

# *From ‘Living Will’ to Conversations with Your Proxy: A New Model for Halakhic Advanced Healthcare Planning*

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One of the most challenging ethical issues that arise in hospitals is determining the appropriate interventions for a patient who lacks the capacity to participate in the decision-making process regarding their own medical care. Over the past forty years, one of the methods that has been developed to prevent such challenging situations from arising is to complete an advance directive ahead of time, while one is of sound health and mind. Completing an advance directive allows one to give expression to their goals, values, and preferences in relation to their healthcare, or to appoint others to speak on their behalf and to participate in medical decision-making whenever one lacks the capacity to do so—and not only at, or regarding care at, the end of life. Completing an advance directive is thus an opportunity to better ensure that others caring for a patient have a clearer understanding of what matters most to that patient.

Furthermore, such documents may also help protect one’s family from unnecessary stress and guilt, as well as enable healthcare providers to better serve the patient. Without such a document, healthcare providers, who often lack long-term relationships with their patients and are, in

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many ways, strangers to both patients and their families, may have little to rely upon for understanding the deeply held values of their patients.

The necessity of having an advance directive is especially acute for traditionally observant Jews who will want to ensure that Jewish law is followed when determining their course of treatment. Nonetheless, the Orthodox community has had a complex history with such documents and currently offers different models with different approaches. In this essay, we will examine the history of this development and explain a new model that we have developed to address this communal need.<sup>2</sup>

## I. Understanding the Terms

From the outset, it is helpful to distinguish three types of terms and documents used in planning future healthcare decisions, particularly for situations where individuals become unable to participate in decision-making for their own care. While related, each of these advance-planning documents serves a distinct purpose:

1. A **healthcare proxy** (a.k.a. healthcare agent) is someone who has been given legal authority via a specific legal document (known alternatively as a Durable Power of Healthcare form, Medical Power of Attorney form, or Healthcare Proxy form) to participate in medical decision-making on behalf of a patient whenever the patient is unable to do so themselves. As a trusted person who can speak and choose for a patient based on the patient's own instructions or the proxy's understanding of the individual's values, it allows the patient's "voice," so to speak, to be present even when the patient literally is incapable of speaking or participating in medical decision-making; it is not just for end-of-life situations, in other words, but is applicable *anytime* a person is unable to participate in their own healthcare decisions. It is thus called "durable" because it stays in effect as long as the patient is mentally incapacitated (including if permanently so).

2. A **living will** is a written document completed by a person that outlines one's wishes about medical treatment if one is terminally ill or unconscious and cannot communicate. It often specifies what types of life-sustaining treatments one does or does not prefer, such as: CPR, mechanical ventilation, dialysis, and feeding tubes. It only gets implemented when an

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<sup>2</sup> Earlier articles on this topic include Rabbi A. Jeff Ifrah, "The Living Will," *Journal of Halacha and Contemporary Society* 24 (1992) 121–152; Daniel Sinclair, "Patient Self-Determination and Advance Directives," *Jewish Law Association Studies* 8 (2000) 173–181; and Rabbi Chaim Jachter, "Health Care Proxies and Living Wills" in *Gray Matter*, vol. 3 (2008), alongside the articles marked below.

individual is unable to communicate and is in a serious, often end-of-life, condition.

3. An **advance healthcare directive (AHD)** is a broader document that typically includes a living will and appoints a healthcare proxy. It serves as a catch-all term for any document that provides instructions about future medical care. It can include: values and goals statements about quality of life; instructions for specific medical treatments; appointment of a healthcare agent, and other instructions associated with healthcare and healthcare-related considerations, including, but not limited to, end-of-life concerns.

As we will see, distinguishing between these types of documents and their purpose is critical to understand the evolution of the halakhically-sensitive versions that were created.

## **II. Historical Background**

There were many motivations for the creation of healthcare proxy forms, living wills, and, eventually, the more comprehensive advance healthcare directives (AHD), which first began to emerge in the late 1960s but gained greater steam during the late 1970s and early 1980s. In part, the motivation was shaped by changing cultural and social norms in the United States in respect to individual autonomy. This concept—that people have the right to live their lives as they see fit and hence make decisions about their lives based on their own values—became more pronounced in many realms of life. In the case of healthcare, too, it became recognized that patients had a right to provide important input regarding their own healthcare, and that this should continue even if they become incapacitated.

Another motivation was that as medical technology advanced, interventions that could prolong life also raised difficult questions about the “quality of life” and whether the right to provide input about one’s own care also granted individuals the “right to refuse” treatment, including potentially life-saving measures which might also result in significant harms. These documents were developed to help individuals clearly communicate their preferences and relieve loved ones from making agonizing choices without guidance. High-profile legal cases and ethical debates further highlighted the importance of having formal, written expressions of one’s healthcare wishes. Ultimately, these tools sought to empower individuals to make thoughtful, values-based decisions about their own

healthcare and to provide clarity for families and healthcare providers during critical moments of decision-making.<sup>3</sup>

There were, however, many concerns raised with these documents. Some feared they would fail to reflect a patient's true preferences due to vague or overly general language, which can lead to misinterpretation by healthcare providers. Additionally, individuals may have difficulty anticipating future medical scenarios accurately, making it difficult to make informed choices in advance. Or, their values may change over time. There is also concern that the documents may not be accessible or available when needed during emergencies. Some healthcare providers may ignore such documents due to legal uncertainties or personal beliefs. Finally, cultural and emotional factors, such as fear of death or mistrust in the healthcare system, can influence whether people create or adhere to living wills, healthcare proxy forms, and AHDs, limiting their effectiveness.

Nonetheless, in the 1980s, several high-profile stories brought national attention to legal problems of end-of-life healthcare decision-making and helped push the case for having these kinds of documents. The most significant of these was the legal decision delivered in *Cruzan v. Director, Missouri Department of Health* (1990). Nancy Cruzan remained in a persistent vegetative state after a car accident. Her family's request to withdraw life-sustaining treatment was denied by the State due to the absence of "clear and convincing evidence" that doing so would be in line with her wishes. The U.S. Supreme Court upheld Missouri's stance, highlighting the necessity for individuals to document their medical preferences in advance.<sup>4</sup>

The Cruzan and other high-profile legal cases served as part of the motivation that pushed Congress to pass the Patient Self-Determination Act (PSDA) of 1990, which was enacted to address growing concerns about regulating patient autonomy in medical decision-making, particularly in end-of-life care.<sup>5</sup> The PSDA mandated that healthcare facilities receiving Medicare or Medicaid funds inform patients of their rights to accept or refuse medical treatment ("right to refuse") and to create advance directives. By institutionalizing these requirements, the PSDA sought to ensure that patients' healthcare preferences would be known

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<sup>3</sup> For a detailed summary and analysis of these legal developments, see Charles P. Sabatino, "The Evolution of Health Care Advance Law and Policy," *The Milbank Quarterly* 88:2 (2010), pp. 211–239.

<sup>4</sup> The legal analysis is vast. For one approach, see Neil M. Gorsuch, *The Future of Assisted Suicide and Euthanasia* (Princeton, 2006).

<sup>5</sup> Edward J. Larson and Thomas A. Eaton, "The Limits of Advance Directives: A History and Assessment of the Patient Self-Determination Act," *Wake Forest Law Review*, vol. 32, no. 2 (Summer 1997), pp. 249–293.

and respected, thereby reducing ethical dilemmas and legal disputes in critical care situations. Beyond empowering people, some advocates of living wills in particular hoped that these initiatives would reduce the amount of “futile,” “extraordinary,” or “unnecessary” medical treatment provided to the terminally ill, thereby limiting suffering and reducing the spiraling costs of these expensive treatments that provided limited benefits.

By this time, most American states had already created various versions of “living wills” and passed legislation regarding who should serve as a patient’s surrogate and hence be able to participate in decision-making on the patient’s behalf if the patient were incapacitated, in the absence of the patient having a living will. By the end of 1997, every state had also enacted some version of a healthcare power of attorney statute recognizing the legality of a patient formally naming an agent via a healthcare proxy form. Many states, moreover, began to combine living wills and medical power of attorney forms, creating the more complex “advance healthcare directive.”

As the initial proponents of “living wills” asserted, the goal was to treat one’s body somewhat like one’s property. Just as one can determine what should be done with one’s estate after one’s death and/or who should handle it, so too should a person have the right to determine the extent of treatment provided by healthcare providers to their body and/or who should manage those decisions. A “will” is necessary to speak on one’s behalf, whether one is dead (regarding one’s estate) or alive but incapacitated (regarding healthcare directives).<sup>6</sup>

This brief description of the history of these documents helps us bring into relief the issues that *poskim* had to determine regarding the development of “halakhic living wills” which, not surprisingly, first emerged in the first years of the 1990s:

1. Do Jews speak about matters of mortality in advance?
2. Does halakhah recognize some notion of self-determination and the ability of a patient to refuse medical treatment, whether they are conscious and communicative or unconscious and uncommunicative?
3. How should the Jewish community respond to the ongoing legal transformations regarding end-of-life care in America and elsewhere?

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<sup>6</sup> The classic article is Luis Kutner, “Due Process of Euthanasia: The Living Will, A Proposal,” *Indiana Law Journal* (1969), 44:4.

### III. Jewish Religious Motivations and Barriers

Jewish Law requires individuals to put their affairs in order before they die.<sup>7</sup> As the Midrash points out, a person cannot tell the Angel of Death to wait for them while they organize their accounts and leave a testament for their family.<sup>8</sup> For this reason, it was the custom in some Jewish communities that whenever anyone became ill, on the third day of their illness a community representative would tell them, “It is our custom to visit all sick people at this time, so do not let our visit cause you any concern. We advise you to prepare a directive delineating your wishes, including any outstanding obligations you have toward others or vice versa.”<sup>9</sup>

Nonetheless, many people understandably have a difficult time discussing such matters, or think it is some sort of a bad omen (*ayin hara*) to do so. However, there is a traditional Jewish belief that purchasing a burial plot while one is middle-aged and healthy is a charm (*segulah*) for a long life.<sup>10</sup> It thus might be argued that completing an advance directive is one as well. After all, even if it does not actually cause a person to live longer, people who think seriously about the fragility of life are more likely to focus on things that really matter and live their lives to the fullest.<sup>11</sup> Indeed, the Midrash records that the sixth day of Creation is described as “very good,” instead of just “good,” because “good” refers to life, while “very good” refers to death.<sup>12</sup> What is good about death? Rabbeinu Yonah states:

Even death is good, to subdue the soul, that there be fear of God upon the hearts and that they do not make this world into the main

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<sup>7</sup> *Shulhan Arukh*, YD 335:7.

<sup>8</sup> *Devarim Rabbah* 9:3.

<sup>9</sup> *Hokhmah Adam* 151:11.

<sup>10</sup> *Kol Bo Aveilut* 1, p. 174, based on *Va- Yikra' Rabbah* 5:5. See also *Mishmeret Shalom* in the back of *Yoreh Deah* (90:9), which argues that it is not “*tiftach peh la-satan*” (opening one’s mouth to the accuser) if one writes a will at age 50 or later. The same age is quoted in the name of R. Shlomo Kluger, who based it on the verse, “During this Jubilee year, you shall return, each man to his property” (Lev. 25:13), as well as the *Tiferet Yisrael* (end of *Nezikin*, “*Derush Ohr ha-Hayyim*” 4), based on the verse, “And you shall sanctify the fiftieth year” (Lev. 25:10). See also *Ma’avar Yabok*, “*Sifte Tzedeck*,” 8. R. Herschel Schachter reports that when R. Mordechai Gifter celebrated his 50th birthday, he told his family that he had just finished putting together his will. Nevertheless, many recommend filling out an advance directive at a much younger age.

<sup>11</sup> Abraham J. Twerski, *Light at the End of the Tunnel* (Rahway: Shaar Press, 2003), p. 18.

<sup>12</sup> *Beresheet Rabbah* 9:12.

one. But there are people that do not give time to their soul to understand their end, because of their preoccupation with acquisitions of the world... which causes them to die without wisdom, as they did not show wisdom to understand their end, to rectify their souls and prepare provisions for their journey.<sup>13</sup>

Similarly, when *Kobelet* laments that God “put eternity in their mind” (3:11), Ibn Ezra suggests that people improperly act as if they have an eternity to live, which is why they never bother to understand God and spiritual pursuits. This is why the Talmud states that one should repent one day before they die, and since we can never know when that death will come, we should live our entire lives as if it is our last day.<sup>14</sup> “If we were wise, we would understand this, and not fail to consider our own end” (Deuteronomy 32:29).

#### **IV. Halakhic Debate over Personal Choice**

As discussed above, a major factor in the introduction of healthcare proxy forms, living wills, and, eventually, the more comprehensive advance healthcare directive (AHD) in American society was the growing belief that honoring personal autonomy is the highest expression of respect for another person.<sup>15</sup> Indeed, secular medical ethics places tremendous value on personal autonomy and rights. Halakhically, this raised concern because Jewish law imposes numerous obligations and requirements upon a traditionally observant Jew, teaching that we are guardians, not owners,

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<sup>13</sup> *Sha'arei Teshuvah* 2:25.

<sup>14</sup> *Shabbat* 153a. Similarly, *Berakhot* 5a suggests remembering one's day of death as a method of preventing sin. See also Ecclesiastes 9:12; Rambam, *Mishneh Torah*, *Hilkhot Teshuvah*, 7:2.

<sup>15</sup> J. David Bleich, *Bioethical Dilemmas: A Jewish Perspective*, 75 (alongside sources discussed below) (Ktav, 1998).

over our bodies,<sup>16</sup> thereby limiting personal autonomy and self-determination.<sup>17</sup>

Nonetheless, there are circumstances where Jewish law does not prescribe specific actions, such as choosing to engage in certain experimental treatments or choosing between two permissible options. In these cases, there is some room for personal choice and individual preference. For example, Rabbi Shlomo Zalman Auerbach notes that some believe that a dying patient has no choice to forgo even a moment of life. That said, he also notes that if such a patient is suffering, although they must receive routine nutrition, hydration, and oxygen—even against their will—the patient may decline medical interventions that exacerbate their suffering *if the patient makes such a request*.<sup>18</sup> A similar, very common example is Rabbi

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<sup>16</sup> See *Shulhan Arukh Ha-Rav*, H̄M, *Hilkhot Nizkei Guf Ve-Nefesh* 4: “One may not strike another, even if given permission to do so, because a person has no ownership whatsoever over his body, to strike it.” See also Rambam, *Hilkhot Rotze’ah U-Shemirat Ha-Nefesh* 1:4. Radbaz (*Sanhedrin* 18:6) writes, “A person’s soul [life] is not his possession, but rather the possession of the Holy One, Blessed be He, as it is written, ‘And all the souls are Mine.’” *Shulhan Arukh*, H̄M 427:10, and *Be’er Ha-Golah* 90 explain that God put each individual in the world for a reason, and one who does not take his life seriously shows disregard for God’s will and commandments. See S.Y. Zevin, “The Case of Shylock,” in *Le-Ohr Ha-Halakhah* (Beit Hillel, 1988), 318–28. On the other hand, R. Shaul Yisraeli maintains that a person does have certain rights over their body, in partnership with God (Yisraeli, *Ha-Torah Ve-Ha-Medinah* 5–6 (1953–54), 106–10 and *Amud Ha-Yemini* 16, 16ff). Indeed, some rabbinic thinkers have pointed out that just as there is a need for subordination to God’s authority, Judaism also encourages an ideal of some personal autonomy, creativity, and individuality as vital to authentic religious life (R. J.B. Soloveitchik, *Halakhic Man* (Jewish Publication Society, 1984), 78–82. See A. Ozarowski, “Rabbi Soloveitchik on Autonomy and Submission,” *The Torah u-Madda Journal* (17/2016–17), 150). Some differentiate between “hard personal autonomy,” which Judaism rejects, versus “soft personal autonomy,” which Judaism accepts (Moshe Sokol, “Personal Autonomy and Religious Authority,” in *Rabbinic Authority and Personal Autonomy* (Jason Aaronson, Inc., 1992), 169–216. See also Jacob J. Schacter, “Halakhic Authority in a World of Personal Autonomy” in M. Harris, D. Rynhold, and T. Wright (eds.), *Radical Responsibility*, (Maggid Press, 2012), 155–76.

<sup>17</sup> See *Magen Avraham*, OH 328:6, and R. Yaakov Emden, *Mor U-Ketziah*, OH 328, for a classic example of a scenario in which an individual may be compelled to undergo a medical procedure against their wishes. See also *Iggerot Moshe* YD 3:36 and Rabbi Prof. Avraham Steinberg, *Ha-Refuah Ke-Halakhah* vol. 1, pp. 161–4 & vol. 6, p. 348.

<sup>18</sup> *Minbat Shlomo* 1:91(24). For more examples of R. Auerbach’s medical rulings that decisions should be made with the consent of the patient, see *Assia* 3 (5743), 323–5 (republished in *Berakhah Le-Avraham*, 135).

Moshe Feinstein's ruling regarding resuscitation orders. Rav Feinstein rules that attempting resuscitation<sup>19</sup> is not required for a terminal patient who is dying and suffering if the patient *does not want* to undergo this painful intervention that will not cure them.<sup>20</sup> Rabbi Feinstein similarly argued that we cannot force-feed a patient with artificial nutrition and hydration *if they do not want it*.<sup>21</sup>

Many contemporary *poskim* have similarly ruled that if an individual with a terminal illness is suffering, the obligation to save them depends upon their own wishes. If they desire to continue living despite their suffering, we must intervene and attempt to save them. However, if their suffering is so severe that they feel death would be preferable to continued life, they may be passively allowed to die, and no one is required to actively intervene to save their life.<sup>22</sup> If we are unable to determine the patient's wishes, these *poskim* rule that we are not obligated to request aggressive interventions, because we assume that the patient would not want a life of suffering to be prolonged.<sup>23</sup>

Patient preferences can thus play a crucial role in highly consequential medical decision-making for a traditionally observant Jew, especially for those who follow the approaches of Rabbi Feinstein and Rabbi Auerbach. Therefore, as long as an AHD is filled out in accordance with Jewish Law and the patient appoints a knowledgeable rabbi to be contacted, not only is it *not* problematic to complete an AHD, but it can *help ensure* that a person is treated in accordance with Jewish Law.<sup>24</sup> For situations in which these leading *poskim* take into account patient preference, it is essential for family members to be aware of that individual's preferences. This point, in fact, seems to be made by Rabbi Feinstein explicitly:

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<sup>19</sup> *Iggerot Moshe*, YD 2:174(3). See also CM 2:74(1).

<sup>20</sup> *Iggerot Moshe*, IHM 2:75(1).

<sup>21</sup> *Iggerot Moshe*, IHM 2:74(3).

<sup>22</sup> Rav Asher Weiss, *Shu"t Minbat Asher* 1:117; Rav Zalman Nechemiah Goldberg, *Moriah* 4–5:88–9, (Elul 5738), 48–56; Rabbi Moshe Sternbuch, *Shu"t Teshuvot Ve-Hanhagot* 6:300; Rav Eliyahu Bakshi Doron, *Shu"t Beit Av* 5:67; Rabbi Hershel Schachter, "Elav Hu Nose et Nafsho," *Beit Yitzhak* (New York, 5746), pp. 104–108; Rabbi Mordechai Willig, *Am Mordechai al Daled Helkei Shulhan Aruch, Siman* 60, pp. 311–312. See also Rav Hayyim Kanievsky, as printed in Rabbi Yosef Aryeh Lorentz, *Mishnat Pikuach Nefesh* (5785 version), vol. 1, pp. 54–55 and vol. 2, pp. 972–973 (*siman gimel*), following the ideas developed by his father, Rav Yaakov Kanievsky (the Steipler Gaon), in *Kariyana De'igarsa* #190.

<sup>23</sup> Rabbi Moshe Sternbuch, *Teshuvot Ve-Hanhagot* 6:300.

<sup>24</sup> *Nishmat Avraham*, YD 339:1(10) (p. 511 in 3rd ed.) and CH 252:2(1) (p. 67 in 3rd ed.); Ifrah, "The Living Will," 129, n. 25; Steinberg, *Ha-Refuah Ke-Halakhah*, vol. 6, pp. 350–3, 366.

In a case where a person is suffering and there is no known cure—even to alleviate the suffering—for such a situation, people often prefer death over a life filled with such suffering... It seems logical that there is no obligation to provide medical treatment to such a patient **if he does not want treatments that merely prolong a life of suffering**. Even in cases where the patient's opinion is unknown, we may presume that he does not wish it, and there would be no obligation to treat him. However, **in the vast majority of cases, the patient has relatives—such as parents, siblings, and others—who are involved in his care, and [the decisions] are incumbent upon them under legal standards.**<sup>25</sup>

On the other hand, for those *poskim* who do not believe that individual preference plays an important role, as noted below, then it also becomes critical to express to the healthcare team that patient choice is less important in the decision-making process for that patient.

It may well be suggested, therefore, that it is an imperative that every traditionally observant Jew complete some form of an AHD to ensure that they will be treated in accordance with Jewish Law.<sup>26</sup> Some halakhic authorities have even argued that every responsible rabbi should have one to serve as a role model.<sup>27</sup> This has become particularly true since many American hospitals now expect and strongly encourage that every patient complete some form of proxy or directive; therefore, it becomes an imperative to utilize a document that is halakhically sensitive. The question that remains, however, is what sort of material should be included in a halakhic advance directive.

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<sup>25</sup> *Iggerot Moshe* HM 74:2(2), emphasis added.

<sup>26</sup> Chafetz Chaim writes (*Shem Olam* 1:7) that the *mishnah*, “If I am not for myself, who will be for me?” is a command to write a will, for if one does not choose for themselves, others will not choose properly for them (he also writes about the importance of having a will in *Abavat Hessed* 3:4). Some have argued that the model of King David preparing the nation and his son Solomon for his impending death (I Kings 2:1–12) is a precedent for the need for everyone to set their affairs in order and not assume that one's children will simply act as one expects. Others cite the model of Jacob's requests and wishes for his children as additional precedent (Gen. 47:28–49:33). See also *Pirkei D-Rebbi Eliezer* 52 that Jacob prayed to God to create illness so that people could receive a warning before dying to afford them the opportunity to share their desires with their family.

<sup>27</sup> R. Feivel Cohen, quoted by R. Chaim Jachter, in his chapter “Estate Planning, Health Care Proxies and Living Wills,” available online and republished in his *Gray Matter*, vol. 3.

## **V. Major Approaches and Different Models**

In light of this discussion, we can now understand the two major approaches taken to advance healthcare directives in the Jewish community during the early 1990s:

### **A. Halakhic Proxy-Only Model**

One approach was to assert that a “halakhic living will” is an oxymoron. The will of a Jew should always be to live. Moreover, the notion that a person has ownership over their body and the “right” to choose for themselves to withhold certain interventions due to poor “quality of life” is foreign to Jewish thought.

This position was taken, most explicitly, by UK Chief Rabbi Immanuel Jakobovits, one of the pioneers of the field of Jewish medical ethics.<sup>28</sup> He was queried by his brother-in-law, Rabbi Max Munk of New York, with regard to whether a patient with Alzheimer’s disease could sign a living will “to prevent artificial prolongation of life in agony and pain.” In his reply, Rabbi Jakobovits rejected any reference to “quality of life” in halakhic literature.

I believe in the Jewish view this has no bearing on the value of life which is absolute and infinite, and certainly not subject to assessment by the patient or anyone else.... I believe the whole notion of a “Living Will” is alien to Jewish thought and law... The Jewish imperatives on saving life (or allowing it to expire under certain circumstances) are incumbent equally on patient, doctor, rabbi, and friends. Of these, the patient is obviously the least objective, being the most interested party... The wishes previously expressed by the patient have no bearing on this decision, since no one can dispose of his own life any more than of anyone else’s. The difficult judgment should be as objective, dispassionate, and personally disinterested as possible, and this may exclude even the closest relatives from having a decisive say.<sup>29</sup>

Rabbi Jakobovits further questioned whether a person can make such decisions in advance while they are in good health, and suggested that it is best for next-of-kin to consult with rabbis and doctors at the time that

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<sup>28</sup> Immanuel Jakobovits, *Dear Chief Rabbi*, ed. Jeffrey Cohen (Hoboken: Ktav 1995), p. 184–189. The correspondence is dated Spring 1990.

<sup>29</sup> *Dear Chief Rabbi*, p. 188.

decisions would need to be made. He further worried that advance directives would create an “excuse” to prematurely suspend treatment even when a doctor was inclined to continue medical interventions.<sup>30</sup>

Another proponent of this view was Rabbi J. David Bleich of Yeshiva University. He asserted, “Judaism cannot sanction a ‘living will’ or the provisions of legislation such as the various versions of the Natural Death Act which have been enacted by a number of state legislatures...**Nor, in the final analysis, does the desire of the patient to have, or not to have, his or her life prolonged play a role in the halakhic obligation to initiate or maintain life-sustaining procedures.**”<sup>31</sup>

A similar position was taken by Rabbi Dr. Abraham S. Abraham. Yet he added that if someone wishes to write an advance healthcare document, then it should only be done to clarify which rabbi should make these decisions.

If one does wish to write such a will, it must contain only the statement that: “In the event of my being unable to participate in decisions of life and death concerning myself, I appoint Rabbi... who will make all such decisions for me and who must be consulted at each step of my illness and for each separate decision, and his decision will be binding on all my caregivers as if they were mine...”<sup>32</sup>

In fact, this suggestion was, more or less, adopted by the Agudath Israel of America (“the Agudah”). The Agudah initially opposed the introduction of healthcare proxies in New York and elsewhere, arguing that the law should not provide for such extensive self-determination in healthcare and that potential for abuse of the agent’s decision-making authority was too great. Yet once these laws were passed, it created in 1990 a “Halakhic Health Care Proxy” that would allow a person to use their liberty to express their desire to follow Jewish law even when they were

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<sup>30</sup> Similar reservations are expressed in Fred Rosner, “Jewish Perspectives on Death and Dying,” *Jewish Medical Ethics*, vol. 2, no. 1 (January 1991), p. 43–44, which originally appeared in the *Journal of Halacha and Contemporary Society* (1986?).

<sup>31</sup> See J. David Bleich, “Treatment of the Terminally Ill,” *Tradition*, vol. 30, no. 3 (Spring 1996), pp. 61–62, emphasis added. His opposition to “living wills” was already expressed in his “Legal Immorality, Not Personal Freedom,” *Shma* (April 15, 1977), pp. 101–102. See also his “The Quinlan Case: A Jewish Perspective,” reprinted in Fred Rosner & J. David Bleich, *Jewish Bioethics*, p. 270 (Hebrew Publishing Company, 1979).

<sup>32</sup> *Nishmat Avraham, Yoreh Deah Siman 339:1, Ot Daled #10* (3rd edition, p. 511). The translation comes from the English version, p. 326.

unconscious and even after their death.<sup>33</sup> The “Agudah model” essentially is a proxy model to designate their healthcare agent (and an alternative in case the primary agent was not available). Yet it also includes a religious-based “directive” that all decision-making should be done in accordance with Jewish law and custom.<sup>34</sup> It further directs the agent to “consult with and follow the guidance of a designated” Orthodox rabbi in ascertaining the requirements of Jewish law.

As the Agudah’s executive director explained in an oft-cited article,<sup>35</sup> the Agudah model explicitly chose not to:

- 1) Tell individuals which rabbis or organizations they should choose to serve as halakhic consultants/decisors. Each person must choose their own rabbi, keeping in mind the necessary halakhic competence to address these weighty matters.
- 2) Spell out precisely what types of procedures, under what types of circumstances, should or should not be undertaken as a matter of Jewish law. As Rabbi Zwiebel put it, “The range of halakhic issues was too great, the changes in medical technology too rapid, the *she’eilos* too dependent upon individual circumstances, to presume to identify in advance the precise course of action to be taken under all future hypothetical situations. Rather than engage in such a speculative and possibly misleading exercise, the Moetzes Gedolei HaTorah felt that the form should simply provide a mechanism that would ensure that *she’eilos* would be posed in whatever circumstances may eventually arise.”

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<sup>33</sup> Chaim Dovid Zwiebel, “The ‘Halachic Health Care Proxy’: An Insurance Policy with Unique Benefits,” *The Jewish Observer*, September 1990, pp. 11–21, available online at JLaw.com and many other websites. Notably, the cover of the issue read, “Whose Plug Is It Anyway? The Torah Answer to the Living Will.” Support for this approach can also be found in “A Letter from Dr. Yoel Jakobovits” (son of Rabbi Immanuel Jakobovits) published in *The Jewish Observer*, October 1991, pp. 14–15. The Agudah’s proxy was reportedly composed by Rabbi Bleich, who is also a professor of law. See Steinberg, *Ha-Refuah Ke-Halakhah*, vol. 6, p. 351 fn. 52.

<sup>34</sup> On religious directives in American law, see Michael A Grodin, “Religious Advance Directives: The Convergence of Law, Religion, Medicine, and Public Health,” *American Journal of Public Health* 83 (1993) and Richard L. Kaplan, “Religion and Advance Medical Directives: Formulation and Enforcement Implications,” *University of Illinois Law Review* (2016), pp. 1737–1748.

<sup>35</sup> Zwiebel, “The ‘Halachic Health Care Proxy’: An Insurance Policy with Unique Benefits.”

In short, pick your proxy and direct them to follow the guidance provided by your rabbi in determining what halakhic decisions must be made. When dilemmas arise, they will be legally empowered to handle the situation. There is little more that a person *can* do, as patients cannot know the future of their healthcare or the options that will be offered to them, and there is little more that a person *should* do, since halakhah requires case-by-case decision-making based on the circumstances presented to a *posek* whom the person has chosen.<sup>36</sup>

#### B. “Halakhic Advance Directive” Model

A different approach to “living wills” was taken by Rabbi Dr. Moshe David Tendler, a *rosh yeshiva* at Yeshiva University and the son-in-law of Rabbi Feinstein. Rabbi Tendler had previously expressed reservations regarding these documents. In a 1977 symposium, written in response to California’s “Natural Death Act” that created the first state living will, Rabbi Tendler questioned many of the ethical assumptions motivating the creation of living wills.<sup>37</sup> In particular, he challenged that a person always

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<sup>36</sup> On a legal level, problems may emerge if the AHD is formulated for the rabbi to have the final say. Some halakhic living wills include expressions such as “In determining the requirements of Jewish law and custom in connection with this declaration, I direct my agent to consult with the following Orthodox Rabbi and I ask my agent to follow his guidance.” Such a formulation, however, leaves ambiguous (perhaps purposely) who has the final call in decision-making: the power of attorney or the designated rabbi with whom the POA is directed to consult? This ambiguity gets further strengthened in versions which include a clause that if the designated rabbi or alternate rabbis are not available, then the agent is directed to “consult and follow” the guidance of a rabbi whom the “agent in good faith believes I would respect and follow.” The impression is that the agent is not really authorized to make such decisions on their own. In fact, one lawyer shared with us that a hospital made a designated rabbi travel to the medical center and sign an authorization form because they felt the rabbi was actually the final arbiter. Several healthcare and estate attorneys, in different states and countries, have suggested to us that the enforcement of such a directive could be challenged based on this ambiguity. The Ematai directive, discussed below, was formulated to protect against such a legal challenge. It crucially includes a repeated directive for all decision-making to be done in accordance with Jewish law and custom while further advising the proxy which rabbi to consult with regarding such matters. The proxy is explicitly designated as the authority to sign off on all decisions.

<sup>37</sup> See Moshe D. Tendler, “Torah Ethics Prohibit Natural Death,” *Shma* (April 15, 1977), pp. 97–99. This is reprinted in his *Pardes Rimonim: A Manual for the Jewish Family* (Ktav, 1988), pp. 92–94.

has a “fundamental right” to determine their healthcare, which he feared would quickly lead to legitimizing suicide or legalizing active euthanasia.

Nonetheless, he acknowledged that there are times, such as when a patient is terminally ill and in intractable pain, that the withholding of medical interventions may be appropriate. At this stage, continued treatments may only postpone death, as opposed to prolonging life. As discussed above, such an attitude is consistent with Rabbi Feinstein’s approach to these issues. Thus a decade later, when queried by Rabbi Munk about a living will and healthcare proxy document, Rabbi Tendler argued that these are halakhically permissible, provided that they include two important provisions:<sup>38</sup>

- 1) The advance directive does not include any options that contravene halakhah, i.e., no decision that constitutes active euthanasia is permitted. In his view, this includes the provision that hydration and nutrition may not be withheld or withdrawn, since “failure to provide food and water to a dying patient is viewed, halakhically, as active, not passive, euthanasia.” Otherwise, the advance directives may include decisions regarding: “CPR, surgical procedures, ventilators, balloon pumps, haemo- and peritoneal dialysis, pacemakers, vasopressors drugs, blood transfusions.”
- 2) The living will includes a provision for the input of one’s *rav* or *posek*, who should approve the decision to prepare a living will and further “serve as part of check/balance controls.”

In the face of the federal mandate to provide living will options, the medical ethics commission of the Rabbinic Council of America, which was chaired by Rabbi Tendler, created a living will that was adopted by the RCA in 1991. The document has two parts: A proxy / durable power of attorney form and an advance directive.<sup>39</sup> The document includes several notable elements. This includes:

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<sup>38</sup> *Dear Chief Rabbi*, p. 187.

<sup>39</sup> The original draft disseminated by the RCA included an “A” option which was only a “healthcare proxy” and a “B” option that included both a “detailed directive” and “durable power of attorney.” Rabbi Tendler indicated that he anticipated that most people would use the A option (i.e., only designate a proxy) and that the B option was available for utilization in consultation with a rabbi. See his letter printed in *The Jewish Observer*, October 1991, p. 14. This, and other elements of the initial draft, including a chart system to indicate one’s directives, apparently created some confusion. In updated versions, the A and B options were eliminated. Instead, the draft simply offered the “appointment of a health

- 1) A provision that requires the concurrence of a designated rabbi with decisions made by the healthcare agent, who should be consulted before any decisions are made, in the event that an advance directive has not been issued on the stated matter. Furthermore, “the rabbi’s decision shall govern my agent and my doctors.”
- 2) The obligation for foods and liquids to be given (i.e., the agent cannot make decisions on those matters). As the RCA explained in a supplementary “background information” sheet (seemingly written by Rabbi Tendler), “the consensus of most *poskim*” is that water and food are not medical treatments that can be withheld in certain circumstances.
- 3) A default directive that authorized posthumous organ donation for transplantation. As the “background information” sheet explained, this was in accordance with Rabbi Tendler’s understanding of Rabbi Feinstein’s acceptance of “brain-stem death” as the halakhic criterion for death, which had also been recently affirmed by the Israeli Chief Rabbinate. In a supplementary letter dated July 1, 1991 the RCA’s president, Rabbi Marc Angel, acknowledged that many *poskim*, including members of the RCA’s own Vaad Halacha Commission, do not accept “brain death” and do not permit posthumous organ donation. For those members who follow that position, he recommended that they utilize the Agudah model.
- 4) A detailed section in which a person may (but is not required to) direct medical treatment preferences under four different conditions:
  - (a) irreversible coma or vegetative state,
  - (b) coma with minimal recovery chances,
  - (c) irreversible brain damage with terminal illness, and
  - (d) irreversible brain damage without terminal illness.
 For each scenario, it asks whether the person wants or does not want specific life-sustaining interventions such as CPR, mechanical breathing, major surgery, kidney dialysis, chemotherapy, invasive tests, blood products, antibiotics, simple diagnostic tests,

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care agent / advanced directive,” i.e., an AHD that includes both a proxy and a directive. For a copy of this version, see <https://hods.org/pdf/Living%20Will%20RCA.pdf>. This version of the AHD, however, eliminated the original option offered by Rabbi Tendler for people to just sign a religious healthcare proxy.

and pain medication. One must then check the appropriate section “I want” or “I do not want.”

This “detailed directive” section was modeled after a similar form widely publicized in the *Journal of American Medical Association* (JAMA) two years beforehand.<sup>40</sup> The “background information” sheet includes Rabbi Tendler’s suggested answers while noting that a rabbi may think that these situations require different types of required halakhic responses. It further stated that it is incumbent upon rabbis to familiarize themselves with the halakhic opinions regarding such treatments as their congregants would inevitably be asking their queries, whether when filling out these directives or during a medical episode.

Another option was created in 1999 by Rabbi Maurice Lamm, author of the well-known *Jewish Way in Death and Mourning* and founding chairman of the National Institute of Jewish Hospice (NIJH). The NIJH released its “Jewish living will” which contained two sections:

- 1) A required proxy form, which included a section that all healthcare decisions “shall be made in accordance with Jewish tradition. In order to effectuate my wishes, if any question arises as to the requirements of Jewish tradition, I direct my agent to consult with Rabbi...”
- 2) An optional advance healthcare directive, specifying their wishes for withholding or continuing life-sustaining treatments under various medical conditions, such as terminal illness, persistent vegetative state, severe brain damage, or lengthy coma. In each case, the person directs whether treatments like CPR or surgery should be withheld or continued, and that pain medication should be administered even if it may shorten life.

Significantly, the second section acknowledges that future medical scenarios may differ from what was imagined at the time the section was completed and hence entrusts the proxy to act in the spirit of the stated preferences. As such, the directives contained therein are in fact only “an indication of feelings” as medical technology may advance far beyond current procedures and “I may not be aware of them and their implications.” It therefore requests the proxy to make decisions in the spirit of the stated preferences and to consult a rabbi regarding questions of Jewish law.

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<sup>40</sup> See Linda Emanuel and Ezekiel Emanuel, “The Medical Directive: A New Comprehensive Advance Care Document,” *JAMA* 1989 261(22), pp. 3288–3293. See also Ezekiel J. Emanuel and Linda L. Emanuel, “Living Wills: Past, Present, and Future,” *The Journal of Clinical Ethics* 1, no. 1 (Spring 1990): 9–19.

These caveats capture the problematic nature of advanced healthcare directives. As legal directives, they are meant to be binding, but the person cannot truly anticipate the medical options that will be before them or their preferences at that time. As such, they actually only want to communicate the general spirit of their wishes, including their desire to follow Jewish law. Yet once one has signed a legally-binding boilerplate directive, healthcare providers are now bound to follow the orders as expressed in writing. This is a significant point which will be addressed further below.

In 2005, an advance healthcare directive was approved under Israeli law through the leadership of a committee headed by Rabbi Prof. Avraham Steinberg, director of bioethics at Shaare Zedek Medical Center, author of the *Encyclopedia of Jewish Medical Ethics*, and one of the primary recorders of the halakhic positions of Rabbi Auerbach and others. Under the “Dying Patient Law,” a person may designate their healthcare agent and elect, in advance, to forgo a number of medical interventions. This is under the explicit provision that a person has received a terminal diagnosis with life expectancy being six months or less.<sup>41</sup>

This terminal diagnosis is a critical element as it allows the person signing the document to have a better perception of a concrete, future scenario: when they are deemed as terminally ill with less than six months to live. The interventions about which one can express a preference include dialysis, surgeries, resuscitation, intubation, chemotherapy, and a range of other treatments.<sup>42</sup> The “Dying Patient Law” directive does not allow for advance directives to stop nutrition and hydration or for palliative extubation as these are prohibited under Israeli law, based on the influence of halakhah.<sup>43</sup>

An alternative official “abridged version” of the “Dying Patient Law” directive allows for a person to designate their proxy and includes a very

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<sup>41</sup> It should be noted that unlike in America, where the Patient Self-Determination Act allows many forms of advance directives, Israeli law requires someone to use the official form. A similar regulation applies in the UK as well. For a halakhic guide to complete a Lasting Power of Attorney in the UK and Israel, see [ematai.org/netivot](http://ematai.org/netivot).

<sup>42</sup> For an attempt to provide halakhic guidance on how to complete the official Israeli form, see chapter twenty of Tzohar’s *Ad Me’ab Ve-Esrin* initiative, available online.

<sup>43</sup> See, most recently, Rabbi Avraham Steinberg, *Ha-Refuah Ke-Halakhah*, vol. 6, part 10, pp. 350–352 and pp. 397–405. See also Steinberg, “The Halakhic Basis of the ‘Dying Patient Law,’” *Assia* 71–2 (2003), pp. 25–29. See also A. Steinberg and C. Sprung, “The Dying Patient: New Israeli Legislation,” *Intensive Care Medicine* 32 (2006), pp. 1234–1237.

short optional advance directive section regarding only resuscitation and intubation. It also allows the option for the agent to override this limited directive which, again, only applies when a person is diagnosed with less than six months to live.<sup>44</sup> This particular form is recommended by Ematai for use in Israel.

## **VI. Problems with “Halakhic Living Wills” and the Transition to Conversational Model**

When released, the initial 1991 RCA model created by Rabbi Tendler caused a bit of a controversy with regard to its absolute stance regarding “brain-stem death” and posthumous “organ donation.”<sup>45</sup> Some challenged whether Rabbi Feinstein and others actually supported the brain-death criterion.<sup>46</sup> Others more broadly questioned the wisdom of creating a form that took sides in an ongoing halakhic debate, thereby precluding the form’s use by many of the RCA’s own members. Besides the dispute over organ donation, some further challenged the rulings within the document as even the question of stopping artificial nutrition and hydration can, in limited circumstances, be a matter of halakhic debate. For example, Rabbi Zev Schostak, longtime director of pastoral care at the Gurwin Jewish Nursing and Rehabilitation Center in Commack, cited rulings of Rabbi Dovid Feinstein, Rabbi Chazkel Horowitz (the Viener Rav), and Rabbi

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<sup>44</sup> An approved Hebrew-English version of this document can be found at [ematai.org/netivotil](http://ematai.org/netivotil). We strongly recommend that a person also complete our Hebrew or English conversation guide (discussed below) and include on this their preference for which rabbi should be consulted since there is no section allowing for this on the official Israeli directive. Israeli law also provides for a “Tofes D, Continuous Power of Attorney” form that governs healthcare decision-making but not questions relating to patients who have received a terminal diagnosis with less than six months to live.

<sup>45</sup> The controversy is discussed in the article of then-RCA president, Rabbi Marc Angel, “The RCA Health Care Proxy: Providing Responsible Halachic Leadership to Our Community,” *Jewish Action* (Spring 1992) pp. 60–62 and Rabbi Yitzchok Breitowitz, “The Brain Death Controversy in Jewish Law” in that same issue. See also “For the Record: The 1991 Health Care Proxy,” including interviews with Rabbi Angel and Rabbi Binyamin Walfish, published in *Halakhic Realities: Collected Essays on Organ Donation*, ed. Zev Farber (Maggid Books, 2017), pp. 235–240.

<sup>46</sup> See Rabbi Chaim Dovid Zwiebel, “A Matter of Life and Death: Organ Transplants and the New RCA ‘Health Care Proxy,’” *The Jewish Observer* (Summer 1991), pp. 11–14.

Hershel Schachter (a member of the RCA's Vaad Halakhah) as contending that nutrition and hydration may, in certain circumstances, be withheld.<sup>47</sup>

In 2009, the RCA released a revised healthcare proxy which adopted, with explicit acknowledgement, the Agudah model: a proxy designation along with a general directive that the agent follow Jewish law in consultation with the designated rabbi. The option of an advance directive was removed. An explanation was offered in the RCA's press release:

The document does not stipulate particular treatments or situations, and does not attempt to anticipate medical conditions or responses that may arise. Few people are able to anticipate such detailed developments that may or may not occur many years in the future. By designating trusted parties to act in one's stead in case one is personally unable to do so, one allows for reasonable decisions by one's agent, in consultation with an informed rabbi, under all situations.<sup>48</sup>

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<sup>47</sup> Rabbi Zev Schostak, "Is There Patient Autonomy in Halacha?" *ASSLA – Jewish Medical Ethics*, vol. II, no. 2 (May 1995), pp. 22–27. Rabbi Schostak asserts that there are times when Rabbi Moshe Feinstein (*Iggerot Moshe* *HM* 2:74:3) would not require feeding a patient against their wishes. He further documents his claim in Rabbi Z. Schostak, "Precedents for Hospice and Surrogate Decision-Making in Jewish Law," *Tradition*, vol. 34, no. 2 (Summer 2000), pp. 40–57, which reports oral rulings from Rabbi David Feinstein. See in particular footnote 46, in which Rabbi D. Feinstein instructed in certain circumstances that artificial nutrition and hydration may be discontinued by simply not refilling the bag with solution and/or nutrients. In this manner, one converts a *kum va-aseh* (an act of commission, withdrawal) into a *shev ve-al ta'aseh* (an act of omission, withholding). Rabbi Schostak also reports this position is held by Rabbi Chazkel Horowitz, the Viener Rav, and Rabbi Hershel Schachter of Yeshiva University. See the latter's 1986 responsum written to Rabbi Maurice Lamm, "*Elav Hu Nose et Nafsho*," published in *Beit Yitzhak* (New York, 5746), pp. 104–108. See also, more recently, R. Schachter and R. Mordechai Willig, "Decision-Making in Acute Critical Illness: A Rabbinic Postscript," *Tradition* 53:1, pp. 94–96, republished in Hebrew in *Tehumin*, vol. 44 along with a response by R. Tzvi Arnon and R. Ariel Vider. This complex and controversial topic of artificial nutrition and hydration goes well beyond the scope of this article. The point is only to note that the RCA model of Rabbi Tendler was taking absolute stances on matters which have a certain amount of halakhic debate in some circumstances.

<sup>48</sup> Available at <https://www.torahmusings.com/2009/08/rca-publishes-revised-halachic-health/>.

Additionally, reference to brain-stem death and organ donation was removed. As the RCA wrote in its supplementary guide, halakhic discussions regarding these matters are “varied and complex” and best left to individual consultation with one’s rabbi.<sup>49</sup>

The RCA’s shift away from advance directives followed the growing recognition in medical circles that living wills do not succeed in their intended goals.<sup>50</sup> During these years, a growing amount of research indicated that advance directives were having relatively little impact on end-of-life decision-making. This included:

- Too few people used legal tools at all and when they did, their healthcare providers did not have access to them.
- People did not understand the forms or the future decisions that they were making.
- The forms provided insufficient guidance and people preferred to give substantial leeway to their surrogate decision-makers.
- Patients’ goals and preferences regularly changed.
- The agent or proxy rarely understood the wishes of the principal.

As noted earlier, acknowledgement of similar problems were embedded in the living will model created by Rabbi Maurice Lamm: advance healthcare directives are frequently a way in which people are trying to communicate their decisions for future circumstances that they cannot fully foresee. Moreover, the documents follow a “legal transactional approach” to create rights and obligations over their body as if they were distributing their property.

Given these, and the other problematic issues which have been discussed above regarding advance healthcare directives, it may be concluded that what is needed is a wholly different approach to advance healthcare planning that may be called a “communications approach.” This approach, which is less legally focused, promotes discussions with family members and physicians about what the future might bring for people with illnesses; how patients would want their beliefs and preferences to guide the decisions; and what measures can be taken to alleviate stresses regarding finances, spiritual matters, family dynamics, and other concerns

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<sup>49</sup> The short “halakhic guidelines” sheet, drafted by Rabbi Dr. Aaron Glatt, is available at <http://rabbis.org/wp-content/uploads/2018/11/RCA-End-of-Life-Decisions-Guidelines.pdf>.

<sup>50</sup> See, for example, the prominent Hastings Center Report by Angela Fagerlin and Carl E Schneider, “Enough: The Failure of the Living Will,” *Hastings Cent Report* 2004 Mar–Apr; 34(2):30–42. See also Anne Wilkinson et al., “Literature Review on Advance Directives” (Rand Corporation, 2007).

of patients and families.<sup>51</sup> In short, there is much that can be done with “advance planning” that is not the same as providing “advance directives” in the strict sense of the term.<sup>52</sup>

## VII. Creating a Halakhic “Conversation Guide”: The Ematai Healthcare Directive and Conversation Guide

As the Agudah/RCA healthcare proxies became the norm in the Orthodox community, anecdotal evidence suggested that many individuals felt they lacked adequate space to describe their personal goals and preferences when utilizing these forms. Consequently, many rabbis and surrogates struggled to discern individuals’ specific preferences when guidance was needed. This represented a missed opportunity to support vulnerable patients in properly observing Jewish law and ensuring their personal preferences were respected at the end of life. Some rabbis suggested that congregants write a brief document outlining their healthcare goals and preferences and attach it to the Agudah or RCA healthcare proxy. While beneficial, without guiding questions to prompt individuals on describing their preferences clearly, these personal statements often lacked clarity and utility for rabbis and surrogates. Additionally, as discussed earlier, engaging in meaningful conversations with family members and rabbis about these difficult issues can be tremendously valuable, yet doing so without structured guidance can be challenging.

A traditional advance directive could theoretically fill this gap. However, simply listing various medical interventions and options when one is not actively facing a health crisis, particularly given the rapidly advancing nature of healthcare, proved ineffective. Experience suggested which types of questions were most likely to arise, but these guiding questions needed to be simple, and the stakes lowered, to encourage productive

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<sup>51</sup> For examples of this approach, see J.A. Rolnick, D.A. Asch, and S.D. Halpern, “Delegalizing Advance Directives—Facilitating Advance Care Planning,” *New England Journal of Medicine* 376, no. 22 (June 1, 2017): 2105–2107; V.L. Bartlett and S.G. Finder, “An Actual Advance in Advance Directives: Moving from Patient Choices to Patient Voices in Advance Care Planning,” *Asian Bioethics Review* 2018:10, pp. 21–36; and Laura Vearrier, “Failure of the Current Advance Care Planning Paradigm: Advocating for a Communications-Based Approach,” *HEC Forum* 28 (4):339–354.

<sup>52</sup> See, for example, CL Auriemma et al., “How Traditional Advance Directives Undermine Advance Care Planning: If You Have It in Writing, You Do Not Have to Worry About It,” *JAMA Intern Med.* 2022; 182(6):682–684. For skeptics of advance care planning, see Sean Morrison, Diane Meier, and Robert Arnold, “What’s Wrong with Advance Care Planning?,” *JAMA Network*, October 2021.

conversations rather than binding, legally definitive decisions on complex issues.

In response to the concerns mentioned above and to minimize barriers to completing advance directive documents, in 2017 Cedars-Sinai Medical Center in Los Angeles created an Advance Directive document, which divides this task into two parts. This form led to Cedars-Sinai's Jewish Advance Directive document, which then became the foundation for the significantly revised Ematai document, now formally known as Ematai's Robert M. Beren Healthcare Directive and Conversation Guide. The first section of the Ematai document is legally binding and closely resembles previous Agudah/RCA forms by simply appointing a healthcare proxy and a rabbi to be consulted when questions arise. It is a brief, simply-designed and user-friendly legal document that allows a person to designate their proxy (and alternates), the rabbi (and alternate rabbis) that they should consult with, and directs that their healthcare decision-making should be done in accordance with Jewish law and custom. This document is carefully worded to ensure that Jewish law is respected in all decision-making, but not to take a specific position on controversial issues, such as brain death. Instead, it authorizes the appointed rabbi to provide guidance consistent with his interpretation of Jewish law.<sup>53</sup> Similarly, the document does not take stances on any specific interventions,

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<sup>53</sup> One version of the RCA-Ematai healthcare directive, approved by Rabbi Willig, Rabbi Schachter, and Rabbi Yehoram Ulman, offers three options regarding posthumous organ donation with the following preamble: "This section is relevant only if death as defined by Jewish law and custom has been determined by my proxy in consultation with my named rabbinic consultant. Please select from the options below.

1) I authorize my proxy to approve transplantation of any organs and tissues permissible under Jewish law and custom.

2) I do not wish to donate any of my organs or tissues.

3) I authorize my proxy to approve transplantation for only the following organs or tissues (specify).

If a person does not want to be an organ donor, they can select #2. If they do want to be a halakhic organ donor, then registering their preference here has the following advantages:

\* If the person and their *pasek* accept respiratory brain-death criteria as the halakhic definition of death, it still allows control of the final decision to remain in the hands of the proxy and the rabbi, which many will prefer more than signing up with a government registry.

\* Alternatively, it allows a person to remain open to the possibility of posthumous organ donation while leaving their preference of the legal criterion for death to a later time and after consultation with their rabbi.

such as resuscitation or artificial nutrition and hydration. These types of questions must be addressed on a case-by-case level in consultation with the rabbi designated in the document.

Separate from the legally binding section is a “conversation guide.”<sup>54</sup> This guide is not legally binding and does not list specific interventions for selection, unlike earlier advance directive forms. Instead, it provides prompts to facilitate meaningful conversations. These carefully selected questions, based on common scenarios that arise as individuals age and at the end of life, help proxies and rabbis gain broader insight into patients’ general preferences regarding healthcare decisions. By describing one’s general goals and values rather than selecting specific interventions, preferences can be more flexibly interpreted and applied to various scenarios. Importantly, the form is structured to ensure rabbis are consulted for any matter impacting Jewish law, and that no options outlined in the guide conflict with halakhic standards.

The conversation starter acknowledges the unpredictable nature of healthcare journeys. While precise situations cannot always be anticipated,

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\* This option also allows for promising medical technology to advance to a point at which organ retrieval may be possible following death by cardiological criteria. In particular, this includes “Uncontrolled Donation after Cardiac Death” (uDCD). In this protocol, donation occurs from someone who dies following an unexpected and unsuccessfully resuscitated cardiac arrest. In the past, organ donation was not possible in such cases. Today, in certain circumstances, when cardiac arrest takes place in limited locations (such as a specially-equipped ambulance or emergency room), and after all attempts for resuscitation have failed and the person has been declared dead, it is sometimes possible to provide oxygen support that will maintain organ vitality and allow for organ retrieval. This technique has not been fully developed around the world, but it has been implemented, in a limited capacity, in several countries (including Israel) to successfully retrieve critical organs like kidneys and lungs. (This protocol should not be confused with controlled donation after cardiac death (cDCD), which is a much more established, albeit controversial, protocol. In a carefully orchestrated process, the doctors withdraw treatment in an operating room which allows for the patient to die and then allow the transplant team to retrieve the organs. This raises many halakhic problems with regard to withdrawing interventions that cause a patient to die very soon afterward.)

It should be stressed that even this version of the Ematai directive remains neutral on the question of time of death and organ donation. Some, however, prefer not addressing this issue at all on their directive. As such, another version of the RCA-Ematai directive, available at [ematai.org/rca](http://ematai.org/rca), entirely omits this question.

<sup>54</sup> Notably, even if someone has completed a different halakhic healthcare proxy form, whether from a lawyer or a different organization, the non-legal “conversation guide” remains greatly beneficial, provided that the chosen rabbi follows the approaches of Rabbi Feinstein and Rabbi Auerbach, discussed above.

discussing general preferences can offer critical direction if decisions need to be made by others. Although discussing end-of-life care with loved ones can be challenging, meaningful conversations about life and death can foster stronger family bonds, trust, and mutual understanding between individuals, proxies, and rabbis. These conversations are a profound gift to loved ones, helping to alleviate potential family tensions and reduce subsequent guilt from uncertainty about whether decisions reflect the individual's wishes.

The conversation guide initiates conversations with six straightforward categories of questions covering:

1. Pain management,
2. Risk-taking,
3. Limiting medical interventions within Jewish law in certain circumstances,
4. Medical disclosure,
5. Concerns about aging, and
6. Preferences for living accommodations.

Responses are indicated on a color-coded sliding scale, simplifying the expression of general perspectives. Additionally, the guide provides space for individuals to express what matters most to them or detail any specific preferences that they may have. Examples include reflecting on past experiences with the deaths of loved ones and what was meaningful or troubling about those experiences (e.g., "I hated how Uncle David suffered from so many painful procedures," "I admired my friend Sarah for fighting until the end," or "It meant a lot that my mother died in her own home surrounded by family."). It also prompts users to complete the sentence: "What matters to me at the end of life is \_\_\_\_." Ultimately, after selecting a proxy and a *posek* (halakhic authority), the guide aims to provide them with a clear picture of an individual's goals and preferences within halakhic guidelines.

As previously noted, there will always be a need for real time decisions to be made on a case-by-case level by a proxy in consultation with the designated *posek*. End-of-life healthcare is very complex and cannot be easily predicted. The conversation guide provides a critical tool for the proxy and rabbi to make individualized decisions in these moments of decision.

Critically, the conversation guide helps ensure halakhic compliance in two key ways: 1) It avoids halakhic pitfalls inherent in boilerplate advance healthcare directives offered by many estate attorneys; and 2) It provides opportunities for individuals to express preferences in scenarios where Jewish law respects personal choice. Versions of Ematai's documents

were adopted as the official directives of the Rabbinical Council of America (RCA) in 2025.

Feedback regarding this approach has been extremely positive. While no document can perfectly resolve all challenges associated with decision-making for incapacitated individuals, the Ematai directive represents the most effective approach yet for addressing these issues. It is a tool to facilitate honest, caring conversations with one's proxy, family, and rabbi to ensure individual preferences are respected, and guarantees adherence to halakhah at life's end. It was created with significant input from many *poskim*, community rabbis, doctors, nurses, social workers, and estate attorneys. We recommend that the guide be revisited every five years or at any significant crossroads in one's healthcare journey.

Ultimately, the "conversation model" is the natural outgrowth of the approach taken by Rabbi Feinstein and Rabbi Auerbach, and the many other *gedolim* who affirm the relevance of personal choice in certain situations. After all, if patient choice is allowed in many common scenarios, then it becomes an imperative for a proxy and rabbi to know the values and preferences of the patient. Those in our community who follow the approach of these leading *poskim* should be asking themselves: What am I waiting for to talk about these sensitive matters?

*Im lo ahshav, Ematai?* If not now, when? 