Jewish Medical Directives for Health Care

INTRODUCTION

Modern advances in medicine have raised many new questions. Normally we make decisions about our own health care as the situation arises, but in some circumstances, we lose the ability to make such decisions. It is therefore important for us to indicate our wishes in advance so that those who care for us can know what we want. In doing this, we should be guided by our commitment to Judaism, to its law (*halakhah*), and to its moral values.

This document is for the purpose of declaring your wishes, that will affect health care decisions made on your behalf should you lose the capacity to decide for yourself. There are 2 parts of the document to consider:

- A proxy directive, or durable power of attorney for health care, allows you to designate a health care agent to make decisions on your behalf.
- An instruction directive, or "living will", asks you to state your preferences regarding types of treatment decisions that may arise.

Together, these directives can help make sure that treatment choices reflect your wishes and interests. Furthermore, the directives have been constructed in accordance with Jewish law and values, as interpreted within Conservative Judaism.

The guidance you offer in these directives can help provide clarity for your physicians and family members and avoid conflict or confusion. The directives would help assure that appropriate decisions are made on your behalf if you temporarily lose consciousness or the ability to communicate as the result of an accident, a surgical procedure, or illness. They also would supply guidance should you become unable to express your choices during the last stages of life.

You can use these forms to request the medical treatments that you would want to receive, and to express preferences among different types of treatment. You also may indicate those treatments that you would judge inappropriate should you become terminally ill or permanently unconscious. These directives would only be used to guide medical treatment if you lose the ability to make decisions and communicate your wishes. If you regain this ability, you would resume making your own decisions directly.

Even if you never lose decision making capacity, filling out these directives could help you to gain a sense of Jewish teachings concerning medical decisions, and give you the opportunity to think about some of the choices people must make about their health care. If you need to make decisions in a stressful situation in the future, your experience in completing this document will serve as a resource to inform your decisions.

You may revoke or amend these directives at any time. Jewish tradition teaches that life is a blessing and a gift from God. Each human being is valued as created *b'tselem elohim*, in

God's image. Whatever the level of our physical and mental abilities, whatever the extent of our dependence on others, each person has intrinsic dignity and value in God's eyes. Judaism values life and respects our bodies as the creation of God. We have the responsibility to care for ourselves and seek medical treatment needed for our recovery-we owe that to ourselves, to our loved ones, and to God.

Decisions may be required about which treatment would best promote recovery and would offer the greatest benefit. Accordingly, each patient may face important choices concerning what mode of treatment he or she feels would be both beneficial and tolerable. Jewish values allow terminally ill patients to rule out certain treatment options (such as those with significant side effects), to forgo mechanical life support, and to choose hospice care as a treatment option. Some medical interventions do not sustain life so much as they prolong the dying process. We may choose to avoid treatments causing us fear or entailing risk or pain, in the interest of the remaining moments of life.

Space has been provided in this directive for you to add your personal comments. This allows you to explain how you understand the choices that you indicate. In completing these directives, you should consult with your clergy to discuss the values and norms of Jewish ethics and values.

You also may wish to talk with your physician to learn about the medical significance of these choices, in particular any decisions your physician feels are likely to be faced in light of your medical circumstances. You may find it helpful to discuss these concerns with family members. Finally, you may wish to speak with an attorney or another person familiar with your state's laws to determine the legal requirements needed to realize your health care choices. The instruction directive can offer important evidence of your wishes regarding some types of treatment and give a general sense of your values and goals.

Medical Proxy (Power of Attorney for Health Care) in Virginia

A proxy agent can talk with your physicians about the details of your medical condition and the treatment options that are available at the time. Your agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made. At the same time, the more your agent knows about your wishes and values, the better he or she will be able to make decisions that reflect your wishes and values. Even if your agent knows you well, it would be helpful for your agent to have a written expression of your desires regarding some treatments. You should go over this document with your agent so that he or she can ask questions and get a sense from your demeanor as to how you want to approach these issues. Both the proxy directive and the instruction directive allow you to specify which should be decisive in case of ongoing conflict. Please be sure that you are consistent in specifying the priority.

Virginia law allows virtually any competent adult (an adult is a person 18 years of age or older) to serve as an agent. Thus, you may appoint as your agent (or alternate agent) your

spouse, adult child, parent or other adult relative. You may also appoint a non-relative to serve as your agent (or alternate agent).
https://www.vsb.org/sections/hl/Virginia_AD_Appoint_an_Agent_only.pdf

If at any time you wish to revoke your Proxy and Directive, you may do so by a signed, dated writing; by physical cancellation or destruction of the document by you or another person in your presence and at your direction; or by oral expression of your intent to revoke it. Any such revocation is effective when communicated to your attending physician.

To avoid possible confusion, it would be wise to try to obtain all originals and copies of the old Proxy and Directive and destroy them. If you do not revoke the Proxy and Directive, Virginia law provides that it remains in effect indefinitely. Obviously, if any of the persons whose names you have inserted in the Proxy and Directive dies or becomes otherwise unable to serve as your proxy, you will need to create a new one.

Under Virginia law, it is your responsibility to deliver a copy of your Proxy and Directive to your attending physician or otherwise notify your physician of the existence of your Proxy and Directive. If you are incapable of doing so, any other individual may make such notification.

We encourage you to use the above form in conjunction with the Advanced Directive provided in this document. We recommend that you register a copy of this form, along with your Advanced Directive, with a national registry, so that it can be accessed by any health care facility via computer. This can be done for a fee by contacting the U.S. Living Will Registry at http://www.uslivingwillregistry.com/ or by calling 1-800-548-9455.

Since it is impossible fully to anticipate what your medical condition will be, what future developments will occur in medical practice, and what particular health care decisions will need to be made on your behalf, without a health care proxy, an instruction directive may be misleading, may be open to alternative interpretations, and may not cover all contingencies. Filling out both a proxy directive and an instruction directive can help to assure that treatment choices are made in accord with your wishes and interests.

Completing the Forms

Both copies of the Advanced Directive should be signed by two witnesses over age 18, neither of whom is your agent or alternate agent. In some states additional requirements may apply. For example, your state may require that one or both witnesses would not inherit any of your property. In some states a directive may need to be notarized.

- You should talk with the people you want to appoint as agent or alternate agent, to make sure that they are willing to serve in that capacity, and to give them a sense of your wishes.

- You should keep a copy of both directives and give copies to the agent and alternate agents.
- You should give a copy of the proxy directive to your physician and to family members.
- You may want to give a copy of the instruction directive to your physician as well, especially if you want that document rather than your agent to be the primary guide in decision making.
- Finally, you may want to carry a card in your wallet or purse that indicates that you have completed an advanced directive, the name of your proxy agent, and how he or she can be reached.

Because medical technology and your own desires may change over time, it is a good idea to review your advance directive from time to time.

PROXY DIRECTIVE Durable Power of Attorney for Health Care
I,___________________________________, hereby appoint:
Name_______________________________ Address_____________________________
phone number(s)______________________ as my health care agent to make health care decisions for me.

This proxy shall take effect when and if I become unable to make or communicate my own health care decisions, due to physical or mental incapacity, and shall remain effective during the period of incapacity.

My agent should make decisions in accord with my wishes. If my wishes are not known and cannot with reasonable diligence be ascertained, my agent should decide in accord with my best interests.

My agent should consult with one or more health care professionals before making health care decisions for me.

I want my agent to be able to receive all medical information and records necessary to make informed decisions regarding my health care.

Instructions for agent: (Please mark one statement)

☐ In an associated instruction directive, I have expressed some of my preferences concerning health care decisions that may arise. I want my agent strictly to follow that document, and only to rely on other sources of knowledge about my wishes and values in situations not covered therein.

☐ In an associated instruction directive, I have expressed some of my preferences concerning health care decisions that may arise. I realize, however, that I cannot fully anticipate what will happen to me in years to come, future developments in medical practice, or the particular health care decisions which will have to be made on my behalf. I want my agent to draw on all sources of knowledge about my wishes and values, and to have ultimate authority to make decisions for me if I cannot do so for myself.

☐ I have not completed any document expressing preferences with regard to health care decisions. My agent should consider all sources of knowledge about my wishes and values.

First Alternate Agent: Should the person appointed above as my agent be unavailable, unable, or unwilling for any reason to serve in that capacity, I would have the following individual serve instead:

Name____
Address____

phone number(s)__________________________________

Second Alternate Agent: Should both the person appointed above as my agent and the person appointed as my first alternative agent be unavailable, unable, or unwilling for any reason to serve in that capacity, I would have the following individual serve instead:

Name____
Address____

phone number(s)_________________________________

I make these instructions, being of sound mind and age eighteen or older, and understanding fully the consequences of these appointments.

Signature: ____

Name: ____

Date: ____

Address: ____

City: ____

I declare that the person who signed this document or asked another to sign this document on his or her behalf, did so in my presence, that I know him or her to be the person named as the subject of this. document, and that he or she appears to be of sound mind and acting of his or her free will, free of duress or undue influence. I am 18 years of age or older, and I am

not designated by this or any other document as the person's health care agent or alternate health care agent.

Witness 1: Signature: ____________________________ Name: ____________________________

Date: ____

Address: ______________________________ City: _________________________________

Witness 2: Signature: _____________________________Name: ___________________________

Date: _________________________________

Address: _________________________________City:_____________________________________

Notarization is not necessary in the Commonwealth of Virginia.

INSTRUCTION DIRECTIVE TO GUIDE HEALTH CARE DECISIONS

NAME: ____ I am a Jew. I express that affiliation in a variety of ways in my life, and I want Jewish teachings and values to guide and inform the way in which I live through all times in my life, including times when I may be temporarily unable to communicate, am seriously ill, or in the final stages of my life.

I know that at some point I may not be able to make decisions about my health care, and so I have completed this form to help make my wishes known. Judaism values life and demands that we seek medical care. I share Judaism's respect for my body, the creation and possession of God, and I consequently wish that all prudent medical treatment be extended to me with the aim of effecting my recovery. Nothing in this directive should be construed as a wish to die, but rather as a wish to live in accordance with the values of Judaism.

I ask that my health care agent, and anyone else participating in the making of medical decisions on my behalf, consider carefully my wishes as reflected in this document or otherwise ascertainable.

This document should not be understood as a rejection of care, but as an indication of my preferences about medical care, including desires to have specific types of treatments administered. I understand that my wishes as expressed in this document, or as articulated by my health care agent or another surrogate deciding on my behalf, will not have greater power to compel treatment than would be the case if I could contemporaneously state my views. I intend this document to help guide my medical care in a variety of situations, including the last period of my life.

Let me say in advance that I fully appreciate the loving care given to me by my family and friends and by members of the health care professions. If I cannot thank you personally at that time, I wish to do so now from the depths of my heart. You are performing a true act of "*hesed*," an act of devotion and love. If the pain I suffer at that time makes me cranky and hard to tolerate, please forgive me. Please understand that I may not be in control of my reactions at that time and that, no matter what I say or do, I deeply appreciate the many kindnesses you have bestowed upon me throughout life and especially at that critical stage.

A. GENERAL VIEWS

1. Goals of treatment: (Please mark one statement)

   ☐ It is my wish that all prudent medical treatment should be extended to me with the aim of effecting my recovery. Should that be deemed impossible, all nutrition, hydration, medication and necessary surgical procedures should be continued where these are understood to be effective measures for extending my life. Medical knowledge, however, may find itself at a loss as to which form of treatment is best for me, or whether a given treatment will be helpful or harmful. In such circumstances I would want a course of action that protects me from unnecessary pain and degradation while pursuing the goal of life.

   ☐ It is my wish that all prudent medical treatment should be extended to me with the aim of effecting my recovery. Should that be deemed impossible, I want those caring for me to act for my benefit, interpreting that value in light of the choices I have made below and any other knowledge you have of me. In some cases in which I am terminally ill or permanently unconscious, choices to withhold or stop life-sustaining treatment may be consistent with my wishes and my understanding of Jewish teachings.

2. Knowledge of my condition: (Please mark one statement)

   ☐ I wish to know all relevant facts of my condition. I can cope better with a known threat than with the unknown.

   ☐ I do not wish to know all the details of my condition, especially if the news is bad. I fear that such knowledge will diminish my will to live and will cast a shadow over the time left to me.

3. Health care agent: (Please mark one statement)

   ☐ In an associated proxy directive, I have appointed as my health care agent to make decisions on my behalf. I want my agent strictly to follow this document, and only to rely on other sources of knowledge about my wishes and values in situations not covered by this document.

☐ In an associated proxy directive, I have appointed as my health care agent to make decisions on my behalf. I cannot fully anticipate what will happen to me in years to come, future developments in medical practice, or the particular health care decisions which will have to be made on my behalf. While I am filling out this document to educate myself and give my agent some idea of my attitudes in these matters, my agent should draw on all sources of knowledge about my wishes and values. It is not this document, but my agent, who has ultimate authority to make decisions for me if I cannot do so for myself.

☐ I have not appointed a health care agent. I would want those making decisions on my behalf to rely on this document in determining my wishes and values.

4. Jewish spiritual consultation: (Please mark one statement)
   ☐ If I can make my own decisions about my health care when critical decisions must be made, I intend to consult my clergy for further advice about the specific issues which arise in the medical situation in which I actually find myself.
   If I cannot make my own decisions regarding my care, I would ask that those making decisions for me likewise review them with my clergyperson:
   Name: ____
   Address: ____
   Phone number(s): ____________________________________

   ☐ Should he or she be unavailable, it is my wish that

IRREVERSIBLE, TERMINAL ILLNESS: If I am diagnosed with an irreversible terminal illness, such that death is expected within six months no matter what treatment is provided, and if that diagnosis is confirmed by more than one physician, the following statements should assist my agent or other decision maker in deciding on my behalf.

1. Diagnostic tests if I am terminally ill: (Please mark one statement)
   ☐ I wish to have available all possible information concerning my condition. Should I be unable to understand such information at the time, I wish my agent, family members, and physicians to have such information available. Even if my condition is medically hopeless, further analysis of my disease may someday help doctors help someone else, including members of my own family who may be prone to the same disease.

   ☐ I do not wish to have diagnostic tests performed on me unless they are clearly related to the effort to make me well.

2. Surgery if I am terminally ill: (Please mark one statement)

☐ I would consent to reasonable surgery as proposed by my physicians. All surgery carries an implicit risk through anesthesia, the increased possibility of infection, and trauma to the body.

☐ I do not consent to such risk except if it is required to extend my life, to restore me to health, or to free me from unbearable pain.

☐ I do not consent to such risk except if it is required to restore me to health or to free me from unbearable pain.

☐ I would not accept such risk if it would merely prolong my life.

3. Amputation if I am terminally ill: (Please mark one statement)
   ☐ I desire above all to live. I am prepared to lose a limb if, in the best medical judgment of my physicians, this is necessary in order to prolong my life. There may come a time when my physicians feel that my life is threatened by infection, and that the most effective defense lies in amputation of the affected limb.

   ☐ I find the notion of amputation unbearable, and the risk of such an operation intolerable. I prefer all other treatments to fight the infection, even if they are significantly less likely to prolong my life.

4. Modes of feeding if I am terminally ill: If I am not able to feed myself or to eat and drink through the mouth even with the help of others, the following would represent my wishes: (Please mark one statement)
   ☐ I would want to receive artificial nutrition and hydration (food and water delivered through a tube) when this would help to strengthen my body, improve my wellbeing or prolong my life. I understand that this procedure may at some point require restraint so that I do not dislodge the tubes (in the case of naso-gastric tubes) or require surgery to place a tube in my stomach or intestine.

   ☐ I would not want to be fed through feeding tubes at all. I fear the risks that such procedures entail. Whatever nourishment can be provided intravenously should be provided.

   ☐ I would want to receive artificial nutrition and hydration on a trial basis. A decision about continuing treatment should depend on its effectiveness in helping to strengthen my body, improve my well-being or prolong my life; and on the degree of pain or severe discomfort that the treatment appears to impose.

☐ I would not want to be fed by artificial means at all. I fear the risks that such procedures entail. I prefer to eat normally for as long as I can, and when I can no longer do that, to let nature take its course.

5. Aggressive medical or surgical procedures if I am terminally ill: (Please mark one statement)
   ☐ I wish above all to live. To that end I would undertake any regimen, however difficult, which stands a reasonable chance of helping me.

   ☐ Aggressive medical or surgical procedures, such as aggressive radiation and chemotherapy, can be most debilitating and destructive. While I desire to fight my disease with all effective tools at my command, I do not wish to undertake treatments which have not been shown to offer meaningful, measurable results. If my physician determines that a given mode of therapy will probably not produce remission or recovery, I prefer to engage in hospice care, accepting the inevitability of my impending death, curbing pain as much as possible, and living out the remainder of my life to the fullest.

6. Mechanical life support if I am terminally ill: (Please mark one statement)
   ☐ I consider that as long as my brain is still active, even if I must breathe with the aid of life support equipment, my life has not yet been called back. These technologies should therefore be maintained. I recognize, however, that if the total absence of brain activity can be verified, I will be considered dead despite mechanically induced respiration and heartbeat.

   ☐ If mechanical means of life support cannot contribute to my recovery, I consider them to be impediments to my death, even though they may prolong biological function. Therefore, I wish that they be forgone or withdrawn when my agent or designated representative, in conjunction with my physicians, conclude that they offer me no reasonable chance of return to unaided functioning.

7. Cardiopulmonary resuscitation if I am terminally ill: (Please mark one statement)
   ☐ Should my cardiopulmonary system fail for any reason, in every case I would like the utmost done in my behalf.

   ☐ If my heart has stopped beating and my condition is such that there is no reasonable expectation of my recovery, I would consider cardiopulmonary resuscitation, by whatever means, to be contrary and therefore ask that my body not be subjected to such handling. In such a case I would consider a Do Not Resuscitate order to be appropriate.

8. Pain relief and risk if I am terminally ill: (Please mark one statement)
   ☐ If I am in pain or significant discomfort, I desire that I be given appropriate medication and other care to relieve my pain and make me as comfortable as possible. However, I do not want any treatment which would impose a risk of greater than 50% of hastening my death.

   ☐ If I am in pain or significant discomfort, I desire that I be given appropriate medication and other care to relieve my pain and make me as comfortable as possible. In the unlikely event that no alternative measures could adequately reduce my symptoms, I would want sufficiently large dosages of medication to avoid pain even if such dosages may entail great risk of the side effect of indirectly shortening my life.
9. Pain relief and sedation if I am terminally ill: (Please mark one statement)
   ☐ I will accept considerable periods of sedation to avoid pain.

   ☐ If I remain alert, I am prepared to accept a reasonable amount of pain in order to maintain my awareness.

10. Hospital or home care if I am terminally ill: (Please mark one statement)
    ☐ I prefer to be supported by the best medical technology. To that end, if my death is not sudden, I wish that it occurs in the confines of a hospital.

    ☐ To the extent that it is practicable and not an undue hardship upon my family, I would prefer to die at home or in a congenial supportive care facility such as a hospice rather than in a hospital.

    ☐ When hospital care is no longer able with confidence to effect my recovery, I would prefer such comfort-oriented care, with the clear understanding that all essential medical care that would accord with my wishes will be continued.

PERMANENT LOSS OF CONSCIOUSNESS: If I am diagnosed to be permanently unconscious, a diagnosis tested over a reasonable period of time and confirmed by more than one physician with appropriate training and expertise, but I am not terminally ill, the following statements should assist my agent or other decision maker in deciding on my behalf.

1. Cardiopulmonary resuscitation if I am permanently unconscious: (Please mark one statement)
   ☐ Should my cardiopulmonary system fail for any reason, and there is a reasonable likelihood that cardiopulmonary resuscitation would be effective in extending my life, I would like the utmost done in my behalf.

☐ If my heart has stopped beating and my condition is such that there is no reasonable expectation of my recovery of consciousness, I would consider cardiopulmonary resuscitation, by whatever means, to be contrary to healing, and therefore ask that my body not be subjected to such handling. In such a case I would consider a Do Not Resuscitate order to be appropriate.

2. Other treatments if I am permanently unconscious: (Please mark one statement)
   ☐ I would want to receive all treatments that would be effective in extending my life, including mechanical interventions such as respirators, even if there is no reasonable hope of my regaining consciousness. All nutrition, hydration, medication, and necessary surgical procedures should be continued where these are understood to be effective measures for extending my life, even if there is no reasonable hope of my regaining consciousness.

   ☐ I would consider mechanical means of life support to be an impediment to my death and would want them withheld or withdrawn.

   ☐ I would want any machines or medications (including antibiotics) used to keep me alive to be withheld or withdrawn. If there is no reasonable hope of my regaining consciousness, I would want to forgo all treatments and interventions extending my life, including artificial provision of nutrition and hydration, which I consider to be medications.

   ☐ If artificial means of providing nutrition and hydration were used during the period in which my diagnosis was being formed and tested, I hereby ask that the feeding tubes (wherever they are attached to my body) be removed once the diagnosis is confirmed, just as other medications and machines which have proven to be ineffective in effecting my cure may be removed.

WISHES IN CASE OF DEATH:

1. Organ donation: (Please mark one statement)
   ☐ I am aware that Jewish law permits and commends the donation of organs and other body parts for transplantation. Accordingly, I desire that when I die any or all of my vital organs and other body parts be donated for the purpose of transplantation. The rest of my remains should then be buried in a Jewish cemetery in accordance with Jewish law and custom.

   ☐ I would want my organs and other body parts to be donated for transplantation only if there is someone who needs them at, or shortly after, the time of my death.

The rest of my remains should then be buried in a Jewish cemetery in accord with Jewish law and custom.

☐ I would want the following body parts to be donated for purposes of transplantation:

- ☐ Kidneys
- ☐ Heart
- ☐ Skin
- ☐ Corneas
- ☐ Liver
- ☐ Pancreas
- ☐ Other ____

The rest of my remains should then be buried in a Jewish cemetery in accord with Jewish law and custom.

☐ I do not wish that any part of my body be used for purpose of transplantation.

2. Autopsy: (Please mark one statement)

☐ I do not want an autopsy performed unless it is absolutely required by government authorities. If such an autopsy is performed, I ask that it be conducted with all possible respect and that all of my body parts subsequently be buried in a Jewish cemetery in accordance with Jewish law and custom.

☐ I would allow an autopsy to be performed if necessary, to provide information that would help save the life of a family member or other identifiable individual. If any autopsy is performed, I ask that it be conducted with all possible respect and that all of my body parts subsequently be buried in a Jewish cemetery in accordance with Jewish law and custom.

☐ I would allow an autopsy to be performed either to help save the life of an individual or if it would enable physicians to learn more about my disease because my case is not routine. If any autopsy is performed, I ask that it be conducted with all possible respect and that all of my body parts subsequently be buried in a Jewish cemetery in accordance with Jewish law and custom.

As God is my rock and my fortress and my deliverer, so may God be my refuge, my shield my salvation, forever.

Signature:____

Name:____

Date:____

Address:____

City:____

I declare that the person who signed this document, or asked another to sign this document on his or her behalf, did so in my presence, that I know him or her to be the person named as the subject of this document, and that he or she appears to be of sound mind and acting of his or her free will, free of duress or undue influence. I am eighteen years of age or older, and I am not designated by this or any other document as the person's health care agent or alternate health care agent.

Witness 1: Signature: __________________________ Name: __________________________

Date: _____________________________________

Address: ____________________________ City: _______________________________

Witness 2: Signature: ___________________________Name: _________________________

Date: _______________________________

Address: _______________________________City:__________________________________

Sources:

Committee on Jewish Law and Standards ~ The Rabbinical Assembly

www.chayimaruchim.com