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Volume VI

SYNAGOGUE OF THE
ALBERT EINSTEIN COLLEGE OF MEDICINE
BIRKAT SHMUEL

ישיבת ר' יצחק אלחנן
תורה ומדע
RABBI ISAAC ELCHANAN THEOLOGICAL SEMINARY

of the publication I am so proud of. Having Rabbi Dr. Shabtai, a physician rabbi talmid chochom who graduated from YU's Wexner Kollel Elyon and is on the Advisory Board of Einstein's Program for Jewish Genetic Health cements the eternal bond between YU's Torah traditions and Einstein in a year where many have questioned the strength of that union. To all of you, you have once again demonstrated why the Albert Einstein College of Medicine is the premier medical school in the world representing the best of modern orthodox Judaism. May your commitment to the ideals of "six", the State of Israel, the legacy of Matan Torah and the dedication to medicine and respect for all people exemplified by the Israeli Red Cross guide you to a glorious future of Kiddush Hashem.

Edward R. Burns, M.D.
Professor of Medicine and Executive Dean
MTA-'69, YC-'73, Einstein-'76

RABBI JASON WEINER

Guide to Filling Out a POLST Form in Accordance with Halakhah

"POLST" ("Physician Orders for Life-Sustaining Treatment") is a physician order outlining the medically indicated plan of care for a patient who, based on best medical judgment, is nearing the end of his or her life. (In general, POLSTs are appropriate for patients with a life-expectancy of 12 months or less). The aim of a POLST is to ensure that the patient receives care consistent with both medical judgment and patient preferences. It is most typically used to prevent unwanted or ineffective treatments, reduce patient and family suffering, and ensure that a patient's wishes are honored.

A POLST differs from an Advance Directive in that Advance Directives are based solely on a patient's preferences – be it identifying the person the patient wants to make decisions when the patient cannot make his or her own, or providing a general guide as to what the patient wants in terms of medical care. A POLST, in contrast, is a physician's order that the health care team can act upon, akin to any other physician order found in a patient's medical record. A doctor or patient can reevaluate and change a POLST form at any time. In fact, it should be reevaluated as the patient's condition changes, just as any other medical order should be reassessed based on the patient's condition.

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We will discuss three of the primary categories of medical intervention that a POLST addresses in most states, and we will present general guidance regarding approaches to them in Jewish Law.

DNR

A DNR (Do Not attempt Resuscitation) order indicates that if the patient's heart stops beating (cardiac arrest), the medical staff will not initiate CPR through chest compressions or electronic defibrillation, but will instead allow natural death to occur. Similarly, a DNR order indicates that if the patient stops breathing (respiratory arrest), the medical staff will not initiate artificial (mechanical) respiration by inserting a tube into the lungs (intubation) and then connecting that tube to a mechanical ventilator. In this case as well, natural death is allowed to occur.

Halakhah strongly emphasizes and often requires the preservation of life. The rule of thumb is that we must do everything we can to prolong life; however, it is not obligatory to initiate medical interventions that prolong suffering at the end of life.[1] It is forbidden to do anything to hasten a patient's death, even by a moment and even if the patient is already dying, but it is not obligatory to **actively** administer interventions that briefly prolong a life of pain and suffering.[2]

Patients who adhere to Halakhah often do not accept a DNR order. However, there are circumstances in which it would be halakhically appropriate to withhold CPR and intubation in order to **passively** allow nature to take its course.[3] There are generally three conditions under which a DNR may

1 *Nishmat Avraham*, *Yoreh De'ah* 339:4 (7), p. 509 in 3rd edition; *Lev Avraham* 32:11.

2 *Iggerot Moshe*, *Hoshen Mishpat* 2:73(1); *Lev Avraham* 32:11; *Shiurei Torah Le-Rofim*, vol. 3, 313.

3 *Nishmat Avraham*, *Yoreh De'ah* 339:4 (2:V), pp. 502-3 in 3rd edition; *Lev Avraham* 32:10; *Iggerot Moshe*, *Yoreh De'ah* 2:174, *Hoshen Mishpat* 2:74.

be permissible (or possibly even obligatory[4]), under the guidance of an experienced expert in Jewish Law and as long as all three criteria are met:[5]

1. Expert medical opinion has determined that the patient is terminally ill, there is no chance of a cure, and the patient is heading towards death (and as such, medical interventions can only minimally prolong life).[6]
2. The patient is suffering very much – physically or emotionally – even though he is receiving medication to control the pain.[7]
3. The patient does not want to undergo resuscitation.[8]

4 *Iggerot Moshe*, *Yoreh De'ah* 2:174(3); Akiva Tatz, *Dangerous Disease and Dangerous Therapy in Jewish Medical Ethics* (Targum Press: 2010), 106.

5 *Nishmat Avraham*, *Yoreh De'ah* 339:4(iii), p. 501 in 3rd edition; *Lev Avraham* 32:10 #6.

6 Definitions of terminal vary from a few months to a year to live.

7 *Lev Avraham* 32:10 #6. The suffering of the family is not a factor (unless the patient is a child). Furthermore, we are concerned only with how much the patient is suffering, not their age, mental capacity, socio-economic status, etc (*Encyclopedia Hilkhatit Refuit*, vol. 5, 157). R. Moshe Feinstein ruled that an unresponsive patient is considered to be suffering because the soul's inability to leave the body at the end of life is considered painful even though it is unrecognizable to an observer (*Iggerot Moshe*, *Yoreh De'ah* 2:174). R. Shlomo Zalman Auerbach similarly ruled that a comatose patient is considered to be suffering and may remain DNR status (*Nishmat Avraham*, *Yoreh De'ah* 339:4(iii), p. 501 in 3rd edition). R. Elyashiv, on the other hand, ruled that an unconscious patient cannot be considered to be in pain and thus cannot be DNR (ibid. and p. 104).

8 Based on these principles, R. Moshe Feinstein ruled that if a patient's heart has stopped for an extended period of time and he can possibly be resuscitated, but he will likely be severely debilitated and thus suffer as a result, the patient should not be resuscitated unless we know that he wants to be, despite the associated pain. When we do not know the patient's wishes, we assume that most people would not want to live that way (*Mesorat Moshe*, 356). When possible, we must ask the patient for his opinion, explaining the value of a continued life of *teshuvah* and *ma'asim tovim* (*Encyclopedia Hilkhatit Refuit*, vol. 5, 155), and we must receive the opinions of multiple expert doctors that the patient is indeed dying (*Iggerot Moshe*, *Hoshen Mishpat* 2:75). If we are unable to de-

We can thus say that the halakhic imperative is that as long as we can keep people alive, we must do so, unless the benefit of such actions is counterbalanced by their causing extreme pain and suffering. At that point, the Torah permits a compassionate response of allowing the death process to occur with appropriate palliative care if that is what the patient or his surrogate desires and a competent rabbi has ruled accordingly for that specific case.

It is crucial to emphasize that even if a DNR order has been initiated, as long as the patient is still alive, doctors must continue to provide attentive care and all the basic necessities of life, as well as make certain that the patient does not suffer.[9] Oxygen is usually considered basic care and should be provided to all patients for whom it is medically indicated. Therefore, if artificial respiration (intubation) is withheld at any point, oxygen supplementation and/or a noninvasive positive pressure airway device should still be provided to alleviate discomfort, such as via a face mask or nasal prongs.[10]

Furthermore, it is important to note that although Halakhah sometimes permits, and may demand, that a dying patient forgo resuscitation or intubation, there is much debate concerning when a tube may be removed from the patient's lungs (extubated) once the patient has already been placed on the respirator.[11] It is generally permitted only to **withhold** life

termine the patient's wishes, we are not obligated to request aggressive interventions because we assume that they would not want a life of suffering to be prolonged (*Teshuvot Ve-Hanhagot* 6:300).

9 *Encyclopedia Hilkhatit Refuit*, vol. 5, 156. *Nishmat Avraham*, *Yoreh De'ah*, p. 325 (#6) (English edition), makes the point that even in those circumstances in which a DNR order is permissible according to Halakhah, all nursing care necessary for the patient's comfort must be administered. A DNR must never be viewed as a DNT (Do Not Treat).

10 Dr. Avraham Steinberg, personal communication, Summer 2015; See also *Iggrot Moshe Ch"m* 2:73(1). However, it would not be permissible to extubate a patient who is respirator dependent simply because one switches them to a breathing mask because the patient will still die very shortly after the extubation.

11 Extubation is desirable when the goal is to wean a patient off of a

sustaining interventions; it is forbidden to **withdraw** them once they have begun (even if they are not basic, essential treatments).[12] It is important to consider this when the decision is made whether or not to intubate.

Accordingly, when consulting a rabbinic authority on DNR questions, it is essential to clarify if there is a plausible cure or possibility for remission in the patient's underlying illness, if the patient is in severe pain, his or her desires, and if the resuscitation procedures are likely to inflict severe discomfort in this patient.[13]

Options: Comfort Measures, Limited Interventions, and Full Treatment

Establishing the halakhically acceptable level of treatment for a given patient in many ways hinges on the approach to the first issue discussed above. In a situation in which a DNR would be permitted, "comfort measures" may be permitted as well. This means that aggressive medical interventions will not be pursued at the end of life and the patient will be allowed to die a natural death. The patient will, however, receive medication to ensure that he does not experience overwhelming pain or other significant distress associated with death. Narcotic pain medications, such as morphine, are often prescribed for patients with terminal diseases to alleviate suffering near the

ventilator so that they can survive without it; if he cannot survive without ventilation, the patient would have to remain intubated. See *Iggerot Moshe*, *Yoreh De'ah* 3:132; *Nishmat Avraham*, *Yoreh De'ah* 339:1(4), pp. 602-606 (3rd edition); Bleich, *Time of Death in Jewish Law* , (Z. Berman Publishing: 1991), 50.

12 *Encyclopedia Hilkhatit Refuit*, vol. 5, 148.

13 R. Avraham Union, *Le-Et Metzo* (VITAS Innovative Hospice Care/ Rabbinical Council of California: 2015, 3rd ed.), 13. Although this was not mentioned as one of the conditions listed above, it is important to ask this question because in a case of a dying patient who is rapidly declining, we would not be required to inflict such pain for no avail (R. Union, personal correspondence, Winter 2015).

end of life.

The alleviation of pain and suffering is a *mitzvah*[14] and should not be withheld out of concern for potential adverse effects.[15] It is halakhically permitted for patients to receive narcotic pain medication,[16] even when it may possibly hasten their death, provided that:

1. The intent is only to alleviate pain, not to shorten the patient's life.
2. The dose of medicine is gradually increased as necessary to alleviate the pain, but each dose on its own is not enough to certainly shorten the patient's life.[17]

The option of "limited interventions" should often be

14 R. Shlomo Zalman Auerbach argues that alleviating pain falls under the obligation to love one's neighbor as oneself (Responsa *Minhat Shlomo* 2-3:86). The *Tzitz Eliezer* (13:87) argues that severe pain is considered debilitating and dangerous, and administration of sophisticated pain medications is considered part of a physician's mandate to heal, which classical *posekim* permitted even in risky scenarios if the intention is to relieve pain.

15 Reponsa *Minhat Shlomo* 2-3:86. The concerns are related to opioids' potential to suppress breathing. However, current medical data suggests that judicious use of opioids does not usually shorten the life of terminally ill patients (Mularski RA, Puntillo K, Varkey B, Erstad BL, Grap ML, Gilbert HC, Li D, Medina J, Pasero C, Sessler CN, "Pain Management Within the Palliative and End-of-Life care Experience in the ICU," *Chest* 135 [2009]: 1360–1369).

Health care professionals can offer patients and families choices for pain control. For example, patients who are alert may choose to receive adequate medication to keep them as comfortable as possible while retaining the ability to communicate. Others may prefer that medication be chosen for maximum comfort even if it renders the patient less responsive (Loike, Gillick, Mayer, Prager, Simon, Steinberg, Tendler, Willig, Fischbach, "The Critical Role of Religion: Caring for the Dying Patient from an Orthodox Jewish Perspective," *Journal of Palliative Medicine* 13:10 (2010):2.

16 *Tzitz Eliezer* 13:87; *Teshuvot Ve-Hanhagot* 3:361; J. David Bleich, "Survey of Recent Halakhic Literature: Palliation of Pain," *Tradition* 36:1 (2002): 89; *Shiurei Torah Le-Rofim*, vol. 3, 396.

17 *Nishmat Avraham*, *Yoreh De'ah* 339:1 (4), p. 499 in 3rd edition.

considered as well, as many halakhic authorities distinguish between treatments that supply natural necessities and those that are considered "aggressive" and not routine. Basic treatments that are unrelated to the patient's primary illness – such as oxygen, nutrition, and hydration – and those that any other patient would receive to prevent complications – such as insulin for a diabetic, antibiotics,[18] and blood transfusions – should generally not be ceased, as doing so may hasten death. On the

18 Although antibiotics must be given even to a DNR patient whenever needed, as with any other patient they may be discontinued when the patient has responded to the medication and has had the full dose. If one does not respond, or the lab results demand some other intervention, the antibiotics are changed as medically necessary. If lab results confirm than an antibiotic has been given unnecessarily then, as with any other patient, it must be stopped (personal communication with Dr. Abraham, Feb. 2015). Additionally, at the end of life, when a patient is suffering and expert medical opinion assumes that there is no chance of a recovery, and life expectancy is estimated to be very short, some rule that supportive medications such as dopamine or very advanced antibiotics need not be renewed once the IV bag has run out (Dr. Avraham Steinberg, in consultation with R. Auerbach and R. Wosner, "Halachic Guidelines for Physicians in Intensive Care Units," *Assia* 4:1 (February 2001), 5-6, reprinted in *Jewish Medical Ethics*, vol. 2 (Jerusalem , 2006), 376-8). This is because antibiotics are only required when they can actually cure an infection. For example, if a dying patient develops an additional illness, such as pneumonia, if it is treatable (i.e. with antibiotics) we must do so in order to prolong the patient's life, even though he or she is dying of the underlying illness anyways. However, if the patient develops a very significant secondary illness, such as an overwhelming sepsis, and the regular antibiotics won't resolve it, then the sepsis becomes considered as part of the dying process. Even though complicated fifth generation antibiotics could be attempted to keep the patient alive slightly longer, this illness is now part of the dying process and the advanced antibiotics needed to fight it are not required, unless a specific bacteria that caused the sepsis can be identified and advanced antibiotics can indeed cure it (Dr. Avraham Steinberg, personal communication, Summer 2015; See also *Iggrot Moshe CH"M* 2:74(2) & 75(4) and *Nishmat Avraham* YD 339:4(iii), pg. 503 in 3rd edition). Furthermore, in situations in which placing an intravenous (IV) catheter for antibiotic administration will lead to excessive pain, IV antibiotics may be withheld (personal communication with Dr. Abraham).

other hand, it is often not required to actively treat or initiate aggressive measures – such as surgery, radiation, or chemotherapy with minimal projected benefit[19] – for a dying patient who is suffering and does not want them, if a competent rabbi has ruled accordingly.[20] A patient who opts for limited interventions in a POLST will be administered IV fluids and may choose to be respirated in a non-invasive fashion. Alternatively, a patient may record that he wishes full interventions to be made under all circumstances.

Artificially Administered Nutrition

Secular POLST documents include the option to refuse nutrition and hydration, reflecting the standard approach in American society, which views artificial nutrition as a medical treatment that can be withdrawn if necessary. In contrast, there is a very strong consensus among rabbinic authorities that artificial nutrition and hydration must be provided to all patients, whether conscious or comatose – even artificially,[21]

19 R. Union, *Le-Et Metzo*, 15. Dr. Abraham clarified in a personal conversation that all major surgical procedures are not considered routine, and as a rule of thumb most procedures for which informed consent is required to be signed are not considered routine. It should be noted that norms for what is routine or not routine can change over time as the practice of medicine evolves, and the input of a rabbinic authority who is familiar with these details is essential.

20 *Nishmat Avraham*, *Yoreh De'ah* 339:4 (7), pp. 498, 509 in 3rd edition; *Lev Avraham* 32:10; *Teshuvot Ve-Hanhagot* 6:300; Steinberg, "The Halachic Basis of the Dying Patient Law," *Assia* 6:2 (2008): 30-40.

21 *Nishmat Avraham* YD 339:4 (7), pg. 509 in 3rd ed.; *Lev Avraham* 32:10 (1); *Encyclopedia Hilkhatit Refuit* , vol. 5, 146. Nutrition and hydration must usually be provided, even artificially, despite the fact that one is not always required to proactively pursue mechanical ventilation, because Jewish Law does not see the provision of nutrition and hydration as a medical intervention but simply as providing the vehicle for bringing natural nutrition to the body. This does not rise to the level of a medical intervention, however, since the food being provided is a basic necessity. A ventilator, on the other hand, must be carefully gaged and continuously adjusted, and is thus seen as a medical intervention and is

such as via an NG tube or PEG[22] – unless medically contraindicated.[23] This is based on the ruling, discussed above, that distinguishes between treatments that supply natural necessities or are accepted as routine, which are required, and those that are considered "aggressive," which are not always obligatory. Halakhic authorities have further ruled that nutrition and hydration may not even be passively discontinued from a dying patient to hasten their death.[24]

therefore not always required in every situation. However, oxygen by mask should always be provided since this is a similar to nutrition and hydration being a natural sustenance and not a treatment (Dr. Avraham Steinberg, personal communication, Summer 2015).

22 *Nishmat Avraham*, *Yoreh De'ah* 339:4 (7), p. 509 in 3rd edition; *Lev Avraham* 32:10 (1); *Encyclopedia Hilkhatit Refuit* vol. 5, 146. When given the option, some recommend choosing a PEG over an NG Tube since it is generally more comfortable and results in fewer complications (Dr. Avraham Steinberg, personal communication, Summer 2015).

23 *Encyclopedia Hilkhatit Refuit*, vol. 5, 146; *Shiurei Torah Le-Rofim*, vol. 3, 320; *Iggerot Moshe*, *Hoshen Mishpat* 2:74 (3); *Minhat Shlomo* 91:24. One of the few authorities who allow withdrawal of nutrition/hydration from a terminal patient is R. Zalman Nechemia Goldberg, who argues that we are obligated to save such a patient only when the patient benefits from being saved. However, there is no obligation to treat a patient who is suffering so much that "death is better than life" or one who has absolutely no cognition or ability to communicate. R. Goldberg claims that withdrawing nourishment would not be considered an indirect cause of death because it is the overall lack of nourishment that the patient dies from, not the action of removing nourishment (*Moriah* 4-5:88-89 [Elul 5738]: 48-56). Many other authorities have challenged R. Goldberg's position; see, for example, R. Levi Yitzchak Halperin, *Halakhah U-Refuah* (Regensberg Institute: 1981), vol. 2, 146-84, esp. 150-55; R. J.D. Bleich, *Bioethical Dilemmas* (KTAV Publishing House: 1998), vol. 1, 106, fn. 36; R. Y. Zilberstein, *Shiurei Torah Le-Rofim*, vol. 3, 317. R. Halperin argues that withholding nourishment should be viewed as an indirect cause of death and is thus forbidden. He sees no difference between one who disconnects the food supply from the patient and one who acts passively and neglects to replenish it.

24 *Minhat Shlomo* 91:24; *Iggerot Moshe*, *Hoshen Mishpat* 2:74(3); *Encyclopedia Hilkhatit Refuit*, vol. 5, p. 146. See also J. Kunin, "Withholding Artificial Feeding from the Severely Demented: Merciful or Immoral? Contrasts Between Secular and Jewish Perspectives," *Journal of Medical Ethics* (2003): 208-212.

If a patient refuses to accept these feedings, one should encourage him to accept them. If he still refuses, however, he should not be forced,[25] nor should one utilize coercive methods such as tying down the patient's hands to prevent him from pulling out the tube.[26] If the patient is competent and expresses clear opposition to a feeding tube, his desire should be granted.[27]

There are some circumstances in which artificial nutrition and hydration may be discontinued in accordance with Halakhah. Patients nearing the end of life often lose interest in eating or have difficulty swallowing or absorbing their intake, which can lead to infections, choking, and aspiration. In such cases, it is sufficient to make patients comfortable by providing minimal feeding by mouth, such as using menthol swabs or ice chips, instead of IV feeding.[28] Moreover, there are times when the provision of artificial nutrition and hydration very close to the time of death is not only dangerous for the patient, but also actually increases the patient's discomfort. Since some base the obligation to continue nutrition and hydration on the assumption that death by starvation or dehydration increases the intensity of the pain and suffering of a dying individual,[29] there may be situations in which the focus should instead be on providing comfort measures, as discussed above.[30] Rabbinic authorities thus rule that if a dying patient will likely die as a result of their underlying illness before dying of lack of nutrition and the patient does not want nutrition, there is no obligation

25 *Iggerot Moshe*, *Hoshen Mishpat* 2:74.Other authorities rule that we should even try to force the patient; see *Minhat Shlomo* 91:24.
26 Loike, et. al., op cit., 3.
27 Ibid.
28 *Encyclopedia Hilkhatit Refuit*, vol. 5, 147; A. Steinberg, "The Use of Percutaneous Endoscopic Gastrostomy (PEG) in Demented Patients: A Halachic view," *Journal of Jewish Medical Ethics and Halacha* 7 (2009): 41–42; *Encyclopedia Hilkhatit Refuit*, vol. 5, 112.
29 *Iggerot Moshe*, *Hoshen Mishpat* 2:74 (3).
30 Bleich, *Bioethical Dilemmas*, vol. 1, 94.

to initiate artificial nutrition.[31] Sometimes this is possible by providing some basic IV or subcutaneous (minimally invasive) hydration to ensure that the patient does not die of dehydration.[32] Similarly, if a patient has no chance of survival and is suffering, one may switch from total parental feeding (TPN) to nasogastric or even to IV feeding, and the IV content may be reduced from concentrated nutrients to basic glucose and electrolytes in water.[33]

31 *Lev Avraham* 32:10 (2). If artificial nutrition has already been initiated, complete withdrawal is forbidden if it will hasten death; see *Nishmat Avraham*, *Yoreh De'ah* 339:4 (7), p. 509 in 3rd edition.
32 *Encyclopedia Hilkhatit Refuit*, vol. 5, 147. This is because a person will normally die much quicker without hydration than they will without food, so even in a situation in which we may not be required to provide nutrition at the end of life, providing hydration is nevertheless encouraged. However, even hydration should be monitored according to the medical situation, not according to philosophical-ethical considerations (Dr. Avraham Steinberg, personal communication, Summer 2015).
33 A. Steinberg, "The Halachic Basis of the Dying Patient Law," *Jewish Medical Ethics* (Jerusalem, 2011), vol. 3, 419 (republished from Steinberg, "The Halachic Basis of the Dying Patient Law," *Assia* 6:2 (2008): 30-40). See also Steinberg, *Encyclopedia of Jewish Medical Ethics* (New York, 2003), 1058.