning or purpose and even where the potential recipient has excellent chances for full recovery and long life. If, on the other hand, the donor is dead, the harvesting of organs to save another life becomes a *mitzvah* of the highest order. In light of the overwhelming opposition to the "brain death" concept, caution and a stance of *shev v'al taaseh* (passivity) appears to be the most prudent course. How the "brain death" problem will play out in other areas such as inheritance, capacity of a wife to contract a new marriage, or the need for *chalitzah* if a man dies leaving a brain dead child will have to await further clarification.

There are, however, two other points that need to be considered. The argument is occasionally made if the *halachah* rejects the concept of "brain" or "respiratory" death, Orthodox Jews would be unable to receive harvested organs on the ground that the recipient would be an accessory to a murder. As others have noted,[27] this conclusion does

not follow. To the extent the organ in question would have been removed for transplantation whether or not this specific recipiient consents, i.e., there is a waiting list of several people, the Orthodox recipient is not considered to be a causative factor (*gorem*) in the termination of a life. There is no general principle in *halachah* that prohibits the use of objects obtained through sinful means. It is true that if, because of tissue typing and the like the organ is suitable for only on recipient and if that recipient declines the transplant, the organ will not be harvested, an Orthodox recipient may indeed be compelled to decline. But this is rarely, if ever, the case.[28]

A second point: as noted, "brain death" is legal definition of death in vast majority of the United States. New York is the only state that requires medical personnel to make a reasonable effort to notify family members before a determination of brain death and to make "reasonable accommodations" for the patient's religious beliefs.[29] In all other jurisdictions, doctors would be empowered unilaterally to disconnect a patient from life-support mechanism once that patient meets legal definition of death.[30] Hospital personnel may or may not defer to the wishes of the family but there s no duty on their part to do so or even to ascertain what those wishes are.[31]

Perhaps one point of consensus that may emerge in an area otherwise fraught with acrimonious controversy would be the desirability of enacting "religious accommodations" exceptions nationwide. After all, even the proponents of a "brain dead" standard understand that others, in all honesty and conscience, may hold a different *halachic* view, one which they should not be compelled to violate. Hopefully, our community will be responsive to such an effort.

V. CONCLUSION

"You preserve the soul within me and You will in the future take it from me " (Daily Prayers). Only God, Who is the source of all life, can take life away. We are enjoyed to cherish and nurture life as long as it is present, no matter how fleeting or ephemeral. Yet it is precisely because each moment of life is so precious that God has imposed on man the awesome responsibility of defining the moment of death, the point after which the needs of the dead may, and indeed must, be subordinated to those of the currently living. No one has ever seen a *neshamah* leave a body and it is the unenviable task of our *gedolim* and *poskim* to tell us when this occurs. May *Hakodesh Baruch Hu* grant them the insight to truly make out Torah *Torat Chayim*.

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Court File No.:

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N :

SHALOM OUANOUNOU, BY HIS SUBSTITUTE DECISION-MAKER AND LITIGATION GUARDIAN, MAXIME OUANOUNOU

Applicant

- and -

HUMBER RIVER HOSPITAL, ALI GHAFOURI, GARRET PULLE, SANJAY MANOCHA, DAVID GIDDONS, CORONER, REPRESENTATIVE OF THE OFFICE OF THE CHIEF CORONER

Respondents

AFFIDAVIT OF TOMER MALCA

I, Tomer Malca, of the City of Vaughan, in the province of Ontario, make oath and say as follows:

1. I have served as a mentor to Shalom Ouanounou in his Judaica studies over the past 10 years.

2. I attended at a Yeshiva in Israel and in Baltimore from age 18 – 24.

3. I came to know Shalom in our Jewish community. He would frequently organize classes in Jewish study in ethics, philosophy and law in different locations and would organize study groups to discuss such topics one to two times per month.

4. Part of my mentorship role to Shalom was to enhance his knowledge of codified Jewish law or Halachic law, Jewish philosophy and ethics that govern the lives of the members of our devout orthodox community.

5. The intent of such sessions was to enhance Shalom's character and contribution to our orthodox Jewish community and to the broader community.

6. The goal was to infuse and enhance understanding of Jewish law, ethics and morality and to improve contribution, connection and responsibility to the community and to traditional Jewish teachings.

7. The goal of such sessions is to do G-d's deeds within the community, including charity, prayer, study and teaching and mentorship of others relative to traditional Jewish laws and ethics.

8. Shalom and I would typically meet in settings involving multiple individuals he would organize for the purpose of classes and study groups on issues including codified Jewish law. This would periodically involve questions relating to health matters, life,

death, continuation and removal of life support and the role of such practices in Jewish law and ethics as followed by our devout orthodox community.

9. I particularly recall having discussions with Shalom at the time that his grandfather became ill. Shalom made clear to me his acceptance of the traditional teachings and rules of Jewish law which include that death occurs when the heart stops beating and the person stops breathing.

10. Shalom's expressed religious beliefs to not accept the concept of brain death as the basis for death under Jewish law or morality.

11. Shalom would speak of principles about how all steps would be required to save just one life. He would speak about how one life may not be set aside to save another. He believes that all life has value, regardless of its state.

12. He would speak about how each moment of life is so precious and how nobody has ever seen the soul leave the body.

13. He would express how the determination of when a person dies is a matter of religious and halachic law, and not a medical matter. His belief is that G-d determines when a person lives or dies and not man.

14. That is not to say that Shalom did not have respect for doctors and the medical system. He believes strongly that the role of the doctor as a healer is to take all steps to preserve life until a person's last dying breath and heartbeat.

15. Shalom is a strict adherent to the traditional principles of halachic Jewish law.

16. He would make regular pilgrimages to the grave site of the great Rabi Nachman in the Ukraine. The purpose of this was to reaffirm and recommit himself to codified Jewish law and to a strict practice of that law in daily life.

17. Shalom lived his life in that same way, keeping kosher, wearing a kipah, wearing tzi tzi, and saying prayers and engaging in other religious rituals daily.

18. Shalom's belief in G-d, belief in the righteousness of codified Jewish law, and belief in the practices of the Jewish religion are a main source of his identity.

19. These values carry over to other aspects of his life in terms of his commitment to the community, to family and to charity.

20. I recall a specific discussion about Adam and Eve in which Shalom recounted that whoever destroys one person in the world is considered as if he destroyed an entire world, while whoever preserves the life of one person in the world is considered to have preserved an entire world.

21. This biblical statement from the Mishnah is not merely a statement of Jewish dogma. It is a fundamental principle and belief by which Shalom has lived his life every day.

22. In discussion of such matters, Shalom would speak of the sanctity of human life and of the sanctity of the image of G-d in which man was created.

23. Based on my understanding of Shalom's Jewish beliefs and values as these have been explained and told to me by Shalom directly, I believe he would consider it a significant violation of his religious beliefs to remove life support in his present circumstance. I further reiterate his belief that death occurs when the heart beat and last breath of man are gone. That is not Shalom's present situation.

24. Shalom's belief is that life support measures should be maintained until that moment of death occurs by Jewish law, at which time the heart and breathing would stop.

25. I am deeply saddened by Shalom's present health situation. However, I am equally concerned that failure to respect Shalom's deeply held religious beliefs would be an affront to Shalom not only in the here and now, but for all eternity.

26. These are Shalom's expressed beliefs as they have been explained to me directly by him.

I swear this Affidavit in support of the Applicant's Application and for no other improper purpose.

Sworn before me at the City of Toronto, in the Province of Ontario, on the 30th day of October, 2017.

A Commissioner, etc.

NATALIA KROUKOVA, B.A., J.D.,
Barrister & Solicitor, Notary Public
519 Marlee Avenue
Toronto, Ontario M6B 3J3

TOMER MALCA

Court File No.:

SHALOM OUANOUNOU, BY HIS SUBSTITUTE DECISION MAKER **v.** **HUMBER RIVER HOSPITAL ET AL**
Applicant Respondents

ONTARIO
SUPERIOR COURT OF JUSTICE

Proceedings commenced at Toronto

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ONTARIO
SUPERIOR COURT OF JUSTICE

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Applicant

- and -

HUMBER RIVER HOSPITAL, ALI GHAFOURI, GARRET PULLE, SANJAY MANOCHA, DAVID GIDDONS, CORONER, REPRESENTATIVE OF THE OFFICE OF THE CHIEF CORONER

Respondents

AFFIDAVIT OF RABBI DAVID SHABTAI MD

I, Rabbi David Shabtai, MD, of the City of Boca Raton in the State of Florida, affirm and say as follows:

1. I am a Rabbi at the Boca Raton Synagogue in Boca Raton, Florida. I am also a Medical Doctor, having obtained my MD from New York University School of Medicine.
2. I have a particular interest in Jewish Medical Ethics and am the author of Defining the Moment: Understanding Brain Death in Halakhah, Shoresh Press, New York, 2012, a 400 page book in which I examine, review and analyze Jewish writings, both historical and contemporary on the topic of brain death as interpreted by Jewish law.

3. I have extensively researched the question of whether Jewish law accepts "brain death" as "death." Unlike some religions, there is no "final arbiter" of questions like this, but rather many learned opinions by "decisors," who are respected scholars learned in Jewish law and often in medicine as well. Individual Rabbis will examine these opinions as the basis for the direction they give their congregants.
4. The overwhelming majority of decisors of Jewish Law do NOT accept "brain death" as the death of the individual according to Jewish Law. They have concluded that a person remains alive until all vital motion has ceased in all parts of the body: as long as a person's heart continues to beat, even with the assistance to the respiratory system of mechanical ventilation, that person remains alive according to Jewish law.
5. In making this Affidavit, I am aware that it will be used to support an Application for an injunction in the Superior Court of the Province of Ontario, Canada, to prevent the doctors treating Shalom Ouanounou from discontinuing his treatment before his heart stops, and for no other purpose.

SWORN BEFORE ME in the City of Boca Raton, Florida, in The United States of America, this 31st day of October, 2017.

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A Commissioner/Notary Public

Rabbi David Shabtai, MD

AMY C. DOWNS
MY COMMISSION # FF964042
EXPIRES March 20, 2020
FloridaNotaryService.com

In and for the State of Florida

Print Name: Amy Downs
My Commission expires on 03-20-2020
Date, if applicable:

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APPLICATION RECORD

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