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A HALAKHIC FRAMEWORK FOR DECISION-MAKING IN ACUTE CRITICAL ILLNESS

Introduction: Terminal vs. Critical Illness

Over the last few decades, literature on end-of-life care in Jewish law has burgeoned. At the same time, little has been written about the overlapping but distinct area of acute critical illness (to which the ongoing COVID-19 pandemic has brought only further attention).

Differentiating between them, I believe, is crucial:

1. “End-of-life” situations refer to patients who have definite, end-stage, terminal disease processes, such as advanced cancer. Steady progression of disease over a short period, culminating in death, is predictable. Medical treatment may slow the clinical course but is not expected to reverse it. Regarding what constitutes the “end-of-life,” there is no clear medical definition.¹ In halakhic literature, expected survival of less than six months is often used as a rough benchmark, though some authorities prefer other definitions.²

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¹ See for instance, David Hui, *et al.*, “Concepts and Definitions for ‘Actively Dying,’ ‘End of Life,’ ‘Terminally Ill,’ ‘Terminal Care,’ and ‘Transition of Care’: A Systematic Review,” *Journal of Pain and Symptom Management* 47:1 (2014), 77–89.

² For a summary, see Jason Weiner, *Jewish Guide to Practical Medical Decision Making* (Urim, 2017), 125–126.

2. “Acute critical illness” is any severe, life-threatening condition. It can arise in a variety of circumstances, including:
 - a. A healthy patient with no known predisposition to disease, as in cases of trauma, poisoning, or sudden, overwhelming infection (sepsis);
 - b. A patient with chronic medical conditions who has now developed a new, unrelated process, such as a patient with a history of strokes, diabetes, emphysema, and heart disease who has contracted influenza or COVID-19; or
 - c. A chronically ill patient whose condition has led to an acute exacerbation, such as a patient with known heart failure whose lungs are now filling with fluid secondary to the heart dysfunction (pulmonary edema).

In all of these cases, critical illness has developed independent of any terminal diagnosis. Of course, terminal and critical illness can also coexist, as in the following two scenarios:

- d. A patient with a terminal illness who is now suffering from a new process, such as a patient with late-stage pancreatic cancer (a terminal illness) in whom severe pneumonia (a critical illness) has developed; or
- e. A terminally ill patient who has entered the final phase of his or her disease, such as a patient with lung cancer who is now struggling to breathe.

Clear principles were established by rabbinic authorities at the end of the twentieth century regarding medical decision-making for patients at the ends of their lives (typically those with a life expectancy of less than six months). But in the setting of acute critical illness in patients without terminal diagnoses, often the trickiest question of all is: *Is this the end of life?*

If we knew that up front—that even the most aggressive interventions will not change the ultimate outcome—then the same principles could be harnessed to help navigate decisions. Frequently, though, the prognosis in acute critical illness is uncertain, and thus the end-of-life literature is of limited help.

At the same time, the prognosis may not be completely unknown. That is, when critical illness develops in already severely compromised individuals (scenarios “b” and “c”), there can be a general sense that the overall likelihood of long-term, meaningful recovery is quite low, even though there is no absolute guarantee that aggressive interventions cannot reverse the process.

TRADITION

A case description might help illustrate this phenomenon:

Beth is a 71-year-old woman with longstanding Parkinson's disease (a progressive neurologic disorder). Her functioning has declined over the years, leaving her wheelchair-bound. More recently, she is frequently confused, though she recognizes family members and communicates with them easily.

Over the last two months, she has suffered from an unrelated, recurrent lung problem that has landed her in the hospital on multiple occasions. Doctors have repeatedly drained fluid from around her lungs, but more fluid collects each time. Extensive testing has not been able to give a firm diagnosis or explanation for why this keeps happening.

During this current hospitalization, Beth's breathing has deteriorated further, despite an oxygen mask and further attempts at drainage. She is more confused and agitated than usual, hallucinating and pulling at the medical equipment.

The medical team informs Beth's family that she is at risk of death if they do not intubate her—that is, sedate her, insert a breathing tube into her windpipe, and connect her to a ventilator (sometimes colloquially called “life support”).

Her family, in turn, consults with their rabbi. He listens intently and asks several questions, including, “Is her condition terminal?” The family does not know how to answer.

Beth's family and doctors share a gut feeling that her steady decline is not about to change course, especially after this abrupt worsening, and that intubation will likely just delay the inevitable but not prevent it. Still, no one, including the hospital's most experienced specialists, can say for sure; they cannot even guarantee that Beth's breathing will not suddenly stabilize on its own. The classic halakhic sources about end-of-life care, which presume clear prognoses, may not directly apply; but is there some other framework that can specifically address the uncertainties of acute critical illness?

Critical Care: Why Not?

If a patient is not known to be terminal, why not provide maximal critical care (also known as “intensive care” and typically delivered in an “intensive care unit” [ICU])? The answer is that acute critical illness, as we

described, can unfold in many different contexts. When it develops suddenly in someone who is otherwise reasonably healthy, as in cases of trauma, meningitis, or a diabetic crisis, there is little hesitation on the part of either medical staff or patients and families to intervene. After all, this is what critical care medicine is designed to do—to stabilize and reverse an acute process and restore baseline health and functioning.

However, the critical illness that hospitals typically see is often in the setting of chronically ill patients with poor baseline functioning, such as Beth. This is not surprising, as those who are already ill are the most likely to become severely ill, and, by definition, any death that is not truly sudden will be preceded by a period of critical illness. These patients are often very elderly; have multiple, progressive, chronic conditions; may have varying degrees of dementia; may be wheelchair- or bed-bound; and may be steadily declining over time, sometimes without clear medical explanation—all of which led to their current episodes of critical illness.

When interventions can easily reverse the immediate process, there is no reason to withhold them. Frequently, though, skepticism lurks, as the same underlying conditions that predisposed these patients towards critical illness will also hamper their recovery. The term “frailty syndrome,” in fact, has been coined to describe a constellation of characteristics that predict lower physical resilience to illness and injury. Patients who are “frail” fare worse after ICU admission than their non-frail counterparts, as they are less able to withstand the twin assault of critical illness together with the aggressive methods used to treat it (see figure).³

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

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

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

³ Justin C. De Biasio, *et al.*, “Frailty in Critical Care Medicine: A Review,” *Anesthesia and Analgesia* 130:6 (2020), 1462–1473.

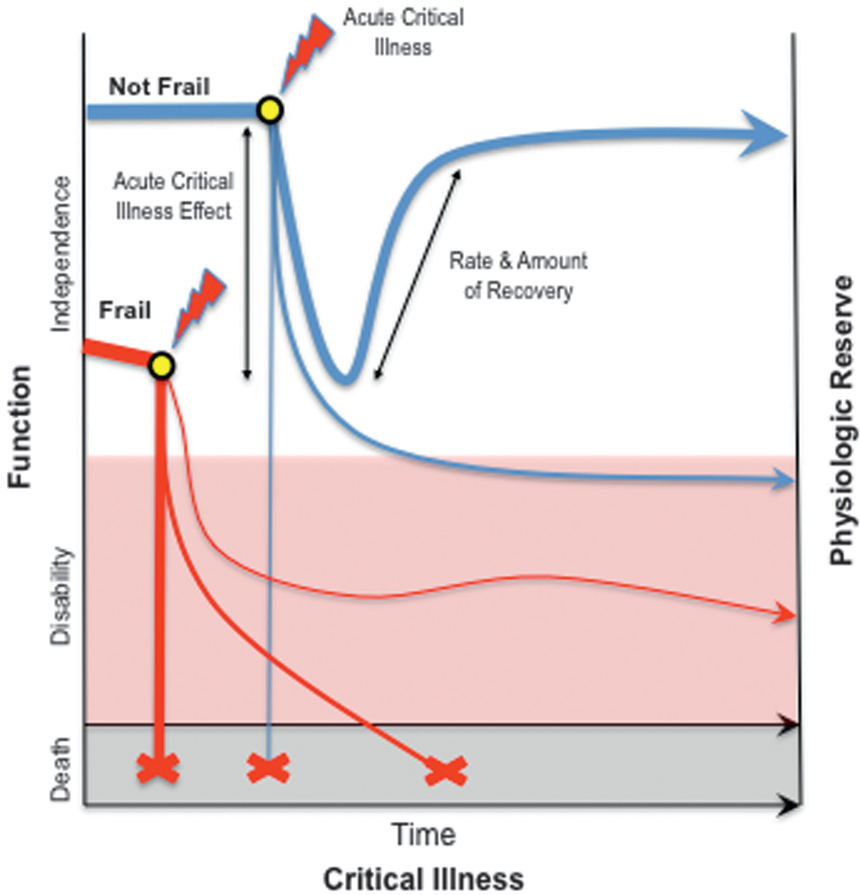


Figure: “Hypothetical trajectories for patients who are frail or not frail prior to becoming critically ill. The thickness of the trajectory lines represents the proportion of patients in each trajectory. For a given insult, frail patients are susceptible to becoming critically ill sooner. Patients who are frail prior to critical illness are more likely to die in the hospital and more likely to develop chronic critical illness or severe disability leading to an early death. If they survive their critical illness, they are prone to recover functional status more slowly or develop permanent disability and a shorter lifespan than those who are not frail.” [Adapted with permission of the American Thoracic Society. Copyright © 2020 American Thoracic Society. All rights reserved. From: Jonathan P. Singer, David J. Lederer, and Matthew R. Baldwin, “Frailty in Pulmonary and Critical Care Medicine,” *Annals of the American Thoracic Society* 13:8 (2016), 1394–1404. *Annals of the American Thoracic Society* is an official journal of the American Thoracic Society. Readers are encouraged to read the entire article for the correct context at doi.org/10.1513/AnnalsATS.201512-833FR. The authors, editors, and The American Thoracic Society are not responsible for errors or omissions in adaptations.]

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

End-of-Life Care in Halakha

What can we learn from the teachings of earlier authorities regarding our situation? That life-prolonging therapies should not always be pursued is widely, though not universally, held. The most frequent rationale for withholding treatment is unavoidable pain and suffering (*yissurin*) that either emanate from the underlying condition or will result from the intervention itself, such as major surgery or prolonged ventilation. Some authorities also consider an irreversible loss of cognition, such as in advanced dementia or severe brain injury, to be an isolated reason to withhold therapy,⁴ though this is more controversial.

In a series of responsa, R. Moshe Feinstein argues that untreatable suffering can be worse than death, and, in that circumstance, life need not be prolonged (*Iggerot Moshe*, H.M. 2:73–75). His primary source is a Talmudic story about R. Yehuda Ha-Nassi, who was suffering at the end of his life and was being sustained only by the prayers of the Sages. Sensitive to his suffering, his maidservant interrupted their prayers, thereby allowing his soul to depart (*Ketubot* 104a). From here, Ran derives that one may pray for a suffering patient to die (*Nedarim* 40a).⁵ Similarly, regarding patients in whom therapies can prolong life but not alleviate suffering, R. Feinstein concludes that “one should not give them treatment but leave them as they are” (2:73:1).⁶ A clinician may reach this decision

⁴ See, for instance, R. Zalman Nechemia Goldberg, “*Hafsakat Hanshama Melakbutit be-Holeh Anush Kedei le-Hatzil Holeh Aher she-Sikkuyav Tovim*,” *Emek Halakha—Assia* 1 (1985), 72, as well as the postscript to this article by R. Schachter and R. Willig.

⁵ Also see *Ketubot* 33b. For an extensive analysis of *Ketubot* 104a and of the use of narrative in halakhic literature, see Alan Jotkowitz, “*Nomos and Narrative in Jewish Law: The Care of the Dying Patient and the Prayer of the Handmaid*,” *Modern Judaism* 33:1 (2013), 56–74.

⁶ According to R. Feinstein, suffering is also the justification behind Rema’s ruling in Y.D. 339:1 that one need not prolong the life of a patient who is actively dying. Also see his responsum Y.D. 2:174, as well as R. Yaakov Yisrael Kanievsky, *Karyana de-Iggarta*, #190. However, there are dissenters to this position, such as R. Eliezer Yehuda Waldenberg. See R. J. David Bleich, “Treatment of the Terminally Ill,” *Bio-ethical Dilemmas: A Jewish Perspective* (Ktav, 1998), 61–112.

TRADITION

on his or her own, but should consult with the patient or family members if possible (2:74:2–5 and 2:75:1).

R. Feinstein was further asked if he would maintain the same position if long-term survival were possible, but still without a solution to suffering. He responds that “in truth, it does not make sense to differentiate” in this regard, though he concedes that compelling proof is lacking. Therefore, in such a case, he empowers the patient to decide for him- or herself, or the family, in the case of a minor (2:74:3).

Still, even in this situation, uncontrolled suffering is taken as an absolute. When any doubt exists, such as the possibility of curative therapy that could also resolve the suffering, R. Feinstein requires continued treatment. For instance:

If treatment can help until the doctors can get hold of a doctor who is greater than those [caring] for the patient; that it is possible that, by prolonging his life, they can get hold of a doctor who might know of a curative treatment; then this [temporizing] treatment should be given, even though it will not reduce suffering but will only prolong his life with the suffering until they can bring that doctor (2:74:1).

Read narrowly, then, these rulings serve as precedent only for situations in which all therapeutic options have been exhausted.

R. Shlomo Zalman Auerbach also allows for aggressive therapy to sometimes be withheld when a patient is suffering. However, his rulings, like those of R. Feinstein, presume some prognostic clarity. For example, R. Dr. Avraham Steinberg formulated guidelines, in consultation with R. Auerbach and R. Shmuel Vosner, for discontinuing intensive care. The conditions for their implementation include:

At least three of the patient’s vital systems have unquestionably and irreversibly failed and all treating physicians—that is, all physicians in the ICU and all assisting specialists—have decided that all possibilities of saving his life have been exhausted and death from his illness or injury is imminent....

The physicians believe that the patient is suffering greatly, and it can be assumed that if there is no hope for recovery, the patient would not wish to continue suffering.⁷

⁷ “Halachic Guidelines for Physicians in Intensive Care Units,” *ASSIA – Jewish Medical Ethics* 4:1 (February 2001), 5–6.

Separately, R. Auerbach was asked about a girl for whom life-saving surgery was proposed but that would inevitably leave her “paralyzed for the rest of her life.” His responsum does not mention any limitation in life expectancy, but permits refusal of surgery on the grounds that “ultimately, the lives of the paralyzed are unfortunate and bitter, and there are even some for whom death is preferable to life” (*Minhat Shlomo* I 91:24).⁸ Again, the outcome of paralysis (of unspecified scope), as well as its presumed consequences, is taken for granted.

In summary, there is ample basis in recent halakhic literature for withholding care from at least some patients who are terminally ill,⁹ and possibly even in cases of long-term, irresolvable suffering. However, when prognostic doubt persists regarding either of these factors, these precedents alone do not provide a sufficient basis for declining interventions.

How Rabbis and Doctors Talk about Prognosis

Applying these principles to acute critical illness might lead to the following conclusion: When doctors can give a clear, definite prognosis that, despite all treatment options, a patient has no possibility of long-term survival, or at least not without ongoing suffering, aggressive care may sometimes be withheld, based on the rabbinic opinions above. Short of that, however, when any uncertainty lingers, the case must be designated as one of “doubt” (*safek*), and full critical care must be pursued.

The problem with this approach, I think, is not a quantitative one, but a qualitative one. It is not that too many cases—indeed, most—will land in the zone of *safek*, but that this approach misconstrues modern medicine’s concept of prognosis. Medicine has evolved into a discipline of probabilities. It does not make predictions about an individual’s trajectory, with or without treatment, but plots his or her case against a background of data: For “*x*” malignancy at “*y*” stage of progression, what are the 1-, 3-, and 5-year survival rates? For a patient of a certain age, gender, and blood pressure, how much will this drug reduce the likelihood of stroke?

At the extremes, some predictions are easier: The chance that a patient with end-stage cancer will be alive years later is, unfortunately, exceedingly small. Still, properly understood, the answer takes the form of a

⁸ R. Auerbach does add, “Especially in this case, in which cure is not certain.” Also see *Nishmat Avraham*, Y.D. 155:2 and 339:4.

⁹ Also see *Nishmat Avraham*, vol. 4, Y.D. 339:2 in the name of R. Yosef Shalom Elyashiv; R. Schachter, *Be-Ikvei ha-Tzon*, 34; and R. Asher Weiss, *Teshuvot Minhat Asher* 1:116.

probability, and outliers cannot be fully discounted. And this is even more true for questions that arise in murkier clinical situations that have less data behind them, such as: Will Beth ever be weaned from a ventilator?

The risk of forcing complex medical assessments into a small number of rigid categories—such as terminally ill, not terminally ill, or in doubt—is two-fold. First, it misses information. There are many cases in which everyone in the room senses that the overall prognosis is poor, but no clearly terminal diagnosis applies. Indeed, that is the very challenge of acute critical illness: One only knows if it was terminal in hindsight. Could it be that halakhic analysis cannot find a way to incorporate the subtleties of a medical case into its assessment?

Second, there is a risk not just of oversimplification, but of distortion. Clinicians who perceive a rabbinic reluctance to work with the inherent uncertainty of medical prognostication may tend to profess certitude, even when it does not exist. Inevitably, every *she'eila* turns on the assessment provided by the medical team, and the possibility for subtle manipulation, conscious or subconscious, always lurks. Thus, it is in the interest of halakha's protagonists to adapt to the language of medical professionals, rather than vice versa. But what tools are at their disposal?

Decision-Making in the Face of Medical Uncertainty

I believe that a *sugya* in *Avoda Zara* may hold the answer to managing the uncertainties of acute critical illness. The Mishna (27a) prohibits the use of pagan doctors, as they are presumed to be barbaric and may wantonly murder their Jewish patients. R. Yohanan, however, qualifies this statement:

When it is in doubt whether the patient will live or die, he may not seek treatment from [pagans]. If he is certain to die, he may seek treatment from them.

He will die? But there is [at least] short-term survival (*hayyei sha'a*)!
We do not concern ourselves with short-term survival (27b).

Even in the setting of certain death, the Gemara raises the concern that a pagan doctor could make things even worse. How so? Perhaps the doctor will kill the patient immediately, whereas a passive course of action would at least preserve the patient's short-term survival (*hayyei sha'a*). Nonetheless, "we do not concern ourselves with short-term survival," meaning that its value should not impede a patient from pursuing possibly curative, though dangerous, therapy.

As proof, the Gemara cites the story of four lepers who were starving outside of the besieged city of Samaria (II Kings 7:3–4). They decided to seek help from the enemy encampment, even though they were submitting themselves to near certain death. As they were destined to die of starvation anyway, why not at least hope that the Aramean soldiers might spare them and offer them some food? Apparently, the fact that they might have been forfeiting their short-term survival was of no concern and did not have to be factored into their decision-making.

From this, *poskim* derive the following principle: When faced with a fatal disease process, a patient has license to pursue an aggressive, dangerous therapy that may provide a cure but also could do more harm and lead to an even earlier demise.¹⁰ In the pursuit of possible long-term survival, the potential for short-term survival is disregarded.

If so, does this mean that a patient *must* ignore the prospect of short-term survival and pursue aggressive treatment? If the likelihood of success is high, R. Moshe Feinstein suggests that this is possibly the case. But if it is equivocal or worse, then the decision belongs to individual patients, who may legitimately reach different conclusions:

R. Yohanan is saying that the halakha depends on a person's preferences... a person, in this regard, has control over his life—to do what seems better to him for his survival (*Iggerot Moshe*, Y.D. 3:36).

R. Feinstein explains that R. Yohanan does not derive a moral principle from the lepers (who are hardly traditional sources of Torah wisdom), but a psychological one: Faced with this kind of dilemma, some people may clutch at the limited time they have left, but others will want to roll the dice for a chance at a cure. Halakha endorses a spectrum of intuitive, human responses; the Biblical account of the lepers simply demonstrates that aggressive risk-taking falls within that range.¹¹

Furthermore, R. Feinstein continues, that patients' preferences will differ should not surprise us, when compared to other areas of life:

This is what we see with regard to finances—that there are people who, for the possibility of large profits, will invest the little money that they have in merchandise, even though if they are not successful, they will lose the little they had; and there are people who would not want to invest the

¹⁰ See *Shevut Yaakov* 3:75 (quoted in *Pithei Teshuva* Y.D. 339:1), *Binyan Tziyyon* 111, and *Abiezer* 2:16:6.

¹¹ However, see *Nishmat Avraham*, Y.D. 155:2 in the name of R. Auerbach.

little money that they have when there is a risk of losing [it]. So, too, can there be different preferences by nature about life. Therefore, we need not dismiss either opinion.

R. Feinstein, then, strongly encourages the use of personal judgment when it comes to managing medical uncertainty, at least within certain limits. When faced with a risky treatment option, a patient may embrace that risk with hopes of a cure or, alternatively, decline treatment, even though premature death will then be assured.

Balancing Risks in Critical Illness

But what risks may one assume or decline? The Gemara, and those who cite it, only speak of the risk of immediate death—parallel to murder at the hands of a pagan doctor. However, we learned from R. Feinstein’s other responsa that *there are outcomes worse than death*—namely, intolerable suffering.

For Beth and others like her, one risk of aggressive interventions is immediate harm. They may die on the operating table or not survive an intubation procedure. Another risk, though, is of persistent suffering: of days, or months, connected to a ventilator; of uncontrolled pain or discomfort; of endless needlesticks; of complications of one procedure that necessitate others; of a revolving door of hospital admissions and discharges that chronic critical illness often leads to; and of the complications of critical care itself.

On the flipside, what are the possible benefits? Of course, Beth’s family hopes for success, but they need to be realistic about what that might look like. If, despite her frailty, Beth survives and recovers from her acute illness, she may emerge weaker and more compromised than before. Even a full rebound from this current episode will not alter the underlying conditions that leave her prone to other bouts of illness. In other words, between her chronic medical issues and new ones that may crop up, Beth is likely to suffer a premature death, whether or not she is intubated right now.

When long-term, stable survival is likely, critically ill patients regularly submit to all of the short-term and long-term risks of intensive care in return for a shot at a reasonable future. But as the probabilities change for those with substantial preexisting frailty and chronic disease, some may opt for their “*hayyei sha’a*”—short-term survival without aggressive intervention—rather than risk an outcome that *would be worse for them than death*.

In short, building upon the rulings of R. Feinstein and R. Auerbach about cases whose prognoses are known, I propose a straightforward

argumentum a fortiori (*kal va-homer*) to deal with the uncertainties of acute critical illness: If a patient can decline treatment because of a risk of immediate death, he or she should also be able to decline treatment because of a risk of uncontrolled suffering, which halakha recognizes as sometimes worse than death.

While I cannot attribute this conclusion directly to R. Feinstein or R. Auerbach, I do not think that their published rulings dispute it. If their case descriptions presume prognostic clarity, that may simply reflect a lay orientation towards medicine, or even the way specific questions were posed to them. However, I do not find anything in their arguments that conflicts with a probabilistic approach towards medicine and a modified halakhic framework that can account for it.

Does Quality of Life Matter?

Furthermore, it seems to me that quality of life considerations can perhaps be revisited here. On the one hand, many authorities, including R. Feinstein, reject poor quality of life, in the absence of suffering, as a reason to withhold life-extending therapy. In his words, “It is absolutely clear and obvious to every observant Jew and those who possess the fear of Heaven that we are obligated to treat, in order to preserve [life] as much as possible, every human, without regard to cognitive capacity” (H.M. 2:74:1).

However, when weighing the risks of critical interventions, I believe that quality of life may regain relevance, even according to R. Feinstein, on two levels. First, whether death is preferable to suffering in any given context may depend on more than just the degree of physical discomfort. Severe pain may be worth enduring as long as dignity and cognition are preserved, for example, but less so when they have been lost.

Second, what risks critically ill patients are willing to assume may depend not only on the pure odds of survival, but also on what kind of survival. Certain risks may be deemed acceptable when the alternative outcome includes a high degree of functioning, but not when it is expected to be severely limited in any case.

Additionally, quality and quantity are frequently correlated, as the same underlying, debilitating conditions that impair functioning also increase both short-term and long-term mortality after critical illness.¹² And as the potential survival benefit of treatment diminishes in both quality and quantity, the concomitant risks loom greater, and decision-making grows ever more delicate.

¹² De Biasio, *et al.*, *ibid.*

Who Decides?

Even if we conclude that just the risk of unbearable suffering can justify the refusal of treatment, a thorny issue remains: What is the definition of such suffering, and who should decide if it has been met? Regarding a definition, recent halakhic literature on terminal illness does not seem to yield any clear consensus. On the one hand, R. J. David Bleich argues that adequate pain control is achievable in almost all circumstances; therefore, “Although the theory espoused by *Iggerot Moshe* and Rabbi Auerbach is well founded, it seems to this writer that there is little room for its implementation.”¹³ R. Auerbach’s rulings, on the other hand, reflect a broad conception of suffering: For example, in addition to his comments about life with paralysis above, he allows a terminal patient to decline needlesticks and takes into account “severe pain or suffering or even *severe emotional distress* (*seivel nefesh*).”¹⁴

Tellingly, R. Feinstein’s responsa make no effort to define suffering, other than to say that “people would rather die than to live a life of suffering like this” (H.M. 2:74:2). When combined with his frequent deferment to the opinions of patients and family members,¹⁵ the impression emerges that suffering may not have a halakhic definition at all. Rather, convention sets broad parameters, within which the individual has further leeway.¹⁶

¹³ Bleich, “Treatment of the Terminally Ill,” 94.

¹⁴ *Nishmat Avraham*, vol. 4, Y.D. 339:2; *Minhat Shlomo*, *ibid.* Regarding sedation as a solution to discomfort, my friend and colleague Dr. Yonatan Wiesen notes the well-documented phenomenon of post-traumatic stress disorder (PTSD) after intensive care (see, for instance, Annachiara Marra, Pratik P. Pandharipande, and Mayur B. Patel, “Intensive Care Unit Delirium and Intensive Care Unit-Related Post-traumatic Stress Disorder,” *The Surgical Clinics of North America* 97:6 [2017], 1215–1235), which has also received recent attention in popular media (see, for instance, articles from April 22 and May 5, 2020 at TheAtlantic.com). This PTSD often involves memories of delusions and hallucinations that occur during sedation, which itself may increase the risk of PTSD. Wiesen reasons that an experience that can cause PTSD is, by definition, potentially “traumatic” and should be considered as a source of suffering (personal communication). Also see the differing opinions of R. Auerbach and R. Elyashiv regarding a comatose patient, quoted in *Nishmat Avraham*, *ibid.*

¹⁵ Also see H.M. 2:73:5.

¹⁶ Also see R. Schachter, *ibid.* Regarding which circumstances are worse than death, various attempts have been made to study patient preferences, the degree of heterogeneity in them, and changes over time and as health status evolves. See, for example, Terri R. Fried, *et al.*, “Changes in Preferences for Life-Sustaining Treatment Among Older Persons with Advanced Illness,” *Journal of General Internal Medicine* 22:4 (2007), 495–501.

One can perhaps adduce further support for this approach from the Talmudic narrative that lies at the heart of R. Feinstein's rulings. When R. Yehuda Ha-Nassi was dying, it was his maidservant who noticed his suffering and concluded that his life had become a burden, while the rabbis continued to pray for his survival! Apparently, she perceived something, if only out of her proximity, that they did not.

In other words, the best arbiters of suffering and its consequences may be patients, along with their caretakers, who can interpret ever-changing medical assessments in light of their deep, nuanced understanding of the overall situation and consider their options accordingly. While rabbinic input is always welcome for the perspective, grounding, and experience it can offer—especially for families that are feeling overwhelmed—it may be more guiding than decisive in complex cases of acute critical illness.

To be sure, this does not mean that, halakhically speaking, patients can choose any course of action they wish. Despite the inherent uncertainty, responsible decision-making involves a thorough investigation of all of the factors at play, the treatment options available, possible adverse events, and the likelihoods of each. The genuine possibility of an outcome worse than death, at least in the eyes of this patient, should be confirmed before any treatment is rejected. Indeed, in many emergent situations, there is often so much uncertainty that aggressive treatment is warranted, at least until the clinical picture grows clearer.

However, if after thoughtful reflection, a patient wishes to decline critical care interventions because the risks of suffering seem to outweigh the possible benefits of treatment, I believe that halakha grants him or her the right to do so.¹⁷ Moreover, a patient who is frail and/or chronically ill, though not technically terminal, and for whom critical care interventions are likely to be more burdensome than helpful may decide *before* critical illness develops to decline such treatments.

What about situations like Beth's, in which the patient is not sufficiently lucid to make such decisions? In the face of uncontrollable suffering, R. Feinstein allows family members (or even physicians) to determine that treatment is contraindicated. I do not see why decisions in acute critical illness should be different. Not only are family members best poised to know the preferences and attitudes of the patient, but, like R. Yehuda Ha-Nassi's maidservant, they are frequently the most intimately familiar with the patient's disease course, functioning, and overall trajectory. The likelihood of meaningful recovery can all turn on the subtleties of these

¹⁷ Also see Weiner, *Jewish Guide to Practical Medical Decision Making*, 146–147, in the names of R. Schachter and R. Weiss.

factors, and, therefore, in my opinion, a caring family member's gut instinct should be weighed very, very seriously. Of course, if a request truly borders on the unreasonable, the treatment team bears responsibility to investigate further.

Finally, as Dr. Benjamin Freedman compellingly argues in his *Duty and Healing: Foundations of a Jewish Bioethic*, good medical decision-making, for oneself or for a loved one, should be seen as a responsibility more than as a right.¹⁸ A patient for whom the risks of critical care interventions are obviously not worthwhile is not just exercising personal autonomy in declining them but is judiciously avoiding an untoward outcome for him- or herself. Similarly, family members who come to the same conclusion for their loved one should feel empowered that they are not only asserting their rights but are protecting the patient from harm.

Recommendations

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

1. Every effort should be made to understand the current disease process (e.g., is this a new disease process or an exacerbation of an existing one?), different treatment options, and the probabilities of different outcomes. At the same time, uncertainty about any or all of these dimensions, or even about the diagnosis itself, should be anticipated.
2. One should avoid thinking of outcomes as binary (either survival or death) and consider also in-between possibilities, such as prolonged short-term survival or chronic critical illness.
3. Similarly, decisions about care need not be binary (e.g., either critical or palliative care). Rather, each intervention should be considered separately, in terms of its risks and chances of success.
4. Important factors to consider that might influence prognosis include:
 - a. Baseline functioning
 - b. Cognitive status
 - c. Nutritional status
 - d. Chronic medical conditions
 - e. Recent trajectory

¹⁸ Routledge, 1999. Also see Judah Goldberg, "Towards a Jewish Bioethic: The Case of Truth-Telling," *TRADITION* 43:2 (2010), 9–29.

5. If, given the above factors, the overall likelihood of meaningful recovery is thought to be high or is unknown, critical care interventions should generally be pursued.
6. If, despite unresolvable uncertainties, the overall likelihood of meaningful recovery is thought to be low, *and* the risk that critical care interventions will lead to outcomes that are subjectively worse than death is significant, then a patient should be given the room to carefully weigh the different options and risks. The patient may choose to either pursue or decline the intervention in question, such as intubation. Rabbinic consultation is certainly encouraged for those who seek further guidance.
7. If a patient's baseline condition is so compromised and frail that the risks of particular critical care interventions will outweigh their benefits in any circumstances (as described in #6), then a patient may decline such interventions even before illness develops—such as through an advanced directive that includes a “Do Not Resuscitate” (DNR) or “Do Not Intubate” (DNI) request.¹⁹
8. If a patient does not have the mental capacity to make such decisions, an appropriate surrogate may make them in his or her place. Again, rabbinic consultation may be valuable.
9. Medically futile treatment should not be undertaken under any circumstances. Likewise, all decisions should be made with the patient's best interests in mind.

Conclusion

I believe that the approach outlined in this essay is not novel; indeed, my sense is that a version of it is already practiced by at least some rabbinic authorities who counsel patients and families about medical decision-making. Rather, my hope for this essay is that it fills a conceptual void in the halakhic literature by providing a legal framework for dealing with prognostic uncertainty. For R. Yehuda Ha-Nassi, impending death is a given but still preferable to suffering; for a Jew considering a high-risk treatment (such as visiting a pagan doctor in Talmudic times), mortality is a threat that he must weigh. Combining the lessons of these two *sugyot*, I believe, can yield a path forward regarding decision-making in the setting of acute critical illness.

¹⁹ For more information about advanced care planning, see, for instance, www.polst.org.