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The Critical Role of Religion: Caring for the Dying Patient from an Orthodox Jewish Perspective

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Abstract

Background and objective: Culturally competent medical care for the dying patient by families and health care professionals is a challenging task especially when religious values, practices, and beliefs influence treatment decisions for patients at the end of life. This article describes end-of-life guidelines for hospital health care professionals caring for Orthodox Jewish patients and their families. Religious perspectives on advance directives, comfort care and pain control, nutrition and hydration, do not resuscitate/do not intubate (DNR/DNI), and extubation are often unfamiliar to the American medical community.

Design: The guidelines for the care of the dying Orthodox Jewish patient were mutually agreed upon by the authors, recognized authorities in medicine, ethics, and Jewish law, who presented their perspectives during a 1-day symposium and who participated in an active working-group session.

Conclusions: Care of the religious patient close to death is enormously complex especially when balancing religious obligations, the role of the rabbi, medical procedures, and personal preferences. These guidelines address from a religious perspective profound issues such as the definition of death, organ donation, and caring for the patient at life's end. The guidelines can be useful for any hospital that serves an Orthodox Jewish population.

Introduction

Culturally competent medical care for an increasingly culturally diverse population requires awareness of the importance of religion and ethnicity in the care of hospitalized patients at the end of life.[1] Medical care in large metropolitan cities guarantees encounters with patients representing diverse religious and ethnic groups. Many of these groups hold values, beliefs, and practices unfamiliar to the American medical community. This may result in misunderstandings and tensions between patients, their families, primary physicians, clergy, and other health care professionals.[2,3]

This article provides as clinical ethics guidelines for the care of the dying Orthodox patient. These guidelines were prepared by experts who represent the fields of medicine, palliative care, bioethics, geriatrics, and Jewish law. They seek to inform readers about the views of Orthodox patients to help physicians and other health care professionals provide culturally appropriate care for their patients.

Orthodox Jews are among the religious groups frequently encountered in New York City, Miami, Chicago, Boston, and Los Angeles. Nationally, Orthodox Jews represent 10% of all Jews in America. Of the total Jewish population, 20% of the under 18-year age group are Orthodox.[4] There is a diversity of perspectives among Jews regarding end-of-life care and what distinguishes Orthodox Jews from Reform, Conservative, and Reconstructionist Jews is their strict adherence to *Halakha* (Jewish law).

In adhering to Jewish law, Orthodox Jews may make medical decisions that differ from those made by other patient groups.[5–7] Differences in how to care for dying Orthodox

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Jewish patients generate profound ethical challenges for health care professionals and the hospital's Ethics Committee. The definition of death as cessation of brainstem function versus cardiac function (as discussed below) is one area where there are divergent views.

In this article we explain several underlying Orthodox religious beliefs and principles that impact end-of-life decisions. We believe the consensus guidelines we present are applicable to any hospital in the world that serves an Orthodox Jewish population. The guidelines underscore both the need for clergy of all faiths to exchange views and ideas with physicians and other health care professionals and for other hospitals to develop their own unique guidelines for the care of the dying patient from varied cultures.

Guidelines

The role of the rabbi

There are two guiding principles in Jewish law as they apply to end-of-life care. The first is that life is of utmost value.[5,6,8–11] The second is that dying is a natural part of life's journey that should be addressed with dignity and compassion. While there is agreement on these principles, there is often debate about the practical implementation of Jewish law to end-of-life care. Especially difficult topics that should be addressed relate to the value of life versus the quality and quantity of life, autonomy versus paternalism, and how to manage pain and nutrition for the dying patient. Consequently, it is advisable for Orthodox patients and their families to be asked if they would wish to consult with a rabbi of their choice as early as possible in the care of the critically ill patient.

In addition to offering pastoral counseling during a difficult time, the family's rabbi is the authority to whom they can turn to determine what *Halakha* requires of them at the end of life. Once a rabbi has been chosen by the family or patient, the health care professional should invite the rabbi, with the family's permission, to visit the patient and meet with the attending physician. In this way, both the family and rabbi will have the opportunity to ask appropriate and timely questions and express to the physician whatever concerns they may have.[12]

Misunderstandings of the patient's medical condition and proposed treatment can arise if family members alone present the rabbi with the clinical situation. Since each patient and medical situation is unique, direct dialogue between the patient (if possible), the family, the rabbi, and the primary physician fosters a better understanding of the range of possible medical interventions within Jewish law that would be appropriate and permissible for that particular patient.

In general, decisions and actions by physicians or other health care professionals that may directly or indirectly shorten life are forbidden. Yet, when death is near, many rabbis recognize that the increased suffering which often accompanies terminal illness must be taken into consideration. According to Jewish law, these decisions will guide which and how much medical intervention should be undertaken to prolong life.

One major philosophical/ethical difference between secular and *Halakhic* practice is that U.S. law promotes and even relies on autonomy of the patient and family in making medical decisions regarding the dying patient (with variations in different countries and cultures). Such decisions may include withdrawing life-support treatments, withholding nutrition and hydration, and in some instances allowing active euthanasia or physician-assisted suicide. Rabbis who follow *Halakha*, however, view patient and family autonomy as more limited, especially related to issues involving withdrawing life support systems.

Within *Halakha*, there are several basic guidelines related to dying patients that distinguish between:

1. Acts of omission and acts of commission;
2. Treatments pertaining to the dying process (or illness) and treatments unrelated directly to the dying process;
3. Treatments that are continuous in nature in which withdrawing of such treatments is considered an act of commission and treatments that are cyclic in nature in which the withholding of the next cycle of treatment is considered an act of omission; and
4. Patients expected to die within 6 months and those patients with less serious medical conditions.[6,10,11]

Jewish patients who adhere to *Halakha*, or family members caring for the dying patient, do not have the authority to insist on the withdrawal of a ventilator which is an act of commission that hastens death. Likewise, they cannot ask that artificial nutrition and hydration be withheld from patients who are unable to eat or drink because withholding a basic sustenance, needed for every living person, is an act of omission that will lead to death.

Advance directives

Orthodox Jewish patients should be encouraged by their physicians and rabbis to appoint a health care agent who is familiar with the patient's values and/or to create a living will so that the patient's religious values and choices will be honored and carried out. The health care agent can request, when the patient lacks decisional capacity, directives such as withholding dialysis or chemotherapy for the dying patient, provided that the patient's rabbi is involved in the decision-making process and concurs.

Comfort care and pain control

Pain management is a critical issue from both medical and religious perspectives. Various classes of medication are available for pain management, including benzodiazepines, neuroleptics, and opioids. Although some rabbis have expressed concern that opioids used for terminal illnesses may shorten life, there is general agreement among rabbinic authorities that appropriate pain control is acceptable and indeed required. It is important to communicate to those making decisions regarding pain management that current medical data suggest that judicious use of opioids does not usually shorten the life of terminally ill patients.[13] Health care professionals can offer patients and families choices for pain control:

1. Sentient patients may choose to receive adequate medication to keep them as comfortable as possible while retaining the ability to communicate with their family.
2. Medication may be chosen for maximum comfort even if it renders the patient less responsive.

Nutrition and hydration

According to virtually all rabbinic authorities who follow *Halakha*, food, water, and oxygen are considered essential components of life that must be offered to the patient. The insertion of a nasogastic feeding tube or a percutaneous endoscopic gastrostomy (PEG) tube is considered by many authorities, under certain circumstances, to be indispensible in providing food and water to the dying patient. This view differs from many medical authorities and laws established by individual states that do not subscribe to these aggressive measures.[6,14–16] If a feeding tube is refused by a competent terminally ill patient, some authoritative rabbis prohibit coercive methods such as tying down the patient's hands to prevent him or her from pulling out the tube. The patient should be encouraged by family and caregivers to accept the feeding tube. If the patient is competent and expresses clear opposition to a feeding tube, however, this choice should be respected. It is often sufficient to offer the patient food by hand feeding. According to this perspective, as long as the patient is eating something, caregivers have satisfied their religious obligation to provide the patient with nourishment even if the required daily caloric intake is not met.

Patients nearing the end of life often lose interest in eating or have difficulty swallowing, which can lead to choking and aspiration. In such cases, it is sufficient to make patients comfortable by using menthol swabs or ice chips.[16] When the decision is made to discontinue artificial nutrition and hydration, the focus of communication should be on "what will be done to demonstrate respect for the patient, rather than on emphasizing what will be withdrawn or withheld."[14,17]

DNR, DNI, and extubation

Most *Halakhic* authorities only permit a do-not-resuscitate (DNR) order for forgoing chest compressions and electronic defibrillation in cardiac arrest. Since these situations are complex and comfort care must be provided at all times, it is best to encourage the family to consult with their rabbi. For example, if a patient has an acute event, such as pneumonia, on top of an underlying terminal illness, the rabbi should be consulted to determine if intubation is required until antibiotic therapy becomes effective. If artificial respiration (intubation) is chosen to be withheld, in accordance with the ruling of a *Halakhic* authority, oxygen supplementation and/or a noninvasive positive pressure airway device should still be provided to alleviate discomfort.

Rabbinic authorities generally agree that terminal extubation is prohibited as this would be an act of commission that hastens death. Yet, this does not mean that a patient, once intubated, must receive full life-sustaining care. For the patient close to death, many rabbis will permit the cessation of monitoring vital signs, blood draws, etc., as well as adjustments of the parameters of the respirator. Similarly, an implanted cardiac defibrillator should be deactivated in patients near death. In this situation, while mechanical ventilation remains in place, comfort care measures can be introduced even though no additional efforts are made to prolong the patient's life. Also, many *Halakhic* authorities distinguish between a continuous form of life-sustaining treatment such as a ventilator or cardiac pacemaker, and an intermittent form of treatment such as dialysis or chemotherapy. As stated earlier, discontinuation of the former (continuous form) is forbidden as it is seen as withdrawing life-support and actively hastening death, whereas in the latter intermittent form of treatment, each new cycle of treatment requires a new decision to either withhold or provide the treatment.

Determining death

Prior to 1968, death had been medically defined as the irreversible cessation of cardiac function. In 1968, however, a Harvard Medical School *ad hoc* committee redefined death as the irreversible cessation of all brain functions including the brainstem. In accepting the Harvard criteria, the patient must be unresponsive even to painful stimuli, show no movement, show no spontaneous breathing, and demonstrate no brainstem reflexes. Nationally as well as internationally, these criteria are recognized as the legal definition of death. The Orthodox rabbinic community is divided on whether to accept brainstem death as indicia of death. Leading Orthodox rabbinic authorities[18–20] accept the Harvard criteria of brain death, provided the diagnosis is confirmed by objective tests, e.g., transcranial Doppler (TCD) showing no blood flow to the brain, or nuclear perfusion imaging studies showing absence of perfusion of the entire brain. There remain other leading Orthodox rabbinic leaders who only accept cardiopulmonary death and thus, even if sustained artificially, the patient is considered alive.[20,21] Lack of consensus on the definition of death among the Orthodox Jewish community and other religious groups, in part prompted a couple of states, such as New York and New Jersey, to require that hospitals make accommodations for people who do not subscribe, for religious reasons, to the legally accepted brainstem definition of death.

The hospital Ethics Committee can help families and physicians determine what these reasonable accommodations should be. Indeed, it is understandably difficult for families to accept that their loved one is legally dead when they see the person with a beating heart, warm to the touch, and with metabolic activity.

Care of the patient near death

In the Orthodox Jewish tradition, it is a sacred privilege to be present when someone passes from life into death. *Halakhic* literature speaks about *goses*, a patient who is imminently dying. While a *goses* should not be left alone, Jewish law forbids one to take any action that would hasten or impede death of the *goses*.[11] Thus, health care professionals should be respectful of that privilege and try to advise the family when they believe death is imminent so loved ones can be at the bedside at the time of death.

Organ donation

The scarcity of human organs is a critical medical issue in the United States and indeed around the world. At the time that a patient has been medically declared brain dead, a member of the organ procurement organization is often available to approach families or next of kin to discuss the possibility of organ and tissue donation. While this is a difficult time for loved ones, still it may be helpful to remind the family of the importance of saving a life, which is a strongly held value in Jewish law.

Two major issues with organ donation confront the Orthodox community and must be resolved in order to support organ donation.[22–24]

Because in the United States brain death defines legal death, it is permissible to remove vital organs for donation from patients who have been carefully evaluated and are diagnosed as brain dead. For Orthodox Jews who only accept cardiac-pulmonary death and do not accept that brain-dead patients are in fact dead, it would be Halakhically unacceptable to remove any vital organ including the patient's heart, lung, and pancreas, even to save another person's life.

For other Orthodox Jews and organizations such as the *Halakha* Organ Donor Society (www.HODS.org) who believe death is the irreversible cessation of respiration confirmed by total lack of brainstem function, donation of vital organs is encouraged as a meritorious act. It is critical, however, that the consulting rabbi, physician, and family members agree on the details of if, how, and when the organs should be removed.

The second issue in the Orthodox tradition involves a widespread belief that a human body should be buried with all of its parts. Although this is absolutely true according to Jewish law, this requirement does not apply to organs being transplanted into another living person. The reason is that the prohibition of burial without all of one's organs is outweighed by the benefit of saving a life through a donation of any vital organ.

Families of the dying patient for whom further therapeutic efforts are no longer considered, should be encouraged to consult with their rabbis concerning organ donation.

After death of the patient

Jewish law encourages rapid burial of the deceased. There is also an urgency for death certificate completion. Therefore, after the patient has died, health care professionals should immediately inform the family and encourage them to contact a Jewish burial committee known as the *Chevra Kadisha*.[25] All communities that serve Orthodox Jewish families have a *Chevra Kadisha* associated with a hospital, whose members ensure that the bodies of religious Jews are prepared for burial according to *Halakha*. The *Chevra Kadisha* will respectfully cover the body, remove the IV or other tubes from the body, transfer, and prepare the deceased for burial. On the Jewish Sabbath and Jewish holidays, however, removing the body may present a religious obstacle and the deceased may have to remain in the hospital morgue until the Sabbath or holiday is concluded. If the *Chevra Kadisha* cannot arrive due to the Sabbath or Jewish holidays, they or the family's rabbi will send a *shomer,* or religious guardian, who will stay with the body (or sit outside the hospital morgue) until the deceased is removed from the hospital.

Conclusions

Jewish *Halakhic* values and practices are not always in accord with the secular values and practices of medical centers. The guidelines presented here highlight areas where variation in beliefs, values, and practices are particularly relevant to the care of the dying Orthodox Jewish patient. Designed to help health care professionals develop attentive and individualized plans of care for each patient, these guidelines emphasize that each Orthodox Jewish patient and family should make its own decisions regarding what *Halakha* requires. When Orthodox patients and/or their families request care or medical interventions with which the medical team is uncomfortable, an effort should be made to contact the family's rabbi to be confident that all parties understand the requirements of *Halakha*.

Enhancing the capacity of health care professionals to better respect, guide, help, and comfort the religious patient and the family at life's end is a critical component of providing comprehensive patient care. Respecting the religious and cultural values of the patient, in addition, is not only a Jewish concern but is a generic concern at a hospital where there are patients of diverse traditions.

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