Advanced Illness and Orthodox Jewish Law: Approaches to Communication and Medical Decision Making

Introduction:

Interactions between Orthodox Jewish patients at the end of life and medical practitioners are frequently difficult. Orthodox Jewish law places a great emphasis on extending life, and many Orthodox Jews assume—sometimes incorrectly—that they must pursue aggressive care under all circumstances according to Jewish law. Clinicians concerned with avoiding unnecessary suffering express resistance to what they feel are unfortunate decisions by Orthodox Jewish patients to pursue futile care. Physicians are often uncomfortable dealing directly with Rabbis as participants in medical decisions, but they are also frustrated when they are asked by families to defer to Rabbis with whom they have not spoken directly. Orthodox Rabbis are typically consulted on medical decisions quickly and over the telephone by a family member in a moment of crisis. Furthermore, although they tend to seek out high-level academic medicine, Orthodox Jews are often simultaneously believers in medical science and mistrustful of doctors and hospitals. They may fear that secular medical ethics will fail to honor their spiritual concerns by focusing only on secular and particularly pragmatic or financial objectives. Among people for whom the horrors of the Nazi Holocaust and other crimes are a very real part of their personal experience and history there may be a strong level of distrust of Gentile society's level of respect for the value of each individual Jewish life. Orthodox Jewish families may also express a continuing hope for divine intervention in saving the life of their loved ones, a type of belief that treating clinicians often have trouble incorporating into medical decision making.

These conflicts stem in part from legitimate conflicts over principles. But they also stem from lack of communication and poorly informed decisions. In some cases, this leads to unnecessary physical suffering; in others, it leads to family conflict or to needless emotional pain as people believe, in some cases falsely, that they face terrible choices between their desire to end suffering and their religious obligations.

Several changes in medical practice can, taken together, dramatically improve both the quality and outcomes of medical decisions at the end of life for Orthodox Jewish patients who choose to involve Rabbis in their medical decisions.

- Rather than discouraging Rabbinical participation in the medical decision-making process, health care practitioners should work with Orthodox patients and families who are facing end-of-life situations to involve Rabbis as fully informed partners.
- Whenever possible, Rabbis who are going to advise patients on the requirements of Jewish law should get their medical information directly from physicians rather than summarized by a family member.
- Details matter a great deal in the Orthodox Jewish adjudication of end-of-life medical decisions.

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- Advance care planning conversations are particularly sensitive with Orthodox patients. It is even more imperative that they take place before a crisis if possible.
- Learn how "*Halachic* Living wills" can enhance coordination and hospice access for Orthodox patients.
- Be sensitive to Orthodox Jewish requirements around informing patients of a terminal prognosis.
- The right hospice can work for Orthodox Jewish patients.
- Use a chaplain to facilitate communication and decision making.

Methods: This article grew out of over two years of community-based research conducted by Metropolitan Jewish Health System (MJHS), a major integrated delivery system in New York that includes a large hospice and a palliative care program. UJA-Federation of New York, the world's largest local philanthropy, funded our initiative to research palliative care needs and challenges in Orthodox Jewish communities in New York as part of a major "Jewish Healing and Hospice" grant-making and direct service initiative. MJHS collaborated with community and health care organizations in two sites with large observant populations, Brooklyn and Nassau County, to synthesize a broad spectrum of tools: active ongoing focus group discussions with key Rabbis and physicians, one-on-one interviews with patients, caregivers, and several prominent Orthodox Rabbinical authorities; mailed surveys; consumer focus groups; and literature review.

The cases described below are actual cases, with names changed for confidentiality.

Advanced Illness and Orthodox Jewish Law:

Classical Jewish law strongly espouses first and foremost the principle of the sanctity of life. To save a life, even the Jewish Sabbath and holidays including *Yom Kippur* must be abrogated. The application of the laws of medical treatment and the decision to withhold available remedies are very much questions of Orthodox Jewish law, known as "*Halacha*." Moreover, *Halacha* begins with the strong assumption of the intrinsic value of life of any duration.

Nevertheless, there is active discussion among leading religious authorities about circumstances in which medical intervention with the goal of prolonging life may be considered futile or unjustified due to intense suffering. One well-respected religious authority included in our research, Rabbi Tzvi Flaum, stated as follows: "There is confusion about *Halachic* decision making at the end of life. However the difference between philosophical and practical aspects are taken into account by experienced *poskim* [Rabbis who make legal determinations]. The *Halacha* supports ameliorating pain and suffering and definitely supports pain management in illness and throughout life, until the very end."

In our research, clinicians who are committed to preventing avoidable or unnecessary suffering repeatedly expressed resistance to what they feel are unfortunate decisions by Orthodox Jewish patients to pursue futile care. In many practice settings in New York, clinicians express mounting frustration with both the nature of the medical decision-making process in these cases and the outcomes of that process. These frustrations are captured by the case of Yetta W., described below.

Case One:

Yetta W. was an Orthodox woman who lived in the New York metropolitan area until her recent death at age 78. She was diagnosed with Alzheimer's disease in 1991 when she was 63. For most of her course of illness, Yetta W. was at home. Her two children, who are also Orthodox, were very involved in her home care and ultimately arranged for 24 hour help. In the summer of 2005, Yetta W. had an aggressive systemic infection leading to a hospitalization in a community hospital. With a two week course of IV antibiotics administered in the hospital, she stabilized, although she was now suffering from decubitae, periodic fevers, and dysphagia. The daughters discussed the possibility of continuing to care for their mother at home, but were concerned with the need to maintain her at home with tube feeding. She was discharged into a Jewish nursing home, where she continued to deteriorate and was susceptible to more infections, increasingly triggered by her non-healing wounds.

Yetta W.'s family regularly consulted with their Rabbi by phone. He said to them explicitly that "You have to keep on treating, and when God is ready to take your Mom, he will take her." Based on these consultations the family insisted on a broad spectrum of aggressive treatment including IV antibiotics and medications to sustain blood pressure. As tube feedings were increasingly aspirated, the nursing home began regular suctioning of her lungs, causing Yetta W. visible distress. She was placed on oxygen through a face mask that also caused visible discomfort.

At this point Yetta W. was enrolled in a hospice program. Both the non-Jewish hospice nurse and a Jewish chaplain approached the family about changing the course of treatment in ways that would not significantly shorten her life. They recommended employment of an oxygen tent rather than a mask, the use of opioids to reduce pain, and discontinuing aggressive treatment of aspiration pneumonias. Although family members listened respectfully to these recommendations, they deferred to their family Rabbi's directive to continue treatment, based on periodic phone conversations. At no point did the Rabbi discuss Yetta W.'s condition directly with treating staff or with the hospice chaplain.

After several months of continued aggressive treatment, Yetta W. expired in the spring of 2006.

This case illustrates important principles for professional practice derived from our research.

- Rather than discouraging Rabbinical participation in the medical decision-making process, health care practitioners should work with Orthodox patients and families who are facing end-of-life situations to involve Rabbis as fully informed partners.

Yetta W.'s family trusted their Rabbi greatly on two levels: both as a respected spiritual advisor who was close to them, and as an arbiter of the demands of Orthodox Jewish law. The hospice chaplain's efforts to dissuade them from continuing their previous treatment choices could never be seriously entertained when their family Rabbi disagreed. However, the Rabbi did not participate in family meetings held in the hospital, the nursing home or the hospice. If a family or patient trusts a Rabbi to serve as a major (or the primary) participant in medical decision making, the clinical team will be enhancing its effectiveness in dealing directly with him.

- Whenever possible, Rabbis who are going to advise patients on the requirements of Jewish law should get their medical information directly from physicians rather than summarized by a family member.

Yetta W.'s Rabbi was presented by her daughters with a binary decision: "Should we continue to treat her with every possible modality to prolong her life, or should we not?" Yet medical practitioners often think about end-of-life medical decisions in less binary terms, particularly in terms of significant prolonging of life. Rabbis participating in the decision-making process need most of all accurate and detailed medical information that can help them to understand in what sense an extension of life is truly at stake. Every Rabbi we spoke with indicated that the specific medical circumstances can make an enormous difference in their determination according to Orthodox Jewish law.

The importance of insisting on direct communication with Rabbis is underscored by what can be tangled intra-family dynamics around medical decisions and religious observance. One reason that Rabbis often speak with a family member rather than speaking directly with the doctor is that the family may not unanimously agree on the Rabbi's role. Different kinds of Orthodox Jews actively seek out and abide by Rabbinic input into medical decisions to varying degrees. Among more traditional Orthodox Jews, Rabbis are regarded clearly as decision makers. In more "Modern Orthodox" settings, Rabbis are more often seen as counselors, providing wisdom, guidance and support while patients and/or families make medical decisions. This sometimes results in conflicts within Orthodox families about whether to refer end-of-life medical decisions to a Rabbi or whether to follow one family member's understanding of Jewish law rather than another's or the patient's. In our research, we learned of numerous instances of conflict within families about the role of the family's Rabbi in end-of-life situations. It is important for clinicians to ensure that any Rabbi participating the decision-making process is receiving accurate and detailed medical information even as they seek to navigate these conflicts. This is especially true because these conflicts within families may be based on shared assumptions about the requirements of Jewish law that may be rendered moot after detailed consultation with a Rabbi.

Case Two: Sara K.

Sara K. was an Orthodox woman living in Brooklyn, New York who passed away in 2005 in her mid-90s. She survived the Nazi concentration camps in a narrow and dramatic escape from a gas chamber, and became the mother of two daughters in the United States, both of whom are also Orthodox. In 2000, when she was 90, she became increasingly physically frail and her kidney disease worsened into kidney failure. Sara K. was now largely bed-bound, living at home with a combination of paid care and informal care from her daughters. She was sometimes disoriented but was cognitively able to discuss her medical decisions. One of her daughters had her fill out a "*Halachic* Living Will" that was made avilable in her daughter's synagogue. This form designated a Rabbi—in Sara K.'s case, the Rabbi of her daughter's synagogue—to be consulted on medical decisions.

These consultations took the form, initially, of conversations between both daughters and the Rabbi. The most immediate decision was whether to initiate dialysis, and the consulting Rabbi asked to speak in person with Sara K.'s primary care physician together with both daughters. Because of the potential danger involved with three weekly transfers to a dialysis center, Sara K.'s daughters were reluctant to go forward with the treatment, and the consulting Rabbi was prepared to support a decision against dialysis as itself involving significant risk to life. Given the medical need for dialysis and its concomitant risk, the Rabbi ruled that Sara K. herself should decide. Sara K. understood that she could not live without dialysis and she therefore indicated that she had no choice but to go forward with the treatment.

Together, Sara K.'s family, her Rabbi and her physician developed a treatment plan in which Sara K. would undergo dialysis but would otherwise be maintained at home through the course of her remaining years. The Rabbi stated that, "I felt that given the lady's frail state, that this was an entirely reasonable decision. Whenever you take an older person like this to a hospital, true you may help in dealing with whatever they have, but you could also open them up to all other kinds of infections and other things. So, you don't whether you're doing good or not by doing it, so there's no reason to subject a woman like this to further suffering."

In 2004, Sara K. developed a series of infections requiring IV antibiotics. These were delivered at home with supervision from a home health nurse. She began to suffer from appetite loss, and the home health nurse recommended that she receive a feeding tube. The nurse explained to both of Sara's daughters that the procedure would require a hospitalization. Their initial consultation was in-person with their Rabbi, who asked to speak to their physician before discussing the situation further. The Rabbi learned that Sara K.'s physician was not supportive of placing a feeding tube, both because of the risks associated with a hospitalization and an invasive procedure and because of the difficulty of managing tube feeding in such a medically complex patient without adverse medical consequences. Sara K. continued to receive food by mouth for several months in her home. In 2005, after multiple antibiotics failed to eliminate her systemic infections, Sara K. expired in her home. According to their Rabbi, her daughters expressed comfort in the knowledge that "they did whatever they could, but they also were faithful to *Halacha* but they also did whatever was possible without causing her extra suffering."

In Sara K.'s case, direct Physician-Rabbi communication was crucial to a fully informed decision-making process (notably, that communication took place because of a documented "*Halachic* Living Will" and the fortuitous insistence of the Rabbi on speaking with the physician at multiple points in her course of illness). Sara K.'s case also underlines important additional principles for treating Orthodox patients with advanced illness:

- Details matter a great deal in the Orthodox Jewish adjudication of end-of-life medical decisions.

Every Orthodox religious authority with whom we spoke emphasized the enormous difference the details of a medical situation can make for Orthodox Jewish law. In Sara K.'s case, the serious risks involved in transfers out of her home provided a basis in Jewish law for her to make a decision herself about proceeding with dialysis. Later in her course of illness, her Rabbi made a determination to continue mouth feeding despite her loss of appetite. Under circumstances in which tube feeding can safely prolong life, it is typically mandated by Orthodox Jewish authorities even in end-of-life situations. However, as explained by her physician, initiating and continuing with tube feeding as Sara K.'s condition worsened involved grave medical risks as well as cognitive and physical suffering, while continued mouth feeding did not pose short-term risk to life as such. Sara K.'s consulting Rabbi took these factors into account in his determination of the requirements of Jewish law.

In another case, an oncologist described the following discussion with two sons of a patient who were also Rabbis. It exemplifies an effective communication between the terms of Jewish law and medicine on an end-of-life prognosis.

"*They were concerned – Halacha says you're not allowed to shorten a persons life. So, when I said, 'Well, she looks kind of uncomfortable with that mask there; she keeps pulling it off. I think she'd be a lot more comfortable if she had a big face tent rather than this mask.' They said, 'Well, will that shorten her life?' I said, 'Probably not; I don't think so.' They said, 'And what about if we don't transfer her to the ICU, will that shorten her life?' It's hard to say exactly. I mean, should we monitor a little more closely there? It's certainly not going to shorten her life in any meaningful way to my way of looking at things. Could she live an hour longer if she were in intensive care? It's hard for me to say. I suppose it's possible. But, in any medically meaningful way? That's what I had to tell them. Those were the kind of questions they were asking.*"

- Advance care planning conversations are particularly sensitive with Orthodox patients. It is even more imperative that they take place before a crisis if possible.

Sara K. and her daughters had already discussed and decided upon a plan of care that avoided hospitalization when Sara K. developed loss of appetite. With any family, it can be difficult to choose against aggressive medical treatment in a moment of crisis. This is particularly true for Orthodox families for whom there is a strong religious obligation to prolong life. Orthodox Jewish families

in medical crisis often feel that they are being challenged to stand up for their religious principles and obligations against a hostile medical establishment. In the context of an agreed care plan, what would otherwise seem like a test of a family's faith can become the culmination of a thoughtful, considered process of actualizing their religious principles.

Because of the demands of a typical workday for both physicians and Rabbis, it can be difficult to coordinate a meeting or a conference call on short notice. These potential difficulties represent another reason to have an all-party conversation around pending treatment choices before a crisis hits if possible.

- Learn how "*Halachic* Living wills" can enhance coordination and hospice access for Orthodox patients.

Sara K.'s daughter arranged for her to designate her Rabbi as a health care proxy using a form called a *Halachic* Living Will. A *Halachic* Living Will designates a specific Rabbi as a health care proxy, and may, depending ion the specific format used, also lay out other advance care directives. Importantly, a *Halachic* Living Will not only honors a patient's desire to have a Rabbi participate in medical choices but also documents that role as the patient moves through the health care system and is treated by clinicians who may not be aware of the importance of incorporating the Rabbi into treatment decisions. A *Halachic* Living Will can also facilitate admission to hospice by assuring that medical decisions will remain consistent with Orthodox Jewish law even as the patient receives hospice services.

There are different available *Halachic* Living Will forms that vary in the specific decision-making structure they authorize. *Halachic* Living Wills can be obtained from:

Metropolitan Jewish Hospice 1-866-958-7423
Agudath Israel of America (212) 797-9000
The Commission on Medical Ethics of the Rabbinical Council of America (212) 807-7888.

- Be sensitive to Orthodox Jewish requirements around informing patients of a terminal prognosis

Sara K. participated in medical decisions including her decision to pursue dialysis and to fill out a living will, without an explicit discussion of prognosis. Orthodox Jewish law requires care in sharing information about a terminal diagnosis with the patient. As a matter of principle, it states that "where possible one should not reveal to a relative the true state of patient for by his behavior he may bring patient to despair of recovery" (*Shach*, Commentary of the *Shulchan Aruch*). Notably, major Orthodox religious authorities have indicated that this obligation should not prevent an otherwise religiously appropriate choice for palliative treatment. According to Rabbi Dr. A. Abraham, Medical Director of *Sha'are Tzedek* Medical Center in Jerusalem, Israel and an acknowledged expert in Orthodox Jewish law and medical decisions, "We can choose to

conceal the truth re: prognosis of terminal illness such as advanced cancer telling patients that they will live. I have done this for forty-five years. I have always refused to have patients know that they are admitted to hospice and expected to die."

Our third case is a particularly troubling one, in which mistrust and miscommunication between a family, a hospice and a Rabbi literally endangered a patient despite the increasingly desperate efforts of his daughter. This case illustrates the severe consequences of an inappropriate hospice admission for an Orthodox family, as well as underscoring the importance of direct physician-Rabbi communication.

Case Three: Nathan D.

Nathan D. was a man in his 80s who was himself an Orthodox Rabbi who lived with his wife in the Midwest until he died in 2005. He had three children: a daughter in Israel, a son who is a dentist who lived in his community, and a daughter in New York who is an anesthesiologist. The mother of these children, Nathan D.'s first wife, had died many years earlier, and he subsequently remarried. In 2001 he was diagnosed with multiple myeloma. Initially he was treated with some success. By 2005, he was no longer responsive to any treatments to modify the course of his cancer. As Nathan D.'s condition deteriorated, his daughter in New York began making frequent trips to his community to spend time with him and sharing caregiving responsibilities with her brother and her stepmother.

Nathan D. enrolled in a hospice program at the recommendation of his oncologist. There ensued a series of confrontations between Nathan D.'s family—usually represented by the daughter who was a physician—and the hospice program with regard to care. These confrontations took place initially around balancing the risks of over-sedation and the management of his bone pain, and later around the issue of nutrition as Nathan D.'s appetite deteriorated and he was taking in less food and losing weight. Nathan D.'s son consulted over the phone with a prominent local Rabbi on these medical decisions. Based on these consultations, the family and Nathan D. understood that nutritional hydration was required under Jewish law. The hospice eventually agreed to provide intravenous nutrition, but only as long as Nathan D.'s anesthesiologist daughter stayed in the area and herself connected the bags and the IV. This arrangement was a tense truce that nearly resulted in Nathan D. withdrawing from the hospice program. The daughter was obligated to stay in Nathan D.'s community, away from her own family and job, in order to continue providing this care for her father. Although the hospice opposed IV nutrition, both the patient and family understood both to be to his benefit and to be required by *Halacha*.

After several weeks of this standoff, Nathan D. developed renal failure. He suffered side effects of pain medications that were not being excreted as his kidneys failed. He began to experience fluid overload that was severely exacerbated by his intravenous nutrition. Nathan D. was now cognitively no longer able to participate in medical decisions—he had moments of wakefulness and coherence, but most of the time he was sleeping or delirious. Nathan D.'s physician daughter took on an increasingly overwhelming burden of coordinating medical decisions between her family's Rabbi (as transmitted through her brother), the hospice, and the other family members. While the family's Rabbi ruled that dialysis was not mandated, his instructions to continue IV nutrition still stood. Nathan D.'s son had a brief phone conversation on the issue of intravenous feeding with the consulting Rabbi in which the Rabbi was confused by his inquiry, stating that as he had told him earlier Jewish law does not allow food to be withheld from a dying patient. As Nathan D.'s kidneys deteriorated into complete failure, he stopped making urine altogether. In need of medical advice but having lost trust in the religious sensitivity of the hospice, Nathan D.'s daughter consulted urgently with an Orthodox physician friend of hers who was more familiar with palliative medicine. Nathan D.'s daughter placed her call to her friend in the middle of the night, in tears and on the verge of collapse, with her father essentially drowning as his lungs filled with fluid. This physician urged Nathan D.'s daughter to go back to the family's Rabbi and revisit directly with him the issue of intravenous nutrition, explaining that in this case continuing it was causing demonstrable harm. Together, Nathan D.'s children called their Rabbi that night and gave him a clearer picture of the clinical situation. He immediately indicated that they must stop IV nutrition. Two days later Nathan D. expired.

▶ The right hospice can work for Orthodox Jewish patients.

Hospice services give patients access to a comprehensive suite of services, strong interdisciplinary team management, and an approach to care that emphasizes treatment of the whole person and support to the patient's family. Orthodox Jewish access to these services is complicated, however, by the need to adjust hospice care planning and treatment protocols to take into account Orthodox religious obligations. In addition to the delegation of significant medical decision-making authority to a Rabbi, hospices treating Orthodox Jewish patients may be asked to devote resources to medical interventions such as nutrition, hydration, and resuscitation that they may not typically make available to other patients. Home care for Orthodox patients also involves major cultural competency challenges related to observance of *kosher*, Sabbath and other laws. For these reasons, referring clinicians should look for hospices that know how to treat Orthodox Jewish patients.

In the New York area, the development of hospice services designed to meet the needs of Jewish patients and their families of all denominations has been a major focus of the Jewish Healing and Hospice Alliance of UJA Federation New York, an alliance that includes Metropolitan Jewish Hospice. Metropolitan Jewish Hospice features a "*halachic* pathway" geared toward the Orthodox community in which a patient designates the Rabbinic (Jewish Legal) advisor of the hospice or the Rabbi of their choice as their health care proxy and responsible

for ensuring that all medical decisions made about patient care meet *Halachic* guidelines. This unique pathway ensures that interventions such as nutrition and hydration be continued even at the hospice setting where curative procedures are no longer being pursued.

Case Four: Pesach L.

In early 2006, a hospital chaplain and a social worker in the New York area together approached an Orthodox couple in their late 40s in the hospital foyer on a Friday morning. The Rabbi—who was himself Orthodox and social worker—asked the couple if they need accommodations for the coming Sabbath or any other assistance. The couple replied that the husband's father, Pesach L., was in the hospital. They were about to meet with Pesach L.'s doctor and were feeling pressured into making a difficult decision.

Pesach L., an advanced cancer patient, had suffered respiratory failure and was admitted to the hospital via a 911 call. In the absence of a DNR, Pesach L. was resuscitated and admitted. The attending oncologist was Jewish and non-observant. He asked Pesach L.'s son if he wanted to sign a DNR order. Pesach L.'s son confided in the chaplain that if he did sign the DNR, he feared the nurses and doctors would abandon care of his father altogether. Additionally, he was unclear if the *Halacha* would permit a DNR in any case. He asked if the chaplain could accompany them to the impending meeting with the doctor and the hospital's director of nursing. The chaplain agreed and they proceeded to the meeting. When they arrived they were told that the father had "coded" a second time and had been revived again.

As the meeting began, the doctor again recommended that a DNR be signed. He explained that the father's cancer was in an advanced stage and he would probably code again very soon. Pesach L's son and his wife seemed distressed and still unsure of what to do. They were not sure of the implications under Orthodox Jewish law of signing a DNR. The Jewish Sabbath was coming quickly, making it difficult to locate their Rabbi for purposes of consultation.

The hospital chaplain was able to review with the couple both the entire medical situation and their options under Jewish law. He acted as a mutually trusted interlocutor between the family and the treating clinicians. Pesach L.'s son agreed to sign a DNR. As the meeting concluded, Pesach L. coded again, and shortly later he expired.

Hospital clinicians often treat emergent care admissions with whom they have no pre-existing relationship. Pesach L.'s case brings out our final practice recommendation, a particularly important one for emergent hospital situations.

- Use a chaplain to facilitate communication and decision making

Orthodox hospital chaplains can be enormously useful facilitators of value-neutral conversations between clinicians, patients and families. Rabbis and Doctors need trusted "interpreters" to help them understand complex medical or *Halachic* issues and terminology.

There are multiple channels available to hospitals looking for a full-time or part-time chaplain. The National Association of Jewish Chaplains (www.najc.org) and the New York City Board of Rabbis provide training and education for Jewish chaplains. This includes formal programs in clinical pastoral education, the basic educational degree for all chaplains in health care settings, while incorporating Jewish spiritual values and beliefs. Some Rabbis have received training in counseling in their Orthodox seminaries such as the one sponsored by Yeshiva University (www.yu.edu), up to and including an MSW or other counseling-related degree. Community Rabbis are also regularly called to service in hospitals or other settings and may have appropriate experience to take on a chaplaincy role.

Conclusion and Additional Resources:

This article has focused on the needs of Orthodox Jews regarding medical decision making. The guidelines described here can help clinicians to prevent or manage conflict about Orthodox Jewish law and palliative care.

It is also important to note that health care organizations that serve Orthodox Jews would do well to learn about broader issues of religious observance and spiritual expression. Metropolitan Jewish Hospice and Metropolitan Jewish Palliative Care have developed a suite of cultural competency materials for health care providers with funding from UJA-Federation New York, of which this article is a part. These materials are available through Metropolitan Jewish Hospice at 1-866-958-7423, or through UJA-Federation NY.