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Hospice Care

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There has been a natural aversion and distrust towards the concept of hospice care for end of life palliation in the Orthodox Jewish community. Although there are little firm sociologic data to support such a statement, it is generally accepted that for patients who have various terminal diseases such as cancer, degenerative neurologic diseases and multi organ failures one still should "do everything" as it may save the patient. This approach differs sharply from both the gentile population and the non-observant Jewish population, which frequently embrace hospice for end-of-life care. This difference is easily explained by a rich tradition of Talmudic approaches that address the sanctity of life as well as a general lack of knowledge as to what services hospice can and should provide. An examination of the rulings of contemporary *poskim* will demonstrate that there can be a place for hospice care in appropriate circumstances in accord with Jewish law and tradition.

Why is there an issue in providing solely palliative care according to Halacha?

Jewish teachings are suffused by the concept that Jewish life is of infinite value and, as such, every moment of it has inestimable worth. That reasoning suggests that our obligation to treat patients are the same whether treatment can prolong life for many years or only several seconds. In fact there is a Talmudic source for this conclusion. The *Shulchan Aruch*

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(Orach Chaim 329:4) teaches that if a building collapses on the Sabbath and a person is trapped under the debris, then one is obligated to do everything, including violating all Sabbath laws, to save him even if he may survive for only a few moments. This is derived from the biblical verse "You should keep my statutes and my laws, which if a man obeys, *'va'chai bahem'* [he shall live by them], "(*Vayikra* 18:5). The phrase "he shall live through them" is interpreted to mean that he shall not die because of them, thus justifying Sabbath violations to save a life. This is one of the major sources of the "do everything" approach.

Diametrically opposed to this position is a Talmudic passage from which it can be inferred that for patients in extremis one need not do everything. The Gemara in *Ketubot* 104a reports the story of Rav Yehuda Hanasi, ("Rebbe"), the redactor of the Mishnah, who suffered from what is described as a severe terminal gastrointestinal disease. His condition was so poor that it was only the constant prayers of his disciples that was keeping him alive. Rebbe had a maidservant who was considered to be very pious. When she saw how much Rebbe physically suffered from his disease, she prayed that the angels of heaven who deal with death would overpower the angels of earth mustered by the prayers of Rebbe's disciples to protect him from death. Her prayers initially did not work because Rebbe's multitude of students prayed fervently that he should live. The maidservant then took a heavy clay urn and threw it on the floor, shattering it completely and generating a great sound. The loud noise so startled the students that they momentarily stopped praying, thus allowing the soul of Rebbe to depart to its eternal rest.

The Ran,[1] Rabbeinu Nissim, a 13th century authority, states that it is both permissible and praiseworthy to pray for the death of a patient who is gravely ill and in extreme pain. Furthermore, the Gemara in *Taanit* 23a recounts the story of

1. *Nedarim* 40a.

Choni Hama'agil, the preeminent Torah scholar of his era, who fell asleep for 70 years. Upon awakening from his long slumber, he had become a forgotten man and was not given his due honor even when entering his old *beit medrash*. He was in such psychological pain that he prayed for his own death--and it was granted. These episodes clearly demonstrate that in the face of physical or mental suffering, there are appropriate times to pray for someone to die quickly, a lesson that contradicts the concept of requiring the extension of life at all costs.

Distinct stages in the definition of "end of life"

The generic expression "end of life" is too broad and vague to be helpful in making halachic decisions. At the extreme state is a *goses*, an individual whose life and soul are just about to depart the body. For a *goses* no medical therapy is appropriate; interventions are prohibited lest one prematurely snuff out his life. Rav Moshe Tendler quotes his father-in-law, Rav Moshe Feinstein, as defining a *goses* as a person who is in extremis and cannot survive more than three days.[2,3,4] In contemporary times, it is quite difficult to identify exactly who should be characterized as a *goses*, given the fact that so many critically ill people are maintained on respirators, intravenous drugs and fluids, and sometimes on cardiac assist devices. The definition does imply irreversible death which cannot be prolonged by artificial means. In any case, we need not deal with this category in depth, as the controversies in end-of-life care primarily deal with the pre-*goses* state.

More relevant is the state often analogized to a *treifah*. A *treifah* animal is one which is not expected to survive more than one year. A human *treifah* is a person who is alive but

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2. Tendler, M.D. *Responsa of Rav Moshe Feinstein* Vol. I *Care of the critically ill*, KTAV, Hoboken, NJ 1996.

3. *Iggerot Moshe, Choshen Mishpat* Vol.2 75:5.

4. *Perisha, Yoreh Deah* 339:5.

dying.[5] A *treifah* is the concept that according to many Torah scholars defines terminal illness today.[6] Many halachic questions related to the permissibility of high-risk surgery depend on whether a person is in the *treifah* state. Some *poskim* believe that in humans, one should be classified as a *treifah* only if expected to live for less than six months, while others maintain that a *treifah* for humans is also 12 months.[7,8] This dichotomy of opinion is dependent on the definition of a human *treifah*. The Rambam opines that the definition varies over time periods, depending on the medical expertise of the generation.[9] Others disagree with this position.[10] In either case, the relevant issue relates to a person with a defined terminal illness who is not expected to survive in the long term despite therapy. For the purposes of this study, we will define a terminal condition as one that is irreversible, incurable and will directly and rapidly cause the patient's demise.However, in actual practice, a competent halachic authority needs to make that ruling on a case-by-case manner.

One final concept is that of medical futility. This is defined as an exceedingly small likelihood that a specific intervention such as chemotherapy or surgery will benefit the patient. To be more specific, it means that the treatment is highly unlikely to either extend the person's life or make her or him feel better. Since the goal of medicine is to help the sick and not to provide treatments that do not benefit patients, it is important for physicians confronting patients with terminal illnesses at the end of life to consider whether specific treatments are futile.

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5. Rambam, *Mishneh Torah, Issurei Bi'ah* 1:12.

6. Steinberg A: *Encyclopedia of Jewsih Medical Ethics.* 2003 Vol. 3, pg.1046, Feldheim, Jerusalem.

7. *Iggerot Moshe, Choshen Mishpat* Vol. 2 75:2.

8. *Chochmat Shlomo Yoreh Deah* 155:1.

9. Rambam, *Hilchot Rotzeach* 2:8.

10. *Chazon Ish, Even Haezer, Hilchot Ishut* 26:3.

What medical services are required for the terminal patient?

Although secular medical ethicists have discussed a broad range of medical therapies felt to be unnecessary or inappropriate for the dying patient, Halacha takes a more proscriptive view. In 1995 four giants of Torah in Israel published a list of mandatory treatments for the terminally ill. These included intravenous or gastric feeding tube nutrition, intravenous fluid replacement, insulin therapy if needed, controlled doses of morphine for pain relief, antibiotics as needed and blood transfusions if needed. The Rabbis were R. Yoseph Shalom Eliashiv, R. Shlomo Zalman Auerbach, R. Shmuel HaLevi Wozner, and R. Nissim Karelitz.[11] Similarly, Rabbi Moshe Feinstein states that even for terminally ill patients there is a clear-cut benefit of nutrition and, in the absence of contraindications, the patient should be given intravenous feeding.[12]

Secular ethicists and many physicians are against the use of feeding tubes in dying patients or those with advanced dementia, marshaling evidence that their use is not clearly associated with increased survival and may promote serious adverse consequences such as aspiration and subsequent pneumonia. From a halachic perspective these arguments are not relevant given the rulings above, and patient families have the right to demand their use unless absolutely contraindicated. While IV hydration and nutrition might be preferred in the short term, the ability to maintain long-term intravenous access is frequently limited due to difficulties in keeping veins patent. Thus, a feeding tube may become necessary.

The Talmud itself may hint at the concept of a feeding tube. When Rabban Yohanan ben Zakkai was negotiating with the

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11. *Yated Ne'eman 29 Kislev* 5755.
12. *Iggerot Moshe, Choshen Mishpat* II:74, 1984.

Roman Emperor Vespasian, he said to him, "Give me Yavneh and its sages, the family of Rabban Gamliel, and doctors to cure Rabbi Zadok."[13] Rav Zadok had fasted extensively for 40 years to stave off the destruction of Jerusalem, and became deathly ill with contraction and shriveling of his intestines. The Talmud suggests that the care for Rav Zadok was a process of graduated feeding from liquids to semisolids, akin to what we now do with feeding tubes.[14]

Rabbinic opinions regarding aggressive therapy for terminally ill patients

Consistent with the introductory themes of "doing everything" versus "not", there is a broad diversity of contemporary rabbinic opinions as to the general theme of aggressive therapy. We will deal with some of these major opinions before focusing on specific therapies.

In the "do everything" camp, most prominently, is Rabbi Eliezer Waldenberg, a pre-eminent *posek* who often ruled on medical issues, who opined that the physician must try to extend life and treat all patients even in the face of physical suffering and even if the patient refuses treatment.[15]

Opposing this somewhat lone view are the positions of other *Gedolei Yisrael,* notably, Rabbis Y.S. Eliashiv, S.Z Auerbach, and M. Feinstein. As an example, Rav Eliashiv is quoted that if a terminally-ill patient is suffering terrible anguish and requests that his life not be extended by treatments that increase his suffering, it is permitted to withhold life-prolonging treatment, and there is no prohibition to not extending life in these circumstances.[16]

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13. *Gittin* 56b.

14. Rav Moshe Faskowitz, personal communication.

15. *Tzitz Eliezer,* Vol. 5, Ramat Rachel #288.

16. Abraham A.A., *Nishmat Avraham* Part 4, *Yoreh Deah* 339.2 Artscroll, NY, 2003.

Rav Auerbach states that "in terminal states of illness, there is no requirement to take measures to extend this period and cause further pain and suffering."[17]

Controversial Issues in End of Life Care

Do not resuscitate (DNR) – Before undertaking a discussion of this topic, it is appropriate to define it. DNR means do not perform cardiopulmonary resuscitation. CPR is undertaken when a patient's heart stops, or he or she stops breathing. In the setting of a healthcare facility, the procedure entails a doctor or nurse compressing the patient's chest by at least 2 inches at a rate of 100 compressions a minute in order to externally compress the heart and maintain blood flow to the brain and other tissues. Simultaneously, the patient needs to be given a source of oxygen, either through breaths into the mouth or via a compressible bag connected to oxygen. These measures alone are rarely successful, so they must be supplemented by intravenous drugs and an externally administered electric shock to the heart, termed defibrillation, or in the case of a respiratory arrest, connection of the patient to a mechanical ventilation machine, a respirator. CPR is continued until the patient either resumes having a heartbeat and pulse or, if the procedure is unsuccessful, the patient is declared dead.

CPR has about a 5% chance of survival in elderly patients and an even lower success rate in the terminally ill. CPR can cause rib fractures and those few who survive are often left with severe and irreversible neurologic damage.[18] A recent meta-analysis that amalgamated data from 47 separate studies that reported survival to discharge in hospitalized adult cancer patients involving 1707 patients who underwent CPR

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17. Op. cit. and *Minchat Shlomo* No. 91,sec 24.

18. Kinzbrunner BM: "Jewish Medical Ethics and End-of-Life Care"; *J Palliative Med* 2004;Vol 7, No.4, pp. 558-573.

found that in patients with metastatic disease, there was a 5.6% success rate of CPR. These included rates of 3.4% for patients with lymphoma and less than 1% for those with leukemia.[19]

Taken together, these studies show a very low rate of success of CPR in terminally-ill patients, coupled with a high risk of irreversible brain damage in those who do survive. These medical facts should inform halachic decisions to either allow a "Do not resuscitate" order on a specific patient or mandate that CPR be performed.

In halachic discussions of DNR, it is accepted by many that CPR may be withheld from or refused by Jewish patients who are terminally ill when the patient states his or her wishes.[20] Similarly, in the appropriate circumstance, to be determined by a qualified Orthodox rabbi, it is permissible to withhold CPR and attachment of a patient to a respirator in the case of terminal illness.[21,22]

Do Not Intubate (DNI) – This order differs from DNR in that it applies to individuals who have a normal heartbeat but cannot breathe on their own sufficiently well to maintain a normal oxygen level in the blood. Examples of patients and diagnoses to which this applies include terminal patients who develop overwhelming pneumonia or massive pulmonary embolism, patients with terminal emphysema and patients with amyotrophic lateral sclerosis (ALS). The latter condition is a neurologic disorder in which patients progressively lose

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19. Reisfield GM, Wallace SK, Munsell MF, Wenn FJ, Alvarez ER, Wilson GR: "Survival in cancer patients undergoing in-hospital cardiopulmonary resuscitation: A meta-analysis". *J Resuscitation*, 2006 71:152-160.

20. Schostak Z: "Ethical guidelines for the treatment of the dying elderly". *J Halacha Contemp Soc* 1991, Fall:XII, 62-86. Quotes opinion of Rav Shlomo Zalman Auerbach, cited by A.S. Abraham in *Halachah Urefuah* 2:189.

21. Steinberg A: *Encyclopedia of Jewsih Medical Ethics.* 2003 Vol. 3, pg.1058, Feldheim, Jerusalem.

22. *Iggerot Moshe, Choshen Mishpat*, Vol. 7, 74:1.

all of their muscle activity, including that of the respiratory muscles required for breathing, while maintaining full cognitive ability. Once they can no longer breathe on their own, patients must be placed on a respirator or else they will die. As the disease is incurable, once on the respirator, they can last for years and years, totally paralyzed and unable to communicate despite have full mental capacity.

Several *poskim* rule that it is permissible to withhold connecting a patient with ALS to a respirator if that is his or her wish, because of the profound suffering he or she will experience for many years. This approach is held by Rabbis S.Z. Auerbach, Y.S. Eliashiv and I. Lau.[23]

If a terminal patient has a treatable pneumonia in which it is appropriate to treat that pneumonia, or a case of likely reversible congestive heart failure (fluid in the lungs), and the patient needs a respirator to tide him or her over till the pulmonary process is cleared (see use of antibiotics), then a DNI is not appropriate.

Blood transfusions – Most *poskim* require blood transfusions as needed for terminally ill patients. Rav Moshe Feinstein explained that the transfused red blood cells aid in oxygenation and can make the patient more comfortable. If the patient is in deep permanent coma or clinically brain dead, then transfusions may not be necessary.

Removal from a Respirator – In general, only withholding life-prolonging interventions is permitted by Halacha, but it is forbidden to withdraw therapy already started. Stopping therapy is considered the performance of an action while withholding therapy is considered a passive non-action. Most Rabbis rule that it is never permissible to disconnect a patient from a respirator if that is what is needed to maintain life.[24]

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23. *Nishmat Avraham* Part 4, *Yoreh Deah* 339:2.
24. *Tzitz Eliezer* Part #17 #72:13.

Rav Moshe Feinstein, in a novel position, states that if a respirator needs to be serviced or if the patient needs to be removed from the respirator for a minute or so to suction out respiratory secretions, then there is no requirement to reconnect the respirator if medical observation ascertains that the patient is not breathing spontaneously.[25] This position led to the development of integrated timers on respirators that were developed in Israel, to allow temporary automatic shutoff to ascertain whether a patient is capable of spontaneous breathing. Modern day respirators no longer need to be disconnected to allow for suctioning.

With regard to initially connecting a terminally-ill patient to a respirator, that issue will be dealt with in the section on general principles. Special note must be given for the patient with amyotrophic lateral sclerosis (ALS). This terrible disease causes complete muscle paralysis, eventually affecting the respiratory muscles, while maintaining the patient's brain function completely intact. Eventually, they cannot breathe on their own and are forced to decide whether to go on to a respirator and live the rest of their life completely paralyzed, unable to communicate and respirator-dependent while being fully cognizant of the world around them. Most patients elect not to go onto a respirator and face decades of total paralysis and incredible suffering, choosing instead hospice care during the terminal stages of their disease. Whether this is allowable under Halacha is controversial. Dr. Abraham S. Abraham cites a discussion he had with Rav Auerbach in which Rav Auerbach allowed a patient with ALS to refuse ventilator treatment.[26] Needless to say, such a decision requires close consultation with a sensitive and highly experienced *posek* .

Dialysis – Dialysis is indicated in the face of kidney failure that is so severe that the patient will die without it. As the risk of initiating dialysis is relatively small, then if the patient is

25. *Iggerot Moshe Yoreh Deah* Part 3 #132.
26. *Nishmat Avraham, Yoreh Deah* 339:2.

not otherwise suffering from pain, it is appropriate to provide this treatment. This is especially relevant to provide emotional support so that the patient does not feel neglected.[27]Naturally, if the patient is a *goses*, then it is prohibited to provide such an intervention.

According to Rav Moshe Feinstein, in his discussion of pneumonia treatment,

> If the terminally ill patient is in great pain, and he would prefer to die rather than continue living under these conditions, it may well be proper not to treat him in any manner that would prolong the dying process. This means it might be best to withhold treatment for the second illness, since if the pneumonia is cured, it would impose on the patient the burden of his first disease, for which relief is not available.[28]

It is possible that the same reasoning would apply to initiating dialysis.

Rav Moshe continues that this is a decision which the patient must make. When the patient is incompetent, his family must be consulted, since the mitzvah "to heal" initially falls on the family. However, the family's authority is not absolute. It is subservient to halachic and medical opinion.[29]

Antibiotics – Antibiotics are one of the several items that the four Israeli *poskim* mentioned above require in terminally ill patients.[30] However, in the case of a patient who is suffering from great pain, Rav Moshe Feinstein's dictate in the case of pneumonia may apply, and antibiotics could be withheld, but that would depend on a rabbinic ruling.

Chemotherapy – This is a nuanced topic both from a

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27. *Iggerot Moshe Choshen Mishpat* II:74 (1984).
28. Loc. cit.
29. Loc. Cit.
30. *Yated Ne'eman* op.cit.

medical as well as halachic perspective. Cancer chemotherapy, as well as radiotherapy and biologic therapy, is given in one of three settings. It may be given as adjuvant therapy in association with surgery to prevent recurrences of the cancer. This is always halachically appropriate when medically indicated. It may be given for curative purposes, again always halachically appropriate. Finally, it may be given to terminally-ill patients for palliation. In the latter case, the therapy might be prescribed to effect tumor shrinkage which can make a patient feel better and possibly prolong life, but rarely so. Alternatively, oncologists may prescribe "so-called palliative chemotherapy" even when it is not expected to work, but merely to give the appearance of "doing something". This is often demanded by families. Some Rabbis require disease specific medications to be given to a terminally-ill patient, even if the treatment cannot cure him.[31] According to Rav Moshe Feinstein, one should not give these medications because they are of no help, but only prolong the life of suffering.[32]

In deciding between these two opposing opinions, one need take into account how much additional suffering the futile chemotherapy will cause. If the therapy will cause increased suffering in the face of medical futility, it probably should not be given. Yet, if the chemotherapy is not expected to prolong the patient's life beyond twelve months it would be the patient's choice as to whether to accept palliative chemotherapy, assuming he or she is capable of making that choice.

A recent study from the Dana Farber Cancer Institute of Harvard University and Cornell University Medical College involved 386 terminally-ill cancer patients. They entered a study in which about half elected to have chemotherapy that was limited to palliation with no expectation of cure or

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31. Rabbi B.P. Toledano *Barkai* Vol. 4, 5747 p.428.

32. *Iggerot Moshe, Choshen Mishpat* II #74:1 73:5.

improvement, and half elected to have palliative care with no chemotherapy. The average time to death was about four months and there was no difference in overall survival between patients receiving palliative chemotherapy and those who were not. The use of palliative chemotherapy was actually associated with an increased risk of dying in an intensive care unit, a decreased risk of dying at home, and a lower likelihood that patients died in their preferred place.[33] This gives further support that palliative chemotherapy is usually not helpful and therefore not indicated, especially if it is highly toxic and will increase the patient's suffering.

It should be noted that newer biologic agents, including gene-based therapies, are becoming available as part of clinical trials and eventually will become FDA approved for treatment. As these newer agents may both extend and improve life, even if not curative, they may eventually be widely recommended for palliative therapy and would then be halachically appropriate.

Surgery – A nuanced view of the subject of surgery for terminally ill patients is also required. Some procedures may be performed to make a patient more comfortable or even to alleviate acute pain. These are almost always sanctioned by Halacha as they improve the patient's quality of life, sometimes immediately. The controversial issue revolves around risky surgery that may extend life but may be so dangerous as to pose an imminent danger for survival. Here, Rav Moshe Feinstein provides a rational approach which is relevant to both risky surgery as well a high-risk medical therapy. He states that for a patient who would not survive a year if untreated, but the treatment involves a significant risk, then it is permissible to assume a large risk in order to achieve a cure if death would be certain without the treatment.

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33. Wright AA, Zhang B, Keating NL, Weeks JC, Progerson HG: "Associations between palliative chemotherapy and adult cancer patients' end of life care and place' of death:prospective cohort study" *BMJ* 2014;348:1219.

"However, if the treatment will only prolong life for only a few months and not for a full year while the patient may die immediately because of the treatment's toxicity, I believe it is forbidden to undertake such a course of treatment."[34]

Narcotics for pain relief – Medication may be chosen to obtain the maximum comfort for terminally-ill patients with intractable pain, even if it renders the patient less responsive.[35] While there may be a fear that high dose narcotics may cause a patient to stop breathing, this can usually be mitigated by adding small incremental doses which are designed to achieve pain relief rather than respiratory depression.

Definition of Hospice and Palliative Care

Hospice is a home or hospital established to relieve the physical and emotional suffering of the dying. Although special hospitals for the terminally ill existed prior to the 20th century, it was not until after World War II that recognition of the special needs of the dying led to the modern hospice movement. Cicely Saunders, one of the initiators of the movement and the founder of St. Christopher's Hospice, London (1967), and other health professionals recognized that many established procedures of modern medical care could be inappropriate when applied to those who are dying. The aggressive life-prolonging measures routinely taken in intensive-care units often only increased the discomfort and isolation of terminally-ill patients and deprived them of the opportunity to die in a peaceful and dignified fashion. In response to the absence in the medical system of provisions for the supportive care of this class of patients, the modern hospice was developed.

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34. *Iggerot Moshe, Choshen Mishpat* II:75 (1984).

35. Loike J, Gillick M, Mayer S, Prager K, Simon JR, Steinberg A, Tendler MD, Willig M, and Fischbach RL: "The critical role of religion: Caring for the dying patient from the orthodox Jewish perspective". *J Pall Medicine*: 13(10) 1-5, 2010.

The hospice functions as a sympathetic and reassuring environment dedicated to making the last days of the dying as pleasant as possible. The prevention of physical pain is the first priority, and analgesics, tranquilizers, and physical therapy are used to alleviate physical suffering. Hospices emphasize the prevention, rather than the mere control, of pain through vigilant monitoring and by the tailoring of drugs and their dosages to patients' individual needs. Patients in hospices receive moral support from loved ones as well as the staff itself, and a variety of measures are used to further their emotional and spiritual well-being.

Patients are usually admitted to a hospice on referral by a physician after a prognosis for survival of only months or weeks. Care may be provided completely within a health facility, on an outpatient basis, or at home.[36]

Palliative care, on the other hand, seeks to improve the quality of life of patients with terminal disease through the prevention and relief of suffering. It is facilitated by the early identification of life-threatening disease and by the treatment of pain and disease-associated problems, including those that are physical, psychological, social, or spiritual in nature. Palliative care is also sometimes described as hospice, but is a more general approach. While *hospice care* does imply palliative care, it is specific to care provided near the end of life. In contrast, palliative care covers the duration of a patient's illness and, hence, may be delivered over the course of years.[37]

Home versus Inpatient Hospice

For patients who can be managed at home by family and

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36. "Hospice." *Encyclopaedia Britannica Online Academic Edition.* Encyclopædia Britannica Inc., 2014.

37. "Palliative care." *Encyclopaedia Britannica Online Academic Edition.* Encyclopædia Britannica Inc., 2014.

with help, hospice services can be provided to allow a patient to live his or her final days at home and to die at home. This is often a patient preference. The hospice organization will work together with the patient's physician and provide skilled nursing visits, management of pain medication and social work consultation. The assigned case manager can also facilitate transfer to inpatient hospice if needed. For most of the day, though, there are no hospice personnel present within the home. The major advantage of home hospice care is the comprehensive management of pain and social service needs. It is important to appreciate that while Medicare will pay for all aspects of home hospice care, it will not cover chemotherapy or other drugs to treat the underlying illness once the patient chooses to receive hospice care. As such, all decisions and discussions as to the appropriateness of not continuing palliative chemotherapy and the like must be made before choosing hospice. One can, however, reverse one's decision and change back from Medicare for hospice to standard Medicare, which will pay for illness therapy.

In-patient hospice provides 24/7 skilled nursing care and an on-site physician supervision for patients who are both terminal and too sick to be managed at home without 24-hour-a-day care. The in-patient hospice also provides comprehensive pain management but supplements this with round-the-clock nursing care, I.V. hydration, oxygen, transfusions, antibiotics and bed sore prevention.

The Challenges of Hospice

Many people are repelled by the thought of hospice for a variety of reasons. There are concerns that some hospice care organizations may not respect the halachic wishes of the patient or family, and literally offer no treatment other than pain relief. Other concerns relate to the patient not being told of his or her diagnosis, so the family is thus reluctant to refer the patient to hospice. The first concern does have a basis in reality, as there are certain hospice organizations that are

philosophically committed to a distinct type of restricted care. The challenge, then, is to find an organization that will totally respect the family's wishes. These institutions do exist.

As to the concern of not telling the patient, in my experience, that situation is usually a fiction created by the family with good intentions, as they try to save the patent from depression. In reality, when someone is racked with pain, is losing weight rapidly, and is too weak to perform everyday tasks, they know absolutely that something is terribly wrong. It may be much more kind to inform the patient and then make his or her remaining time more meaningful with expressions of sympathy and love, having friends visit to comfort. It enables one to confront the real problems of the terminally ill such as pain relief and non-specific terror that they experience from not knowing why they are so sick. In addition, knowing their diagnosis allows them to become meaningfully involved in future planning, such as creating or updating wills and making their wishes known to spouse and children. It is important to realize, however, that telling or not telling a patient the truth about their condition is a halachic question that needs to be discussed with a competent rabbinic advisor.

Why Hospice Care is so Important

There are many real-life needs of the terminally ill patent that may be best served in a hospice setting, once the patient reaches the end-of-life stage before anticipated death. These include the obvious needs for oxygen, expert pain relief and feeding. Equally important, though, are those services which usually cannot be adequately provided at home, such as body cleansing and bathroom aid, frequent turning to prevent bed sores, and the numerous manipulations that are difficult or impossible because of the need to maintain *kibud av v'em* (respect for parents) with its many halachic implications. The hospice environment provides all of these in a peaceful, not cramped, comfortable setting. It is virtually impossible for

most families to provide a truly high level of end-of-life care at home because of limitations of space, facilities and finances. Both Medicare and Medicaid as well as commercial insurance and long-term care pay generously for hospice care. It is the family's responsibility to insure that a chosen hospice will cooperate fully with the family in their wishes to provide halachically appropriate hospice care.

Caveats in Defining Halachically Appropriate End of Life Care

It goes without saying that the first step in deciding whether and how to seek hospice care needs to start with a consultation with an Orthodox Rabbi, who is expert in the halachot of end-of-life care. It is appropriate to begin to discuss matters with one's congregational Rabbi who may or may not be such an expert, but who will certainly be involved in pastoral care and may actually work together with the halachic expert to provide day-to-day guidance.

Next, if at all possible, it is critical to discuss substantive questions with the patient himself or herself. It is actually the patient's wishes with regard to therapy that are most important, both halachically and from a secular ethical perspective. Their explicit written or verbal wishes should be obtained and, if possible, legally binding advanced directives and health care proxy should be completed. Sometimes, these forms are somewhat restrictive and may not address the nuanced wishes of the patient. In such cases, it might be helpful for the patient to dictate a letter and sign it in the presence of witnesses, to establish a richer, but legally binding set of directives. From a halachic perspective there may be unique circumstances when the patient's wishes may not be halachically acceptable, thus emphasizing the need for consultation with rabbinic authorities well-versed in these issues.

If hospice care is planned, then the family should discuss their specific wishes, developed in consultation with the

patient and their rabbinic *posek*, with the hospice organization. The discussions must include DNR/DNI, feeding, hydration, antibiotics and transfusions. In most cases, the hospice will respect the family's wishes and it is the family's responsibility to insist on these halachically-mandated requirements. These discussions must be undertaken before the final choice of a hospice organization to insure its agreement. If the patient has been hospitalized and cannot make it to hospice care, then the family should have the exact same conversation with the treating medical staff of the hospital to insure an orderly end according to Halacha and the family's wishes.

It is instructive to end with a long quote on the topic from one of the generation's greatest halachic decisors, Rav Moshe Feinstein. In a *teshuva* asking whether there are patients who should not be treated so as to prolong their lives for a little while, he states:

> With regard to a terminally ill patient who can live for several weeks or months, such patients often should not be treated. In cases of intractable pain, we have clear instructions from the account of the death of Rebbe, where the Talmud records that the actions of the maid servant were right and proper. Furthermore, the Ran in *Nedarim* 40a states that "it is sometimes proper to pray to Hashem for the death of a critically ill person if he is suffering greatly and there is no rational hope that he will recover."

Rav Moshe then rules that,

> For such a patient who has no hopes of surviving free of pain, but it is possible, by medical methods to prolong his life, then it is improper to do so. Rather, the patient should be made as comfortable as possible, and left without any further intervention. I must emphasize that it is absolutely forbidden to do anything or to provide any drug that will shorten the patient's life, for even a moment. If it is possible to provide drugs that will make

> the patent comfortable so that he will not be in pain, then efforts should be made to prevent the patient from dying."[38]

Those efforts, as previously stated, include oxygen, feeding and hydration.

This perspective, I believe, provides an appropriate balance between maintaining the sanctity of life, being sensitive to human suffering and providing the most respectful end-of-life care all under the umbrella of Halacha.

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38. *Iggerot Moshe Choshen Mishpat* II:73.