

End of Life Care: Practical Decision-Making
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Past sessions on this and other topics <https://torontotorah.com/nusbaum>

Our agenda

The broad range of opinions in Jewish law regarding withholding care in cases of terminal illness can often confuse Jewish patients who are attempting to prepare a DNR. This becomes even more challenging when a family is split regarding the rabbinic opinions in front of them. And healthcare decisions become even more complicated when the patient is unconscious or otherwise incapacitated, and the patient's family is trying to navigate their options. How can a medical professional help patients and their families in these situations?

Relevant previous sessions

Oct '12 Patient Consent and Capacity (abridged)	https://www.yutorah.org/lectures/lecture.cfm/783340/
Dec '14 Medical Assistance in Dying	https://www.yutorah.org/lectures/lecture.cfm/830798/
Dec '15 Giving Up in Judaism	https://www.yutorah.org/lectures/lecture.cfm/846186/
Nov '17 Informing a Patient of a Terminal Diagnosis	https://www.yutorah.org/lectures/lecture.cfm/889699/
June '21 Withholding/Withdrawing/MAiD	https://www.yutorah.org/lectures/lecture.cfm/1004519/

General introduction

1. CPSO, *Planning for and providing quality end-of-life care*

<https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Planning-for-and-Providing-Quality-End-of-Life-Care>

Quality Care and Communication

1. When helping patients plan for or when providing end-of-life care, physicians must endeavour to understand what is important to the patient in order to ensure that the patient's goals of care are understood and that quality care is provided.
 - a. In doing so, physicians are advised to provide assistance to patients or substitute decision-makers (SDM) in order to help them articulate the patient's goals of care.
2. Physicians must communicate effectively and compassionately with patients and/or SDMs, in a manner and tone that is suitable to the decisions they may be facing. This includes initiating communication as early as possible and as regularly as is necessary to share information, helping patients and/or SDMs understand the information shared, and answering questions.
3. Where patients and/or SDMs wish to involve family and/or others close to them in the patient's care, physicians must obtain consent to disclose personal health information about the patient and document this decision.

Advance Care Planning

4. As it is never too early for physicians to discuss advance care planning with their patients, as part of routine care physicians are advised to:
 - a. discuss the importance and benefits of advance care planning, choosing an SDM, documenting and disseminating advance care plans to their loved ones, SDM, and health-care providers, and reviewing advance care plans throughout life; and
 - b. help patients engage in such planning by providing necessary medical information and opportunity for discussion.
5. When significant life events or changes in the patient's medical status occur, physicians are advised to:
 - a. encourage patients who have already engaged in advance care planning to review existing advance care plans; or
 - b. where the patient has not already done so, remind patients of the importance of this process, create opportunities for discussion, and encourage them to engage in this process.

Table 2: ID3 for ACP discussions – Introduce, Discuss, Decide, Document				
	<ul style="list-style-type: none"> » Introduce: “Can we talk about where things are with your health, and where things might be going?”* » Seek permission: “Is this okay?”* » Inform: What is ACP and why is it important? Describe the process. Explain that the patient’s decisions can be revised as their health/life situation changes. » After introducing the idea of ACP, it may be appropriate for the patient to return for a dedicated appointment to continue the rest of the process. 			
	<p>Discuss</p> 	<p>“How much do you (and/or your family) know about your illness?”</p> <p>“What information would you like from me?”*</p>	<p>“What are the most important things you want to do in life?”</p> <p>“What are some abilities in life you can’t do without?”*</p>	
	<ul style="list-style-type: none"> » Decide on an SDM: “If you are unable to speak for yourself about medical decisions, who do you want to speak for you?”* » Decide on patient-centred principles of care that are based on, and comply with, the values that the patient has identified as being most important in their life. » This component of the ACP discussion may require multiple discussions, if there is no medical indication for an urgent decision. 			
<p>Document</p> 	<ul style="list-style-type: none"> » Document the designation of the SDM. The patient should ensure that their SDM is aware of their role and informed of the patient’s priorities and wishes. » Document any principles of care decisions that have been made. » Ensure that documentation complies with relevant provincial/territorial/regional regulations regarding the documentation of designated SDMs and decisions specifying principles of care. 			
<p>*Indicates text that has been adapted from the <i>Serious Illness Conversation Guide</i>,⁸ licensed under the Creative Commons Attribution Non-Commercial-ShareAlike 4.0 International License, http://creativecommons.org/licenses/by-nc-sa/4.0/.</p>				

3. Sock Culture <https://www.yutorah.org/lectures/lecture.cfm/961655/>

4. Schwartz Rounds, <https://www.theschwartzcenter.org/programs/schwartz-rounds/>

The Schwartz Rounds program, now taking place in hundreds of organizational members in the U.S., Canada, U.K., Ireland, Australia and New Zealand offers healthcare providers a regularly scheduled time during their fast-paced work lives to openly and honestly discuss the social and emotional issues they face in caring for patients and families. In contrast to traditional medical rounds, the focus is on the human dimension of medicine. Caregivers have an opportunity to share their experiences, thoughts and feelings on thought-provoking topics drawn from actual patient cases. The premise is that caregivers are better able to make personal connections with patients and colleagues when they have greater insight into their own responses and feelings.

Panelists from diverse disciplines participate in the sessions, including physicians, nurses, social workers, psychologists, allied health professionals and chaplains. After listening to a panel’s brief presentation on an identified case or topic, caregivers in the audience are invited to share their own perspectives on the case and broader related issues.

Case #1: Helping Wilma make her advance care plan

Sarah, a family physician, has a Jewish patient, Wilma, age 60. Wilma suffers from diabetes and high blood pressure, and has now developed chronic heart failure, and Sarah wants to discuss an advance care directive with her. Wilma expresses a desire to follow Jewish law, but she does not know a rabbi she trusts. What does Sarah need to know about Jewish law and withholding care? What are the differences between the Agudah/Chayim Aruchim form and the form promoted by the Beth Din of America?

5. The DNRc – Do Not Resuscitate Confirmation form

http://www.mhpcn.net/sites/default/files/Do%20Not%20Resuscitate%20%28DNR%29%20Confirmation%20Form_1.pdf

6. The range of views on withholding care in the case of a terminal diagnosis

For detail, see <https://www.yutorah.org/lectures/lecture.cfm/1004519/>

Approach	Proponents	Application Notes
Do everything	Rabbi J. David Bleich Rabbi Eliezer Waldenberg	<ul style="list-style-type: none"> • There is no such thing as “artificial measures” • We do withhold harmful “life-saving” measures like IV fluids which will lead to edema
Extend long-term life even with suffering; Extend short-term life without suffering	Rabbi Yaakov Kanaievsky Rabbi Yitzchak Zilberstein	<ul style="list-style-type: none"> • The definition of “short-term” is much-debated: <ul style="list-style-type: none"> • 1 year (Rabbi Moshe Feinstein) • 6 months (Rabbi Dr. Avraham Steinberg) • On a trajectory of death (Rabbi Asher Weiss)
Extend life without suffering; Always provide food/oxygen	Rabbi Moshe Feinstein Rabbi Shlomo Z. Auerbach Rabbi Dr. Avraham Steinberg RCA Guidance	<ul style="list-style-type: none"> • This may require treatment for other conditions, like infections • For more, see sessions linked at the top of the sheet
Patients may choose in situations where normal people forego treatment	Rabbi Hershel Schachter	<ul style="list-style-type: none"> • This may even include food and oxygen

7. Yuen, Reid, Fetters, *Hospital Do-Not-Resuscitate Orders: Why They Have Failed and How to Fix Them*

Journal of General Internal Medicine, 2011 Jul, 26 (7) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3138592/>

Four ways in which DNR orders remain problematic today include:

- DNR discussions occur too infrequently and patients’ preferences regarding resuscitation are neglected.
- DNR discussions are delayed until it is too late for the patients to participate in decisions regarding resuscitation.
- Physicians do not provide adequate information to allow patients to make informed decisions.
- Physicians inappropriately extrapolate DNR orders to limit other treatments.

8. Halachic Guidelines to Assist Patients and their Families in Making “End-of-Life” Medical Decisions

Rabbinical Council of America, <https://www.rabbis.org/pdfs/hcpi.pdf>

As a word of caution, a DNR order can often be interpreted by the medical staff in a broader sense than intended. It may be perceived as an order to refrain from any aggressive therapy for the patient – DNT, Do Not Treat. It is essential that the family clarifies their specific intentions and all limitations to the DNR order.

9. A popular secular site <https://www.makingmywishesknown.ca/>

10. The old RCA form <https://hods.org/pdf/Living%20Will%20RCA.pdf>

- Specifies Orthodoxy of the patient, Orthodox rabbi as consultant
- Details specific treatments in great detail, with the patient stating wishes for each one
- If the rabbi isn’t available, they should consult the Bioethics Commission of the RCA

11. The new RCA form https://rabbis.org/wp-content/uploads/2020/11/RCA-HealthCare-Proxy_11-9-2020.pdf

- Specifies Orthodoxy of the patient, Orthodox rabbi as consultant
- Helpful Halachic companion document at <http://www.rabbis.org/pdfs/hcpi.pdf>
- No discussion of specific treatments
- If the rabbi isn’t available, they should “undertake all essential emergency and/or life sustaining measures”

12. Chayim Aruchim form https://www.chayimaruchim.com/images/Ontario_Halachic_Medical_Directive.pdf

- The only one of these forms that is designed to fit Ontario's legal requirements
- Specifies Orthodoxy of the patient, Orthodox rabbi as consultant
- No discussion of specific treatments in the main expression of wishes
- If the rabbi isn't available, they should follow the "do everything" position, which is set out in great detail

13. Five Takeaways

- 1> The DNR covers EMS/Fire; for hospitalization we need an expression of the patient's wishes, which may be a DNR but doesn't have to be that.
- 2> If a patient wants to conform to Halachah, there is a broad range of mainstream views, from Do Everything to near-maximal patient autonomy.
- 3> We generally don't withdraw care, although there are circumstances where some withdrawal may take place.
- 4> Rabbis are generally uncomfortable with DNR other than where hope is lost and resuscitation would be harmful.
- 5> Modern halachic forms avoid trying to address a checklist of cases, and instead focus on identifying a POAPC and conveying general values.

Case #2: How does Wilma choose a view from among the rabbinic ideas?

Sarah explains to Wilma that there is a broad range of halachic views regarding withholding care from people dealing with terminal illness. Wilma is bewildered, and does not know how to decide which approach to follow. When faced with multiple opinions, how does one choose?

14. How does a doctor choose a rabbi? <https://www.yutorah.org/lectures/lecture.cfm/851037/>

15. Mishnah, Avot 1:16

רבן גמליאל אומר עשה לך רב והסתלק מן הספק...

Rabban Gamliel said: Make a teacher for yourself, and absent yourself from doubt...

16. Rabbi Moshe Tzuriel (21st century Israel), **עשה לך רב**

ועוד פשוט הוא כי בכל ענין או נידון שונה שיש בהוראות, יכול השואל להחליף מן אדם אחד לאדם אחר. וכל שכן בזמננו, שישנם רבנים הבקיאים וחרפים מאד במקצוע אחד (גניח, איסורי שבת) ואינם מומחים ביותר במקצוע אחר (גניח, מצוות התלויות בארץ וכיו"ב).

It is also clear that in every matter and subject on which there are rulings, a questioner may switch from one person to another. Certainly today, when there are rabbis who are expert and very sharp in one area – such as Shabbat prohibitions – but are not highly expert in another area, such as agricultural mitzvot and the like.

17. Talmud, Eruvin 6b-7a

ומי עבדינן כתרי חומרי? והא תניא "לעולם הלכה כבית הלל, והרוצה לעשות כדברי בית שמאי עושה כדברי בית הלל עושה, מקולי בית שמאי ומקולי בית הלל רשע, מחומרי בית שמאי ומחומרי בית הלל עליו הכתוב אומר 'הכסיל בחשך הולך', אלא אי כבית שמאי כקוליהון וכחומריהון אי כבית הלל כקוליהון וכחומריהון!"... אמר רב שיזבי כי לא עבדינן כחומרי דבי תרי היכא דסתרי אהדי.

But would we practice two stringencies? We have learned, "The law follows Beit Hillel, and one who wishes to follow Beit Shammai may do so, or Beit Hillel may do so. Following Beit Shammai's leniencies and Beit Hillel's leniencies is wicked. Following Beit Shammai's stringencies and Beit Hillel's stringencies – regarding him Kohelet 2:14 says, 'And the fool walks in darkness.' Rather, practice Beit Shammai's leniencies and stringencies or Beit Hillel's leniencies and stringencies!"... Rav Shizbi said: We don't follow the stringencies of two views where they contradict each other.

18. Rabbi Shimon ben Tzemach Duran (14th-15th century Algiers), Tashbetz 3:210

ואם עבר על דבריו, ונשאל והתירוהו לעבור על דברי רבו, שאין ההיתר היתר וההרם עליו. דבר זה איפשר לדמותו לבני העיר שקבלו עליהם דברי רב אחד, שהמתיר כנגד אותו רב חייב נדוי.

If one violates [the local rabbi's] words, and one asks [another rabbi] and is given license to violate his rabbi's words, the license is no license and he is ex-communicated. This may be compared to a city where they accept the words of a rabbi; one who permits against him is ex-communicated.

19. Rabbi Moshe Isserles (16th century Poland), Choshen Mishpat 25:1 (from Terumat haDeshen)

אין להקל בדבר שהחמירו בו החבורים שנתפשטו ברוב ישראל, אם לא שקבל מרבתי שאין נוהגין כאותה חומרא.

One should not be lenient in a matter in which the compositions that have spread throughout most of Israel have been strict, unless one has received from his masters that we do not follow this stringency.

20. Rambam (12th century Egypt), Mishneh Torah, Hilchot Avodah Zarah 12:14

ובכלל אזהרה זה שלא יהיו שני בתי דינין בעיר אחת, זה נוהג כמנהג זה וזה נוהג כמנהג אחר, שדבר זה גורם למחלוקות גדולות שנאמר "לא תתגודדו" - לא תעשו אגודות אגודות.

This prohibition includes having two courts in one city, this one acting this way and that one acting another way; this causes great strife, as Devarim 14:1 says, "Do not cut yourselves" – do not become groups and groups.

21. Rabbi Moshe Isserles (16th century Poland), Orach Chaim 493:3

ולא ינהגו בעיר אחת מקצת מנהג זה ומקצת מנהג זה, משום לא תתגודדו.

They should not act in one city, some in one way and some in another way, due to "Do not cut yourselves."

22. Three Takeaways

- 1> The view a patient adopts on End of Life care need not be the authority whose views they follow in all areas of Halachah, so long as the patient is not following self-contradictory practices
- 2> Knowing the range of views can be helpful where the patient knows what they want, and is only looking for assurance that this fits within Halachah
- 3> Where the patient actually wants to select a view, it may be appropriate to follow the view most accepted in the community

Case #3: Two versions of Wilma's wishes

Wilma appoints her husband David and her daughter Rachel, an ER doctor, as joint powers of attorney for personal care. Subsequently, Wilma suffers a heart attack, resulting in brain damage; she falls into a coma and remains so for ten days. Doctors ask David and Rachel for guidance regarding the care plan for Wilma. Based on his experiences during their 35 years of marriage, David believes that Wilma would want any and all interventions necessary to prolong her life. David's report is consistent with Sarah's advance directive. However, Rachel contends that after the advance directive was prepared, Wilma expressly told her that she does not want her life prolonged if she is comatose and unlikely to regain consciousness. What guidance does Jewish law offer for resolving this dispute?

23. Dr. Daniela Lamas. *When Faced With Death, People Often Change Their Minds*, NY Times Jan 3 '22

<https://www.nytimes.com/2022/01/03/opinion/advance-directives-death.html>

24. Speak-Up Ontario, Questions About the Substitute Decision Maker

<https://www.makingmywishesknown.ca/questions-about-the-substitute-decision-maker/>

When your substitute decision maker has to step in and make decisions for you, he or she is required to honour and apply the wishes, values and beliefs that you communicated when you were still mentally capable.

If your wishes are not known, your SDM is required to act in your "best interests". "Best interests" has a specific meaning in law. It involves your SDM considering the values and beliefs you had when capable. In addition, the SDM would consider:

- your health condition;
- if you were likely to improve, remain the same or deteriorate without the treatment;
- the risks and benefits of the treatment options.

25. Rabbi Moshe Feinstein (20th century USA), Igrot Moshe Choshen Mishpat 2:74:2, 5

ב: ברובא דרובא הא יש להחולה קרובים ואף אב ואם ואחים וכדומה העוסקים ברפואת החולה שעליהם יותר מוטל גם בדינא
ה: ובאם החולה הוא תינוק או אף גדול שאינו יודע להחליט רשאי אביו ואמו וכל המשפחה להחליט, והרשות שיש להם משום דרוב חולים
סומכין על דעת האב והאם על המשפחה כאחים ואחיות ובניהם שרוצים מה שיותר טוב להחולה ולבני ביתו, וכשליכא קרובים ודאי יש
לסמוך על דעת הב"ד שבעיר.

2: In most cases the patient has relatives, even father and mother and brothers and the like, who are involved in his treatment, for it is legally their responsibility to a greater extent.

5: If the patient is a baby, or an adult who cannot decide, his parents and the whole family may decide. This permission stems from the fact that most patients depend upon their parents' opinion and even upon the family, like brothers and sisters and children, who want what is best for the patient and his family. When there are no relatives, it is certainly better to depend upon the view of the local court.

26. Ontario Hierarchy, <https://www.makingmywishesknown.ca/the-substitute-decision-maker-hierarchy-in-ontario/>

Possible SDMs	Description
1. Guardian of the person	Someone appointed by the court to be your substitute decision maker.
2. Attorney named in a Power of Attorney for Personal Care	The person or persons YOU have chosen to be your substitute decision maker if you prepared a Power of Attorney for Personal Care when you were mentally capable of doing so.
3. Representative appointed by the Ontario Consent and Capacity Board	A family member or friend who applies to the tribunal, known as the Consent and Capacity Board, to be named as your "Representative," which is a type of substitute decision maker. However, if you prepared a valid Power of Attorney for Personal Care, the Consent and Capacity Board will not appoint anyone, even if they apply, because the substitute decision maker YOU chose in the Power of Attorney for Personal Care will rank higher in the hierarchy.
4. Spouse or partner	<p>Two persons are "spouses" if they are:</p> <ul style="list-style-type: none"> a) Married to each other; or b) Living in a common law marriage-like relationship and, <ul style="list-style-type: none"> i) have lived together for at least one year or ii) are the parents of a child together or iii) have together signed a cohabitation agreement under the Family Law Act. A cohabitation agreement is a document that two people who live together but are not married can sign in which they agree about their rights and obligations to each other during the time they live together and on separation. The types of things they can include in the agreement are rights to financial support from each other, ownership and division of property, and the education of their children. <p>Two persons are not spouses if they are living separate and apart because of a breakdown of their relationship.</p> <p>Two people are "partners" if they have lived together for at least one year and have a close personal relationship that is of primary importance in both people's lives. Partners include friends who have lived together for at least one year in a non-sexual relationship and have a special personal family-like relationship.</p>
5. Child or parent or Children's Aid Society or other person lawfully entitled to give or refuse consent to treatment in place of the incapable person	The person who has the legal right to give or refuse consent for treatment. This does not include a parent who only has a right of access. If a Children's Aid Society or other person is entitled to give or refuse consent in place of the parent, then the parent would not have the legal right to be a substitute decision maker.
6. A parent who only has a right of access	If someone who has the legal right to give or refuse consent for treatment for a child is not available, then a parent who only has a right of access is the substitute decision maker.
7. Siblings	If you have a number of siblings that meet the requirements of an SDM, they are all EQUALLY ranked.
8. Any other relative (see the next page if you have more than one relative)	People are relatives if they are related by blood, marriage or adoption. If you have a number of relatives that meet the requirements of a decision maker, they are all EQUALLY ranked.
9. Public Guardian and Trustee	If no person in your life meets the requirement to be a substitute decision maker, then the Public Guardian and Trustee of Ontario, a public government organization, is your substitute decision maker.

27. Rabbi Shlomo Zalman Auerbach (20th century Israel), *Shulchan Shlomo, Erkei Refuah I* pg. 75

אם החולה הוא במצב של חוסר הכרה שאי אפשר לדבר על כך עם החולה, אפשר שיכולים גם לסמוך על בני המשפחה אשר יודעים ברור שהם חפצים מאוד בטובתו של החולה ויכולים לאמוד את דעתו של החולה ורצונו במצב כזה אם להסכים או לא.

If the patient lacks capacity, so that one cannot discuss this with the patient, perhaps one may rely on the family members who we know, clearly, desire very much the best interests of the patient, and they can gauge the patient's views and desire in such a situation, whether to agree [to the treatment] or not.

28. The secular procedure for resolving a conflict between attorneys

CMA, <https://policybase.cma.ca/en/viewer?file=%2fdocuments%2fPolicyPDF%2fPD99-03.pdf>
<https://www.makingmywishesknown.ca/questions-about-the-substitute-decision-maker/>

29. End of Life and Critical Care - Where to Turn for Life's Toughest Questions

Rabbi Etan Ben-David, Rabbanit/Chaplain Etta Ben-David, Rabbi Dr. Judah Goldberg

<https://www.yutorah.org/lectures/lecture.cfm/987993/>

30. Four Takeaways

- 1> Judaism, like the secular system, prefers to use Substituted Judgment – what would the patient want?
- 2> If no attorney has been named, and a patient is incapacitated, the secular system and Halachah both default to family members
- 3> Where there is a conflict between joint attorneys, there may be a halachic system for deciding whom to follow, but resolution via negotiation would be ideal.
- 4> The attorney may need your encouragement and empowerment

Case #4 – Acute care

Sarah's patient, Beth, is a 71-year-old woman with longstanding Parkinson's disease. Her functioning has declined over the years, leaving her wheelchair-bound. More recently, she is frequently confused, though she recognizes family members and communicates with them easily. Over the last two months, she has suffered from an unrelated, recurrent lung problem that has landed her in the hospital on multiple occasions. Doctors have repeatedly drained fluid from around her lungs, but more fluid collects each time. Extensive testing has not been able to give a firm diagnosis or explanation for why this keeps happening. During this current hospitalization, Beth's breathing has deteriorated further, despite an oxygen mask and further attempts at drainage. She is more confused and agitated than usual, hallucinating and pulling at the medical equipment. The medical team informs Beth's family that she is at risk of death if they do not intubate her—that is, sedate her, insert a breathing tube into her windpipe, and connect her to a ventilator (sometimes colloquially called "life support"). (Goldberg, Rabbi Dr. Judah, *A Halakhic Framework for Decision-Making in Acute Critical Illness*, Tradition 53:1 (2021)) How can Sarah help Beth's family with this decision?

31. Rabbi Dr. Judah Goldberg, *A Halakhic Framework for Decision-Making in Acute Critical Illness*, Tradition 53:1

<https://traditiononline.org/a-halakhic-framework-for-decision-making-in-acute-critical-illness/>

In Beth's case, her confusion, weakness, and immobility will all work against her ever getting back to her previous state of health. At the same time, there is also suspicion that her lung condition is progressive and irreversible, even though no one can say with certainty, as no one knows what is causing it.

Her odds may be slim; but what is there to lose? Here, it is important to remember that there are other possible outcomes besides complete success or total failure. Intubating Beth, for instance, could have any one of the following three effects:

1. Bridge her to definitive therapy and full recovery;
2. Fail to prevent rapid, inevitable death; or
3. Stabilize her only partially.

In the last scenario, Beth might die anyway, but the process will be more drawn out. Alternatively, she may be left with chronic critical illness, in which she survives this episode but never regains the ability to breathe on her own and is left ventilator-dependent. As these possibilities are often associated with further discomfort, complications, and suffering, they need to at least be considered before any course of action is taken.

32. Rabbi Moshe Feinstein (20th century USA), Igrot Moshe Choshen Mishpat 2:73:1

ובאינשי כה"ג שהרופאים מכירין שא"א לו להתרפאות ולחיות, ואף לא שיחיה כמו שהוא חולה בלא יסורין, אבל אפשר ליתן לו סמי רפואה להאריך ימיו כמו שהוא נמצא עתה ביסורין, אין ליתן לו מיני רפואות אלא יניחום כמו שהם.

In such people, where the doctors recognize that he cannot be healed and live, and that he will not live as a sick person without pain, but they can give him medicine which will extend his life as he is, with suffering, then one should not give him medicine, but leave them as they are.

33. Rabbi Moshe Feinstein (20th century USA), Igrot Moshe Yoreh Deah 3:36

כשהרוב הוא לחיים מסתבר שחייב כדכתב גם כתר"ה מסברא, אבל בספק השקול מסתבר שאין לחייבו, דאם הוא חס על חיי שעה שלו הודאין ואינו רוצה ליכנס בספק לאבד זה בשביל ספק שירויה עוד זמן ודאי רשאי.

It is logical to say that when most patients live, he is obligated [to undergo the treatment], but if the odds are even then it is logical to say we should not obligate the patient. If he is concerned for his definite, short-term life, and he does not want to enter into possibly losing that life for the possibility of gaining more time, he certainly is licensed.

34. Rabbi Dr. Judah Goldberg, *A Halakhic Framework for Decision-Making in Acute Critical Illness*, Tradition 53:1

If, despite unresolvable uncertainties, the overall likelihood of meaningful recovery is thought to be low, and the risk that critical care interventions will lead to outcomes that are subjectively worse than death is significant, then a patient should be given the room to carefully weigh the different options and risks. The patient may choose to either pursue or decline the intervention in question, such as intubation. Rabbinic consultation is certainly encouraged for those who seek further guidance...

Rabbi Hershel Schachter and Rabbi Mordechai Willig have given their endorsement to the following recommendations for ethical and halakhic decision-making in the setting of acute critical illness:

1. Every effort should be made to understand the current disease process (e.g., is this a new disease process or an exacerbation of an existing one?), different treatment options, and the probabilities of different outcomes. At the same time, uncertainty about any or all of these dimensions, or even about the diagnosis itself, should be anticipated.
2. One should avoid thinking of outcomes as binary (either survival or death) and consider also in-between possibilities, such as prolonged short-term survival or chronic critical illness.
3. Similarly, decisions about care need not be binary (e.g., either critical or palliative care). Rather, each intervention should be considered separately, in terms of its risks and chances of success.
4. Important factors to consider that might influence prognosis include:
 - a. Baseline functioning
 - b. Cognitive status
 - c. Nutritional status
 - d. Chronic medical conditions
 - e. Recent trajectory
5. If, given the above factors, the overall likelihood of meaningful recovery is thought to be high or is unknown, critical care interventions should generally be pursued.
6. If, despite unresolvable uncertainties, the overall likelihood of meaningful recovery is thought to be low, and the risk that critical care interventions will lead to outcomes that are subjectively worse than death is significant, then a patient should be given the room to carefully weigh the different options and risks. The patient may choose to either pursue or decline the intervention in question, such as intubation. Rabbinic consultation is certainly encouraged for those who seek further guidance.

35. Two Takeaways

- 1> A patient may opt to avoid life-extending care if that could lead to suffering, even if there is no fear that this care could abbreviate the patient's life
- 2> A healthcare professional can be very helpful in explaining the potential outcomes and their odds to the patient.