

# PREPARING ADVANCE DECISIONS

(‘Living Wills’, ‘Advance Directives’ and Advance Directions’)

Although every individual may have a different idea about what would, for them, constitute a ‘good death’, for many this would involve:

Being treated as an individual, with dignity and respect;

Being without pain and other symptoms;

Being in familiar surroundings; and

Being in the company of close family and/or friends

We have practical things we need to process in order to create the “good death” each of us should seek. Imagine the gift of preplanning our funerals and sparing our families the need to pick out a plot, select a casket, and decide whether or not we wanted *taharah*- ritual washing before burial.

Imagine sparing our families the discussion regarding whether we wanted to donate our organs and, if so, which organs we wanted donated. Most importantly, though, imagine the gift of them knowing that they are following our well-thought-out decisions regarding what medical care we want to receive as we are dying.

Let your family and doctors know:

Who you want to make health care decisions for you when you can't make them.

The kind of medical treatment you want or don't want.

How comfortable you want to be.

How you want people to treat you.

What you want your loved ones to know.

# JEWISH PERSPECTIVE:

## A RANGE OF OPINION

- ☆ Life is a blessing and a gift – we therefore have a responsibility to care for ourselves and our loved ones
- ☆ 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. 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.
- ☆ Human life is essential and so *pikuach nefesh-the obligation to save a life*, is considered a major value to uphold. This obligation applies to both an immediate threat and a less grave danger that has the potential of becoming serious. *Pikuach nefesh* is derived from the biblical verse, “Neither shall you stand by the blood of your neighbour” (Lev. 19:16). According to *pikuach nefesh* a person must do everything in his or her power to save the life of another, except sacrifice one’s own life. Even traditional Judaism views that one may donate an organ to a person in critical need, so long as it does not put the donor’s life at risk.
- ☆ It is not a Jewish act to end life before its time *but* technology creates dilemmas we don't know how to face
- ☆ “A dying person is considered as a living person in all matters. It is forbidden to touch the person to prevent the hastening of death” (Code of Jewish Law: Yoreh Death 339:1)
- ☆ “Even if a patient has agonised for a long time, it is forbidden to hasten death by, for instance, closing his eyes or removing a pillow from under his head.” (ibid)
- ☆ In accordance with Judaism’s tradition of respect for life, and its consequent bans on murder and suicide, traditionally Jews reject any form of active euthanasia (“mercy killing”) or assisted suicide. This position requires decisions that 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.

Varying Positions:

### **Reform/Masorati (Conservativ) Position:**

As ever there is a spectrum of opinion and interpretation amongst our Rabbis:

There is universal agreement:

- on the value of life and the individual's responsibility to protect his or her life and seek healing.
- That there is a large area of autonomy in which a patient can make decisions about treatment when risk or uncertainty are involved.
- That terminally ill patients are able 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.

Where there is disagreement:

‘Life under the siege of a terminal illness is an impaired life, therefore one may decide that treatment that extends life without a hope for a cure would not benefit and therefore may be foregone.’ Rabbi Elliot Dorf

Resulting in:

**Viewpoint A** affirms the supreme value of protecting all life. Even the most difficult life and that of the shortest duration is still God given, purposeful, and ours to nurture and protect. All nutrition, hydration, and medication should be provided whenever these are understood to be effective measures for sustaining life. Some medical interventions, however, do not sustain life so much as they prolong the dying process. These interventions are not required. The distinction may best be judged by our intent. We may choose to avoid treatments causing us fear or

entailing risk or pain, in the interest of the remaining moments of life. We may not avoid treatment in an attempt to speed an escape into death.

**Viewpoint B** finds basis in Jewish law to grant greater latitude to the patient who wishes to reject life-sustaining measures. Life under the siege of a terminal illness is viewed as an impaired life. In such a circumstance, a patient might be justified in deciding that a treatment that extends life without hope for cure would not benefit him or her, and may be forgone.

Letter to the Editor, The Times

Until now I have opposed assisted dying because of the “slippery slope” argument that it might lead to involuntary assisted dying, but I have changed my mind – both because of the safeguards pre-opposed the Demos report and because, as a minister of religion, I have too often seen people spend their last weeks suffering in pain or sedated into oblivion. As someone whose faith values the sanctity of life, surely I honour best God’s love, and the terminally ill who, even palliative care cannot help, by allowing them to die peacefully if they so wish rather than departing in agony in the name of a misguided understanding of faith.

The accusation that assisted dying is “playing God” is actually a compliment: we are constantly using our God-given abilities to overturn nature, whether it be intervening to save a premature baby or carrying out heart transplants for adults; alleviating the pain and distress of death is equally appropriate and is nothing other than a religious response.

Rabbi Dr Jonathan Romain.

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**Traditional Position:**

The traditional position makes a clear distinction between withholding or withdrawing treatment.

“Man does not possess absolute title to his life or his body. He is charged with preserving, dignifying and hallowing that life. He is obliged to seek food and sustenance in order to safeguard the life he has been granted; when falling victim to illness or disease he is obliged to seek a cure in order to sustain life. The category of *pikuach nefes*-preservation of life extends to human life of every description and classification including the feeble-minded, the mentally deranged and yes, even a person in a so-called vegetative state. Shabbos laws and the like are suspended on behalf of such persons even though there maybe no chance for them ever to serve either G-d or fellow man. The mitzvah of saving a life is neither enhanced nor diminished by virtue of the quality of the life preserved.”

Thus, “death with dignity,” the rallying cry of the modern day euthanasia movement, clearly does not find its roots in the law or values of Torah. Elderly persons who speak of their desire to die rather than become a financial or emotional “burden on the children” may have the most noble of intentions, but nobility of intention is not the yardstick by which Jews measure conformity with God’s will. Those who champion only the *quality* of human life as the overriding value in health care decisions disregard the longstanding Jewish emphasis on the *sanctity* of human life, even in its most diminished qualitative form.

You cannot withdraw a ventilator, but you can withhold aggressive treatment if there is no possibility of saving life and probably even prolonging life.

In sum, the complexity of the halachic issues, the diversity of views among rabbinic authorities with respect to certain *she'eilot-questions*, the relative difficulty of finding rabbis prepared to offer halachic guidance -- none of these considerations detracts from the fundamental fact that for the Jew, the framework of analysis and decision on these issues must be the *halachah*.”

Rabbi J. David Bleich

# ADVANCE DECISIONS

## THE STEPS

1. *Decide your position on the key issues.*
2. *Decide if you want to appoint a LPA (“Lasting power of attorney”; proxy”) and if you want this person to be different from your financial and administrative power of attorney.*
3. *Choose the form you want to complete. The difference in the forms is in the amount of commentary you want to write to explain your choices, or the detail you wish to include.*
4. *Talk to your GP, family, friends, your rabbi – whomever will help you clarify the issues for yourself*
5. *Complete the Health Care Agent proxy and Advance Decision directive, ensure they are witnessed*
6. *Lodge the forms with your lawyer, GP, family, friends, LPA*

### **NOTE: APPOINTING A LASTING POWER OF ATTORNEY**

*(“Health Care Agent”, “Health Care Proxy”)*

*Experts in Jewish law and in medical ethics agree that you can best guide treatment decisions by appointing a Health Care Agent and an Advance Decision directive. Nevertheless, conflicts could arise in the future between what your agent judges that your wishes would be and the way in which someone else interprets the Advance Decision directive. In most cases, discussion among those involved would help to clarify your wishes. 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. If you appoint a proxy agent s/he 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 demeanour as to how you want to approach these issues.*

### **REVIEWING YOUR DECISIONS**

*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. Opinions differ as to how frequently you renew your choices; some recommend annually (perhaps as part of your lead up to the High Holydays) and some suggest every four to five years. The more current it is, the more powerful.*

### **CARRYING A CARD IN YOUR WALLET**

*You may want to carry a card in your wallet or handbag that indicates that you have completed an Advance Decision directive, the name of your Health Care agent, whether this information is lodge with your GP/local hospital and how they can be reached.*

## ADVANCE DECISION OPENING STATEMENT

To my family, my doctors, my lawyer, and my rabbi  
To any medical facility in whose care I happen to be  
To my Health Care Agent

Death is as much a reality as birth, growth, maturity and old age – it is the one certainty of life. If the time comes when I, \_\_\_\_\_ can no longer take part in decisions for my own future, let this statement stand as an expression of my wishes, while I am still of sound mind.

If the situation should arise in which there is reasonable expectation of my recovery from mental incapacity, I request that I be allowed to die and not kept alive by artificial means or “heroic measures”. I do not fear death itself as much as the indignities of deterioration, dependence, and hopeless pain. I therefore ask that medication be mercifully administered to me to alleviate suffering even though this may hasten the moment of death.

This request is made after careful consideration. I hope you who care for me will feel morally bound to follow its mandate. I recognise that this appears to place a heavy responsibility upon you, but it is with the intention of relieving you of such responsibility and of placing it upon myself in accordance with my strong convictions, that this statement is made.

Signed  
Date

Witness 1  
Name  
Date

Witness 2  
Name  
Date

Copies of this request have been given to:


## ADVANCE DECISION

## APPOINTMENT OF MY HEALTH CARE AGENT

(For this proxy to have legal standing, it **must** be witnessed by two, non relatives)

I, \_\_\_\_\_, am over eighteen and of sound mind.

Should I become medically unable to make health care decisions for myself, I name \_\_\_\_\_ my \_\_\_\_\_ (put in your relationship i.e. trusted friend, partner etc) as my representative to make medical decisions for me. S/he can be contacted at \_\_\_\_\_ (contact details)

Signed and witness by me  
Designated proxy care agent:

Date

Witness 1  
Address  
Date

Witness 2  
Address  
Date

Copies of this proxy have been given to

1. LPA
2. Family
3. GP/Hospital that has your records
4. Others (Lawyer, friend etc)

For this proxy to be legal, it must be registered with the office of the Public Guardian ([www.publicguardian.gov.uk](http://www.publicguardian.gov.uk) / 0845 330 2900).

Note: There is currently a £20 charge for this registration.

## ADVANCE DECISION DOCUMENT

*(Please mark one statement)*

- This document concerns health care decisions that may arise. I want my LPA strictly to follow the document, and only to rely on other sources of knowledge about my wishes and values in situations not covered therein.  
Or
- I realise, 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 LPA 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.  
Or
- I have not appointed a LPA and would ask my family and doctors to make their best judgement on my health care with due regard to this document.

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 traditions of Judaism and God's desires.

I ask that my LPA, 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 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. 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. In the tradition of our people, I ask that the spirit, strength and comfort of God abide with us always.

Further comment:

Signed

Date

REVISED DATE:

**WITNESSED BY:**

I declare that the person who signed this document, 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.

SIGNATURE	SIGNATURE
PRINT NAME	PRINT NAME
ADDRESS	ADDRESS
DATE	DATE

Advance Decision documents do not have to be registered, the LPA does.

# ADVANCE DECISION DIRECTIVE

## 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.

Or

- 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. If I am terminally ill or permanently unconscious, choices to withhold or stop life-sustaining treatment are consistent with my wishes and my understanding of Jewish teachings.

Additional comments:

### 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.

Or

- 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.

Additional comments:

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

- In an associated proxy directive I have appointed as my LPA 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.**

Or

- In an associated Advance Decision directive I have appointed as my LPA 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 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.**

Or

- 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.

Additional comments:

**4. Rabbinic 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 rabbi 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 rabbi:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number(s): \_\_\_\_\_

Should he or she be unavailable, it is/is not my wish that another rabbi be consulted.

OR

- I would leave the decision about rabbinic consultation to the discretion of those deciding on my behalf.

OR

- I do not intend, nor does anyone on my behalf, need to consult with a rabbi

Additional comments:

**B. 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.

OR

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

Additional comments:

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

- I would consent to reasonable surgery as proposed by my physicians. I do not consent to such surgery except if it is required to extend my life, to restore me to health, or to free me from unbearable pain.

Or

- I do not consent to surgery except if it is required to restore me to health or to free me from unbearable pain. I would not want surgery if it would merely prolong my life.

Additional comments:

**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.

Or

- There may come a time when my physicians feel that my life is threatened by infection, and that the most effective defence 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.

Additional comments:

**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 nasal-gastric tubes), or require surgery to place a tube in my stomach or intestine.

Or

- 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.

Or

- 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.

Or

- 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.

Additional comments:

**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 regime, however difficult, which stands a reasonable chance of helping me.

Or

- 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.

Comments:

**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 God-given 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.

Or

- If mechanical means of life support cannot contribute to my recovery, I consider them to be impediments to my death at God's behest, 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.

Comments:

**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.  
OR
- 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 to God's will, 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.

Comments:

**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.  
Or
- 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.

Comments:

**9. Pain relief and sedation if I am terminally ill:** *(Please mark one statement)*

- I will accept considerable periods of sedation to avoid pain.  
Or
- If I remain alert, I am prepared to accept a reasonable amount of pain in order to maintain my awareness.

Comments:

**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 occur in the confines of a hospital.  
Or
- 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.

Comments:

**C. 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.  
Or
- 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 God's will, 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.

Additional comments:

**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.  
Or
- 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.  
Or
- All means of nutrition and hydration 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 want any machines or medications (including antibiotics) used to keep me alive to be withheld or withdrawn.  
Or
- 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.

Comments:

**D. 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 or cremated in a Jewish cemetery in accordance with Reform Jewish custom.  
Or
- 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 or cremated in a Jewish cemetery in accord with Reform Jewish custom.

Or

- 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 or cremated in a Jewish cemetery in accord with Reform Jewish custom.
- I do not wish that any part of my body be used for purpose of transplantation.

Comments:

**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 Reform Jewish custom.  
Or
- 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 or cremated in accordance with Reform Jewish custom.  
OR
- 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 Reform Jewish custom.

Additional comments:

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

## Advance Directives (Living Wills)(Advanced Decision) (England and Wales)

Excerpted and adapted from patient.co.uk

### Terminology

The term *advance directive* (increasingly being replaced by the term *advance decision*) means a statement explaining what medical treatment the individual would not want in the future, should that individual 'lack capacity' as defined by the Mental Capacity Act 2005. The term 'living will', whilst helping people to understand the concept, is somewhat misleading in that, unlike a will, it does not deal with money or property. Moreover, it can relate to all future treatment, not just that which may be immediately life-saving. An advance directive is legally binding in England and Wales. Except in the case where the individual decides to refuse life-saving treatment, it does not have to be written down, although most are and a written document is less likely to be challenged.

Whilst the patient has capacity their word overrides anything contained in their advance directive or anything their legal representative may say.

(If doctors have doubts about the validity of an advance decision they should consult early with their indemnity organisation and they may be able to apply to the Court of Protection to overrule it.)

### The advantages of an advance directive

An advance directive enables an individual to think about what they would like to happen to them in the event that they lose the capacity to take informed decisions about their care.

Examples of such decisions include:

- The use of intravenous fluids and parenteral nutrition (feeding a person intravenously)
- The use of CPR (cardiopulmonary resuscitation)
- The use of life-saving treatment (whether existing or yet to be developed) in specific illnesses where capacity or consent may be impaired - for example, brain damage, perhaps from stroke, head injury or dementia.
- Specific procedures such as blood transfusion for a Jehovah's Witness.

Even if a directive is not eventually issued, the topic may motivate the individual to discuss future arrangements with their doctor, family and friends.

### Limitations of an advance directive

An advance directive cannot be used to:

- Ask for specific medical treatment.
- Request something that is illegal (e.g. assisted suicide).
- Choose someone to make decisions for you, unless that person is given 'lasting power of attorney'.
- Refuse treatment for a mental health condition (doctors are empowered to treat such conditions under Part 4 of the Mental Health Act).

A doctor may not follow an advance directive if:

- The individual makes changes which invalidate the directive (e.g. a change to a religion which prohibits the refusal of treatment).
- There have been advances in treatment which may have affected the initial treatment (unless the individual specified in the directive that such advances would be declined).
- There is ambiguity in the wording of the directive (e.g. the wording is not relevant to the current medical condition).

A directive may be invalid:

- If it is not signed.
- If there is reason to doubt authenticity (for example, if it was not witnessed).
- If it is felt that there was duress.
- if there is doubt as to the person's state of mind (at the time of signing).

### **Management of an advance directive**

For a directive to be enforced, it is first necessary that the clinical team be aware that such a provision exists. It could be recorded in the individual's computerised or manual notes and a form for the purpose is available from the National End of Life Care Programme website.

Just as a will has an executor, so a directive may have a healthcare proxy. This person may also have 'lasting power of attorney'. Such a provision is common when a person is no longer competent to manage his or her own financial affairs. The role of the proxy is to see that the wishes of the individual are carried out. He or she does not have the power to make decisions. The wishes of the patient may not be overruled by relatives.

An advance directive does not have to be drawn up by a solicitor but neither does a will. However, in both cases, the involvement of such a professional should substantially reduce the chance of an oversight that would result in failure of the will to be observed. A will usually has to be signed by the author and co-signed by two independent witnesses who are not beneficiaries of the will. It is sometimes said that only one witness is required for an advance directive but to replicate a will, two may be safer and they should be people who do not stand to benefit from the estate.

An advance directive can be rescinded or updated at any time but, at the time that it is implemented, the individual is in no position to offer an opinion. If the contents are changed, all old wills should be destroyed.

### **Drawing up a directive**

Before such a document is produced, it is important for the individual to discuss it with their family. The following checklist may help:

**Matters to consider when planning an advance directive**

<b>Opinion about the following situations</b>	<i>Would prefer to die</i>	<i>Would probably prefer to die</i>	<i>Uncertain either way</i>	<i>Would probably prefer to live</i>	<i>Eager to stay alive</i>
Permanently paralysed but able to relate to others.					
Totally dependent on others. Needs to be fed.					
Aware but unable to communicate.					
Confused and very poor memory.					
Constant uncontrolled pain.					
Brain damage. In coma. If regained consciousness, markedly impaired.					
Terminal illness, not necessarily cancer.					

After detailed consideration of the implications, a directive may be drawn up as, for example, those outlined below:

I, (name) of (address) wish the following to be considered in the event of my incapacity to give or withhold consent for medical intervention.

If ever I am unable to communicate and have an irreversible condition and I am expected to die in a matter of days or weeks, or if I am in a coma and not expected to regain consciousness or if I have brain damage or disease that makes me unlikely ever to recognise or relate to people then I want treatment only to provide comfort and relieve distress, even if this may shorten my life. I do not want treatment that can only prolong dying.

I consent to any acts or omissions undertaken in accordance with my wishes and I am grateful to those who respect my free choice. I reserve the right to revoke or vary these conditions but otherwise they remain in force.

If I am certified brain dead, should any of my organs be of value to others, I give consent to their removal for the purpose of transplantation.

State where copies may be lodged. The person must sign and date the document.

Beneath this may be two signatories, also with dates below a statement to the effect that the above signed in their presence and was, to the best of their knowledge under no duress and of sound mind. They also believe that they will not benefit from the estate.

### **Who should make an advance directive?**

An advance directive can be made by anyone who is over 18 years old, is of sound mind and cares about the issues involved. Some people may be especially likely to choose the option, including those with incurable cancer, those with a progressive neurological disease and those with mild memory loss, as they are still of reasonably sound mind but at risk of progressing to dementia.

If, as a doctor or healthcare professional, you are approached by someone who is considering an advance directive there are several points to make:

- Think very carefully about the content of such a directive before committing yourself.
- Discuss it with those close to you and try to cover all eventualities.
- It is a valid legal document that cannot be overruled by family.
- It is not possible to request illegal action such as euthanasia.
- It is not possible to request interventions that the medical team regards as excessive and inappropriate.
- It can be changed or revoked at any time if you are competent to do so.
- It must be signed, dated and witnessed.
- It is not essential to make it via a solicitor but there may be some safeguards in doing so.
- Doctors and family should know that such an advance decision exists and where it is lodged.
- Make sure that you also have an up-to-date ordinary will. About a third of people die intestate.

# The Liverpool Care Pathway for the Dying Patient (LCP)

From the MARIE CURIE PALLIATIVE CARE INSTITUTE LIVERPOOL (MCPCIL) LCP Briefing Statement - March 2011

The LCP Programme is a major initiative to improve care of the dying within healthcare. Seventeen years ago it was recognised that hospices had a model of best practice to promote a dignified death with the appropriate support for relatives and carers, however, there was no plan in place outside of the hospice setting to support care in the last hours or days of life. The LCP is an integrated care pathway whose purpose is to transfer the key principles of the hospice model into general health care settings supported by a robust training and education programme. There is a systematic 10-step implementation process within a 4 phased service improvement model to support the appropriate use of the LCP.

The LCP Continuous Quality Improvement Programme incorporates:

## 1 Aim

To improve care of the dying in the last hours or days of life

## 2 Key Themes

To improve the knowledge related to the process of dying

To improve the quality of care in the last hours or days of life

## 3 Key Sections

Initial Assessment

Ongoing Assessment

Care after death

## 4 Key Domains of Care

Physical

Psychological

Social

Spiritual

The patient's condition is continually monitored in order to assess the patient's needs and to give support to the relatives/carers. Clinical experience has shown that in around 3% of cases, the patient's condition can improve and the patient is no longer deemed to be in the dying phase. A full reassessment of the patient is then undertaken and an alternative management plan is put into place.

Recognition of dying is not in itself a decision that automatically leads to withdrawal or withholding of care, treatment or interventions. It does however require a review of the current situation and current care, treatment and interventions – healthcare professionals need to stop, think, assess and change care according to the patient's individual needs and communicate this change in the focus of care effectively to all concerned. The views of the patient, relative / carer should always be listened to and taken into account as part of any decision making process.

# ADVANCE DECISIONS

## RESOURCES

There are various organisations that provide Advance Decision directives and information to support your decision making.

The following are the key have explored for this workshop:

Compassion in Dying [www.compassionindying.org.uk](http://www.compassionindying.org.uk)

Age UK [www.ageuk.org.uk](http://www.ageuk.org.uk)

Patient UK [www.patientuk.org.uk](http://www.patientuk.org.uk)

5 Wishes (USA) [www.fivewishes.com](http://www.fivewishes.com)

Office of the Pubic Guardian [www.publicguardian.gov.uk](http://www.publicguardian.gov.uk)

Two useful books for Jewish perspective

*A Time to Prepare*, Richard Address, UAHC Press 2002 (USA)

*Behoref hayamim: In the Winter of Life: a values based guide for decision making at the end of life*, Center for Jewish Ethics, RRC Press, 2002

NOTES: