NEW YORK MEDICAL COLLEGE
A MEMBER OF THE TOURO COLLEGE AND UNIVERSITY SYSTEM

Volume 3: Questions of Jewish Law for Physicians, Patients, and Students

TOURO UNIVERSITY
NEW YORK MEDICAL COLLEGE

MEDICAL HALACHAH ANNUAL

ONE

MUST EVERY JEW DIE WITH CHEST COMPRESSIONS? A HALACHIC APPROACH TO CODE STATUS AND DO-NOT-RESUSCITATE (DNR) ORDERS

Jonah (Yonah) Rubin, MD

Rabbi Shlomo Brody, PhD

The authors wish to thank R. Mordechai Willig and R. Yitzchak Breitowitz for their review to ensure halachic accuracy and endorsements.

We also wish to acknowledge and thank the following individuals for their insightful review and comments on various aspects of this article: R. Professor Avraham Steinberg, R. Dr. Judah Goldberg (Shaare Zedek Medical Center, Emergency Medicine), Dr. Michael Klompas (Brigham & Women's Hospital, Internal Medicine and Epidemiology), R. Dr. Irving Lebovics (Cedars-Sinai, Dental Division, Bioethics), Dr. Ari Moskowitz (Montefiore Medical Center, Critical Care and Resuscitation Science), Dr. Beth Popp (Mt. Sinai, Palliative Care), R. Dr. Eddie Reichman (Montefiore Medical Center, Emergency Medicine), Dr. Ellen Warner (University of Toronto, Oncology), R. Dr. Jason Weiner (Cedars-Sinai, Senior Rabbi and Director of Spiritual Care, Bioethics). We also wish to acknowledge and thank Dr. Michael Young (Massachusetts General Hospital, Neurology) for his expertise and assistance in drafting the section on disorders of consciousness.

Jonah (Yonah) Rubin is an Assistant Professor of Medicine at Harvard Medical School and an attending physician in Pulmonary and Critical Care and Cardiac Surgical Critical Care at Massachusetts General Hospital. He is a consultant for the Optimum Care (Ethics) Committee at Massachusetts General Hospital and a member of the Harvard Medical School Center for Bioethics. In previous issues of this journal, he authored articles delineating a halachic framework and approach to extracorporeal membrane oxygenation/mechanical circulatory support (ECMO/MCS) and organ transplantation.

Rabbi Shlomo Brody is the executive director of Ematai, an organization dedicated to helping Jews navigate halachic dilemmas regarding aging and end-of-life care. He is also a columnist for the Jerusalem Post and previously served as a rebbi at Yeshivat Hakotel. He received semichah from the Israeli Chief Rabbinate and his doctorate from Bar Ilan University Law School. He is the author of A Guide to the Complex: Contemporary Halakhic Debates and Ethics of Our Fighters: A Jewish View on War & Morality.

INTRODUCTION

Upon hospital admission, patients or their healthcare proxies are often asked a jarring question: What does the patient want done if their heart stops beating? Should clinicians administer cardiopulmonary resuscitation (CPR) and all it entails in the hopes of reversing course, or should they allow the patient to pass away without further intervention?

A sudden loss of heart function, or "cardiac arrest," is the physiologic event by which nearly everyone dies (more on this later) but sometimes is reversible. Generally, decisions about the appropriateness of clinical interventions are made by physicians. Yet, many states and countries legally require patient or family involvement in decisions about intervening for a cardiac arrest specifically. This is often helpful, as it catalyzes important discussions about prognosis, the patient's wishes, and the goals of the hospitalization. Other times, it creates unnecessary angst and anxiety by creating an illusion of choice—and a decision forced on the family, with resultant guilt and sometimes lifelong second-guessing—in a situation where there was truly no choice to be made. Thrust into these positions unexpectedly, many instinctively ask that clinicians "do everything." Halachic Jews, who place supreme value on every moment of life, are understandably particularly inclined to choose what may seem to be "erring on the side of life." A better understanding of the relevant scientific and halachic facts can substantially enhance this process.

If halachah indeed instructs us to always "do everything," it begs the question: Must every Jew die with chest compressions? The answer to this rhetorical question, of course, is no. It is well known that halachah places tremendous value on every moment of life; nearly all prohibitions are suspended for the possibility of saving or even temporarily prolonging life.[1] For nothing else do we set aside the laws of Shabbos, kashrus, and our strictest practices. Much less known, however, is that there are important limitations. The Gemara establishes that one may not touch a dying person—such as closing their eyes—as it may directly hasten their death.[2] This principle is codified and expanded upon in the *Sefer Chassidim* and cited in the *Shulchan Aruch* and *Rama*.[3] Another passage in *Sefer Chassidim*, cited by later authorities, establishes further that one should not try to extend the life of an imminently and irreversibly dying person:

> *We do not cry out [for a moribund person] at the moment of the soul's departure, lest his soul return and he then suffer terrible affliction. "There is a time to die" (Koheles 3:2). Why must Koheles teach this? [To teach that] when a person is moribund [goses], and his soul is departing, we do not call out that his soul return to him, because he would anyway live only a few more days, and those days would be painful. And why does [Koheles] not say, "There is a time to live"? Because this is not dependent on a person, as there is no controlling one's day of death.*[4]

This indicates not only that one need not extend a person's life in their final moments, but also that it is forbidden to do so. For a terminally ill patient clearly in their final moments of life, for whom nothing can reverse that trajectory, one may not interfere with the dying process.[5] As we will see, even in situations where patients are not in the throes of death but are terminally ill and suffering, halachah may grant such patients the choice to forgo further interventions. In other instances, individuals would certainly be advised and even halachically required

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1 *Yoma* 85a. See R. Prof. Avraham Steinberg, *Harefuah K'Halachah*, vol. 10:1 (*Choleh Hanoteh Lamus* 1:1), and the footnotes there, including discussion of the various opinions and implications regarding whether halachah considers life to be of infinite (minority opinion) or superior (majority opinion) value.

2 *Maseches Semachos* 1:3–4; *Shabbos* 151b.

3 *Sefer Chassidim* 723; *Yoreh Deah* 339:1.

4 *Sefer Chassidim* 234, quoted approvingly in *Beis Lechem Yehudah*, *Yoreh Deah* 339; *Igros Moshe*, *Yoreh Deah* 2:174:3; and *Tzitz Eliezer* 13:69:11.

5 See also *Nishmas Avraham*, *Yoreh Deah* 339, p. 496 (3rd ed.).

to pursue all measures, including CPR, to reverse a cardiac arrest in the hopes of recovery.

To put this in halachic terms, one must understand the patient's halachic status during a cardiac arrest. At first glance, one might consider a patient amid a cardiac arrest to be the ultimate *goses*—truly in the final moments of life. After all, their heart has stopped, which only several decades ago signified immediate death. The development of CPR and resuscitation science has transformed that reality. We now better understand the various causes and types of cardiac arrests, and our ability to sometimes reverse them means that even amid a cardiac arrest, a patient may yet belong to any of three major halachic categories: (1) *chayei olam*—likely to survive for a full life-span, such as over a year; (2) *chayei shaah*—likely to live only for a limited period of time, such as less than six months to a year; or (3) *goses*—almost certainly irreversibly and imminently dying.

Physiology and the medicolegal system impose a layer of complexity. Patients or their proxies[6] must determine in advance what to do when a cardiac arrest occurs.[7] There is no time for deliberation once it begins. Thus, all hospitalized patients have a "code status" entered in the medical record—a predetermined plan of action for a cardiac arrest—which prompts that jarring question upon hospital admission. There are generally four options, with slight variation across states and countries:

1. **Full code**: All resuscitative measures will be taken during a cardiac arrest.
2. **Do Not Resuscitate (DNR) or Do Not Attempt Resuscitation (DNAR)**:[8] Should a cardiac arrest occur, chest compressions and electric shocks will not be administered, and the patient will be allowed to pass without intervention. This designation is the focus of this paper.
3. **Do Not Intubate (DNI)**: Should the patient develop respiratory failure that will prove fatal unless intubated and mechanically ventilated (attached to a ventilator/respirator), the patient will forgo this intervention and instead be made comfortable and allowed to pass without intervention.[9]
4. **Comfort Care**, **Comfort Measures Only (CMO), or similar term**: A designation made at the end of life signifying that the patient will

6 It is important for everyone to express their general wishes and preferences to their healthcare proxy and power-of-attorney after consulting with their rabbi. Some decisions regarding a DNR might need to be made unexpectedly and when a person is no longer able to speak for themselves. As will be discussed, halachah at times relies on the patient's known preferences. Patients should consult with their local advisors and rabbi about what documents are best in their location and for their situation. In Israel, for example, the healthcare directive for the "terminally ill" allows people to designate whether they would want or not want CPR if they have a prognosis of six months of less. One may also document which rabbi they want to be consulted for questions about their care. See *Harefuah K'Halachah*, vol. 6:10, p. 397. Alternatively, a person might want to express their wishes and preferences through a halachically appropriate conversation guide, which is not a legal document. Ematai's model, approved by R. Hershel Schachter and R. Mordechai Willig and distributed by many rabbinic organizations, may be found at ematai.org/netivot.

7 In some states and countries, like the United Kingdom, physicians at times do have authority to unilaterally impose a DNR, usually when they believe CPR will be physiologically futile. The patient is generally entitled to be notified of this decision, but there have been some high-profile cases in which DNR orders were inappropriately issued without patient notification. Some further assert that patients with disabilities are more likely to receive a DNR order. This can raise additional halachic issues beyond the scope of this paper. See Christina Warner, "DNR Orders, Disability & the Right to Decide," *Counsel Magazine*, June 12, 2023, https://www.counselmagazine.co.uk/articles/dnr-orders-disability-the-right-to-decide.

8 While the term "DNR" is more widely recognized, some institutions have modified this to "DNAR," as it more accurately reflects what is to be performed—not necessarily resuscitation, but an *attempt* at resuscitation.

9 This code status is often made in conjunction with DNR as either "DNR/DNI" or "DNR but OK to intubate." Different considerations, beyond the scope of this paper, guide the decision surrounding intubation. However, because intubation is a key component of resuscitation during a cardiac arrest, one's code status cannot be "resuscitate but do not intubate." Some implications of these options and their combinations will be discussed in a later footnote.

> only receive medications and interventions aimed at ensuring their comfort (such as pain and anxiety control) but not those aimed at treating or reversing any underlying disease (such as chemotherapy or antibiotics).[10]

The DNR designation is specific to cardiac arrest and should not impact other treatments, such as chemotherapy, antibiotics, pain management, nutrition, dialysis, or other procedures.[11] Nonetheless, DNR designations sometimes raise alarm and skepticism. Will the medical team offer less treatment and be less conscientious if the code status is DNR/DNI? With this concern in mind, some advise that no one ever agree to be DNR. What is the harm in remaining full code?

In this paper, we comprehensively explore the medical and halachic context needed for approaching these life-altering decisions. By clarifying misconceptions and addressing real concerns, this overview aims to serve as a framework for rabbinic authorities, physicians, and the public to have more informed and nuanced discussions about code status.[12] Understanding these concepts in advance can prevent chaotic decision-making later when patients or their families are experiencing great emotional distress and decisions need to be made urgently; in such times, it may be difficult to process what seems contrary to popular belief. Ideally, these concepts and principles should be incorporated into mainstream Orthodox Jewish education.

In Part 1, we provide an overview of cardiac arrests, illustrate how the various types and contexts of cardiac arrests impact prognosis, and review the recent medical literature. We emphasize limitations in applying research data to individuals and the importance of discussing each case with an experienced, directly involved physician. In Part 2, using this information, we apply various halachic positions regarding end-of-life care to patients in cardiac arrest, with expanded discussion surrounding patients with disorders of consciousness, dementia, and frailty. In Part 3, we address the legitimate concerns about a DNR being confused with "do not treat" and other related considerations.

Code status decision-making can have life-and-death consequences. While we have tried to accurately cite a range of mainstream sources in the text and footnotes, one's personal halachic authority may have other views or traditions. All decisions regarding DNR should be made in consultation with one's rabbi in concert with an experienced, directly involved physician.

PART I: CARDIAC ARREST AND RESUSCITATION

What Is a Cardiac Arrest, and How Can It Be Reversed?

A cardiac arrest is when the heart stops effectively pumping due to any of numerous causes[13] and is the physiologic process by which nearly everyone dies.[14] Without a heartbeat, circulation fails, and all the

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10 Whether or not nutrition or supplemental oxygen are necessary for comfort is subject to discussion, and most institutions will discuss this with the relevant stakeholders (the patient or proxy) on a case-by-case basis. The halachic significance of these specific interventions in end-of-life care was previously discussed in this journal by R. Prof. Avraham Steinberg: A. Steinberg, "Management of Profound Multi-Organ Failure: A Halachic Approach to Medical Futility," *Touro University/New York Medical College Medical Halachah Annual* 1 (2023): 17–20.

11 We have found that at least one center in Texas systematically links DNR designations with an explicit order regarding other treatments that helps avoid any confusion—either Allow Natural Death (AND) or Continue Other Treatment (COT). This is not widely performed elsewhere.

12 The decision to forgo CPR is not limited to hospitalized patients. Patients who wish to be DNR and/or DNI if they suffer a cardiac arrest at home can complete paperwork to create such a designation, such that if emergency medical services are called and their DNR/DNI status is known, the emergency personnel will refrain from attempts at resuscitation. While many of the principles and considerations will overlap, this article is focused on hospitalized patients.

13 This is not the same as a heart attack (or myocardial infarction), which is when blood flow to a coronary artery supplying the heart is obstructed, causing heart muscle cell injury (ischemia) and possibly death, impaired heart function, and possibly leading to dangerous arrhythmias and a cardiac arrest.

14 The alternative criteria for declaring legal death, "brain death" (also called "brainstem death" or, in Israel, "respiratory

organs fail shortly thereafter. Because there is no blood flow to the brain, the patient also nearly immediately loses consciousness, and even with eventual reversal of the cardiac arrest, the brain may suffer severe, irreversible injury due to oxygen deprivation (called "anoxic brain injury"). Cardiopulmonary resuscitation (CPR) is an algorithmic protocol that includes chest compressions that attempt to manually maintain blood flow throughout the body and—at least temporarily—reverse the cardiac arrest to restore the native heartbeat. It generally does not and cannot reverse the underlying process that led to the cardiac arrest. Sometimes, a cardiac arrest is caused by a reversible insult that CPR can buy time to immediately address and resolve, thereby preventing a repeat arrest. Other times, though, a cardiac arrest is the culmination of a terminal process that cannot be undone.

For example, if someone is accidentally electrocuted, this may cause a near-fatal arrythmia and cardiac arrest. By performing CPR (including an electric shock or defibrillation), the arrhythmia may be aborted and the heartbeat restored. In this rare instance, CPR both reverses the cardiac arrest and treats the underlying cause (an arrythmia induced by electrocution). There is no reason to suspect that the patient will immediately or shortly thereafter suffer another cardiac arrest.

In another case, if a person drowns, the lack of oxygen to the heart can also cause a cardiac arrest. If caught in time, CPR might reverse the cardiac arrest. In this case, as usual, CPR does not treat the underlying cause, which is a lack of oxygen—but this can be addressed with intubation and mechanical ventilation, which will prevent another arrest and allow overall recovery over time—hopefully without significant anoxic brain injury. Similarly, a diabetic who overdoses on insulin and becomes hypoglycemic may suffer a cardiac arrest as a result. Again, CPR can manually maintain blood flow to the organs and even temporarily reverse the cardiac arrest, but it cannot undo the underlying cause. It can merely buy time for immediate administration of glucose to reverse the hypoglycemia and prevent a repeat arrest. CPR was developed and refined for cases like these, where the underlying cause of the arrest is reversible. Restoring the heartbeat or simply manually maintaining circulation even for a few moments may provide the time needed to treat the underlying cause and prevent imminent recurrence of an arrest.

In a final example, consider a patient in the intensive care unit with multisystem organ failure who is deteriorating despite all available medical interventions. Such a patient is dying, and as each organ system fails, ultimately, the cardiovascular system—the heart itself—shuts down as well. This too culminates in a cardiac arrest. Administration of CPR might bring back a heartbeat momentarily—perhaps for minutes, maybe hours, almost certainly less than the few days mentioned by the *Sefer Chassidim*—but in this case, there is nothing to reverse the underlying cause of the cardiac arrest. Unfortunately, such a patient can be fully expected to suffer another cardiac arrest soon. It is in this context that some clinicians succinctly state, "CPR works when the heart is the first organ to fail, not the last."

What Does CPR Entail?

The algorithm for CPR has evolved over time, and in the United States, is guided by the American Heart Association.[15] Chest compressions require

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brain death") reportedly accounts for approximately 2 percent of deaths in the United States. Discussion of the intricacies of death by neurologic criteria—medical and halachic—are beyond the scope of this paper. For those who do not accept use of neurologic criteria to determine halachic death, all death occurs via cardiac arrest. See D.M. Greer, "Determination of Brain Death," *New England Journal of Medicine* 385, no. 27 (2021): 2554–61. https://doi.org/10.1056/NEJMcp2025326; and A. Seifi et al., "Incidence of Brain Death in the United States," *Clinical Neurology and Neurosurgery* 195 (2020): 105885. https://doi.org/10.1016/j.clineuro.2020.105885.

15 For out-of-hospital, bystander-performed CPR, current recommendations are for hands-only CPR: chest compressions only, and no rescue breaths or mouth-to-mouth resuscitation. Automatic external defibrillators (AEDs) are designed for layperson use and may deliver an electric shock if appropriate. More information about the lifesaving skill of bystander CPR is available

appropriate positioning, timing, strength, depth, and relaxation such that each compression expels blood from the heart to perfuse the brain and other organs. Time must be allowed between compressions for the heart to refill. The advanced cardiovascular life support (ACLS) protocol, followed in hospitals and by trained emergency personnel, includes intubation for mechanical ventilation, use of non-automated external defibrillation, and administration of certain medications, including epinephrine, amiodarone, and lidocaine.

Defibrillation (or shocking) is only sometimes a component of CPR, which distinguishes the two major types of cardiac arrest. The first type is a shockable rhythm: ventricular tachycardia (VT) or ventricular fibrillation (VF). Simply put, the heart is in such severe overdrive and disorganization that it cannot pump effectively. The second type is a non-shockable rhythm: pulseless electrical activity (PEA) or asystole. Simply put, the heart is in underdrive and not contracting meaningfully or at all. Defibrillation can only help restore an ineffective shockable rhythm to an effective cardiac rhythm. Cardiac arrest with a shockable rhythm is more likely to be due to an acute, unexpected cause (electrocution, electrolyte abnormality, heart attack, etc.) and is more likely to be reversible—both the acute arrest and the underlying cause. Non-shockable rhythms are more likely to be irreversible and due to an irreversible problem.[16]

What Are the Harms of CPR?

As will be discussed, the major concerns and halachic considerations of CPR are not actually about CPR itself, but rather when "successfully" restoring spontaneous circulation prolongs the death of a dying patient or the suffering of a terminally ill patient. For a patient suffering from an underlying condition before cardiac arrest, reversing the arrest will at best return the patient to that state, and this itself has important halachic implications. However, it is also important to note that complications from cardiac arrest and CPR itself may add to post-arrest suffering.

As mentioned, impaired circulation during cardiac arrest can cause oxygen deprivation and devastating anoxic brain injury. The amount of damage will vary depending on the timing, quality, and duration of the resuscitative efforts, ranging from no damage at all to leaving a patient in a vegetative state or even clinically brain-dead, and thus will have variable contribution to any post-arrest suffering.

Furthermore, CPR and all it entails is traumatic to the face and neck, upper airway, chest wall, lungs, heart, major blood vessels, and abdominal and visceral organs.[17] Chest compressions will break

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at the American Heart Association website: "Hands-Only CPR," https://cpr.heart.org/en/cpr-courses-and-kits/hands-only-cpr and "Algorithms," https://cpr.heart.org/en/resuscitation-science/cpr-and-ecc-guidelines/algorithms.

16 Extracorporeal CPR (ECPR) is a novel technique by which some patients, in some centers, can be placed on veno-arterial extracorporeal membrane oxygenation (ECMO) during a cardiac arrest to support their circulation (and allowing discontinuation of manual or mechanical chest compressions) and provide time to treat the underlying cause of the cardiac arrest. This is not currently a standard of care, is not available in all centers, and each center independently sets its own candidacy criteria. ECPR is slowly making its way into American and European guidelines for cardiac arrest care. Generally, given the urgency, one might only have moments to decide—or no time at all—if their loved one will go on ECMO. ECPR is generally only offered when it is thought likely to bridge to a patient's recovery or, in rare instances, a transplant or durable mechanical device. However, it can lead to distressing situations where a patient is put on ECMO and has no viable pathway to come off. Navigating this complex scenario presents significant halachic challenges and was discussed in a previous issue of this journal. As this technology evolves, new halachic considerations may emerge as well. This is beyond the scope of this review. See J. Rubin and J. Weiner, "Adult ECMO and Mechanical Circulatory Support: Framing the Halachic and Ethical Issues," *Touro University/New York Medical College Medical Halachah Annual* 1 (2023): 29–46.

17 P. Ram et al., "Breaking Your Heart—A Review on CPR-Related Injuries," *The American Journal of Emergency Medicine* 36, no. 5 (2018): 838–42. https://doi.org/10.1016/j.ajem.2017.12.063/; A.C. Miller et al., "A Systematic Review and Pooled Analysis of CPR-Associated Cardiovascular and Thoracic Injuries," *Resuscitation* 85, no. 6 (2014): 724–31. https://doi.org/10.1016/j.resuscitation.2014.01.028. Note that data from autopsy studies may alter the true percentage of injuries, since such studies are only performed in those who died.

a patient's ribs in at least 33% and up to 97% of cases, and the sternum in at least 20% and up to 43% of cases.[18] Rates of internal organ injury and bleeding are less well-known but also present. Internal bleeding in the chest may occur in 10–18% of cases, around the heart specifically in 9%, and with coronary artery rupture or laceration in 38% of cases.[19] Upper airway injuries were found in up to 75% of cases.[20] Other studies identified facial bruising and retinal hemorrhages as well as fractures of the hyoid and thyroid cartilage.[21] While some of these are not themselves life-threatening or painful, they illustrate the aggressive nature of what some mistakenly perceive as an entirely benign procedure, often performed in the final moments of one's life.[22]

How Effective Is CPR? Public Perception and the Complex Reality

Recent advances in CPR have pushed the field of resuscitation science forward. The scientific literature to be discussed demonstrates the importance

18 D. Smekal et al., "CPR-Related Injuries After Manual or Mechanical Chest Compressions with the Lucas Device: A Multicentre Study of Victims After Unsuccessful Resuscitation," *Resuscitation* 85, no. 12 (2014): 1708–12. https://doi.org/10.1016/j.resuscitation.2014.09.017; Y. Gao et al., "Safety of Mechanical and Manual Chest Compressions in Cardiac Arrest Patients: A Systematic Review and Meta-Analysis," *Resuscitation* 169 (2021): 124–35. https://doi.org/10.1016/j.resuscitation.2021.10.028; N. Friberg et al., "Abstract 103: Rib and Sternum Fractures After Cardiopulmonary Resuscitation: An Autopsy Study," *Circulation* 130, suppl. no. 2 (2014). https://doi.org/10.1161/circ.130.suppl_2.103.; R.S. Hoke and D. Chamberlain, "Skeletal Chest Injuries Secondary to Cardiopulmonary Resuscitation," *Resuscitation* 63, no. 3 (2004): 327–38. https://doi.org/10.1016/j.resuscitation.2004.05.019; Kim A. Collins, "Cardiopulmonary Resuscitation-Related Injuries in Elders," in *Geriatric Forensic Medicine and Pathology*, eds., Kim A. Collins and Roger W. Byard (Cambridge, 2020).

19 J.P. Krischer et al., "Complications of Cardiac Resuscitation," *Chest* 92, no. 2 (1987): 287–91. https://doi.org/10.1378/chest.92.2.287; A.C. Miller et al., "A Systematic Review and Pooled Analysis of CPR-Associated Cardiovascular and Thoracic Injuries," *Resuscitation* 85, no. 6 (2014): 724–31. https://doi.org/10.1016/j.resuscitation.2014.01.028.

20 Krischer, "Complications," 287–91; ibid., Raven et al.

21 Y. Hashimoto et al., "Forensic Aspects of Complications Resulting from Cardiopulmonary Resuscitation," *Legal Medicine* 9, no. 2 (2007): 94–99. https://doi.org/10.1016/j.legalmed.2006.11.008; I. Hood et al., "Resuscitation and Petechiae," *American Journal of Forensic Medicine and Pathology* 9, no. 1 (1988): 35–37; K.P. Raven et al., "Artifactual Injuries of the Larynx Produced by Resuscitative Intubation," *American Journal of Forensic Medicine and Pathology* 201, no. 1 (1999): 31–36. https://doi.org/10.1097/00000433-199903000-00008; M. Gregersen and A. Vesterby, "Iatrogenic Fractures of the Hyoid Bone and the Thyroid Cartilage: A Case Report," *Forensic Science International* 17, no. 1 (1981): 41–43. https://doi.org/10.1016/0379-0738(81)90187-0; Y. Hashimoto et al., "Laryngeal Fractures Due Presumably to Tracheal Intubation in Resuscitation," *Nihon Hoigaku Zasshi* 46, no. 2 (April 1992): 159–64.

22 When a cardiac arrest begins, the patient becomes immediately unconscious. Whether or not and how much a patient might feel these injuries is uncertain, but experts believe it is certainly possible. A recent multicenter study of 567 patients, using electroencephalography (EEG), cerebral oxygen monitoring, and interviews of cardiac arrest survivors, concluded that "consciousness, awareness, and cognitive processes may occur during cardiac arrest." Patients may survive cardiac arrest and not recall feeling pain, but this does not mean they did not experience pain at the time. Another study also hinted at the likelihood that some patients may regain consciousness. There are data to suggest that CPR itself, by restoring blood flow manually, can restore consciousness as well. This is an area of active investigation. For those who regain consciousness after successful CPR, the significant pain from the aftereffects of the intervention is certainly felt long afterward and compounds any preexisting suffering. As we mentioned, many times, patients will briefly have return of spontaneous circulation only to suffer another cardiac arrest immediately or shortly afterward. See S. Parnia et al., "AWAreness during REsuscitation—II: A Multi-Center Study of Consciousness and Awareness in Cardiac Arrest," *Resuscitation* 191 (2023): 109903. https://doi.org/10.1016/j.resuscitation.2023.109903; G. Xu et al., "Surge of Neurophysiological Coupling and Connectivity of Gamma Oscillations in the Dying Human Brain," *Proceedings of the National Academy of Sciences of the United States of America* 120, no. 19 (2023): e2216268120. https://doi.org/10.1073/pnas.2216268120; C. Koch, "Do Not Go Gently into That Good Night: The Dying Brain and Its Paradoxically Heightened Electrical Activity," *Proceedings of the National Academy of Sciences of the United States of America* 120, no. 22 (2023): e2305985120. https://doi.org/10.1073/pnas.2305985120; R. Gray, "Consciousness with Cardiopulmonary Resuscitation," *Canadian Family Physician* 64, no. 7 (2018): 514–17.

of relying on the experienced bedside clinician for prognostication, which is essential for a halachic analysis. This is particularly important because there are common misconceptions about the efficacy of CPR.

Studies reveal laypersons' estimates of survival from cardiac arrest to be over 50%[23]—an optimistic overestimate. Public perception of CPR is skewed for multiple reasons. Major distinctions between various types of cardiac arrests are underrecognized. Cardiac arrests are discussed among people and in the media as if they are all equal, and thus perceptions from anecdotal stories of survival or contexts with higher resuscitation success rates carry significant weight.

To take a well-known recent case: In April 2023, professional football player Damar Hamlin of the Buffalo Bills suffered a cardiac arrest during a game and survived without any evident neurologic deficits. The medical details of his hospital course are not public, but numerous factors distinguish him from the sick, elderly patient in the intensive care unit. He is young, in excellent physical shape without significant comorbidities and no other organ failure, had a sudden-onset cardiac arrest seemingly triggered by rare timing of blunt trauma to the chest at a specific point during the cardiac cycle (commotio cordis)—reversible with an electric shock—and had a witnessed cardiac arrest with immediate intervention. Despite all these positive prognostic factors, his survival, even with neurological deficits, was not certain. This is in stark contrast with the sick, elderly patient with multiple comorbidities and multi-organ failure whose cardiac arrest is the culmination of progressing illness. But some may group all cases into a general bucket of "cardiac arrest" and conflate their prognoses.

Television propagates—or perhaps created—this misperception. In a 1998 study in the *New England Journal of Medicine*, the authors diligently watched every episode of TV shows *ER* and *Chicago Hope* and fifty episodes of *Rescue 911*, recording the outcomes of every cardiac arrest. Sixty-five percent of arrests occurred in children or young adults, and 75 percent survived. A similar study in 2015 based on two years of running medical dramas, *House* and *Grey's Anatomy*, found survival to hospital discharge was 75 percent.[24] Furthermore, outcomes from CPR on television were binary, resulting in either death or full recovery. Patients surviving CPR but left in vegetative or other states of suffering do not exist in Hollywood but are unfortunately common in hospitals.

Reality is more complicated. Many studies have tried to determine the overall efficacy of CPR by reviewing patient outcomes. However, the truth about overall outcomes, and especially the prognosis for a specific patient, is exceedingly challenging to prove in scientific studies for four major reasons:

First, every study by definition includes only patients who underwent CPR. Patients who were advised and/or chose to be DNR do not undergo CPR and do not survive a cardiac arrest. Thus, the patients included in CPR outcome studies are predominantly those who were advised to remain full code because CPR was considered possibly effective and reasonable.[25] Thus, blindly applying CPR outcomes from large studies to prognosticate a specific patient's chance of survival from a cardiac arrest is invalid.

Second, innumerable factors contribute to a patient's likelihood of survival from a cardiac arrest: whether it was witnessed with immediate initiation of chest compressions, if it occurred in versus outside the hospital, chest compression quality, patient comorbidities, the heart rhythm

23 C.A. Marco and G.L. Larkin, "Cardiopulmonary Resuscitation: Knowledge and Opinions Among the U.S. General Public. State of the Science-Fiction," *Resuscitation* 79, no. 3 (2008): 490–98. https://doi.org/10.1016/j.resuscitation.2008.07.013.

24 C.C. Bitter et al., "Depiction of Resuscitation on Medical Dramas: Proposed Effect on Patient Expectations," *Cureus* 13, no. 4 (2021): e14419. https://doi.org/10.7759/cureus.14419.

25 Of course, the studies will also include those who chose to remain full code despite the physician's advice against this. One can likely safely assume, however, that the majority of patients included in the studies followed physicians' guidance.

during the cardiac arrest (PEA versus asystole versus VT/VF), and, most importantly, the underlying cause of the arrest. Studies cluster multiple cardiac arrests to determine an overall rate of survival and would similarly mistakenly be applied to determine an individual's specific chance of survival. Some studies, particularly large studies conducted by the American Heart Association, try to tease apart these patient populations as best as possible in subgroup analyses, which helps demonstrate and alleviate the challenge, but ultimately, prognostication is best determined (and still not infallibly) by the experienced clinician who understands the specific patient's situation.

Third, even for the same patient, a cardiac arrest can occur for any of several reasons, and the likelihood of reversing any cardiac arrest depends on its etiology. In some cases, particularly in healthier patients, it might be impossible to predict what might cause an unexpected cardiac arrest. In critically ill patients, who are also closely monitored, the cause of a looming cardiac arrest is often much more predictable.

Finally, the outcomes reported by studies do not necessarily reflect outcomes that patients care about. Reported rates of successful immediate reversal of the cardiac arrest within studies (known in medical literature as "ROSC," return of spontaneous circulation) do not reflect those who died from a cardiac arrest hours later. Studies reporting "survival to discharge" or "thirty-day survival" do not capture (1) readmissions nor (2) patients who survived the arrest but suffered severe anoxic brain injury and remained in a persistent irreversible vegetative state. Many studies therefore try to report "neurologically favorable survival" and quantify neurologic favorability, but this also necessarily introduces subjectivity in both directions.

With these limitations in mind, the reported data to be discussed are less helpful in specifically prognosticating for the individual and more helpful in illustrating the wide range of potential outcomes and the relative impact of prognostic factors that the bedside clinician will consider.

A study in the *New England Journal of Medicine* of over 84,000 in-hospital cardiac arrests found that overall survival to discharge in 2009 was only 18.6%, which is actually an improvement from 13.7% in 2000.[26] Of those who survived, 30% had clinically significant neurologic disability, and 10–20% had "severe" disability.[27] When splitting the groups further, outcomes varied widely. For patients with non-shockable rhythms, survival to discharge was 7–14%, with up to 25% of those limited survivors suffering "severe disability." For those with shockable rhythms, survival was better at 28–40%, with up to 18% of survivors with "severe disability."

Further subgroups had significantly higher independent risk of death, particularly those with other comorbidities. These include patients with metastatic cancer (42% increase in mortality), on medications to support blood pressure, i.e., vasopressors (40% increase in mortality), on a ventilator (35% increase), with liver injury (35% increase), and others. Some groups, on the contrary, had a higher independent chance of survival, such as those with arrhythmias (20% increase in survival), diabetes (13% increase in survival), and a heart attack (10% increase), as well as women (6% increase).

Another study of over 114,000 adults who suffered an in-hospital cardiac arrest in an intensive care unit from 2006 through 2018 found that in 62% of cases, CPR at least temporarily reversed the cardiac arrest. However, only 19% of patients survived to hospital

26 S. Girotra et al., "Trends in Survival After In-Hospital Cardiac Arrest," *New England Journal of Medicine* 367, no. 20 (2012): 1912–20. https://www.nejm.org/doi/full/10.1056/NEJMoa1109148.

27 In medical research, different scoring systems can be used to define severity of disability. This study used the cerebral-performance category (CPC) score, which ranges from 1 to 5, where 1 is "good cerebral performance: conscious, alert, able to work, might have mild neurologic or psychologic deficit" and 5 is "brain death: apnea, areflexia, EEG silence, etc." A score of at least 3 is considered "severe" and is described as including a wide range of neurological injury: "conscious, dependent on others for daily support because of impaired brain function, ranges from ambulatory state to severe dementia or paralysis."

discharge.[28] When stratifying by type of cardiac arrest, need for assisted ventilation, and need for vasopressors, outcomes varied widely. Fewer than 9% of those on vasopressors with a non-shockable rhythm survived to discharge, whereas 43% of those not on pressors and with a shockable rhythm survived to discharge.

As above, several caveats preclude application of these numbers to an individual. Nineteen percent of patients survived discharge, but not every patient had a 19% chance of survival.

Ultimately, depending on the specific case, expected survival from cardiac arrest ranges from zero to perhaps 50%. An experienced clinician is needed to appropriately advise on the likelihood of survival of the specific patient based on all available data. The halachic determination of whether one should undergo CPR—ranging from possibly forbidden to required—will often depend on this calculus.

PART II: HALACHIC PERSPECTIVES

With this medical background, there can clearly be no "one-size-fits-all" halachic ruling about CPR. In the past, it might have been reasonable to make broad statements like, "All efforts toward resuscitation should always be made, since they may save a life." With the knowledge we have today, our conversations can and therefore must be more nuanced. No single scientific paper, even the aggregated medical literature, and certainly not individuals with anecdotal experience, can prognosticate for an individual patient. Only an experienced physician or clinical team, intimately familiar with the patient's clinical case, able to properly contextualize the scientific literature for this individual, and informed by clinical experience—including as-needed consultation with colleagues—can best prognosticate how a patient may fare in a cardiac arrest, including what type and etiology of cardiac arrest is likely to occur.

A best-available prognosis is essential for a halachic authority to determine whether such a patient may be classified as *chayei olam*, *chayei shaah*, or a *goses*, which will be further clarified below. We will further discuss how even within these categories, there are subcategories with halachic significance that consider the patient's pain and suffering and their wishes.

While we will introduce some positions, halachic authorities argue over the prognostic criteria that determine whether a patient is a *goses*, *chayei olam*, or *chayei shaah*. While we provide and use working definitions, a comprehensive discussion of these definitions is beyond the scope of this review.[29] Rather, we provide a halachic framework for patients in each category and demonstrate the range of valid possibilities for whatever criteria might be used to designate each halachic status.

Halachic Perspectives on Code Status: *Goses* (the Actively Dying)

We began with the *Sefer Chassidim*'s accepted ruling that a *goses*, a patient in the final stages of dying, must not be disturbed. The *Rama*, based on the *Sefer Chassidim*, explicitly states that when a patient is actively dying, one may remove an impediment that is prolonging the patient's death.[30] Certainly, nothing

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28 L.M. Cagino et al., "Trends in Return of Spontaneous Circulation and Survival to Hospital Discharge for In-Intensive Care Unit Cardiac Arrests," *Annals of the American Thoracic Society* 20, no. 7 (2023): 1012–19. https://doi.org/10.1513/AnnalsATS.202205-393OC.

29 These concepts are discussed in more detail in two other articles in this issue.

30 *Yoreh Deah* 339:1. See the discussion in *Sefer Ruach Yaakov*, pp. 46–47. The *Rosh* (*Kiddushin* 4:15) may indicate that even a *goses* might have multiple stages: one when the patient can still speak and reason, and a later stage where the patient is already confused. R. Yitzchak Zilberstein suggests that the *Rama* and others, who forbid preventing/prolonging death, might be referring only to the end-stage of a *goses*. Even within this view, a patient with the aforementioned prognosis who is now in cardiac arrest is well past the criteria of this later stage—clearly in the very final moments, where all would agree the patient should not be disturbed. See *Shiurei Torah L'Rofim* 3:89, pp. 311–16 (as translated in *Medical-Halachic Responsa*, trans., Fred Rosner, vol. 6 [Maimonides Research Center, 2022], pp. 5–13).

should be actively done to prolong death, such as CPR, in such a patient's final moments.[31]

In modern times, it is difficult to define a *goses*. To the best of available medical knowledge, an experienced clinician can identify such patients for whom CPR is physiologically futile, i.e., it will not reverse the active dying process.

In such cases, CPR would ideally not be offered as an option at all, but as above, this conversation sometimes is compelled by the law. When R. Dr. Abraham, author of the famed *Nishmas Avraham*, asked R. Shlomo Zalman Auerbach for the definition of a *goses*, he replied, "You're the doctor!" R. Dr. Abraham understood this to mean that this clinical diagnosis can be made only with a physician's expertise, and even though this diagnosis will at times be mistaken, the laws of *goses* apply once such a diagnosis is made.[32]

Halachic Perspectives on Code Status: *Chayei Shaah* (the Terminally Ill)

Some patients are terminally ill with a poor prognosis, leaving them with *chayei shaah* but not necessarily a *goses*. Halachically, with some exceptions to be noted herein, we generally continue to treat their condition as best we can in these circumstances. What should be done when a cardiac arrest occurs?

Oftentimes, depending on factors previously described, the cardiac arrest itself will alter their prognosis and render them a *goses* at that moment, and the aforementioned positions will apply. But even if not, when a patient with a terminal illness is suffering, nearly all major halachic authorities recognize the patient's right to decline interventions that will prolong or worsen their suffering.

This is the clear conclusion of major halachic authorities including R. Moshe Feinstein,[33] R. Yaakov

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31 *Nishmas Avraham*, *Yoreh Deah* 339:1 (3rd ed.), p. 493 (as cited above).

32 See *Nishmas Avraham* ibid., who states that a *goses* is a person who should not have CPR done following a cardiac arrest. He further writes (in his own English translation): "Most doctors and members of burial societies with experience of the dying sense when a patient becomes a *goses*. However, although a patient may live for days after senior physicians and nurses have thought that he was a *goses*, nevertheless the moment this decision is made, various halachot apply to him." Perhaps R. Dr. Abraham is drawing on the concept that *rov gosesim l'misah* (*Shevuos* 33a). Although a *goses* is one who is actively, imminently dying, Chazal still state that only the majority of *gosesim* die, seemingly allowing for a realistic degree of diagnostic uncertainty. For more on the difficulty of determining the status of a *goses* and various possibilities, see *Igros Moshe*, *Choshen Mishpat* 2:73; *Shevet Halevi* 9:244; the ruling of R. Elyashiv in *Tziyunei Halachah al Aveilus*, pp. 5, 171; and *Harefuah K'Halachah*, vol. 6, p. 423ff.

33 *Igros Moshe*, *Choshen Mishpat* 2:73 (trans., at times abbreviated, by R. Moshe Dovid Tendler in *Responsa of Rav Moshe Feinstein*, vol. 1):

> ***Therefore, if a patient is terminally ill and in intractable pain, so that there is no hope of his surviving in a condition free of pain, but it is possible, through medical or technological 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. To do so would be an act of murder.*

Igros Moshe, *Choshen Mishpat* 2:74:

> ***You ask for further clarification of responsum no. 73. The analysis I gave is lucid and leaves no room for misinterpretation. Nevertheless, I will reiterate: If physicians have no means of healing a terminal patient or of improving his quality of life by reducing his pain, but do have the ability to keep him alive for a limited time, then they should not do so***…*You expressed concern about my introduction of the concept of quality of life, which I did by pointing out that in terminal patients a life of pain need not be preserved. The medical community [you said] will extend this concept to the physically or mentally challenged, and that may lead to involuntary euthanasia. In truth, I do not see how my analysis will make this eventuality more likely to happen. Nothing in my analysis even hinted at a concept of quality of life which would exclude those who have mental or physical disabilities. It is, or should be, absolutely clear, without any doubt, to anyone who has studied our Torah and who fears Hashem, that one must heal or save every individual without any differentiation based upon his intelligence or physical stamina.*

Importantly, R. Moshe continues and extends this ruling even to secondary, treatable illnesses for which treatment will

Yisrael Kanievsky (the Steipler Gaon),[34] R. Shlomo Zalman Auerbach,[35] R. Yosef Shalom Elyashiv,[36]

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prolong survival, and suffering, from the primary illness. This ruling would seemingly apply to a cardiac arrest due to any cause, regardless of its immediate reversibility, in patients suffering with a terminal illness:

> *This concerns a case where a patient is terminally ill, but then acquires a second illness for which there is a cure. [For example, a terminal cancer patient develops pneumonia, an illness for which there is a cure. Should he be treated for the pneumonia even though the treatment, if successful, will restore him to his life of pain from the original illness?] If the patient's illness is causing him great pain, and he would prefer to die rather than live under these conditions, it may well be proper not to treat him in any manner that would prolong the dying process. This means that it might be best to withhold treatment for the second illness, since if the pneumonia is cured, it would impose upon the patient the burden of his first disease, for which relief is not available. This is a decision which the patient must make. When the patient is incompetent, his family must be consulted.*

Igros Moshe, *Yoreh Deah* 174:3, with regard to maintaining the life of a potential organ donor:

> *You ask whether it is permissible for the doctors to keep a patient in an intensive care unit, providing him with all heroic measures, solely for the purpose of maintaining him as a potential donor. If prolonging the life of this patient means that he will be maintained in a state of suffering, then it is forbidden to do so. We know from the Shulchan Aruch, Yoreh Deah 339:1, that the Rama permitted removal of the crystal of salt put under the tongue of a dying patient, which was at that time believed to be [a means of] prolonging his life. Removal of this deterrent to dying was permitted because of the anguish the patient was suffering.* ***Surely, it is forbidden to do anything that will prolong a life of anguish.*** *Moreover, if the patient is not suffering and it is possible to prolong his life, then it is certainly not permitted to cease therapy. The only justification for refraining from further treatment is that the quality of life of this pain-ridden patient is such as to justify refraining from further treatment.*

In the original Hebrew version, R. Moshe explicitly discusses this in the context of *chayei shaah*.

34 *Karyana D'Igrasa* 190. The text has been translated as follows:

> *Concerning the principle that "whatever one can do to prolong a person's life, even only for chayei shaah, it should be done": In truth, I too heard in my youth the aforementioned idea, and I did not know if it comes from a reliable source. In my eyes, this matter requires intensive investigation, for in Yoreh Deah #339 it is clearly stated that it is permissible for one to remove an impediment to a suffering person's death, if this will prevent severe suffering, as long as one does not move or touch the dying person himself.* ***Therefore, with regard to taking a passive stance [where actively treating him would increase his suffering], I do not see a prohibition. On the contrary, there is a source from which one can derive that it is correct to refrain in this situation****; see Beis Lechem Yehudah in Yoreh Deah, ibid., s.v. "mi'koach she'omrim," that one should not put salt on the person's tongue to prolong the process of dying [goses].* ***Although perhaps one could counter that a goses is different [as he is already in the process of dying], nevertheless, it would seem that as long as the treatment will lead only to chayei sha'ah, and cannot really save his life [ein bo hatzalah mamash], it is analogous to that of a goses, for a goses is nonetheless considered alive in respect to all matters****.*

Note that this letter is cited *halachah l'maaseh* and with far-reaching conclusions by R. Chaim Kanievsky in *Kovetz Teshuvos MeiRabbeinu Maran HaGrach Kanievsky*, *zt"l*, *siman* 3, found in R. Yosef Aryeh Lorintz's *Mishnas Pikuach Nefesh: Hei'ir Yosef* (5763), p. 276. See also his *teshuvos* in this same spirit in *simanim* 11–13 ibid. For specific application of this ruling to CPR, see R. Prof. Steinberg, "Halachic Basis of the 'Dying Patient Law,'" *Jewish Medical Ethics and Halacha* 6, no. 2 (2008): 30–40.

35 *Minchas Shlomo* 1:91:24:2 (trans., Aryeh Dienstag, "Rabbi Shlomo Zalman Auerbach's Stance on End-of-Life Care"):

> *Many debate the question of treatment of a terminal patient [goses]. There are those who think just as one desecrates the Shabbat for temporary life [chayei shaah], so too one is obligated to force a patient [to accept the treatment] on this, for he does not own himself to give up on even one minute. However, it makes sense if the patient suffers from great pain and suffering or even from very strong emotional pain, I think it is required to give the patient food and oxygen even against his will, but it is permitted to refrain from giving medications that cause pain to the patient if the patient requests this. However, if the patient is G-d-fearing and this will not disturb his mind too much, it is preferable to tell him that one hour of repentance in this world is preferable then all of life in the next world, as is seen in Tractate Sotah 20b that it is a "merit" to suffer seven years rather than to die immediately.*

It is worth noting that in many instances, again depending on the clinical context, performing CPR will not restore the patient to a point where they can repent in any way.

36 As reported in *Nishmas Avraham*, *Yoreh Deah* 339, pp. 504–6 (3rd ed.). From his English translation (p. 323):

> *Rav Elyashiv, shlita, was asked about a patient with ALS who asked not to be connected to a respirator. In a responsum (written in his name by Rav Yosef Efrati, shlita) the Rav, shlita, rules:* ***A patient who is beyond care, and all that medical***

R. Ovadiah Yosef,[37] R. Eliyahu Bakshi-Doron,[38] R. Asher Weiss,[39] and many others,[40] who assert that under the following conditions, a patient (or their surrogate decision-maker) may decline aggressive medical interventions: (1) the patient is suffering, physically or mentally; (2) the patient has an irreversible terminal illness; and (3) any further intervention may only prolong their life for a short period (*chayei sha'ah*) according to their treating physicians.[41]

Where does CPR fit into this picture? CPR cannot reverse a terminal illness. If a patient is already suffering from their terminal illness, with only *chayei shaah* to live, then CPR is an intervention that meets all three criteria. A patient need not undergo CPR to prolong their suffering and end-of-life state.

Some patients are living with an irreversible terminal illness with only *chayei shaah* to live but are not acutely suffering. In other words, they meet

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> ***science can offer him is a prolongation of chayei shaah at the cost of additional suffering due to the treatment itself, may refuse the treatment.*** *If, however, the treatment is not accompanied by additional suffering, it is forbidden to listen to him. I also heard this personally from Rav Elyashiv, shlita. In a recent (August 2001) conversation that I had with Rav Elyashiv, shlita, concerning a terminal patient, he rules that since the patient was conscious and suffering, one was permitted to desist from intubating him or dialyzing him since these measures would only serve to prolong his chayei shaah. However, the patient, who was himself a great sage, should be given the choice to decide what he wished his doctors to do. I asked him whether this ruling would change if the patient lost consciousness, and he answered, "No, there would be nothing to gain by any further treatment as such artificial ventilation or dialysis."*

Notably, the 3rd edition (pp. 505–6) includes a further clarification by R. Dr. Abraham to refute the rumors that Rav Elyashiv required CPR or artificial ventilation in terminally ill patients.

37 As reported by his grandson R. Yaakov Sasson, *Sefer Ruach Yaakov* (5770), pp. 44–47.

38 *Teshuvos Binyan Av*, *Yoreh Deah* 5:67, translated by the authors: "Since the baby is in a very serious medical condition and **his chances of living more than a year are extremely slim, and he will probably suffer incapacitation and agony, the parents are allowed to sign a form stating that they are prepared not to perform CPR on the baby in the event that he does not breathe**."

39 *Teshuvos Minchas Asher* 1:116 (English, vol. 1, chap. 19). This responsum addresses a patient with a gangrenous leg for whom the physicians recommended amputation, but the patient refused. Death was certain without amputation, and there was a 30–40% risk of death even with amputation. R. Asher Weiss writes, after reviewing the opinions of R. Moshe Feinstein and R. Shlomo Zalman Auerbach:

> ***In my humble opinion, the entire idea of acceding to the wishes of the sick person to withhold treatment pertains only to a terminal patient who has but a short time to live****. Moreover, there is no permission to withhold therapy unless he actually asks not to be healed due to his great suffering…However, a person is not permitted to refuse to have his life saved on account of other considerations, such as honor, economic hardship, and the like. And although we cannot force him, it is, nevertheless, a mitzvah to try to convince him in whatever way possible to accept the recommended treatment, as long as his reason in refusing it is not due to concern about pain and suffering…In any event, in my humble opinion, since we are dealing with a person with a severe illness, and the amputation of the limb is itself a difficult surgery which entails potential danger, and in this case the doctors say there's a 30 to 40% danger that the man will die even if he undergoes the operation, one does not force him to do the surgery if he wishes to avoid it.*

We will note that regarding CPR for a cardiac arrest in such cases, we are discussing a treatment that is not recommended and carries a much higher risk of death than 30–40%.

40 This position is best summed up in *Nishmas Avraham* (3rd ed.), *Yoreh Deah*, p. 510. (In the English version, see pp. 324–25) and in R. Mordechai Halpern, "*Hachyaah L'Choleh Sofani*," available online at https://www.toraland.org.il/6167. See also R. Avraham Union, *L'Eis Metzo* (Rabbinical Council of California), pp. 18–23; R. Dr. Jason Weiner, *Jewish Guide to Practical Decision Making*, p. 122; R. Eliezer Melamed, *Peninei Halachah: Likkutim*, 2:14:5–7 (adding here the consenting opinion of R. Shlomo Goren); R. Zev Schostak, "Jewish Ethical Guidelines for Resuscitation and Artificial Nutrition and Hydration of the Dying Elderly," *Journal of Medical Ethics* 20, no. 2 (1994): 95; R. Prof. Steinberg, "The Halachic Basis of the 'Dying Patient Law,'" 30–40 and in *Harefuah K'Halachah*, vol. 6, p. 362 and on. See also the recording from R. Dovid Cohen available at https://torahanytime.com/lectures/284887, particularly at 23:00 and 53:30.

41 See *Teshuvos Igros Moshe*, *Choshen Mishpat* 2:74:1.

criteria 2 and 3 but not 1. However, as we described, CPR itself is not a benign intervention and can often leave the patient with lasting harm and suffering for their final days and weeks. Thus, pursuing CPR itself may make the patient meet all three criteria. If one who is already suffering can decline CPR, one similarly would not be required to introduce suffering. It is thus important to have an individualized conversation with the experienced clinician about the likely outcomes post-CPR for such terminally ill patients in order to make informed decisions and so that the patient does not end up in a tragic position of tremendous pain and suffering.

This point is particularly crucial, since some halachic writings make a misleading suggestion that CPR is benign and painless. This emerges, for example, in the writing of one esteemed halachic authority, who was asked by a physician whether they must respect a DNR order for a terminally ill patient with cancer. This authority ruled that chemotherapy should be withheld because "it won't heal him and will only prolong his suffering." But, this authority continues, if the patient was not suffering from their terminal illness and had a cardiac arrest, then "if it is possible to easily resuscitate him without causing him undue suffering, one should do so…This situation is not similar to the case where we concluded that chemotherapy treatment should be withheld, as chemotherapy is considered a medical effort, similar to undergoing a surgery…but resuscitating a patient is more comparable to reviving a patient who has fainted, which, of course, one must do."[42]

As discussed, CPR frequently causes significant traumatic injuries, which is more likely in the elderly and frail. Those who survive, whether for a short or long period of time, can be left with severe and irreversible neurologic deficits. CPR is very different from reviving someone who fainted and in fact is an even more invasive and aggressive intervention than chemotherapy. Of course, when CPR can save an otherwise healthier patient's life, these considerations are less important; the fact that the treatment might cause pain or injury is overridden by the potential to save them and restore their previous baseline condition, as we will discuss in the next section. But when the success of the intervention is highly doubtful, the likelihood of pain and/or prolonged suffering is highly probable, and the anticipated extension of life is limited, CPR may not be halachically required or even permitted.[43]

Indeed, as R. Dr. Mordechai Halperin has documented, the default practice in Shaare Zedek Medical Center follows the instructions of R. Auerbach[44] and R. Elyashiv to not perform CPR and other similar

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42 *Shiurei Torah L'Rofim* 3:192, p. 339, as translated in *Medical-Halachic Responsa*, trans. Fred Rosner, vol. 6, pp. 47–48.

43 Thus, the following statement of one well-intentioned group regarding DNR orders needs significant correction: "Does halacha permit a patient or family member to make these directives, either in advance or at the actual time that it becomes applicable? Generally speaking, halacha does not allow for these directives, although there may be **rare instances** where some authorities may permit a DNR/DNI order in the case of a terminally ill patient at a very late stage of illness." See the Chicago Mitzvah Campaign's "Torah Guidance for End-of-Life Issues" at https://chicagomitzvahcampaign.org/wp-content/uploads/2022/03/Chayei-Shaah-Torah-Guidance-for-end-of-life-issues-final-1.pdf. It is unclear which *poskim* they have in mind who would require resuscitation in all but rare circumstances. Most likely, this inaccurate formulation was written to cause people to hesitate to sign DNRs in light of concerns of them being misused or abused, as discussed later in the article. One *posek* who requires CPR if it can extend a person's life for at least three days is R. J. David Bleich, "Care and Resuscitation for a *Goses*," *Ohr Hamizrach* 45:3–4 (5757): 93. As R. Bleich notes, his position runs counter to that of R. Feinstein. In any case, it is not clear that CPR will extend the life of someone with late-stage illness for three days.

44 R. Prof. Steinberg, "The Halachic Basis of 'The Dying Patient Law,'" p. 35, includes resuscitation in the list of interventions that R. Shlomo Zalman Auerbach (*Minchas Shlomo* 1:91:21) would not require for the terminally ill. This list includes ventilation, surgery, dialysis, chemotherapy, and radiation therapy. (This is in contrast to the requirement of fulfilling a person's "natural needs" by providing them with food, drink, and oxygen.) Prof. Steinberg's cogent claim is that cardiac arrest is a severe, clearly fatal complication, and CPR in these cases offers little possibility of cure while certainly increasing pain and suffering. As noted in *Nishmas Avraham*, *Yoreh Deah* 339:2 (3rd ed., pp. 498–99), R. Shlomo Zalman did not require painful interventions that

interventions on patients with terminal illness.[45] As R. Elyashiv exclaimed on one occasion, when asked about dialysis and intubation for an end-stage terminally ill and suffering patient, "What for?"[46]

When is a patient with a terminal illness considered to have *chayei shaah*? Israeli law governing the treatment of the terminally ill—which defined it as those with a prognosis of under six months—was deeply shaped by halachah.[47] The six-month time period is based in part on the position of R. Chaim Ozer Grodzinsky, who implied that *chayei shaah* is up to a period of six months. The law also followed this position, since medical prognoses were deemed as most accurate up until this amount of time. It could be, of course, that a person given a prognosis of six months to live will survive longer, such as up to a year. This was the amount of time deemed by R. Shlomo Kluger and R. Moshe Feinstein to constitute *chayei shaah*. The law, following this logic, asserts that a terminally ill patient with a life expectancy of six to twelve months may elect to state in advance that they do not want resuscitation or other interventions that will, at best, only extend their life for a short time while they continue to suffer from their illness.[48]

For patients already with a prognosis of less than a year, undergoing cardiac arrest certainly further worsens their prognosis. This is a severe medical complication, and CPR might only help to extend *chayei shaah* that includes increased suffering. The precise definition to be applied for a specific patient must be determined by a reliable halachic authority in conjunction with the clinical team.

Halachic Perspectives on Code Status: *Chayei Olam* (Non-terminally ill)

For previously healthy patients who are hospitalized for any indication that is not terminal, it can generally be assumed that if they were to unexpectedly suffer a cardiac arrest, it would be due to a sudden and possibly reversible new complication. Such a patient, with *chayei olam* to live, is likely nearly always required to undergo CPR for the possibility that they will meaningfully recover.[49]

Notably, there are three categories of patients who may be currently anticipated to live *chayei olam* (i.e., they do not have a terminal illness) but have a unique condition that has prompted distinct evaluation by various halachic authorities: patients with (1) disorders of consciousness, (2) advanced dementia, and (3) significant frailty. The thought of deciding, in advance, not to perform a potentially lifesaving intervention on a patient currently with *chayei olam* is a grave consideration. The exploratory analysis that follows raises important points and considerations for ongoing halachic discussion. To reiterate our introduction, decisions for individuals must be made with a qualified halachic authority and experienced physician knowledgeable about the specific case.

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might only temporarily extend a person's life but would not cure their underlying disease. See also R. Yosef Aryeh Lorintz, *Mishnas Pikuach Nefesh*, *siman* 6, pp. 17–19, who also understands R. Auerbach's position as not requiring medical interventions that are painful and have minimal possibility of cure. Cf. R. Akiva Tatz, *Dangerous Disease & Dangerous Therapy in Jewish Medical Ethics* (Targum, 2010), p. 145.

45 See R. Mordechai Halpern, "*Hachyaah L'Choleh Sofani*," as well as his comments at the end of Dr. Sodi Namir, "*Ha'arachas Chayei Hacholeh Hasofani*: *Chovah oh Reshus*?" *Assia* 63–64 (1998): 9–17.

46 *Nishmas Avraham*, *Yoreh Deah* (3rd ed.), pp. 504, 506. It is possible that R. Yitzchak Zilberstein would also agree that this is a case in which resuscitation is not allowed, since following cardiac arrest, a person who already was terminally ill has now reached the second stage of *gesisah*, discussed earlier.

47 R. Prof. Steinberg, "The Halachic Basis of the 'Dying Patient Law,'" 30–40.

48 See *Chochmas Shlomo*, *Yoreh Deah* 155:1; *Igros Moshe*, *Choshen Mishpat* 2:75b. See also R. Weiner, *Jewish Guide to Practical Decision Making* (Urim, 2017), pp. 135–136, fns. 38–40.

49 Notably, in no subgroup of any study we could find of hospitalized patients was survival >50% from a cardiac arrest. For possible implications, see *Teshuvos Minchas Asher* 1:116 (*Rav Asher Weiss on Medical Halachic Issues*, vol. 1, chap. 19), discussed above in fn. 40.

Disorders of Consciousness

"Disorders of consciousness" is a broad term encompassing a spectrum of neurologic states in which patients exist with varying degrees of impaired neurological awareness. These patients maintain brainstem reflexes and rudimentary neurological functions, but they have such severe neurological injury that awareness of self or environment—and capacity for subjective experience generally—are disrupted. These disorders—described in Plum and Posner's classic book on the "Diagnosis of Stupor and Coma" and more recently codified in American Academy of Neurology (AAN), American Congress of Rehabilitation Medicine (ACRM), and National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) Guidelines—constitute a spectrum that includes

- **coma**: no behavioral evidence of wakefulness or awareness,
- **vegetative state** or "**unresponsive wakefulness syndrome**" (VS/UWS): preserved eyes-open periods of wakefulness but no behavioral evidence of awareness, and
- **minimally conscious state** (MCS): preserved wakefulness with behavioral evidence of minimal awareness, further subcategorized into MCS+ and MCS− depending on presence or absence of behavioral command-following.

Before 2018, the term "permanent vegetative state" (PVS) was used to describe patients who remained in vegetative state for longer than three months (for nontraumatic etiologies) or twelve months (for traumatic etiologies). However, the 2018 guidelines recommended replacing the term "permanent" with "chronic" in light of more recent studies suggesting that while "the majority of patients who remain in VS/UWS across the first three (after nontraumatic) and twelve months (after traumatic) postinjury will remain in this condition permanently, a substantial minority will recover consciousness beyond this timeframe," thus challenging the notion of permanence.

An in-depth review of the differences between the various disorders of consciousness is beyond the scope of this essay, but it is important to recognize a key distinction with halachic significance between a vegetative state and a minimally conscious state that has not been sufficiently addressed in the halachic literature.[50] The vegetative state specifically is defined as a state in which a patient has "spontaneous eye-opening, signaling wakefulness, but no evidence of purposeful behavior suggesting awareness of self or environment" for greater than one month after a brain injury.[51] A minimally conscious state is a "condition of severely altered consciousness in which there is definite, but often subtle and inconsistent, behavioral evidence of self- or environmental awareness." In other words, a patient in a minimally conscious state has behavioral evidence of residual capacity for pain perception.

Well before these distinctions were developed in medical literature, R. Shlomo Zalman Auerbach and his son-in-law, R. Zalman Nechemia Goldberg, disagreed[52] regarding the need to perform CPR for a patient in a "vegetative" state.[53] R. Auerbach, following the suggestion of R. Dr. Abraham S. Abraham, holds

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50 The possibility of pain in such patients is briefly noted by R. Avraham Union, *L'Eis Metzo*, p. 22.

51 J.T. Giacino et al., "Practice Guideline Update Recommendations Summary: Disorders of Consciousness: Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology; The American Congress of Rehabilitation Medicine; and the National Institute on Disability, Independent Living, and Rehabilitation Research," *Neurology*. 91, no. 10 (2018): 450–60. https://doi.org/10.1212/WNL.0000000000005926/.

52 The word *tzemach*, or "vegetable," is used to describe patients within this spectrum. The positions cited here seem to assume that the patient will not be able to recover and cannot feel pain. For patients in modern times, where finer distinctions can be made between previously simply "vegetative" patients, improved/updated terminology might be necessary to communicate halachic opinions regarding these patients. Regardless, decisions for these patients must be made based on the best available data for the patient in conjunction with a halachic authority.

53 R. Steinberg, *Refuah K'Halachah*, vol. 6:10, pp. 378–79. R. Auerbach's position is reported in *Nishmas Avraham*, *Yoreh Deah*

that if there is a cardiac arrest after a continued progressive clinical decline following the natural history of a terminal, progressive process (in other words, perhaps, *chayei shaah*), resuscitation is not required. However, if the cardiac arrest occurred suddenly, i.e., without any previous indication of physical decline (in other words, perhaps they have *chayei olam*), then CPR would be required if it would not cause undue suffering and was not against their will.

R. Auerbach's position assumes (1) that a person in a vegetative state would not feel the pain of CPR or its effects and (2) that when dealing with patients with otherwise healthy bodies, resuscitative efforts that would restore them to their baseline state—even vegetative—should be performed. R. Goldberg, in contrast, believes that a vegetative patient who would not wish to live this way should not have CPR performed just to restore him to this vegetative state. R. Goldberg, in other words, challenges the second assumption. These positions were taken in the late 1980s or early 1990s.[54] Notably, R. Shlomo Zalman also agrees that CPR should be withheld if it would cause undue suffering (i.e., in cases where the first assumption does not hold). Thus, according to both opinions, for patients with disorders of consciousness who feel pain, concern for protracted suffering may permit withholding CPR even with *chayei olam* to live.[55]

Our current understanding of disorders of consciousness and recognition of the limitations in traditional clinical approaches to characterizing these conditions underscores the need to revisit earlier assumptions, particularly regarding pain perception (assumption 1). It is estimated that approximately 15–20% of patients believed to be unconscious (coma/VS/UWS) following severe brain injury based on traditional criteria are more likely to be covertly conscious, with dissociation between cognitive capacities and capacities for overt self-expression.[56] Thus, some patients characterized as behaviorally

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(3rd ed.), pp. 503–4, and R. Goldberg's position is found in his essay in *Hakinus Habeinleumi Harishon L'Refuah*, *Etikah V'Halachah* (Schlesinger Institute, 1993), p. 295. R. Moshe Hershler also asserts that interventions that will only restore a person to a state of unconsciousness do not need to be performed. See *Halachah V'Refuah*, vol. 2, ed., R. M. Hershler, p. 34. A similar position is also taken by R. Moshe Sternbuch (*Teshuvos V'Hanhagos* 6:300). See also the related discussion regarding patients with advanced dementia in Dr. Yisrael Katz, "*Hanshamasam V'hachayasam Shel Cholim B'Dementziah Miskademes*," *Techumin* 31, pp. 63–70. Dr. Katz notes, like R. Steinberg, that R. Hershel Schachter also believes that we should respect the choice of patients with advanced dementia or severe brain injury to withhold further intervention. See his essay "*V'Eilav Hu Nosei es Nafsho*" in *Beis Yitzchak* 5746, pp. 104–8; "*B'Dinei Meis V'Gavra Ketila*," *Assia* 49–50, p. 204; and, most recently, the statement of R. Schachter and R. Mordechai Willig, "Decision-Making in Acute Critical Illness: A Rabbinic Postscript," *Tradition* 53, no. 1: 94–96.

54 For general bioethical discussion of these cases, including those dealing with Orthodox patients, see C. Weijer, "Cardiopulmonary Resuscitation for Patients in a Persistent Vegetative State: Futile or Acceptable?" *Canadian Medical Association Journal* 158, no. 4 (1998): 491–93; G.L. Crelinsten et al., "CPR for Patients in a Persistent Vegetative State?" *Canadian Medical Association Journal* 159, no. 1 (1998): 18.

55 See *Nishmas Avraham*, *Yoreh Deah* (3rd ed.), p. 503. See also *Harefuah K'Halachah*, vol. 6, pp. 375–77, regarding R. Shlomo Zalman's opinion that a patient with amyotrophic lateral sclerosis (ALS) may decline intubation, even though this may extend their life by several years. This novel position demonstrates that there is a threshold at which some halachic authorities permit one to decline interventions that would prolong their life when reasonable people would not wish to live in such a way, even for *chayei olam*. No explanation is given for why pain in this case changes the requirement for intervention in spite of the fact that we are dealing with *chayei olam*. Perhaps the combination of pain and minimal chance of neurological recovery allows the patient to refuse such an intervention. Indeed, R. Steinberg suggests that given the assumption that vegetative patients do not have a chance for recovery, R. Moshe Feinstein would not require such painful interventions to keep them alive. See *Harefuah K'Halachah*, vol. 6:10, p. 378, n. 137. As will be noted in the following section, other halachic authorities extend this beyond disorders of consciousness.

56 J. Claassen et al., "Detection of Brain Activation in Unresponsive Patients with Acute Brain Injury," *New England Journal of Medicine* 380, no. 26 (2019): 2497–2505. https://doi.org/10.1056/NEJMoa1812757; D. Kondziella et al., "Preserved Consciousness in Vegetative and Minimal Conscious States: Systematic Review and Meta-Analysis," *Journal of Neurology,*

comatose or in a vegetative state can and do indeed feel pain and suffering. This challenges the assumption behind the ruling that all such patients should receive resuscitation.

Accordingly, we believe that even those who follow the reported position of R. Auerbach must evaluate each patient on a case-by-case basis, accounting not only for the factors relevant for a conscious but otherwise clinically identical patient, but also obtaining the best neurologic assessment of their ability to feel pain and suffer.

Advanced Dementia

Advanced or severe dementia has been defined as "profound memory deficits (e.g., inability to recognize family members), minimal verbal abilities, inability to ambulate independently, inability to perform any activities of daily living, and urinary and fecal incontinence."[57] This definition is helpful but insufficient, as dementia proceeds along a spectrum, and the degree of debilitation and consciousness will vary between patients; each patient must be assessed individually. Still, while there are multiple types and causes of dementia, patients with advanced dementia are in some ways clinically more straightforward than those with disorders of consciousness, as the process is known to be progressive and irreversible. Interestingly, R. Dr. Abraham groups the aforementioned statements in the name of R. Auerbach regarding "vegetative" patients along with patients with severe Alzheimer's disease, though he does not specify the degree of debilitation in these patients.[58] Coupling these two categories creates some confusion. Patients with dementia clearly experience pain, although they might not be able to express it. There is substantial data in the medical literature that patients with advanced dementia experience substantial pain even if not readily apparent. Approximately 50% of patients with severe dementia experience daily, notable pain.[59] Because it is less apparent, it is also undertreated.[60] Clinical scoring systems have been developed to help identify and quantify pain in those with advanced dementia. The Pain Assessment in Advanced Dementia Scale (PAINAD) is a validated tool to assess pain by assessing quality of breathing, vocalization, facial expressions, body language, and consolability.[61] The Abbey Pain Scale also assesses physical and physiological changes.[62] These can help, but as dementia progresses, the clinical clues guiding these scores become less reliable.

Neurosurgery and Psychiatry 87, no. 5 (2016): 485–92. https://doi.org/10.1136/jnnp-2015-310958; B.L. Edlow, J. Claassen et al., " Recovery from Disorders of Consciousness: Mechanisms, Prognosis, and Emerging Therapies," *Nature Reviews. Neurology* 17, no. 3 (December 2021): 135–56. https://doi.org/10.1038/s41582-020-00428-x.

57 S.L. Mitchell, "Clinical Practice: Advanced Dementia," *New England Journal of Medicine* 372, no. 26 (2015): 2533–40. https://doi.org/10.1056/NEJMcp1412652.

58 *Nishmas Avraham*, *Yoreh Deah* (3rd ed.), p. 503.

59 S.L. Mitchell et al., "The Clinical Course of Advanced Dementia," *New England Journal of Medicine* 361, no. 16 (2009): 1529–38. https://doi.org/10.1056/NEJMoa0902234; A. Corbett et al., "Assessment and Treatment of Pain in People with Dementia," *Nature Reviews. Neurology* 8 (2012): 264–74. https://doi.org/10.1038/nrneurol.2012.53; J. van Kooten et al., "Prevalence of Pain in Nursing Home Residents: The Role of Dementia Stage and Dementia Subtypes," *Journal of the American Medical Directors Association* 18, no. 6 (2017): 522–27. https://doi.org/10.1016/j.jamda.2016.12.078.

60 W.P. Achterberg et al., "Are Chronic Pain Patients with Dementia Being Undermedicated?" *Journal of Pain Research* 14 (2021): 431–39. https://doi.org/10.2147/JPR.S239321; M. Boltz et al., "Pain Incidence, Treatment, and Associated Symptoms in Hospitalized Persons with Dementia," *Pain Management Nursing* 22, no. 2 (2021): 158–63. https://doi.org/10.1016/j.pmn.2020.08.002.

61 V. Warden et al., "Development and Psychometric Evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale," *Journal of the American Medical Directors Association* 4, no. 1 (2003): 9–15. https://doi.org/10.1097/01.JAM.0000043422.31640.F7.

62 J. Abbey et al., "The Abbey Pain Scale: A 1-Minute Numerical Indicator for People with End-Stage Dementia," *International Journal of Palliative Nursing* 10, no. 1 (2004): 6–13. https://doi.org/10.12968/ijpn.2004.10.1.12013.

As such, it remains unclear why, according to the standards of R. Auerbach, a patient or their decision-maker should not be able to elect to forgo CPR in a situation of advanced dementia, even in cases of a sudden cardiac arrest.[63] This is because assumption 1 of his original ruling as suggested by R. Dr. Abraham—that patients won't feel pain from CPR and its effects in these circumstances—does not seem to be medically correct. Cases should be discussed with a halachic authority, because the common default assumption that CPR must be performed may be incorrect. This will be discussed further in the following section relating to frailty, as patients with advanced dementia frequently have frailty as well.

Frailty

Frailty has been defined as a "clinically identifiable state of diminished physiological reserve and increased vulnerability to a broad range of adverse health outcomes."[64]

While not a discrete, recognized illness such as cancer or diabetes, frailty is a clinical condition that impacts prognosis even when one might otherwise say that a patient has "nothing wrong" or "no medical illness." Halachah does not recognize age as an independent factor in halachic decision-making.[65] While not everyone who is elderly is frail and not everyone who is frail is elderly, frailty and age frequently co-occur, and when this is the case, the frailty, rather than age, can have meaningful prognostic and, therefore, halachic importance, especially in the event of a cardiac arrest.

Research studies often calculate scores such as the Clinical Frailty Scale to diagnose and/or grade the severity of a patient's frailty to compare outcomes between groups.[66] Many studies have evaluated the efficacy of CPR in hospitalized frail and/or elderly patients and demonstrate that such patients have a significantly reduced chance of survival after in-hospital cardiac arrest. In a study of 179 patients, fewer than 2% of those with high frailty scores survived a cardiac arrest to discharge (compared to 32% with low frailty scores).[67] A systematic review and meta-analysis of several studies including in aggregate over a thousand patients found that patients with frailty had three times the odds of dying in the hospital compared to those without frailty.[68] Several studies identify a similar trend looking at age alone. As discussed earlier, trends found in studies cannot be generically applied to any individual. The studies only suggest that this cohort of patients warrants particularly close attention and expert clinical evaluation when planning for a possible cardiac arrest. For a specific patient, an experienced clinician may be able to reliably identify if a patient is likely to survive a cardiac arrest and for what duration.

With this in mind, we must consider the prognostic implication of a cardiac arrest in the frail patient. R. Dr. Abraham writes, "A patient with a chronic, incapacitating, but not-terminal disease should be treated as any other patient, including the administration of full resuscitation, even if only for *chayei shaah*. Thus, the very aged and senile, someone with advanced Alzheimer's disease, or a *shoteh*, must all

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63 See also *Harefuah K'Halachah*, vol. 6, pp. 379–80.

64 D.H. Kim and K. Rockwood, "Frailty in Older Adults," *New England Journal of Medicine* 391, no. 6 (2024): 538–48. https://doi.org/10.1056/NEJMra2301292.

65 *Harefuah K'Halachah*, vol. 6, p. 379.

66 K. Rockwood and O. Theou, "Using the Clinical Frailty Scale in Allocating Scarce Health Care Resources," *Canadian Geriatrics Journal* 23, no. 3 (2020): 210–15. https://doi.org/10.5770/cgj.23.463.

67 C. Wharton et al., "Frailty Is Associated with Adverse Outcome from In-Hospital Cardiopulmonary Resuscitation, " *Resuscitation* 143 (2019): 208–211. https://doi.org/10.1016/j.resuscitation.2019.07.021.

68 F.I. Mowbray et al., "Prognostic Association of Frailty with Post-Arrest Outcomes Following Cardiac Arrest: A Systematic Review and Meta-Analysis," *Resuscitation* 167 (2021): 242–50. https://doi.org/10.1016/j.resuscitation.2021.06.009.

be treated like any young, robust, and healthy individual."[69] The implicit assumption is that a cardiac arrest will not alter the patient's prognosis.

With new data regarding hospitalized patients with frailty, we must reexamine this assumption. Indeed, many—perhaps most—frail patients without another terminal condition may have a prognosis of greater than one year. For some patients, this remains true even if suffering a cardiac arrest, and they remain *chayei olam* during a cardiac arrest and are likely obligated to remain "full code." However, for other patients with frailty, the moment they enter a cardiac arrest, their prognosis—and halachic status—may immediately change.[70] Some new issue or condition must have arisen to prompt a cardiac arrest, and the frail patient population broadly (again, not necessarily relevant for the individual) has poor immediate and short-term survival rates following CPR. As such, a given patient with frailty might have a prognosis of greater than one year upon hospital admission, but upon cardiac arrest—before even initiating CPR—this prognosis may have changed. At that moment, they might have the status of *chayei shaah* or even a *goses* and meet the criteria outlined in the previous sections.

R. Hershel Schachter and R. Mordechai Willig, following an analysis by R. Dr. Judah Goldberg of patients with acute critical illness and frailty, assert that patients may at times choose to withhold certain interventions in spite of the fact that they do not have a terminal diagnosis at the time of the decision.[71] A discussion of the various possible interventions that arise in end-of-life care is beyond the scope of this review. Each intervention has different rates of success and complications and accomplishes different goals. For the intervention of CPR specifically, based on data reviewed herein, there are certainly patients whose prognosis at the moment of a cardiac arrest (with or without CPR) can be reliably predicted to the degree of certainty necessary to establish their status as either *chayei shaah* or *goses*. This requires more attention and discussion, as many *poskim* do not address frailty per se as a condition that impacts the halachic obligations of medical interventions.[72] As always, determining the halachic status of the patient and its halachic implications must be made in concert

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69 *Nishmas Avraham*, *Yoreh Deah* 339 #7, p. 509 (trans. from *Nishmas Avraham*, *Yoreh Deah*, p. 324, English ed.)

70 See R. Y. Dovid Kaye, "End-of-Life Issues in Halacha: DNR, Feeding Tubes, and Palliative Care," *Jewish Medical Ethics* 7, no. 1 (2009): 353, who argues, "In the geriatric long-term care population, the heart stoppage itself is often the final common pathway to death following the lethal deterioration of other organ systems. The heart rhythm and cardiac output is usually not capable of being permanently restored. In such situations, CPR serves no clinical purpose…Assessing all the evidence, CPR is not beneficial for patients who are near the end of life and may be harmful. From a halachic perspective, therefore, CPR may be withheld from or refused by Jewish patients who are terminally ill or at the end of life where agreement exists that there is no clinical value to the procedure." For a similar conclusion, see Dr. Michael Gordon, "Cardiopulmonary Resuscitation in the Frail Elderly: Clinical, Ethical and Halakhic Issues," *Israel Medical Association Journal*, vol. 9 (2007): 177–79, who argues that in long-term care facilities, "CPR has been shown to offer little if anything in terms of survival. Even under the conditions where on-site arrest teams are available, the outcomes from CPR are at best grim."

71 See R. Dr. Judah Goldberg, "A Halakhic Framework for Decision-Making in Acute Critical Illness," *Tradition* 53, no. 1 (2021): 78, which halachically analyzes frailty, and the postscript by R. Schachter and R. Willig, which includes: "While a patient may not arbitrarily cause himself harm, he may forgo treatment in situations in which reasonable people might conclude that the downsides outweigh the benefits. If the patient lacks [sufficient] cognition, a family member or healthcare proxy can decide to decline treatment based on the previously expressed directives of the patient, or, if necessary, by analyzing what the patient would want to be done in such a case…R. Auerbach writes that if a patient is aware and not demented [*lo nitrafa daato*], he should be encouraged to pursue every treatment despite the physical or severe emotional pain involved. He should be told, 'Better one hour of repentance and good deeds in this world than the entire life in the World to Come' (Avos 4:22). Nevertheless, if the situation is so unfortunate that reasonable people might not want to continue living in these conditions, the patient has the authority to decline further care." A Hebrew version of these articles appeared in the Israeli journal *Techumin* 44 along with a response from R. Tzvi Arnon and R. Ariel Vider.

72 See *Harefuah K'Halachah*, vol. 6, pp. 379–80.

with a reliable halachic authority in conversation with their doctor.

PART III: ADDITIONAL CONCERNS AND CONSIDERATIONS

"If a Patient Is Made DNR, the Medical Team Stops Caring": DNR = Do Not Care or Do Not Treat?

A common and legitimate concern regarding changing one's code status to DNR is the fear that the medical team will no longer care as much or work diligently to treat a patient, as they see the patient as "dying," having "given up," or simply, erroneously, not interested in receiving other care.[73] In truth, a DNR status means only that the patient will not undergo CPR if they suffer a cardiac arrest. All other care and interventions should proceed as usual or at least be discussed with the family.

Nonetheless, these fears are not unfounded. Sometimes, the DNR can be misinterpreted, or overinterpreted, likely because of substantial overlap between patients who are DNR and those who also do not wish to pursue other interventions, as well as confusion regarding what the term "resuscitation" includes.[74] There are data reflecting this phenomenon, discussed below. At times, halachah would similarly support withholding these other interventions. Yet, when it is an intervention that would otherwise be offered but is not even discussed because the patient is DNR, this is inappropriate and raises concerns about improper limitations in care.

In 2002, a survey of 241 physicians presented hypothetical patient scenarios followed by treatment decision choices and found that patients with DNR orders were 7% less likely to have blood cultures drawn, 12% less likely to have a central line placed, and 12% less likely to be given a blood transfusion.[75] A similar survey-based study of 533 internal medicine residents in 2019 had similar findings,[76] and several studies of different designs and contexts reveal a similar pattern.[77] Based on these concerns, some are reluctant to proceed with a DNR status under any circumstances.

However, while this concern is legitimate, it can be mitigated. Furthermore, choosing to place this consideration above all others in determining a code status is not without significant risk.

As discussed above, CPR is halachically inappropriate for a *goses*. For those with *chayei shaah* and suffering, CPR would prolong and likely worsen the suffering. Refusing a DNR when halachah requires or permits withholding CPR commits the patient to nevertheless receive CPR and all it entails. Indeed, if

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73 See, for example, R. Dr. Akiva Tatz, *Dangerous Disease and Dangerous Therapy* (Menucha, 2010), pp. 146–52 and Dr. Albert Matalon, *Matters of Life and Death* (Feldheim, 2019), pp. 113–18. See also the nuanced discussion in Dr. Moshe Ornstein, *Cancer in Halachah* (Israel Bookshop, 2024), pp. 235–40.

74 https://www.nytimes.com/2024/08/26/well/patients-dnr-orders-ignored.html.

75 M.C. Beach and R.S. Morrison, "The Effect of Do-Not-Resuscitate Orders on Physician Decision-Making," *Journal of the American Geriatrics Society* 50, no. 12 (December 2002): 2057–61. https://doi.org/10.1046/j.1532-5415.2002.50620.x.

76 E.K. Stevenson et al., "Association Between Do Not Resuscitate/Do Not Intubate Status and Resident Physician Decision-Making. A National Survey," *Annals of the American Thoracic Society* 14, no. 4 (2017): 536–42. https://doi.org/10.1513/AnnalsATS.201610-798OC.

77 S.C. Zweig et al., "Effect of Do-Not-Resuscitate Orders on Hospitalization of Nursing Home Residents Evaluated for Lower Respiratory Infections," *Journal of the American Geriatrics Society* 52 (2004): 51–58; J.L. Chen et al., "Impact of Do-Not-Resuscitation Orders on Quality of Care Performance Measures in Patients Hospitalized with Acute Heart Failure," *American Heart Journal* 156 (2008): 78–84.https://doi.org/10.1016/j.ahj.2008.01.030; D.K. Richardson et al, "The Impact of Early Do Not Resuscitate (DNR) Orders on Patient Care and Outcomes Following Resuscitation from Out-of-Hospital Cardiac Arrest," *Resuscitation* 84 (2013): 483–87. https://doi.org/10.1016/j.resuscitation.2012.08.327; M.A. Mohammed et al., "Process of Care and Mortality of Stroke Patients with and Without a Do Not Resuscitate Order in the West Midlands, UK," *International Journal for Quality in Health Care: Journal of the International Society for Quality in Health Care*18 (2006): 102–6. https://doi.org/10.1093/intqhc/mzi081; R.I. Cohen et al., "The Impact of Do-Not-Resuscitate Order on Triage Decisions to a Medical Intensive Care Unit," *Journal of Critical Care* 24 (2009): 311–15. https://doi.org/10.1016/j.jcrc.2008.01.007.

choosing to place this consideration above all others, i.e., to require all halachically observant patients to remain full code out of concern they will otherwise receive less care, one is concluding, de facto, that all hospitalized Jews will die with chest compressions.

To avoid this problem, some suggest that such patients remain full code but constantly have a surrogate decision-maker present at the bedside to immediately invoke a DNR the moment the patient has a cardiac arrest. The underlying logic is that such a patient will receive all the attention of a patient who is full code and still avoid the dangers of CPR in the final moments.

This well-intended approach has three flaws: First, many hospitals do not permit a continuous bedside visitor presence. Moreover, in many jurisdictions, there can only be one or two patient representatives authorized to change a code status, such that a rotation of bedside family members would not help. Second, even with the best resources, intentions, and bedside presence, the likelihood that the patient receives CPR remains high. The bedside decision-maker may have briefly stepped out or been distracted. Furthermore, a cardiac arrest in a patient who is full code is an emergency and chaotic. The first responder, usually not a physician, may not have the ability or authority to refrain from initiating CPR based on the word of a bedside family member when the patient's legal, documented status is "full code." Third, and perhaps most importantly, another poorly recognized complication of this approach is how it may in fact create precisely the distraction or inattention it seeks to avoid. When a patient is dying in the ICU without hope of recovery or suffering from a terminal illness and facing a possible cardiac arrest, a key focus of clinical conversations during hospital rounds and throughout the day is on the communication with the family and/or surrogates to ensure they understand what is happening. Generally, when families understand the prognosis, they appropriately transition the patient's code status to DNR or comfort care. When a family or surrogates insist on the patient remaining full code even when it is thought to be clinically futile (i.e., the underlying cause of the arrest cannot be reversed), the team becomes concerned that they are not clearly communicating the reality to the family. Those healthcare professionals most likely to perform CPR often become overwhelmed with moral distress and fear that they will need to participate in this invasive intervention on a patient in their final moments. In a very real way, these concerns often dominate the conversations about the patient. As only a finite amount of time can be spent on any given patient, attention is necessarily drawn away from the direct clinical care of the patient. Thus, in the hope of enhancing clinical attention toward the patient, insisting on a full code in situations where it is most clinically (and halachically) inappropriate may have the opposite effect.

A better way to mitigate the concern that a DNR will be misinterpreted as "do not treat" is by having clear, open, and honest communication with the clinical team regarding the goals and wishes. The aforementioned studies reveal a modest, not overwhelming, occasional misinterpretation of a DNR as a wish to withhold more than just CPR. Importantly, they reflect a clinician's mistaken assumption about what a patient would want based on their having or not having a DNR. No assumptions about a patient's treatment decisions can be made from their willingness to undergo or forgo an attempt at resuscitation. As noted, a DNR only means that CPR will not be performed if the patient suffers a cardiac arrest. Nevertheless, some—especially the less clinically experienced—make this mistake, and for understandable reasons: Most patients who are DNR do indeed also not wish to undergo more invasive interventions. A study of over 18,000 outpatients who had a formal DNR in place found that 50% also wanted only comfort care, and 43% only wanted limited additional interventions.[78] Only 7%

78 E.K. Fromme et al., "POLST Registry Do-Not-Resuscitate Orders and Other Patient Treatment Preferences," *JAMA* 307, no. 1 (2012): 34–35. https://doi.org/10.1001/jama.2011.1956.

otherwise wanted "full treatment." This may explain why, albeit incorrectly and inappropriately, some clinicians assume that a patient who is DNR also wants less invasive approaches to care.

Best practice, and common practice, is for clinicians to have clear conversations with the family members and/or surrogates to clarify the goals and wishes of the patient, where these concerns can be discussed and clarified. If no such conversation is initiated by the clinical team, families should feel empowered to initiate such discussions with experienced senior members of the clinical care team, where these wishes and concerns can be discussed in depth and detail. At such a meeting, a family can reiterate (if this is indeed the wish) that the patient wants absolutely all care other than CPR, and that this should be clearly communicated to all members of the team. Explicitly clarifying the goals should very much mitigate the concern that assumptions about goals may be made instead.[73] When a family can carefully express that they understand the prognosis, accept that the patient should be DNR, but otherwise want to discuss all options, this will reduce distress among caregivers concerned that the family does not understand the clinical reality.[79]

The Misleading Power of the Anecdote: The Majority Are Not the 1%, and Physicians Are Fallible

Stories are powerful; people emotionally connect with stories in a way that even overwhelming data and evidence cannot overcome. Data can demonstrate that significant smoking leads to lung cancer or chronic obstructive pulmonary disease, but some will nevertheless ignore it based on the anecdote of the grandfather who smoked a pack a day for years and died of old age. Data suggest that anecdotal evidence is even more compelling to people in situations of high emotional engagement.[80]

When is emotional engagement higher than when a loved one is approaching the end of life? There are and certainly will be many stories of individuals who rejected a physician's abysmal prognosis, even surviving a cardiac arrest, and went on to live more years against the odds without suffering. In fact,

79 As we were completing this essay, Ematai's helpline was consulted by a Jewish family with an elderly parent hospitalized in a Texas hospital. The hospital's policy allows for the designation DNAR/COT: Do Not Attempt Resuscitation—Continue Other Treatment. This helped make it absolutely clear to the staff that the family wanted all other interventions. Indeed, the patient continued to receive vasopressors, artificial nutrition, dialysis, and other interventions. A long-term strategic goal of the Jewish community may be to advocate for including such designations in local hospitals. In the interim, another possible means of mitigating this concern that is possible today, albeit also with certain risks, is setting a code status as "DNR but OK to intubate." This status reflects a patient who is clearly interested in invasive interventions—intubation, no less—but simply does not want CPR, understanding that in the event of a cardiac arrest, they wish to pass peacefully. Indeed, a survey-based study of 275 clinicians found that patients with a DNR that explicitly permits other procedures were more likely to receive non-arrest procedures—but also, inappropriately, CPR itself (N. Ariyoshi et al., "Wanted and Unwanted Care: The Double-Edged Sword of Partial Do-Not-Resuscitate Orders," *Journal of Palliative Medicine* 21, no. 2 (2018): 143–48. https://doi.org/10.1089/jpm.2017.0144.). This code status is of course most appropriate for a patient who truly does wish to be intubated if needed for respiratory failure. If such a patient (or their family member/surrogate) later wishes to transition to a complete DNR/DNI, this can be done. Furthermore, respiratory failure and the resultant need for intubation usually does not occur suddenly and emergently. Therefore, if the patient with a code status of "DNR but OK to intubate" does eventually develop respiratory failure, there will more likely still be time (relative to reversing a "full code" before an arrest) to reverse this code status immediately before an actual intubation if the family/surrogates suddenly change their mind. Regardless, it is important to recognize that the etiology and clinical trajectory of respiratory failure is most often very different than that of cardiac arrest, and the fact that a medico-legal code status usually combines decisions about cardiac arrest with those about respiratory failure obscures this reality. While uncommon, a code status of "DNR but OK to intubate" might be appropriate for some ill patients. A discussion of DNI is beyond the scope of this paper.

80 T.H. Freling et al., "When Poignant Stories Outweigh Cold Hard Facts: A Meta-Analysis of the Anecdotal Bias," *Organizational Behavior and Human Decision Processes* 160 (2020): 51–67. https://doi.org/10.1016/j.obhdp.2020.01.006.

even the data partially support this. Take the aforementioned study in which only 2% of patients with severe frailty survived a cardiac arrest to hospital discharge. Extrapolating from that abysmal prognosis alone, 20 of 1000 patients would still be expected to survive, although possibly still suffering. When one of those 20 individuals shares their story, no one is concurrently sharing the stories of the jarring deaths of the other 980 patients. With all previously discussed limitations of research on outcomes in cardiac arrest in mind, no study that we found had a 0% survival in a subgroup. It is important to recognize, therefore, that these stories do not negate the data. Compelling anecdotal evidence is misleading. The physician remains correct in prognosticating a 98% chance of death for individuals like those in the frailty study. Furthermore, as above, decisions about code status in halachah are not only about expected survival from a cardiac arrest, but the suffering of the *chayei shaah* that they may be left with.

Halachah guides the real, tangible world and can be guided only by the best available data that exist therein. Physicians who are most aware of the patient's medical situation, who have substantial clinical experience, and who keep up to date with the relevant literature are the primary source for the best available data for this given patient, even though the clinicians certainly are fallible. Just as any halachic authority is fallible, but halachah itself requires one to rely on their expertise and experience to take the most informed halachic action, so does halachah require one to rely on an experienced and informed physician's expertise to prognosticate and inform a halachic decision. Unless there is particular reason to believe that a physician's prognostication is compromised, the stories and exceptions do not invalidate this as the primary halachic source for prognostic information. If there is a situation in which, for whatever reason, one believes the physician is not providing an accurate prognosis, they must then instead seek the opinion of an experienced physician that they do trust rather than rely on stories or exceptions as the alternative.

CONCLUSION

As medical knowledge advances, our understanding of and approach to medical procedures must advance as well. A better understanding of the risks and benefits of CPR and how they vary by case, coupled with better clinical and prognostic information for patients with critical illness, disorders of consciousness, dementia, and frailty, allows for a more nuanced discussion about code status in halachah than was previously possible. At times, one may be halachically obligated to undergo CPR, at times to be completely left alone, and importantly, at times, one has a choice. In all scenarios, there are potential benefits and risks to any code status, and one must have the wherewithal to identify them. Common misconceptions must be corrected and disproportionate emphasis of some factors over others overcome to ensure that one reaches the best halachic decision for the individual patient.

It is fitting to conclude with the words of R. Moshe Feinstein in one of his several responsa on these matters:[81]

> *I have devoted lengthy responsa to these questions because they involve life-and-death decisions and often lack the clarity that would enable one to make a [proper] halachic decision. It is, therefore, very important to utilize the services of as many learned sages as are available, to consult as many physicians as possible, and to arrange for rabbis and physicians to discuss each case thoroughly so that, with the help of Hashem, a proper decision can be reached.*

81 *Igros Moshe*, *Choshen Mishpat* 2:74:17.