"End Of Life Issues"

A Handbook for Rabbis and Cantors

December 2006

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Introduction

Rabbi Elazar ben Azaryah said, "Where there is no Torah, there will be no good conduct; where there is no good conduct, there will be no good Torah. Where there is no wisdom, there will be no reverence; where there is no reverence there is no wisdom. Where there is no understanding there is no knowledge; where there is no knowledge there is no understanding…" (Pirkei Avot 3:17).

This memra from Pirkei Avot is the basis for my presentation of this very difficult but necessary topic. As Rabbis and Cantors we will be plunged into a sea of painful emotions and intricate situations which are beyond our control. Much of what we may encounter will be very stressful, leaving us feeling ill prepared and inadequate. My hope for this paper is to provide the reader with knowledge leading to wisdom, wisdom leading to reverence and reverence leading to Torah as we discuss our feelings and decisions.

The various topics presented in this paper are an integration of my five units of clinical pastoral education as well as my rabbinical education and medical background. Over the years I found end-of-life decision making to be the most challenging, and yet one of the most important, functions a clergy member will perform. Understanding basic medical law, medical technology and implementation as well as Jewish law and ethics are imperative to implementing appropriate decision making and guidance for our patients and congregants.

The topics on chaplaincy incorporate some techniques to help us identify our own feels as we receive "the call." Many helpful techniques are used, such as exploring our feelings toward the situation, learning how to handle our own stress, listening, and experiencing physical pain

and spiritual suffering. Tool used by chaplains are explained in light of techniques used to give structure to a pastoral care session. These tools help to facilitate the healing process through the use of spiritual assessment and life review.

This paper's medical complement stems from my medical knowledge. Over the years I have taken my medical knowledge for granted. Today I realize that many of the critical decisions we are going to be asked to respond to throughout our careers will require a basic understanding of what is happening to the patient medically. This includes a clinical explanation of pain and the different types of pain that can develop with or precede spiritual pain, the difference between a feeding tubes an IV or other medical treatments, the effects on the body as CPR are performed, the medical criteria used for diagnosing brain death or a persistent vegetative state. Jewish law on withholding or withdrawing food or medicine, and the Halakah concerning the refusal of treatment or implementation of a do- not- resuscitate order. Also presented are the criteria regarding organ donation and the process of advanced care planning including ethical wills?

I found these topics to be the most common and yet the most intricate and confrontational. There really are no typical situations. Each one is unique and each one has its own story. Our job as clergy members is to utilize our pastoral care skills and knowledge of Jewish law and sacred texts to guide our congregants with wisdom and reverence. Remembering always that as we walk the path of our journey, we will walk with the light of Torah in our hearts.

"The Call"

It was two o'clock in the morning and I was awakened by the ring of the telephone. I jumped out of bed, startled and some what dazed. My heart seemed as if it was leaping out of my chest into my throat. I could barely breathe. As I composed myself, I picked up the telephone receiver and placed it to my ear. I heard the hurried voice of a nurse requesting my presence at the hospital. She informed me of a three year old child about to be taken off life support. She requested my immediate presence in the Pediatric Intensive Care Unit. "Does the family know you are calling me?" I asked. The nurse becoming more anxious paused and responded, "Yes". I told her I was on my way. I quickly got dressed and jumped in my car. The hospital was about 15 minutes away with no traffic, and at 2:30 in the morning this was not a problem. When I was 5 minutes away from the hospital, I received another call. It was the nurse. She informed me, "the family is requesting a priest". I paused for a moment and informed the nurse that I would contact the priest, as soon as I reached the hospital. I went to the hospital called the priest and spent some time with the family until the priest arrived to administer last rites. The next day I reexamined my conversation with that nurse. I came to the conclusion that if I had stopped to ask the appropriate questions at the beginning of the telephone call, I could have saved time by contacting the priest at that moment. Or perhaps they did not need me to be there at all. Also, who was my actual patient? Was my patient the child, the parents, or the nurse? It could have been anyone, or it could have been everyone.

"The call": every clergy member lives with hidden stress of the possibility he or she will receive the emergency telephone "call." We know that our jobs include these

situations but some how our bodies just never get used to the, emotional and physical jolt. Throughout our clergy training, we have some preparation in dealing with crisis situations and bikkur cholim visitations. But as clergy members, we also need to know how we personally react to stress in order for us to be able to assist others through their stress. As we become familiar with our roles as clergy, we quickly learn that each situation is new and different. No matter if we have been clergy membes for 25 years or months, we pray that we will be able to react to each new situation. Some of our anxiety can be diminished by just knowing what questions to ask when we receive "the call". Our anxiety can also be diminished by our own understanding of how we hand our stress while handling our patients' stress at the same time.

By definition, stress is the response of the body to danger. The heart and blood vessels, the immune system, the lungs, the digestive system, the sensory organs, and the brain are all stimulates and are ready to take on the situation at hand. This response by the sympathetic nervous system is called "the Fight or Flight Response." Our bodies are flooded with a hormone called cortisol. This response signals to our bodies that something is happening to us. Opposing the Fight or Flight response is the alternate named the parasympathetic response. This provides the body with a normalizing or quiet response. We don't have much control over our bodies' reaction to stress since, stress reaction is hereditary. Different people react differently to the exact same stress. Some biological signs that you are under stress are increased or decreased sleep, fatigue, agitation, stomach upsets, headaches, irritability, chest pain, high blood pressure, depression, anxiety and reoccurring thoughts. Most of us have experienced at least one of

these symptoms from time to time, even when we have no idea that we were under attack from the claws of stress.

Knowing how to handle our own stress is the beginning of an effective pastoral care visit. The time of day, the day of the week, the time of the month, and the time of year (winter blues, anniversaries. etc.) can affect our ability to be present, in a therapeutic manner. Some hints for managing stress include "be organized, make lists so as not to task your mind." "Use a schedule and prioritize your time and demands on it and your attention. "Recognize your limits and set them accordingly. Setting limits on what you take on and on what others ask of you can be a great help in decreasing our stress as clergy members. Recognize typical stress." (Selye 2005, p.1). Burnout is the most common complaint of those who work in highly charged stressful situations; it is defined as a state of emotional, mental, and physical exhaustion. Contributing factors are professional isolation, emotional and physical drain from providing constant empathy, ambiguous successes, and erosion of idealism and lack of expected rewards. As caregivers, we need to know what our issues are so we can recognize counter-transference and know our emotional limits. We should be aware of how we are functioning in any given setting and give ourselves the freedom to take a time-out. As well as our own limits, we need to be aware of our teammates emotional limits and needs. Taking care of ourselves and our teammates is a basic element in being an effective pastoral counselor. It is our responsibility to work through these situations so that we can be present in a therapeutic manner for our patients. In order to do this, we must care for ourselves first.

Taking care of ourselves so that we can care for others is of the utmost importance in a clergy member's life. When faced with burnout or counter-transference, consider the following suggestions from Servio Carroll, NCSP :

- Alter periods of exercise with periods of relaxation.
- Structure your time, keep busy.
- Reassure yourself that you are normal and having normal reactions. Don't label yourself crazy, weak or ineffective.
- Talk with others. Talking about your feelings, issues and events is healing.
- Reach out. People do care. Spend time with others.
- Maintain as normal a schedule as possible.
- Give yourself permission to feel rotten. It's normal.
- Keep a journal, write through sleepless hours.
- Do things that feel good to you.
- Realize that those around you are also under stress.
- Don't make any big life changes.
- Do make routine daily decisions. Regain control.
- Eat regular meals, even if you don't feel hungry.
- Get plenty of rest, as much as you can.
- Flashbacks are normal, don't fight them. They'll decrease in time and become less painful.

Taking part in a support group of close clergy friends can give you the opportunity to alleviate some of your own stress. As Carroll (1998[p.1]) notes "however, strong emotional feelings in a crisis situation signal the need to deal with unresolved issues." (Servio Carroll, NCSP, is a school psychologist and crisis team manager in the Sheridan, Wyoming schools. These issues may need to be resolved by a profession during several therapy sessions.

When we do not attend to our stress it can increase the amount of stress we carry around inside of us. This can produce a highly stressful situation that can be categorized as a trauma. "Psychological trauma is the unique individual experience of an event rendering conditions in which 1) the individual's ability to integrate his/her emotional experience is overwhelmed or the individual experiences (subjectively) a threat to life,

body, integrity, or sanity." (Pearlman & Saakvitne[1995], p.60) When someone is experiencing trauma, the stress overwhelms the individual's ability to cope, leaving the person devastated and even fearing death as well as emotionally, cognitively and physically exhausted. When stress runs high the ability to process simple directions or perform simple tasks become overwhelming and almost impossible. Knowing about this element of stress will enable the clergy members to provide supportive environments without increasing the stress of the patients. Being mindful of our own stress levels, while using a period of simple meditation or visualization, can be essential to a productive visit. Meditation prior to a pastoral visit can help to center our emotions while opening ourselves to be a true presence in our pastoral counseling for our patients. Remember, each time a clergy members visits a patient, he or she brings G-d and Judaism into the room. This can be an overwhelming responsibility producing stress in us and in the patients.

As we have stated in previously, the first question one should always ask is, "Who is calling and requesting this visit?" Many of us often overlooked this question and yet it is the most important question to ask prior to making the visit. Many times, it is not the congregant calling for the visit. It could be the people who are caring for the patient, a son, daughter, family member, a friend, a nurse, or a doctor who may feel the patient is in need of a visit from the rabbi or cantor. This originates from the caller's anxiety regarding the condition of the congregant that precipitates a telephone call to the clergy member. It is good advice to ask this important question in order to know who really needs your presence. Many times, you will work with a family member more than your actual congregant in dealing with the illness of a loved one. There have been

numerous occasions on which I have been called to see a congregant, thinking that was the person requesting my visit. However, after the fact, I realized that my patient was really the daughter, the husband , the friend, or the nurse. Each person connected to that patient has the potential to need our assistance. Keeping yourself open to the experience of visiting the sick will enhance your experience and the experience of those lives you touch.

Before we begin our encounters as pastoral caregivers, we need to be aware of some interpersonal terminology, which will help us understand ourselves as well as our congregants. First, there are two pertinent terms that we should be familiar with before entering any counseling session. They are *transference* and its partner *counter-transference.* "Transference is when, the patient sees in the therapist, the reincarnation, of some important figure out of his childhood or past, and consequently transfers on to him feelings and reactions which undoubtedly applied to this prototype. This fact of transference soon proves to be a factor of undreamt-of importance, on the one hand an instrument of irreplaceable value and on the other hand a source of serious dangers. This transference is ambivalent: it comprises positive (affectionate) as well as negative (hostile) attitudes towards the analyst, who as a rule is put in the place of one or other of the patient's parents, his father or mother. From "An Outline of Psychoanalysis" by Sigmund Freund 1940)

Transference has been around since the beginning of man's life on Earth. We can see active transference in the Torah. "And there we saw giants who come of the giants; and we were in our own eyes as grasshoppers, and so must have been in their

eyes". (Tanak, Numbers 13:33)[1], "These distortions are an inevitable aspect of human relationships that can contribute to misconceptions and misunderstandings between people, as well as to healing, love, and erotic feelings." (Friedman [2001] pg 94-95)

Counter-transference is the pastoral counselor's emotional reactions to the patient that are based on the pastoral counselor's unconscious needs and conflicts, as distinguished from his or her conscious responses to the patient's behavior. "Counter-transference occurs when our own issues from our past are revisited due to the sights, sounds, stories or issues raised by the victims or survivors. Given the range of events we have experienced since birth, I think it would be safe to say that all adults have unresolved issues to some degree." (Carroll [1998], p.2) As professionals experienced in working with people whose unresolved issues are burdening their healing process, we help them to face and try to resolve these issues. These issues can remind us of our own unresolved feelings. Addressing our feeling and processing them in a safe environment as they arrive , will allow for us to freely walk with our congregants through their suffering.

In addition to counter-transference, caregivers face burnout when their core needs are not addressed. As pastoral care counselors, we become accustomed to trauma events, finding it difficult to talk about our experiences to friends or relatives who may not understand. Although we have been trained to helping others, we often forget those skills when it comes to ourselves or our colleagues. Perhaps we are afraid to be seen as weak or unable to deal with our feelings or problems or unable to deal with the stress of our job.

Dr Richard Schwartz has established that clergy members are especially vulnerable to " performed transferences". These transferences can be grouped into three

categories: "1) transference based on previous experiences with parents and other family members in positions of authority; 2) transferences based on previous relationships with clergy; and 3) transferences based on experiences of or relationship with G-d"
(Friedman [2001] pg 95)

Transference allows others to experience the clergy members as larger than life with the capacity to be wise and loving at all times and is based on the wish for a super-parent. Many people hope that the clergy members will be the great healers of the community as well as to be all things to all people at all times. Clergy members reactions to such demands can be to try to be all things to all people in hope that they will be loved and accepted, "the people pleaser." Or some may become extremely angry and disgruntled as a reaction to these unrealistic expectations placed upon them by others. In these situations, burnout is becomes the major complaint among clergy members.

Knowing who is requesting your pastoral care visit, can eliminate an awkward situation when you enter the patient's room. Under the new confidentiality laws, the patient is the only one who can request a visit from his or her community clergy member. Before going into the room to visit a patient, you should center oneself by taking a few minutes to focus on your own feelings. Ask yourself the following questions: What am I feeling? Am I tired, anxious or sad? Does this patient hold any memories for me? What are they and how do I feel about them? By bringing these issues up prior to the actually making the visit , you can be true to yourself and work past those issues while being truly present for your patient. Then a healing relationship can be established. In the beginning

this can seem like a daunting process. However remember that it is a skill and will become easier as you master the technique.

Prior to entering a patient's hospital room, the clergy members should be aware of the transference present from Jews . The patient may be experiencing guilt or shame in a relations to the clergy member. These feelings stem from the patient's fears that the clergy member will think less of the patient because he or she doesn't go to synagogue as much as he or she should or feelings of inadequacies concerning their knowledge or observance of Judaism. The patient will need some reassurance that the clergy member is not there to judge the member, the focus is to offer support and healing. It is a privilege to be invited into the life of one who is suffering, fearful, and at their most vulnerable time in his or her life. As clergy members, we find ourselves day after day in the midst of human pain and suffering. Even though we do not take on the pain of others, we do become open to their hearts, minds, and souls. This allows for a human connection, which through empathetic listening , allows the clergy member to experience the feelings of the patient. Remember, even thought we are sharing the feelings of the patient, we do not take them on as our own. Maintaining adequate boundaries with our being distant is the trick to effect empathetic listening. Everyone can learn the skill of *empathetic listening*. However, this does take practice. Some technical skills to promote empathetic listening are the using of attentive posture, maintaining appropriate eye contact with the use of gesturing and expressions that match the mood and expressions of the speaker. When a listener is truly focused on the speaker empathetic listening can naturally occur. The true skill of empathetic listen is knowing how to listen with an open heart. Peter K. Gerlach, MSW of the Stepfamily Association of America August 7, 2005, provides us

with some techniques for what empathetic listening should sound like. First he says that "the listener can summarize while the speaker is still talking, picture a butter knife in a stream of water; if the blade is parallel to the flow of empathy, inserting it does not disturb the flow (the speaker's stream of thought)." "Inserting *your* needs opinions or thoughts, which is an interruption, which is like turning the blade of the knife sideways in the flow." Doing this sends signals to the speaker that you are not connecting and listening to the speaker and his or her situation. Empathetic listening can sound like any one of the following sentence openings: " So you think that", "What you need now is", Seems your unsure of ", " You're really feeling" or " It seems to you That" These are just a few of the many sentence openings that can help facilitate the process of empathetic listening. The real challenge in the empathetic listening process is to remaining in the moment with the speaker. Many times, our minds tend to wander or begin to focus on one problem of the speaker. We may want to try to fix the speaker's problem, and interject our own opinions. This is not the goal of empathetic listening. The goal is to remain with the speaker through his or her emotional situation and not allow our minds to stray from this. This skill is much easier said than done. In our society, we are constantly thinking about what we have to do and, find it difficult to remain in the moment concentrating on the task at hand. We have to consciously retrain our minds to stay in the present situation. Sometimes I find myself exhausted after a good pastoral visit. Empathetic listening is an intense skill to master. There is no easy way to develop it but practice will make you better. This skill needs to be practiced continually; the benefits will be visible in all of our relationships in our lives and both the listener and the speaker will benefit from this attentive practice. By meeting the patient where the patient

is and using the skill of empathetic listening the clergy member can uncover the spiritual needs of the patient.

The Chaplain's Tools

A fundamental tool found to direct the process of pastoral counseling is spiritual assessment. Spiritual assessment is the structured process by which health care providers and clergy members can identify patients' spiritual needs pertaining to their mental and physical health care. "The spiritual assessment is a tool to help us develop a thorough and useful understanding of the sufferer's situation, needs, and resources." (Davidowitz-Farkus [Friedman, 2001] p 104) The summary of the spiritual assessment is the foundation used to organize a beneficial plan of spiritual care. Whether the patient is in a hospital or is recovering at home a spiritual assessment can always be useful. There are multiple formats of the spiritual assessment. No one is better than the other. Some are more intricate than others in which the user must spend more time with the patient As Jewish pastoral care givers we search out the history of our own tradition within the area of spiritual assessment. Today we find our spiritual connection to G-d through prayer and text study. As part of this text study, midrashim can be used to begin a spiritual assessment. " We wrestle with the text, try to understand them and by extension of ourselves." (Davidowitz- Farkus [Friedman,2001] p.107) Since each one of us writes our own spiritual text, and carry our own torah through out our lives, the interaction between the text and those for whom we are caring for become essential for understanding the spiritual place of the patient. While reading texts with patients, many feelings may be uncovered through explaining of the story and feelings of the characters within the context of the story. This is therapeutic for the patient if done in a caring and nurturing environment. Some of the following topics are worth questioning in the

spiritual assessment; Where do you find G-d in the world? How do we find and approach G-d? Can we approach G-d in tefilah, Torah, deeds and or by living in a community?

As we use the spiritual assessment tool, we must remember that there are no right or wrong answers or feelings. The spiritual assessment process uncovers situation of the patient's situation. The assessment presents us with the patient's past experiences combined with his or her current stress and doubts about the present and future.

Many spiritual assessment tools are non denominational and may be used by all in spiritual distress. These tools may be helpful for you with Jewish patients as well as non Jewish patients. "At St. Elizabeth's Hospital in Washington, D.C., the Chaplain Program, headed by Clark Aist, conducts a "Spiritual Needs Assessment" on each inpatient, concluding with a treatment plan that identifies religious/ spiritual needs and problems, role of pastoral intervention, and religious/spiritual activities recommended."

"Spirituality relates to ideas of meaning, of purpose and of the continuity of life. It does not always include a religious component. Meaningful spiritual assessment comes from understanding that there can be no one clear definition of 'spiritual needs'. It requires a 'person centered approach', focused on the individual."(Mitchell,[1998]p.1)

Pastoral caregivers will receive many types of answers during their interviews with the patients. Some of these answers will give us great insight into the emotional and spiritual states of the patient. Each person has a spiritual dimension to his or her life. This process can be understood by terms of religious feeling or in terms of personal meaning within a larger context . Clergy members must try to find the interpretation that

best fits to the patient. Individuals who report a strong spiritual life often report the following, according to (Mitchell,[1998]p2):

- A greater sense of purpose
- A greater sense of having come to terms with dying
- Better communication
- Better relationships

During the last stages of a person's life, there is a significant relationship among a patient, the patient's clergy member and their physician. The clergy member and physician should keep in mind that patients can and do experience significant spiritual growth and gain meaningful fulfillment during their illness and during the last stages of life. It is up to the clergy member to educate the patient's physician about the significance of these issues for the healing process. The clergy member should educate the physician on how spiritual this patient has tended to be in the past. How inclined toward spiritual life he or she is now whether or not he or she would like (or has had) a pastoral care visit and whether there are religious rituals that are important to the patient. Patients have many fears and concerns about their illness. Patients facing a life-threatening illness are often thinking about questions that they do not articulate easily or freely. Often requires someone, such as the physician, or the clergy member must give permission to the patient to discuss these issues. The following two questions are key: How will the illness proceed? What will happen to me? Many patients are fearful of the unknown and the finality of death. However,it is the process of dying that most fear. Frequently, the patient is consumed with

thoughts of death and dying and is in dire need of someone to discuss these issues. Some of the patient's concerns may be the following: How will I die? Where will I die (home, nursing home, ICU, hospice etc.)? What do I need to do (estate planning, life review, advance care planning etc.)? How much pain will I feel?

The physician or clergy member may give permission for people to talk about these things by introducing the subject in a general way by saying, "Many people in your situation think about dying. Is that something you are thinking about?" As patients face these questions, they also have to adjust to major changes and losses. Some of their questions may include the following: Who will care for the people I love that depend on me? Who will care for me? Will I be a burden? Will they still love/respect me? What about my job?

When someone is ill and especially when someone is admitted into a hospital or health care facility, that person may feel a sense of loss of control over his or her body and life due to the real possibility that one's plans are interrupted by the illness. Independent people who have never considered being otherwise now face dependence. Loss of body control, including the ability to feed, bath, and toilet oneself, is certainly a frequent concern. These losses of control can facilitate feelings of fear and anxiety associated in many people's minds with indignity and shame.

During these times, religion and spirituality can be a great source of strength. While it is helpful to know the religion and religious denomination to which a person affiliates with, the degree to which religion is important and must be evaluated separately. Some questions that can be helpful in this assessment are the following: How often the patient

has gone to services in the past? Would he or she would like to do so now? Are there particular prayers or scriptural resources that mean a lot to the patient? Some patients engage in spiritual activities that are outside of organized religion. The level of activity in these pursuits is also relevant to the assessment.

Occasionally, physicians will feel comfortable praying with a patient. It has been noted in several studies that many patients would like their physician to do so. However, this is not a necessarily a part of the patient-physician relationship. Although, it can be helpful if the physician is comfortable in allowing the patient to express religious feeling with the physician, as this can be pertinent to their healing process. The physician should be sure that the best available resources have been made available to the patient for his or her spiritual care. If the physician does not feel comfortable praying with the patient, maybe the clergy member can suggest that the physician be included in the prayers offered by the clergy member.

Rituals can be an important part of a person's spiritual life. They provide us with the physical expression of our spiritual needs and connect with the Divine source and our spiritual community. It may be beneficial to ask if the patient wants special prayers, declarations, rituals or last actions. Someone should be designated to make sure that special prayers or actions and last prayers or declarations are carried out, as the patient and family would like them to be.

Many patients experience spiritual crisis and/ or spiritual suffering along with an illness. Many aspects of advanced illness are not commonly appreciated to be fundamentally spiritual. Yet, the search for meaning and purpose in life is a spiritual

quest. When someone perceives loss of connection to a community or to a way of life, the loss may challenge his or her own sense of meaning and purpose. Feelings of guilt or unworthiness may be manifestations of spiritual suffering. If these aspects of spiritual suffering remain unrecognized, an appropriate plan for relief cannot be instituted. Some aspects of advanced illness may be noted to be spiritual. For example, patients may question their faith, express a need for forgiveness and reconciliation, or feel abandoned by G-d.

We write a spiritual assessment for a patient whom we suspect is in spiritual pain. For those patients who are facing a life-threatening illness, establish a comfortable atmosphere that invites discussion of spiritual issues. Express your interest in the patient's pain beginning by asking specific questions, such as the following:"Would you consider yourself to be a spiritual person?","What role does religion play in your life?" "Have you thought about what will happen after you die?" "What are the things that matter most to you?" "How have you tried to make sense of what's happening to you?" "If you were to die suddenly, are their important things you feel would be left undone?" "As you look back on your life, what has given your life the most meaning?" "What are some of the things that give you a sense of hope?" Listen for deeper meanings in the patient's description of his or her situation and how he or she is feeling at the present time. In order to do this accurately we need to be aware of our own beliefs and disbeliefs towards religion and the spiritual dimension. As pastoral care providers, we must be sensitive to the beliefs and practices related to healing, dying, death, and life after death. We must acknowledge the resources for the family and the patient's coping process. By definitions most patients and families experience some level of spiritual suffering. The

goal of the pastoral care giver is to develop a plan of care to lessen or alleviate the the patient's spiritual distress. The following are some questions we can ask to learn more about the patient's and their family's spiritual framework for end- of -life medical care. "What is your philosophy of life?" "Are you affiliated with any tradition and how important is it to you? To whom or what do you turn to in crisis? "Are there spiritual beliefs you hold that conflict with the general philosophy and goals of your treatment or palliative care? Does your religious faith have beliefs that will help you cope with this news/ as your disease progresses?" "How has this illness affected your physical, spiritual and emotional states?" "You said your greatest fear is that you will suffer. What would that look like to you? What do you mean by suffering? Are you suffering now? Has being sick made a difference in how you believe? What do you miss most as a result of your illness? And are there any rituals that will help to decrease your anxiety or help you feel less alone? What are you hoping for during this time?" (Endlink.[2006] p.5). These questions can help you produce a framework for you spiritual assessment and produce a foundation for your care plan.

The following are some additional formats of spiritual assessment questions currently being used by clergy and chaplains.

A. RELIGIOUS BACKGROUND AND BELIEFS

1. What religion did your family practice when you were growing up?
2. How religious were your parents?
3. Do you practice a religion currently?
4. Do you believe in God or a higher power?

5. What have been important experiences and thoughts about God/Higher Power?

6. How would you describe God/Higher Power? Personal or impersonal? Loving or stern?

B. SPIRITUAL MEANING AND VALUES

1. Do you follow any spiritual path or practice (e.g., meditation, yoga, chanting)?

2. What significant spiritual experiences have you had (e.g., mystical experience, near-death experience, 12-step spirituality, drug-induced, dreams)?

C. PRAYER EXPERIENCES

1. Do you pray? When? In what way(s)?

2. How has prayer worked in your life?

3. Have your prayers been answered?

HOPE Assessment

Yet another approach to spiritual assessment is entitled HOPE, in which the acronym of HOPE is used to perform the assessment. HOPE has been designed for medical professions as an easy way for physicians, nurses, and chaplains to incorporate spiritual care into the medical treatment plans of the patient. Physicians often hesitate to inquire into this universal dimension of human experience, yet studies suggest patients welcome the inquiry.

H--sources of hope, strength, comfort, meaning, peace, love and connection

O--the role of organized religion for the patient

P--personal spirituality and practices

E--effects on medical care and end-of-life decisions

Questions used in this approach are on included in this article:
Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment GOWI ANANDARAJAH, M.D., and ELLEN HIGHT, M.D., M.P.H American Family Physician

Spiritual Assessment Questions for the –FICA Assessment are as follows:

F) Faith and Belief

1) What are your spiritual or religious beliefs?

2) Do you consider yourself spiritual or religious?

3) What things do you believe in that give meaning to your life?

I: Importance and Influence

1) Is it important in your life?

2) How does it affect how you view your problems?

3) How has your religion/spirituality influenced your behavior and mood during this illness?

4) What role might your religion/spirituality play in resolving your problems?

C: COMMUNITY

1) Are you part of a spiritual or religious community?

2) Is this supportive to you and how?

3) Is there a person or group of people you really love or who are really important to you?

A: ADDRESS

1) How would you like me to address these issues during your treatment?

During the interview process, be aware not only of the spoken word but also note body language and visual cues indicating possible religious or spiritual beliefs and practices. Some visual cues indicating possible religious or spiritual beliefs and practices may include the following: representations of religious figures or community leaders, religious symbols or art, prayer books or scripture, books about the meaning of illness or healing practices, religious clothing such as a prayer shawl, altars or shrines, herbal remedies, and any other objects considered sacred, invested with healing powers, or used for specific religious practices.

The most important part of the assessment process is the use of language as a possible indicator of spiritual or religious framework. As patients and families ask questions about their illness, discuss treatment plans, or carry on casual conversation, listen for phrases suggesting explicit religious beliefs such as the following: "If God wills it". "It is in the hands of the man upstairs", "This medicine is a blessing", "When she makes her transition...", Also closely listen for statements that speak to a more general philosophy about illness, fate, and the value of life such as the following: "You play the hand you are dealt"," He's always been a fighter", "There are some things worse than death" etc. As people share pieces of their life stories, their core values, and perspectives are likely to emerge.

The language used by the patient's can be an indicator of possible spiritual suffering. Some commonly heard statements that may indicate spiritual suffering include the following: "What's the point of living like this?", "Why is God doing this to me?", "I just wish I was dead", "Can't you do something?", and "When she gets better..." Some questions

questions asked of the staff that seems to be purely medical may, in fact, be also indicate the existence of spiritual suffering. For example, a family member asks "How much longer, Doctor?" The family member may seek factual information regarding prognosis, need to know in order to plan for the patient's care needs, doubt their own ability to cope emotionally, or perceive that the patient is experiencing prolonged suffering.

Often the patient may convey signs of spiritual suffering through the use of metaphorical or symbolic language. This may be a key to unresolved issues or unmet spiritual needs. Much has been written about the unique language of terminally ill persons. Cultures where it is not accepted customary to speak directly about illness and death often uses coded words to talk about these issues. Those who are ill, regardless of their traditional background will use language and images whose meaning should not to be taken literally .In some cases, this language may refer to a set of religious beliefs or spiritual understanding of the world .For example, "I am ready to go home," may indicate that the person wants to leave the hospital and die in their own house. It may also refer to heaven.

Sometimes physical symptoms, including physical pain, are entirely biological in origin and should be treated using the appropriate medication. However, many symptoms may also indicate the existence of unaddressed emotional or spiritual pain Unaddressed emotional or spiritual pain should be suspected in cases where symptoms include: physical pain that is unrelieved after extensive and appropriate medication intervention, pain that is unspecified or that frequently changes location, anxiety, and increased shortness of breath. Restlessness or agitation, fatigue, flat affect or withdrawal and or insomnia can be signs of underlining spiritual distress.

The clergy member or medical staff can identify behavioral cues which uncover core values and/or to underlying spiritual suffering. Such as a patient declining assistance with personal hygiene and basic care needs, experiences power struggles with family members or caregivers, has a history of practice/affiliation, refuses religious leader or stops religious practices, isolates himself or herself, withdrawal from primary relationships, declining pain medication when physical pain is present, and/ or shows a lack of engagement in activities that bring comfort or joy. Once we have identified these behaviors then we can begin to develop our plan for the spiritual assessment.

Some objectives of the spiritual assessment are to define the difference between religion and spirituality, summarize the historical and present relationship between psychology and religion/spirituality, learn how to conduct spiritual assessments and how to structure interviews and other instruments, and identify common spiritual problems that hinder true spiritual express and health of the individual. Once these questions are answered the clergy member begins to structure his or her pastoral care visit in a manner to promote healing. Health care professionals should know how to contact the patient's clergy member or spiritual representative relevant to the patient's faith and beliefs and should be aware when input is required. Educating the health care staff about the clergy member's availability is crucial to the health and spiritual well being of the patient. It is a good practice to stop at the health care desk on the patient's floor to inform the nurse that you are have completed your visit. Let the staff know when or if you will be back for another visit. This ensures continuity of the patient and does not leave the care giver in the dark should the patient have a spiritual break through when you are not present Before you begin to formulate your care plan, one must keep in mind that you should not attempt to make the

patient over and transform him or her into someone you think they should be. Spiritual health is purely individual and should be left up to the patient. We each have a unique relationship with G-d. This relationship can only grow when the individual wants it to change and not before then.

However, there are situations when time is of the essence. "As pastoral caregivers, we often encounter people who are in acute spiritual pain from loss or trauma. The caregiver must meet the suffering individual in the place of challenge. This work must be done using both intelligence as well as with heart." (Davidowitz Farkus [Friedman 2001] p 104). Spiritual pain is a result of the experience of illness, which may threaten an individual with, spiritual disintegration, isolation, and loss of meaning. Spiritual assessment suffers from the misconception that spirituality equals religiousness. Atheists may have spiritual needs. Chaplains and members of the multidisciplinary team are experienced in meeting spiritual needs, and can assist the individual's search for meaning from different faith perspectives, or from none.

The pastoral care giver may choose to use the process of 'Life Review' in helping the patient assess confused feelings and unresolved issues. The pastoral counselor should encourage the patient to tell his or her story through his or her life's journey to the present moment. This is known as a life review. Life review is a process that involves listening attentively to the patient's story of his or her life and explores the patient's feelings of unworthiness and fears about what he or she has left undone. The patient must be able to speak openly about his or her fears and their mortality. Feelings of inadequacy should be challenged gently by reflecting on the accomplishment of the patient's life.

Then the pastoral care giver is able to encourage the patient to work out the remaining situations that he feels he or she have been left undone. Geriatricians Lewis and Butler have emphasized this point: " The therapeutic possibilities of the life review are complex. There is the opportunity to reexamine the whole of one's life and to make sense of it, both on its own terms and in comparison with the lives of others. Identity may be reexamined and restructured. "There is the chance to resolve old problems, to make amends and restore harmony with friends and relatives." (Byock [1996] p.10-11)

The process of story telling is a valuable validation of a person's life. Stories about a person's life can be facilitated by anyone. With the aid of pictures or a photo album precious memories and feelings maybe assessed through it. This process may facilitate the development of an ethical will for the patient's children, relatives, and friends. We will discuss ethical wills further on in this paper.

When suffering begins to overwhelm the process of the life review we turn to the original point and time of suffering. The meaning of suffering may well be equated with spiritual pain and spiritual anguish. "It has been stated that suffering can include physical pain but is by no means limited to it." (Cassel [2004]p.1) It is true that for some suffering can have a meaning, to others it is useless and then often unbearable. However the emotional pain of a person's emotional pain increases when he or she lacks an emotional support system.

Kaye (1990) explains a wide variety of emotions experienced by those in spiritual pain and has classified them in terms of: the *past* (painful memories, regret, failure, guilt) the *present* (isolation, unfairness, anger), and the *future* (fear, hopelessness).

When someone is ill or in the hospital for any reason, he or she may feel isolated from his or her world. The patient experiences feelings of fear and anxiety, during long periods of pain, in his or her physical, emotional and spiritual selves. The patient may question the meaning of life while facing his or her own mortality. In many cases, patients have no one to talk with concerning these issues burdening their souls. "For some patients, the experience of acute illness evokes concerns about their relationships in their live, especially with a spouse, children or a parent." (Friedman [2001] p. 191) Since the clergy members are that connection to the Jewish community, we are expected to provide spiritual support through the process of the illness. Many recent studies have confirmed the positive outcome of a patient, healing their relationships through the use of spiritual connection and practice. Clergy members can facilitate this process by providing access to prayer, encouraging the participation in daily davening and instructing the staff on Jewish customs and holidays. The observance of Shabbat can play a major role in adding a sense of spiritual personhood to the patient. Lighting candles, reciting the Motze and Kaddish, experiencing visits from friends and relatives will help enrich the patients' sense of connection to the Jewish community while remaining in the hospital.

The Mitzvah of Pastoral Care

Judaism requires that every Jew participate in the mitzvah of visiting the sick. In the Talmud , Resh Lakish is asked by one of his students, "Where is visiting the sick indicated in the Torah? In the verse, If these men die the common death of all men, or if they be visited after the visitation of all men". "How is it implied? Raba answered (The verse means this) if these men die the common death of all men who lie sick in a bed and men come in and visit them, what will people say? The Lord hath not sent me for this task". (BT Nedarim 39b)[2] This citation from the Talmud teaches us that the obligation in visiting the sick is part of the spiritual evolution of humans on Earth. It is not a direct commandment but it is found between the letters of the text. It is found by understanding how G-d treated those who were in pain. In our world it is natural that people get sick and in that natural course of life, it is natural that we respond to this situation with our care and concern as part of the human race and the Jewish people.

Visiting the sick, Bikur Cholim is a subdivision of the mitzvah of loving kindness. The goal of Bikur Cholim is to provide a healing relationship that will lessen the suffering of the patient. The Talmud states that we imitate the essence of G-d when we fulfill the mitzvah of Bikur Cholim. The Talmud also derives the concept of Bikur Cholim from G-d's visit to Abraham through the appearance of angels on the third day of his circumcision. (BT Sotah 14a)[3] In these verses G-d appears to Abraham to become a presence through a relationship of healing. (Genesis 18:1-3)[4] The Talmud offers social guidance about whom to visit and limits visitation to those with headaches, bowl trouble and eye disease (BT Nedarim 41a)[5]

These guidelines were established to protect the vulnerability and possible embarrassment of the sick. "Family members can not be expected to carry the entire burden of the patient's illness and problems, "Bikur Cholim remains an important imperative mitzvah for friends when a patient is living at home." (Dorff [1998] p. 194)

An essential element in visiting the sick is to never abandon a patient. Pastoral care visits becomes a critical therapeutic intervention when we witness and valid patient's suffering and pain. Frequently, patients who are agitated can be calmed by the presents of another person holding their hand, sitting at their bedsides or touching their brows. These gentle expressions of nurturing can assist in the healing process for the mental, physical, and spiritual healing of the patient.

In the Babylonian Talmud Nedarim 40a [6], we find the teaching of our sages to be congruent with this philosophy, "Rab Helbo is sick. But none visited him. He rebuked them (the scholars), saying, " Did it not once happen that one of R. Akiba's disciples fell sick, and the Sages did not visit him? So R. Akiba himself entered (the house) to visit him, and because they swept and sprinkled the ground before him, he recovered. " 'My master, said he, "you have revived me!'" Rabbi Akiba went forth and lectured: He who does not visit the sick is like a shedder of blood. Rab said: He who visits the sick will be delivered from the punishment of Gehenna, as it is written, "Blessed is he that considered the poor: the Lord will deliver him in the day of evil." (Psalms 41)[7] The poor means non other than the sick...as found in the Book of Samuel II, "Why art thou so poorly (dal) thou son of the king?" (Samuel II 13:4)[8] "But what is his reward in this world? The Lord will preserve him, and keep him alive, and he shall be blessed upon the earth; and thou will not deliver him unto the will of his enemies" (Psalms 41:3)[9] "The Lord

will preserve him--- from the evil urge and keep him alive. (Saving him) from sufferings: and he shall be blessed upon the earth." It was also taught in the Talmud, "There is no measure for visiting the sick. What is meant by, there is no measure for visiting the sick? R.Joseph thought to explain it; its rewards are unlimited. Rabbi Abbaye said "Even a great person must visit a humble one. Raba said (One must visit) even a hundred times a day. R. Abba son of R. Hanina said: He who visits an invalid takes away a sixtieth of his pain. Said they to him: If so, let sixty people visit him and restore him to health? He replied: The sixtieth is as the tenth spoken of in the school of Rabbi". (BT Nedarim 39b)[10]

As visitors of the sick, (pastoral caregivers) are asked to be a *ben gil*. The commentators of the Talmud interpret a *ben gil* as meaning the visitor should be of the same age as the one who is visited. However, others interpret the idiom to mean that the visitor must be the same astrological sign as the ill person. (The Ran BT Nedarim 39b)[11] The belief is that the *ben gil* is able to establish the deepest level of rapport, which is most available to a *ben gil*. As a clergy members, we are asked to function as a *ben gil* for those we have never met or have very little connect with. To do this we must search deep within ourselves to find our wounded selves . Then and only then can we establish true empathy and becoming conduits for the patient's pain.

An important component of the Bikur Cholim visit is praying for and with the choleh. We learn this from the Talmud, "When R. Dimi came; he said He who visits the sick causes him to live, whilst he who does not causes him to die. How does he cause (this)? Shall we say that he who visits the sick prays that he may live and whoever does not visit the sick will ask mercy that (the sick person) should die? Would you think this?

But (It must mean) that whoever does not visit the sick will no task mercy, neither that the sick person should live or die". (BT Nedarim 40a)[12] One of the Commentaries suggests, "There are times when one must ask mercy for the ill person that he should die. Such as when he suffers so much in his illness and it is impossible that he should live." The Talmud continues with the story of an act of mercy upon the suffering of the Rabbi:

"On the day when Rabbi died the Rabbis decreed a public fast and offered prayers for heavenly mercy. They furthermore, announced that whoever said that Rabbi was dead would be stabbed with a sword.

The rabbi's handmaid ascended the roof and prayed: 'The immortals desire the Rabbi (to join them) and the mortals desire Rabbi (to remain with them); May it be the will (of G-d) that the mortals may overpower the immortals'. When, however, she saw how often he resorted to the privy, painfully taking off his tefillin and putting them on again, she prayed: 'May it be the will (of the Almighty) that the immortals may overpower the mortals.' As the Rabbis incessantly continued their prayers for (heavenly) mercy she took up a jar and threw it down from the roof to the ground. (For a moment) they ceased praying and the soul of Rabbi departed to its eternal rest. 'Go', said the Rabbis to Bar Kappara, and investigate." He went and, finding that the Rabbi was dead, he tore his cloak and turned the tear backwards. (On returning to the Rabbis) he began: 'The angels and the mortals have taken hold of the holy ark. The angels overpowered the mortals and the Holy Ark has been captured'" (BT Ketubot 104a)[13]

" The later codes go even further they not only allow one to desist from praying for a person's recovery but explicitly permit one to pray that G-d speedily take the life of a dying person in pain." (Dorff [1998] p.198)

Pastoral caregivers provide prayer to instill hope in the situation and the person. 'Prayer is sometimes a tool used to transform and sometimes a means to "avert the bitterness of a severe decree, "bringing peace but not a cure"'(Friedman [2001] p.130) The Misheberach prayer prays for a complete recovery of body "Rufat haguf" and the soul "efuat hanefesh". This prayer identifies the dual concept of illness and suffering. The body may be healed, but the soul continues to suffer, or the soul is healed, but the body continues to suffer. The concept of the miseberach is that healing is possible even when there is no possibility of a cure. " Prayer is a step into the unknown and a surrender to the possibility that life is much larger than we night have imagined" (Friedman [2001] p.131)

There are many prayers within the Jewish tradition that can work for many situations. However, there are times when traditional liturgical prayer is not fulfilling or personal enough to express a person's suffering. Spontaneous prayer can be most effective in these situations. When assisting in a prayerful conversation with G-d, spontaneous prayer can structure a persons suffering, giving it words and a reality by making the situation something real that can be dealt with. By organizing the person's thoughts and providing a structure, spontaneous prayer can be one form used to connect with the Divine. This connection can promote healing of the most intimate nature. " The pastoral care giver's goal is to help each person to find the language through which his or her individual heart and soul can speak" (Friedman,[2001] p. 132) Sometimes liturgical prayer can provide the words, what the soul is feeling. Sometimes this form of prayer can be the true connection to the Divine. It is the pastoral caregiver's responsibility to find the language, that expresses the feelings and suffering of their patients. Rebbe Nachman of

Bratzlav "taught his students to speak out to G-d from the depths of their hearts. He encouraged them to go to a secluded place in the woods and give their voice to spontaneous, uncensored speech." (Friedman [2001] p 133)(Arthur Green, The Tormented Master Woodstock, Vt: Jewish lights publishing, 1992) This practice can be very cathartic for the patient as he or she tries to enunciate the feelings of torment of his or her soul Spontaneous prayer can bring the patient to a place where his or her pain is identifiable. Only then can we articulate our feelings and needs to the Divine.

Pain and Suffering

Part of Bikur Cholim; is attending to the physical needs of the sick. (Friedman [2001] Ozarowski p.25) As pastoral care givers we are interacting with those in various levels of pain. This pain may begin at the spiritual level and transform into the spiritual level and vise versa. We must be knowledgeable about the assessing the different levels of pain The fact that "suffering" can exacerbate physical pain is well described by Rene Leriche who wrote some 60 years ago wrote "Pain is the resultant of the confounding factors, a logical approach and the use of validated tools may help to clarify the different aspects of a patient's pain". A body chart or sketches giving a graphical description of pain can be useful for reference purposes when pain is being assessed, especially when assessing the pain of a child. Notice the area of pain; the colors they choose to describe their pain and the size of the painful area.

Pain assessment tools must measure: intensity of pain, relief of pain, psychological distress, and the functional impairment. Physical pain can be a manifestation of emotional pain. Sometimes our emotions are too much for our mental abilities to bear. In that event our pain energy turns into a physical manifestation of pain.

Clergy members have the ability to begin talking about the physical pain and walking with the patients, through that pain to the emotional component of the physical pain. In order to walk with our patients, we must understand what the physical pain looks like. The medical staff uses a universal system of assessing physical pain. They perform a detailed history taking which is vital to a comprehensive assessment. Listen to the patient carefully and determine the following areas of pain. By carefully listening to the patient,

we can sometimes hear beyond the realm of the physical pain into the area of emotional and spiritual pain. A physical pain assessment examines the following elements of the pain

- Site and number of pains
- Intensity/severity of pains
- Radiation of pain
- Timing of pain
- Quality of pain
- Aggravating and relieving factors
- Etiology of pain
  - Pain caused by cancer
  - Pain caused by treatment
  - Pain associated with cancer related debility (e.g. decubitus ulcers or skin ulcers)
  - Pain unrelated to cancer or treatment
- Type of pain
  - Somatic
  - Visceral
  - Naturopathic
  - Sympathetically mediated
  - Mixed
  - Anguish
- Analgesic drug history
- Presence of clinically significant psychological disorder e.g. anxiety and/or depression)

Pain path physiology is identified by the categories that describe the pain as acute, chronic, nociceptive or naturopathic. Each category has subcategories defining their presentations. Acute pain is usually related to an easily identified event or condition. This type of pain has a sudden onset and usually resolves within a period of days or weeks and is usually nociceptive. This pain may be due to an injury or something such as appendicitis etc. Chronic pain may or may not be related to an easily identified path physiologically. It may have many factors and it may be present for an unknown period

of time. Nociceptive pain is presumed to involve: direct stimulation of intact mechanical, chemical, or thermal nociceptors and transmission of electrical signals along normally functioning nerves. Nociceptive pain can be subdivided into two subgroups: somatic pain and visceral pain. Somatic pain involves skin, soft tissue, muscle, and bone due to stimulation of the somatic nervous system. Patients may describe this as sharp, aching, and/or throbbing pain that is easily localized. Visceral pain that involves cardiac, lung, and GI and GU tracts. This results from stimulation of the autonomic nervous system. Patients may find this pain difficult to describe or localize. Nociceptive pain generally responds well to medications such as opioids and/or co analgesics. Neuropathic pain is presumed to result from disordered function of the peripheral or central nervous system (CNS) due to any of many potential causes, including: compression, infiltration, ischemia, and metabolic injury. There are varied subtypes of neuropathic pain including: those sustained by peripheral processes (e.g., painful neuroma or tumor) and those sustained by CNS processes (e.g., phantom pain from a recently amputated limb). Complex regional pain syndrome can be classified by the syndrome (e.g., painful polyneuropathy, phantom pain, etc) Patients tend to describe neuropathic pain with words such as burning, tingling, numbness, shooting, stabbing, or electric-like feelings. The intensity of pain involved may exceed observable injury. Although naturopathic pain may respond well to opioids, adjuvant analgesic medications (tricyclic antidepressants, anticonvulsants, antiarrhythmics, etc) are often required in combined with opioid medications to achieve adequate relief.

The following chart is a good example of how a clergy member can be therapeutic in raising the pain tolerance of people in pain even for a short period of time. Clergy

members can encourage rest and relaxation when anxiety is present. As previously stated in the Talmud, R. Abba son of R. Hanina said: "He who visits an invalid takes away a sixtieth of his pain". (BT Nedarim39b)[14].

Aspects that lower pain tolerance	Aspects that raise pain tolerance
➢ Discomfort	➢ Relief of symptoms
➢ Insomnia	➢ Sleep
➢ Fatigue	➢ Rest
➢ Anxiety	➢ Relaxation therapy
➢ Fear	➢ Explanation/support
➢ Anger	➢ Understanding/empathy
➢ Boredom	➢ Divers ional activity
➢ Sadness	➢ Companionship/listening
➢ Depression	➢ Elevation of mood
➢ Introversion	➢ Understanding of the meaning and significance of the pain
➢ Social abandonment	
➢ Mental isolation	

(Chart adapted from Twycross and Lack)

The process of pain management starts with adequate assessment of the pain .The absence of appropriate assessment is the leading reason for poor pain management. A comprehensive pain assessment addresses the pain's nature and cause. In a personal context pain is psychological, social, spiritual, and a practical issue.

"Pain is more than a physical phenomenon", states CM Sauders in, The Management of Terminally Ill Patients. Despite this, the psychological, social and spiritual aspects of pain are not always considered. A complete assessment of pain requires the assessment of the psychosocial needs, level of anxiety, mood, cultural influences, and fears. These elements have effects on inter-personal relationships, which can affect pain thresholds and possibly interfering with adequate healing during a pastoral care visit. "No less emergent is the suffering of a person whose physical symptoms are

controlled and whose agony derives from the sense of impending disintegration or the loss of meaning and purpose in life." (Byock [2000]p.6)

The Talmud acknowledges suffering through the telling of stories of our great rabbis. The story of Rabbi Hanina ben Teradion brings this to light. "Rabbi Jose b. Kisma died and all the great men of Rome went to his burial and made great lamentation for him. On their return they found R. Hanina b. Teradion sitting and occupying himself with the Torah, publicly gathering assemblies, and keeping a scroll of the Law in his bosom. Straightaway they took hold of him, wrapped him in the Scroll of the Law, placed bundles of branches round him and set them on fire. They then brought tufts of wool, which they had soaked in water, and placed them over his heart, so that he should not expire quickly. His daughter exclaimed, 'Father that I should see you in this state!!!' He replied, "If it were I alone being burnt it would have been a thing hard to bear; but now that I am burning together with the Scroll of the Law, He who will have regard for the plight of the Torah will also have regard for my plight." His disciples called out, "Rabbi, what sees thou?" He answered them, "The parchments are being burnt but the letters are soaring on high." "Open your mouth so that the fire will enter
Into you." He replied, " Let thee who gave me my soul take it away, but no one should injure himself." The Executioner then said to him, "Rabbi, if I raise the flame and take away the tufts of wool from over thy heart, will thou cause me to enter into the life to come?" " Yes, he replied. "Then swear unto me," He swore unto him. He thereupon raised the flame and removed the tufts of wool from over his heart, and his soul departed speedily. The Executioner then jumped and threw himself into the fire. And a bat kol exclaimed: R. Hanina b. Teradion and the Executioner have been assigned to the world to

come. When Rabbi heard it he wept and said: One may acquire eternal life in a single hour, another after many years.(BT Avodah Zerah 18a)[15]

Through the study of this section in the Talmud we become aware that suffering had a purpose in allowing the sufferer to enter into Olam Habah. Within the experience of a true healing relationship, the sufferer and the visitor play signifant roles in the process so that both benefit from the pastoral experience. A healing relationship is required when trying to decrease the suffering of the patient. Although most people experience some level of pain while in the hospital due to a surgery or acute disease process, suffering is the psychological reaction we experience from the actual physical or psychological pain. When illness separates him or her from his or her activities of daily living such as his or her job, family, friends, or hobbies a feeling of loss and isolation becomes a presence felt by all. We can't help but ask the burning question of all who deal with those who suffer, 'is there any meaning in suffering?" " Does G-d want us to suffer?" Suffering is a human condition. " Despite the familiarity with the general situation, the task of a care giver for a person who is suffering can seem overwhelming." (Byock [1996] p.237) But for clergy members, it is surely a great reward to be given the opportunity to apply what we know to help those who are troubled. " In modern, secular, western culture suffering is assumed to be wholly adverse and devoid of value. The predominant personal orientation toward suffering is one of avoidance or alleviation. When we suffer, we present ourselves as patients." (Byock, [1996] p, 2) The word *patient* means *sufferer*, in Hebrew, *choeh.*

"Traditional spiritual orientations toward suffering are instructive" Buddhists feel that suffering arises from out attachment to the physical world." (Byock, [1996] p, 2)

Only through detaching ones self from these worldly desires will one reach enlightenment. For Jews suffering has been a major theme in our history. During the medieval period in the Jewish mystical text the Zohar suffering was thought to elevate a righteous person's soul out of this world making him more meritous in Olam habah. However, the Talmud brings us another philosophy about suffering in the story of Rabbi Johanan. Rabbi Johanan once fell ill and Rabbi Hanina went in to visit him. He said to him: " Are your sufferings welcome to you?" He replied: " Neither they nor their reward." He said to him: "Give me your hand." He gave him his hand and he raised him. Why could not Rabbi Johanan raise himself? They replied: "The prisoner cannot free himself from jail." (BT Berachot 5b)[16] " Judaism teaches that G-d chose us for certain roles in the world's development. " Inevitably, some human suffering will occur and must be accepted for the sake of others or the community as a whole or in congruence with G-d's eternal plan." (Byock, [1996] p, 2) It is our obligations as Jews to free the suffer through the experience of visiting the sick. Eric Cassell contributed a valuable model for understanding suffering. Suffering is defined as a topic of personhood. Each person has a body that is totally unique unto that person. Also each person has his or her own personality, temperament, and uniqueness. Inherently, we all are social beings. This is why family and cultural backgrounds play such an important role in our adulthood, giving us a sense of meaning. Some dimensions of personhood are more visible to others. Most obvious is the community self-seen by your professional activities. Other dimensions are aspirations, dreams, fears, memories and beliefs that are subjective to the individual. Each person has a realm of unconsciousness in which intuition, memories of tastes and smells are experienced as emotions. Every person also has a transcendent

dimension. This is manifested through your relation ship with family, and friends and having a connection to your family to live on through future generations.The fear of loosing these connections that produce suffering within the heart and mind of the patient.

Cassel conceptualizes suffering as "occurring when a threat to the integrality of the person is perceived and asserts that the experience of suffering persists until the threat has passed or until integrality of the person can be reestablished in some manner." (Byock [1996]p.4)

"The meaning of suffering may well be equated with spiritual pain/spiritual anguish. It has been stated that suffering can include physical pain but is by no means limited to it". (Cassell [1982]pp 639-645) There is truth to the fact that some suffering can have a meaning, but to some, suffering is senseless and then often unbearable. A person may be suffering due to the agony produced by the possible loss of self, the meaning of life and his or her purpose in it. With the help of our teachers, Jews find our moral roots and comfort in our sacred texts.

Clergy members can help to ease this sense of loneliness and loneness by making visits to the hospital or patient's home. "Even when suffering derives from the deepest realms of the personal, psychosocial, existential, or spiritual. ` As a health care professional Ira Byock MD approaches suffering after having made some effort to prepare the mind. "It is, perhaps, the nature of study that it never seems sufficient". "Critical contributions from the clinical perspective to my understanding of suffering have included Man's Search for Meaning by psychiatrist Viktor Frankl and more recently, Eric Cassel's article and book, The Nature of Suffering and the Goals of

Medicine. Frankl "asserts that physical discomfort and deprivation are not sufficient to cause suffering, that suffering depends on an experienced loss of meaning and purpose."

Cassell understands through the construct of personhood defines suffering in terms of conditions or events that threaten the intactness or integrity of the person." (Byock, [1996]p.4)

In the pursuit for insight into suffering the medical model is limited. Suffering represents a problem to be managed; the process of dying is a progression of problems to confront. "While this analytical approach is valid within the confines of the medical model it can facilitate a plan for effective intervention. However it is limited, offering no place or terms for a wide range of human expression. Whatever one's religious or philosophical perspective, if the commitment to investigation is desired it becomes undeniable that within the human condition there is opportunity hidden within suffering".... "More generally the problem based model is two dimensional; it cannot be perceive color, tone or the texture of life." (Byock, [1994] p 8-13) The fear we feel while suffering can be crippling. Our duty as pastoral care providers is not to provide the answers. Our duty is to remain committed and walk along side of the one who is suffering. Our skill and desire to navigate through the unpleasantly dark paths along side of our patients, are what we give to those who as suffering. Acknowledging our unknowing along the way is not a disempowering action. Here our honorable function is being able to empathize and listen. We become the conduit for G-d to flow through our vehicle and touch our patient. In saying, "I can only imagine how hard this is for you." We can communicate genuine compassion, assuming the statement expresses a genuine willingness to invest the emotional energy and to accept the personal risk that such

imagination entails." (Byock,[1996]p5) Transformation in suffering is real and possible. We must be present ourselves with a prepared minds and hearts. We must always be a presence and bear witness to their existence and suffering. Our responses to our patients must be as unique as the individual and his or her experiences. We need to allow ourselves the potential to experience and change with the patient through his or her suffering.

However, working with a person who is in great agony, a person under great stress is no longer considered in Jewish law to be a free agent. He is as the phrase is onus's, "under stress" or "compulsion." Such a person is forgiven the act of suicide or asking for assisted suicide. The classic example is King Saul, who fell on his sword. His death and the forgiveness granted him gave rise to the classical phrase, in this case, Onus's k'Shaul . In many cases in the legal literature, the suicide was forgiven and given full religious rites after death if h or she was under great stress in his last days.

However, the law does not mean that a person may ask for death if he's in agony, but that it is pardonable if, in his agony, he does do so.

As clergy members, we will be asked to assist our families, congregants and patients face very difficult decision at the end of their lives. These decisions are complicated and vary widely from one situation to another. We can gain a basic background of the legal and ethical responsibility by exploring the medical law under which physicians need to practice. From there, we can make accurate and ethical decisions by applying Jewish law to these situations. For instance, if a patient is in agony and requested medication, knowing this is definitely a lethal medication, the direct effect of which would be to put an end to the patient's life, the use of such medicine would be

absolutely forbidden. But perhaps this medicine is not immediately, or intentionally, lethal; it's prime purpose and main effect is the alleviation of pain. The harmful effect on the heart of the patient is only incidental to its purpose and is only a possible secondary reaction. The question, therefore, amounts to this: May we take the amount of risk to the patient's life in order to relieve the great agony that he or she is now suffering?

Interestingly, there is very little discussion in the Talmud about the relief of pain. Perhaps it is because there was a lack of pain management treatments available or because most individuals did not endure pain for any great length of time. This was due to the level of medical care, which was available during that time period. Most of the discussion deals with the theological question of why pain is sent to us and how we are to endure it and our attitude to G-d because of it. The Talmud does mention one pain-killing medicine that could be used in the ceremony of piercing the ear of a slave. (Kiddushin21b).[17] This has been identifies as the basis of all modern legal discussions as to whether an aesthetic may be used in circumcision. (Current Reform Responsa,[1991] p.103)

The Talmud does discuss the pain of Rabbi Judah the Prince in Ketubot 104a.[18] "Rabbi Judah The Prince was dying in great agony. The rabbis surrounded his house in concerted prayer for his healing. But Rabbi Judah's servant (who is honored and praised in the Talmud) knew better than the rabbis did how much agony he knew better than the rabbis did how much agony he was suffering. She therefore disrupted their prayers in order that he might die and his agony end."

This Talmudic passage emphasizes the fact that sometime we must show empathic mercy upon others by taking definite action to relieve pain, even if it is possible to reason as follows: It is true that the medicine to relieve his pain itself will weaken his heart, but does not that relieving the pain may strengthen him more than the medicine might weaken him? In all events, it is a matter of judgment, and in general we may say that to relieve his pain, we may incur some risk as to his final hours. " Neither the patient, nor others may induce death, they may pray to G-d to permit death to come" (Dorff [1998] p.197)

Cicely Saunders, founder of the modern hospice movement coined the phrase "total pain" to refer to "physical, spiritual, emotional kinds of suffering commonly experienced by persons with life-limiting illness and their families." The Joint Commission for Accreditation of Hospitals have established new pain standards which represent a step forward, however, their primary focus is on physical pain not spiritual pain. Palliative care recognizes the intricate relationship between physical pain, and emotional and spiritual suffering. "Physical pain itself can be exacerbated by non-physical causes such as fear, anxiety, grief, unresolved guilt, depression, and unmet spiritual needs. Likewise, the inability to manage physical pain well can be due to emotional or spiritual issues." (Saunders, C.M. [1997]p.5)

Any patient has the right to pain management and that right is supported and respected by all involved in the patient's care. Individuals may refuse pain medication due to fear or because they wish to be alert in order to interact with loved ones or because they believe they deserve to suffer. Unrelieved physical pain, among other symptoms,

may itself cause emotional or spiritual suffering. Some emotional or spiritual suffering, especially in certain cultures may manifest itself as physical pain. Spiritual frameworks and religious traditions influence how persons interpret and experience physical pain. Understanding how the mind, body, and spirit are understood in relationship to each other and, in relationship to their spiritual presence or belief is important. This framework is broad and includes suffering of all kinds, whether its cause is physical or due to spiritual or emotional suffering. There are times when cultural interpretations of pain and suffering may conflict with the goals of medical care. These cultural and religious interpretations of pain and suffering can conflict with the stated goal of medical and palliative care: to relieve pain and suffering. This is the reason the interdisciplinary team assesses the person's pain as a team. Often plans to manage pain pharmacologically fail. In these cases, spiritual practices can be implemented to help in the management of physical pain. Clergy members will introduce the practices that have been proven to help in the management of physical pain including: Prayer, Relaxation techniques, chanting, ritual cleansing, acts of atonement, acupuncture, and herbal remedies. Physical pain and other symptoms such as loss of personhood, despair, and feelings of abandonment by God may cause spiritual pain and suffering.

When physical or emotional pain becomes intolerable, patient may resort to requests for assisted suicide. Clergy members, as part of the team should pay attention to spiritual suffering when pain is identified. Once the physical pain has diminished, the interdisciplinary team should explore whether there is any spiritual pain remaining. Spiritual pain and suffering not caused by physical pain or other physical symptoms are

common for persons who are chronically ill. In the case of the terminally ill, once the general goals are confirmed, specific life-sustaining treatment can be discussed.

End of Life Decisions

There are several legal implications to end- of -life decisions that the clergy member should be familiar with. Many times questions about both halakic practices as well medical law practices are presented to the clergy member during this stressful time. Clergy members may be asked to participate in the decision-making and end of life planning process. In order for the clergy member to make the most ethically sound decisions and guide patient to the best of the clergy member's ability, they need to begin with the medical law under which the physician is liable. From there the clergy member can build up his or her knowledge of Halakah to produce an ethically sound decision.

Physicians must function within the constraints of the legal system as well as the wishes of the patients. So it is to the clergy member's benefit to understand this basic health care law. The following section will help us understand the law of various ethical situations found within medicine such as, withdrawal or withholding food or hydration, euthanasia, withdrawal of life support, and or the use of pain management in palliative care.

It is inevitable that the goal of every physician is to hold the hand of life stable by providing life-supporting techniques, making death a choice and an ethical matter. Today, due to our skill in technology and our increased knowledge of medicine, we are able to prolong the lives of those who are terminally ill or are in a persistent vegetative state and are unconscious. This presents ethical dilemmas concerning do-not-resuscitate orders, euthanasia, and withdrawal of life support and prolonging life treatment for those who are in the final stages of life.

There are four categories of medical actions that can lead to the death of a patient. They are withholding/ withdrawal of life support or life sustaining treatment, the provisions of palliative treatment that may hasten death and euthanasia. Life sustaining treatment can include mechanical ventilation, renal dialysis, chemotherapy, antibiotics, artificial- hydration and nutrition.

The goal of medical treatment as well as palliative care is to relieve pain and suffering, not to end a patient's life, but a patient's death may be the side effect of the treatment. In these cases, the term "euthanasia" has been defined as the act of bringing about the death of the terminally ill and the suffering person in a quick and compassionate way. The word "euthanasia is derived from the Greek *eu,* meaning "well, good, or pleasant," and *thantos* meaning 'death'"(Newfield, [2004] p.1) Webster's dictionary defines euthanasia as the mode or act of inducing death painlessly or as a relief from pain. The popular expression for euthanasia is "mercy killing." There is a difference between euthanasia and assisted suicide. The difference is found in the degree of the physician's patiticipation. Assisted suicide occurs when the physician provides the necessary means for the patient to perform the life-ending act. The evaluation of a person's decision begins, depends upon the person's ability to understand, communicate and reason. Patient should not lack the basic decision making capability for what they view is reasonable for their condition. People are entitled to make decisions about themselves that others find judicious as long as they don't endanger others.

Justice Cordoba, in 1914, pronounced that, "every human being of adult years and sound mind has a right to determine what shall be done with their own body". "We demonstrate the respect for human dignity when we acknowledge the freedom of the

individual to make choices in accordance with their own values".(CEJA Report-B(1992)p.3) The physician's obligation to respect a patient's decision does not require a physician to provide medical knowledge to cure a medical disorder, relieving distressing disorders or preventing the occurrence of either" (CEJA Report B {1992}p.1)

The physician must make sure a patient has the capacity to make medical decisions before carrying out the wishes of the dying patient. The wishes of a patient may be misunderstood because a patients depression or misunderstanding of the diagnosis. Many times a psyiatric consult will be ordered to ensure the patient is of sound mind and judgement. Withholding medical treatment or withdrawing treatment is not a contradiction of a physician's obligation to his or her patients. Physicians must offer appropriate treatment to a patient when it is indicating by treating the condition of the patient. They are not initialed to impose a treatment on any of their patients. (Some commentators argue that, if a physician has a strong moral objection to withholding or withdrawing life-sustaining treatment, the physician may transfer the patient to another physician who is willing to comply with the patients wishes. However, New York's highest court has suggested that mechanical life support can never be withdrawn in the absence of clearly expressed wishes by the patient. It is the patient's wishes that most important in these situations.

Withdrawal of some medical treatment may seem more acceptable than others. For instance, the right to refuse artificial nutrition and hydration has been contested by some because the provision of food and water has been a symbolic expression of care and compassion. However, providing nutrients through a tube / IV line may cause unwanted and discomforting symptoms therefore causing the patient to experience a prolonged

painful experience. Withdrawing of life support may seem more difficult than withholding nutritional support. Death occurs because of omission of treatment lacks ethical dilemmas. (CEJA report A -91 Page 5) Most bio-ethicists now recognize that there is no ethical distinction between withholding and withdrawing of medical treatment. The ethical issues lie on the motivations and professional obligations of the physician. For example refusing to start a ventilator for a patient regardless of his or her condition or request because the heir of the patient will give the physician a portion of the estate is clearly unethical. Prohibiting the withdrawing of treatment once it is in place and initiated can cause patients and physicians to decide not to begin treatment at all.

The Physicians Council stated in its 1988 report on euthanasia, that the administering of a drug necessary to ease pain of a patient who is terminally ill and suffering excruciating pain may be appropriate medical treatment even though the effect of the drug may shorten the person's life. A patient competent to make this s decision has the right to weigh against the risk of hastening death against the potential for relief of pain and suffering. Moreover, it should be the decision of the patient in collaboration with the physician in making these decisions. The benefit in allowing the physician to provide palliative care is the relief of unrelenting pain and intolerable suffering. For many patients, relief may be worth even the risk of death.

Passive euthanasia is the quickening of a person's death by allowing the natural biological process to take it's course. Those actions categorized in passive euthanasia are removing a respirator, stopping medications or treatments, food and or water and by not ordering CPR when indicated under normal circumstances.

Jewish law states that "everything possible must be done for every patient in terms of preserving life, treating illness, and relieving suffering. All therapeutic decisions must be in the patient's best interests. The safest, gentlest treatment for a given condition must always be the preferred one". (Ben Tzion Halevi #1) The Torah commands us to guard ourselves diligently (Tanak, Deuteronomy 4:15)[19] and to choose life above all. (Tanak, Deuteronomy 30:19)[20] The preservation of life (pikuach nefesh) is considered to be of paramount importance, surpassing virtually all of the other commandments of the Torah. One may violate Yom Kippur or the Sabbath if there is the slightest chance that human life may be preserved or prolonged. (Tur, Orach Hayim Hilchot Shabbat 328)[21] So, where does palliative care fit within this Jewish philosophy of health and healing?

There are certain phases before death occurs in which medical decisions can be made within the boundaries of Jewish law. Palliative care falls into the approved treatments of the goses. " Once a patient becomes a goses (means has 72 hours or less to live or has been establishes as a terefa a person who has been diagnosed with a terminal illness but could still have a year or more to live, may deny heroic measure to prolong their lives.(American Reform Responsa, [1950] #78)

The argument against euthanasia is that G-d alone gives and takes lives. The difficulty question here is, does euthanasia shorten a life or shorten the dying? In the story of Job, we try to make sense out of the suffering of the human being. We see that Job endures his suffering. Therefore, if suffering is an element within the process of living, do we have the right to shorten this time? Throughout the Bible, we find citations that instruct us not to spill a man's blood, not to murder, (don't kill) etc. However, if we turn to the First Book of Samuel we read about the first recorded instance of euthanasia

through the actions of Saul. (Rosner [1990] p.356)) Rashi supports the idea that this was a mercy killing by the Amalekite. "Saul had thrown himself upon his sword and he was dying when the Amalekite slew him, and yet David ordered capital punishment for this act of the Amalekite. However David'd decree was thought to be for the preservation of the unity of the state and his's kingship. David's action can not serve as a basis for the legal consideration of euthanasia." (Freehoff, American Reform Responsa #78[1950] p. 269)

Professor Louis Ginzberg (1936) states in the The Conservative Responsa on Euthanasia, "in evaluating human life, its duration is of no moment" Sources from the Mishnah, Talmud and Codes will suffice to corroborate this view." "One must not close the eyes of a person in agony of death to hasten the end and thus save pain and one who touches or moves his body sheds his blood". "Said Rabbi Meir (the most famous doctor of the law about the middle of the second century): Alleviating " A person in agony of death is like a closing of the eyes of a dying person is like pulling out the life from the body." The longevity of this law exists from the Mishnah composed around 200 C.E. To the Shulkan Ark composed around 16th century.

Rabbi David Bleich states in his book, Judaism and Healing, "The mitzvah of saving a life is neither enhanced nor diminished by virtue of the quality of life preserved. Nor, does the desire of the patient to have, or not to have, his life prolonged play a role in the halakhic obligation to initiate or maintain life sustaining procedures." "It is true that man has the power to prolong life way beyond the point where life ceases to be productive or pleasurable." (Bleich, [2002] p.180)

The Talmud instructs us that the one who is a *goses* is regarded as a living person in all respects. (Semochot1: 1)[22] Rambam and Caro are sited in the Talmud, stating: "One may not bind his jaws, not stop up his openings, nor place a metal vessel or any cooling object on his navel until such time that he dies. One may not move him, nor may one place him on sand or on salt until he dies." "One may not close the eyes of the dying person. He who touches them or moves them is shedding blood" for Rabbi Meir used to say: "This can be compared to a flickering flame. As soon as a person touches it, it becomes extinguished. So too, whosoever closes the eye of a dying person is considered to have taken his soul." Since the advances of modern medicine rabbis have redefined the state of the 'goses' including those who suffer from a terminal illness even if it will be a year or more before the person dies.

Most rabbinical authorities, including Rabbi Moshe Feinstein an orthodox rabbi and bio-ethicist, have supported the patient's right to refuse treatment when the following conditions have been established. "First, the patient must be in a terminal condition that is, whether the treatment is employed or not, the patient is not expected to live beyond a year. Second, the patient suffers unbearable pain and suffering. Third, the patient has indicated that he or she desires not to be treated. In the event the patient is incompetent or unable to communicate his decision, next-of-kin or the health care proxy may make such a decision based exclusively on what they feel the patient would have wanted". "Fourth, assuming the above three conditions are met, the patient may decline surgery, chemotherapy, and painful invasive treatments but may not decline food, water, or oxygen (which are the normal sustainers of life, the withdrawal of which may be tantamount to murder or suicide)." (Tendler [1996] p.1)

Over the years, there have been many discussions concerning the refusal of antibiotics. These discussions were established to debate the categorization of antibiotics as food or medicine. Since antibiotics are generally a non invasive, non-painful procedures, they can be categorized as food. Because antibiotics will not cure the patient, they are considered to be a element of delaying the death of a patient. There is also some question to whether a feeding tube falls within the category of "food" or "surgery" since a feeding tube is invasive to the body. Most would place a feeding tube in the former but emphasize that even if the patient is obligated to take artificial nutrition, he or she should not be force-fed or physically restrained. In other words it is the patient's decision weather he or she would or would not like to eat.

The physician is obligated to refuse to initiate any affirmative steps that would hasten death. Active euthanasia, regardless of motive, is morally and legally equivalent to murder. On the other hand, Jewish law views the goals and methods of palliative care in a special light.

"Judaism thus attempts to strike a balance between the great mitzvah of prolonging life and recognize that life may become unbearably difficult and painful." (Daniel Eisenberg, MD[1996]p.1)

. The basis for any of these decisions is based upon the amount of pain and suffering the patient experiences at the time of the illness.

Rabbi Eliezer Yehudah Waldenberg an Orthodox Halakhic authority from Shaarei Zedek Hospital in Jerusalem states, "that even if a patient is beyond cure and is suffering greatly and requests that his death be hastened, one may not do so or advise the patient to do so. A terminally ill patient may be given oral or intravenous narcotics or

other powerful analgesics to relieve his pain and suffering even at the risk of depressing his respiratory center and hastening his death, providing medications are prescribed solely for pain relief and not to hasten death." (Rosner, [1990] p.358)

Rabbi Waldenberg explains "the halakah addresses this as blood beating and does not have to be resuscitated". (Abraham [1996] p.185-190) Cardiopulmonary resuscitation is an intervention that may prolong the life of the dying patient may be legally required if there are no clear instructions by the patient or the family members involved in the decision making process. Clergy members should be educated on the process of CPR in order to understand the reason's it is to be performed or withheld. CPR is most important when the heart or lungs stop working unexpectedly and when there is a possibility that the underlying problem can be fixed. Next the procedure involves vigorous pressing on the chest and electric stimulation to the chest. Along with the administering of intravenous medications, some medications may be injected into the cardiac muscle or via the endo-tracheal tube which is placed from the mouth past the trachea. Typically a CPR session lasts for 15 to 30 minutes. However if CPR is not administered within three minutes the patient will lose consciousness which will be followed by death in five to ten minutes. For a patient with an advanced life-threatening illness who is dying of the underlying disease, there is no benefit to CPR. For patients with good overall health status, younger age, and administer within five minutes of cardiac or respiratory arrest, CPR may permit prolonged life.

However CPR does not go without dangers to the body. Chest compressions can result in a sore chest, broken ribs, or puncture a lung "Most people who need CPR also

need to be on mechanical ventilator in an intensive care unit to support their breathing for a period of time. Fewer than 10% of all hospitalized patients survive CPR and return to their previous state. Patients who are able to leave but still need medical care may require continual medical treatment, such as homecare, hospice or rehabilitation.

Before ending your discussion concerning life supporting measures with the patient or family, confirm what you have discussed with the family and patient. Confirm the active interventions that are or will be done for the patient. For many patients, full medical interventions to reverse disease and sustain life are appropriate even when a patient wishes not to be resuscitated visa CPR. In these cases the patient or the family should facilitate a Do-Not-Resuscitate order.

Establishing a DNR or Do Not Resuscitate order is but one example of advance care planning. When undertaking to establish DNR status, the physician may want to consider a range of scenarios, not just the one that appears to be the most pressing. This may also give the discussion a greater sense of proportion to establish general goals before discussing specific treatments, confirm patient and family understanding about the medical condition and the context, use understandable language, avoid implying the impossible is possible, and ask about other life-prolonging therapies.

Advance care planning is most easily accomplished during stable health status. Health changes often require a period for adjustment before the patient has stable goals again. Patients in need of advance directives can include both: patients with known illnesses, and healthy people who experience an unexpected illness or major trauma. It is important for the clergy members , nurses, and physicians to routinely initiate the

advance care planning process with all adults patient in the hospital regardless of their current state of health .

In the face of life-threatening illness or other significant change in health status, advance care planning becomes even more necessary. For pediatric patients with a chronic illness, the optimal timing of advance care planning will vary due to the parent's acceptance level of the disease process but before a child is in a state of crisis. Most professionals including physicians often have a number of concerns that make them reluctant to introduce the topic of advance care planning, including concerns about frightening the patient or sending the "wrong message" and uncertainty about the most effective approach to use at this time. In fact, research shows that most patients welcome the opportunity to discuss their preferences with their physician. However, today most patients are knowledgeable about their responsibility to start advance care planning and will wait to discuss these issues freely with a professional. Physicians, nurses and clergy members who routinely engage in the process find it helpful and not time consuming as they speak with these patients..

One of the specified topics found within the health care proxy/ advanced directives is that of withdrawing of a feeding tube or refusal of food and nutrition. Over the past several years there has been much discussion over the well publicized case of Terri Shivo. The controversy arose out of the fact that Terri had been kept alive for many years with a feeding tube and parental nutrition. Terri's husband wanted to remove this tube and allow her to die a natural death. The husband stated that he knew Terri's wishes in regard to this situation and she would not have wanted to be kept alive in this manner.

This was a great ethical dilemma. Since the treatment had already been established, it is unethical to discontinue it. If Terri had written her health care wishes in a living will, then her wishes would have been honored, and there would not have been such an ethical dilemma to debate.

The Talmud gives reference to the time period of the goses, in which one must provide water and food for these patients. However one is not allowed to feed them with by touching them or moving them. Therefore, it is be up to the goses to feed him or her self. Realistically, at this point the patient is far too weak to feed him or her self; this supports practices found within the palliative care model. The Rambam does not prohibit moving specifically as the Talmud states. The Rambam forbids washing and rubbing a dying person. One of the forbidden tasks not mentioned in the Talmud is the removal of the pillow from beneath a patients head. This was prohibited by Asher in the Tur. This act should not be carried out until after the soul has departed. The reason for this ruling is that it is easier to breathe with a pillow under ones head . The removing of the pillow can cause extra exertion on the patient, therefore promoting death.

Rabbi J. David Bleich, an orthodox bioethicist affirms that "the practice of euthanasia whether passive or active is contrary to the halakic teaching of Judaism". "Any positive act designed to hasten the death of the patient is equated with murder even if the death is hastened only by moments. No matter what the intention is of the person performing an act of mercy killing his deed may be constituted an act of homicide". "The distinction between an active and a passive act applies only to a goses." "Acts of omission are only sanctioned in the care of the goses and not for those who may have a

week or more to live." The definition of a goses has changed over the past several years. Today a goses is anyone who has a terminal illness and can even live a year or more.

On the other hand, as cited in the Sefer Hasidim, "one may not actively prolong the act of dying". If for example one , someone is dying and nearby a wood cutter insists on chopping wood, thereby disturbing the dying patient so that he can not die, we would remove the woodcutter from the vicinity of the dying patient. Also, one must not place salt in a dying persons mouth in order to prevent death from over taking him or her. "It is forbidden to prevent his quick death, lest a cry, or noise restores the soul to the deceased. According to some authorities even medicine must not be used to delay the departure of the soul. (Dorff, [1998] page 199)(Yoreh Deah 339.1)[23]

The Shulkan Arukh in Yoreh Deah 339:1 states, "It is forbidden to cause ones death to be accelerated, even in the case that one is terminally ill for a long time... however if there is some factor which is preventing the exit of the soul, such as the nearby woodchopper out side the window of a patient who is dying because the regular sound of the action keeps the patient's mind connected to the sounds n this world. Also one may remove some salt from the lips of a patient. However the "Taz objects only to the wiping away the salt from the lips, because this action might move or shake the patient, and this would be an overt action in hastening the death." (Freehoff, American Reform Responsa [1950] p. 260) Both the Shulkan Arukh and the Sefer Hasidim state, "One must not scream at the moment at which the soul departs, lest the soul returns and the person suffers great pain. One can not lengthen the pain and suffering of a person's death."

The pasuk in Leviticus 19:18 [24] states, "You shall love your neighbor as yourself", which is interpreted as our obligation as part of the human race is to refrain from doing anything evil or mean to another human being. We give each person the respect and thoughtful consideration to their pain and suffering as we would give to ourselves.

In criminal cases, one should be given a mitzah yafah; the pain usually inflicted by a death sentence is to be reduced both in time and degree by administering a pain killing drug. So how much more so is a person who is sentenced to be a terminal patient ought to be given at least the same consideration as a criminal? Not only may one make a case for active euthanasia in Jewish law, one may also argue that under certain circumstances the killer is not to be considered a murderer. "According to Jewish law, a murderer must have two conditions satisfied. One, the act must be premeditated, and secondly there must be malice present in the act."(Sherwin, [1990] 374)

Since traditional Judaism rejects the notion of unlimited personal autonomy, our bodies and our lives are not our own to do with as we will. Only G-d can terminate and just as we don't have the moral right to kill or harm others , we don't have the moral right to take another person's or our own lives.

"The Right of the Terminally III Act, which specifies that the patient must be at least 18 years old, of sound mind, suffering from a terminal illness, and experiencing pain, suffering and/or 'distress' that is severe and 'unacceptable to the patient' A terminal illness is defined as an " injury or degeneration of mental or physical faculties in reasonable medical judgment will in the normal course without the application of

unordinary measures or of treatment unacceptable to the patient. The physician must provide any medical treatment reasonably available to the patient confined to the relief of pain, suffering and distress with the object of allowing the patient to die a comfortable death."(Newfield [2004] p.8)

When discussing these issues of pain management, refusal and removal of treatment, one can not help but assess the quality of life for the patient. With the advancement of new medical technology this dilemma has reared it concern over and over again.

In the *American Reform Responsa #83,* 1985 the question is asked , " Does Jewish tradition recognize the "quality of life" as a factor in determining medical and general care to preserve and prolong life?" One of the patients mentioned in this responsum is slowly dying of cancer, is in great pain and wants a prescription that will relieve her pain but will probably hasten her death. The conclusion of this responsum stated: "We would not endorse any positive steps leading toward death. We would recommend pain-killing drugs which would ease the remaining days of a patient's life. We would reject any general endorsement of euthanasia, but where all "independent life" has ceased and where the above-mentioned criteria of death have been met, further medical support systems need not be continued." (W. Jacob, American Reform Responsa # 83 [1985] p.140)

"The question here goes somewhat further as we are not dealing with life threatening situations, but with the general question of prolonging life when its quality maybe questionable."

"The individual who seeks from their pain should receive drugs which may help, even though they may slightly hasten death. Suffering itself has never been seen as an independent good by Judaism. Even criminals destined to execution were drugged to alleviate their suffering." (BT Sanhedren 43a)[25] Similarly the executioner of the martyr "Chanina ben Teradyon a victum of the Hadranic persecution. Wrapped in a scroll of Law, he was placed on a pyre of green brush; fire was set to it and wet wool was placed on his chest to prolong the agony of his death. His disciples asked him to open his mouth wide so that fire might enter and thus put an end to his suffering but his answer was it was best that He who has given the soul should also take it away; no man should destroy himself.".(Avodah Zara 18a)[26] (Ginzberg [1936]p.2) Rabbi Israel Bettan of the CCAR states " Channinah would not inhale the fire to hasten his own death, but he allowed the executioner to remove the sponge from his heart. The sponge keeping him alive, was an artificial means which could be removed, but nothing of a positive nature would he permit. (Freehoff, American Reform Responsa[1950] page 265) Therefore, the rabbis see no objection and "would recommend pain-killing drugs which would ease the remaining days of a patient's life." (Reform Responsa # 79[1980] p.139)

It is clear that we should do the best to enhance the quality of life and to use whatever means modern science has placed at our disposal for this purpose. We need not invoke "heroic" measures to prolong life, nor should we hesitate to alleviate pain, but we can also not utilize a "low quality" of life as an executer for hastening death. (December American Reform Responsum #83 [1985] p140.)

In the Responsum from Reform Responsa for Our Time #17 a similar question is asked. If the patient himself gave permission for the use of pain-killing medicines it

would make a difference to our conclusion ? " Most requests for assistance in dying are prompted by the patient's fear of experiencing excruciating debilitating pain. The patient would rather have things over quickly so as to avoid suffering during their last days of life." (Dorf [1998] p.193)

Jewish halakah across the movements call for each one of us to evaluate life from G-d's perspective. "That means that the value of life does not depend on the level of one's abilities; it derives from the divine quality of life of the disabled people, even though everyone would undoubtedly prefer not to be disabled. Our Jewish tradition demands us to bless G-d for making people different, thus boldly reasserting the divine quality of such lives." (Dorff & Newman [1995] p.187)

. As clergy members we will undoubtedly be involved with answering questions concerning the end of life. These questions will include some of the topics already discussed such as pain management , palliative care , removal of life support, refusal of medications and procedures, and yet to discuss organ donation and the writing of Advanced Directives and ethical wills. The following section will hopefully shed light on some these topics so that you can assist your members as you see fit. There are many the topics in which we will be dealing with in our pastoral counseling position. It is important for us to understand all angles of these topics so that we may best advise our patients. We must understand the psychological states of the patient, the medical language and procedures, and, of course, the Jewish law, which accompanies our decisions and our moral center.

" As an editorial in *Annals and Internal Medicine* maintained, far too many people are finding that their expressed desire for with holding life support, as states in

their Advanced Directives , is being ignored by physicians who are preoccupied with the preservation of life that they can no longer see the broader picture of the human context of their work." (Dorff [1998] p.192)

Traditional care emphasizes the use of medical interventions, hospitalization and drugs to cure or control diseases. Traditional medicine can use high tech, and aggressive treatments. This approach is appropriate when a cure is possible. Some choose to take the traditional approach even when a cure is not possible. This is up to the physician and the person. However, some patients and families choose palliative care for the humane treatment of terminal illnesses.

"Fifty- two percent of those who die in the United States each year spend their last days in an acute care hospital, that suggests that too few terminally patients are taking advantage of hospice care." (Dorff [1998] p.192) Similarly, the largest study to add the human context of dying and pain is known by the acronym SUPPORT. This study involves more than 10,000 seriously ill patients. Most of these patients spent their last days in what the researches termed- " An Undesirable State", "including staying in the intensive care unit with an established DNR order and insufficient treatment of pain". (Dorff1998] p. 192) In the author's experience as a nurse and a chaplain , these situations become the most stressful experiences for all involved with the patient. It is a fact of life we will all die. We have no choice in this matter, but we do have a choice in how we die. Medical technology has advanced to the point where we can live longer lives as a result of care available during a critical health crisis. These interventions are to be used to for short periods of time during the acute phase of an illness. Today, the dilemma begins after these measures have been implemented and there is no positive progression towards health.

Hospice's palliative care treatment can be one of the preferred choices prior to arriving at these difficult situations. Hospice can be the intervention" as a response to psychological pressures that prompt people to request help in committing suicide."

(Dorff [1998] p.194) Cases that are found to be "medically hopeless need not and should not amount to psychological hopelessness."(Dorff [1998] p.194)
One of these questions may be concerning the choice of palliative care and hospice.

Hospice care is the number one facility in palliative care. Hospice is a choice one can make to enhance life for the dying person. A person with a terminal disease may choose to stay at home with the support of family and friends. Hospice care emphasizes comfort measures and counseling to provide social, spiritual and physical support. All hospice care is provided under medical supervision. However there is a point in medical treatment when it becomes less aggressive and palliative care begins.

The number one advantage of palliative care or hospice care is pain management. Hospice is one of the leading experts in pain control in our world today. The physical pain that can arise from terminal illness may be debilitating, frightening and dehumanizing. Hospice providers have the skill and knowledge to permit persons to live as pain-free, as comfortable and as full a life as possible. Palliative care provides dignity and value to a person's life up to the moment of his or her death. The value of life and the humane treatment of each individual is a primary teaching of Jewish ethics. " The very familiarity of the home setting and providing the companionship of friends and family, make hospice care clearly preferable to hospitalization when doctrines can not realistically expect to cure the patient" (Dorff[1998] p.194)

When palliative care becomes the primary medical treatment for the patient, we are to treat that person with the same care and respect as a goses. As mentioned previously in the Talmud, during the time period of the goses, one must provide water and food for them but we must refrain from touching or moving him or her. This law

makes feeding the person almost an impossible task. However, once the person is given food and water, he or she must not be force- feed. Since most of these patient are too weak to feed themselves, this action is considered a form of passive euthanasia and is congruent with the palliative care model. One of the treatments modalities used in palliative care is the concept of withdrawal of medicine, fluids, and food, which can be a hard concept for most of us to understand palliative care produces many questions regarding the ethical treatment of the dying. One distinction that must be explained is the difference between passive and active euthanasia.

While most ethicists do not classify providing food and fluids by an intravenous or stomach tube different from other forms of medical treatment, Jewish ethicist consider it a little differently. Although many rabbinic authorities permit withholding or withdrawing of "medicine" that can no longer restore health, some distinguish between nutrition and hydration required by all living beings as medicine. Due to the great advances of modern medicine, there is a difference of opinion on this matter in the Reform movement itself. Together we engage in these challenging decision which our tradition demands of us so that "we play an active role for the dying by not abandoning them." (Dorff [1998] p.197) There are times when food can actual produces a painful response to our loved one. In these cases we may have to make the decision regarding the removal of nourishment from the patient to alleviate any additional suffering. One Responsum states "that the discontinuation of artificial food and water may occur upon the reality that it provides no therapeutic value to the patient. However, the opposing thought is that food and water are just that no matter in what form they are administered

to the patient. Therefore, the idea that by removing the feeding tube, the patient will starve to death prohibits the withdrawal of this treatment. (CCAR (5754.14) p.7)

In order to make an educated decision about withholding a feeding tube, we should be aware of the purpose a feeding tube. We asked, "When is artificial feeding and nutrition most appropriate?' If the condition is temporary and natural swallowing has become difficult or is absent , artificial fluids and nutrition can be provided until the patient recover. The procedure and equipment used when placing the feeding tube is an intravenous catheter, which may be placed in a vein through the skin for fluids, or sometimes nutrition . Alternately, a plastic tube called a nasogastric tube (NG tube) may be placed through the nose, down the throat, and into the stomach. It is approximately 1/8 inch in diameter. This can only be left in temporarily. If feeding through this tube is going to be for a longer duration of time, a more permanent feeding tube may be placed into the wall of the stomach (PEG tube or G tube) This is done via a surgical procedure and is the reason Jewish law may consider it as a non mandatory procedure. Most people would place it in the food category but emphasize that even if the patient is halakically obligated to take artificial nutrition , he or she should not be force fed or physically restrained. In no event may the patient or the physician take any affirmative step that would hasten death via starvation. "This is considered active euthanasia and is forbidden by law according to the opinion" of the orthodox ethicist, Rabbi Moshe Fienstein. The consideration of the liquid placed within the tube for feeding is chemical by nature and does not fit the criteria of satisfying foods. Jewish law has criteria stating that food is to be pleasurable and satisfying to the person. If a person is unable to take in any food or fluids due to illness, he or she will eventually fall into a state much like a deep sleep. This

process will take one to three weeks. Before entering the deep sleep, after the first three days the patient will not experience the any feeling hunger or discomfort. For a person who has an advanced illness, giving artificial hydration and nutrition may not prolong life and may produce added unnecessary pain in their joints. This pain is due to fluid build up from the decrease in the system functioning of the body. A feeding tube may temporarily reduce hunger in someone who is hungry, but cannot swallow. Intravenous fluids may reduce some symptoms, such as delirium due to dehydration. However, all feeding tubes are associated with significant risk. Approximately 30% of patients have signs of the liquid entering the lungs. This aspiration of fluid can cause coughing pneumonia and become a source of infection. . These infections can be life- threatening to the patient. Feeding tubes may feel uncomfortable for the patient. They can block the stomach, causing pain, nausea, and vomiting. the patient. In order to remove or replace any of these tubes the patient can be disturbed by the moving or rubbing the patient necessary for these procedures. As stared before, the Rambam does not prohibit moving a goses as the Talmud states. Since moving the patient may cause the patient to die , Ashe states, "this act should not be carried out until after the soul has departed."

However, Rabbi Walddenberg, an orthodox ethicist, states that " the halakah in regards to blood transfusions, oxygen, antibiotics IV fluids , oral and parenteral nutrition and pain relief medication must be given until the very end." Rabbi Shlomo Zalman Auerbach narrows the criteria by stating that "a person must be given food and oxygen even against his will".(Eisenberg[1995] p.3) "However one may with hold at the patients request medications and treatments that may cause addition pain and suffering to the patient." Rabbi Auerbach, an orthodox rabbi states, "a dying cancer

patient must be given food ,oxygen, antibiotics, insulin and the like but does not have to be given painful chemotherapy ." "Such a patient may be given morphine even if it depresses his respiratory system" "Someone with a terminal illness whose heart stops beating does not have to be resuscitated". (Abraham [1980] p.185-190) As we can see there are various thoughts about these among the religious leaders of our time.

Due to medical advances and the struggles of many clergy members and families, American society has increasingly come to recognize what is known as the "right-to-die". In the famous Cruzan case, the Supreme Court of the United States, in a 5-4 decision, ruled that a patient who has been diagnosed to be in a persistent vegetative state and has clearly communicated his or her wishes regarding the use of life support machinery or the provision of hydration and nutrition has a constitutional right to have those wishes respected even if the patient is not suffering from a terminal condition. A referendum in the state of Washington that would formally legitimate physician-assisted suicides was supported by almost 50% of the electorate and many feel that within the near future, such measures will be routinely approved. Under a recently-enacted federal law, persons entering hospitals or nursing homes must be informed of their rights to execute living wills or other advance directives spelling out ahead of time specific medical interventions that should not be performed .

Judaism promotes the preservation of life "pikuach nefesh." It is considered to be of paramount importance, surpassing virtually all of the other commandments of the Torah. This law must be honored even in the event that one may violate the Shabbat. One must follow this law even if there is the slightest chance that human life may be preserved or prolonged.

Keep in mind, however, that a Jew believes in a soul and that the body is simply an ark for the person's true spiritual essence. Souls come to Earth for many, many purposes. However, we don't know why G-d sends souls into this life. Sometimes the spiritual destiny of a soul is to elicit caring, sensitivity, and nurturing responses from us. Other souls exists to teach us certain things about the meaning of life and love. Judaism rejects the notion that the using of advanced technology to sustain life is somehow an interference with G-d's will. Technology and scientific advancement are not man-made but are in themselves indirect gifts of Divine to be used for the benefit of humankind.

Just as there is a Divine commandment to prolong life, there is a mitzvah to alleviate pain and suffering. But what happens if one value can be achieved only at the risk of devaluing the other ? Consider the patient suffering a terminal illness whose life could be prolonged for no more than six months but only at the cost of painful, debilitating treatments and medications. The patient declines the treatment or procedure to achieve a quicker, less painful death. This is the mitzvah of pikuach nefesh (preservation of life) and not prolonging death.

There has been some discussion in the law, in recent years, of the difference it would make if the dying patient gave certain permission with regard to the handling of his or her body after death. For example, he or she might ask for certain parts of the usual funeral ritual to be omitted; and some authorities say that he may permit an autopsy. This permission was given by the late Rabbi Hillel Posek of Tel Aviv. These statements giving the dying man or woman the right to make such requests deal with what shall be done with his or her body after death, but does not any permission that he or she can hasten his or her own death.

Rabbi Moshe Feinstein clearly allows the terminally ill patients in debilitating pain to refuse life prolonging treatment. Surely, such a patients may refuse resuscitation or intubation if they so choose. Non-terminally ill patients may refuse treatment if the proposed therapy is sufficiently dangerous or unproven to cure or prolong their lives in any way.

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The question of whether to institute the"do not resuscitate" orders is ethically complex. The Torah commandments us, "do not stand by idly while your neighbor's blood is being spilled" a mitzvah that is commonly understood to mean that every Jew has a personal obligation to prevent his friend from harm. This would seem to mandate resuscitation of everyone, since cardiac arrest and apnea certainly represent the ultimate threat to a person's life.

The reason that this is brought into question is because Judaism recognizes our ultimate fate of death. When someone dies, we are forbidden to desecrate the body. Moreover, the Code of Jewish Law (Shulchan Aruch) explains that there is "a prohibition of touching a moribund patient (*goses*) who then was estimated to have less than three days to live." Resuscitation of a *goses* is not required, and in fact may be prohibited, as a forbidden intrusion to the natural dying process. Therefore, the "underlying assumption in Judaism is that one should NOT resuscitate a gravely ill patient." Dr Eisenberg states "one should not resuscitate a patient whose cessation of life functions is because their body could no longer sustain life".(Eisenberg[1995]p.2)

There are times when our congregants may to turn to us in aiding them in making these decisions for their family members. At the onset of the counseling session, we are

obligated to make sure that a person is a goses. Once the patient's diagnosis is verified , and it is known that he or she has less than a year or so to live, we can discuss with the family options for care. These guidelines were instituted to guard the sanctity of life and prevent any unethical motives on the part of the potential organ recipient.

There are certain situations in which the patient's medical status deteriorates even though medical treatment has been fully ordered and administered. The physician may conclude that the patient is considered "brain" dead. This may be difficult for some to understand because the person looks alive. In these cases the patient is usually on a respirator which provides the cardio-pulmonary functions of the heart and lungs. The member has a pulse, respirations and appears warm to the touch. There even may be some small movement of the extremities. Patients in this condition can not live with this mechanical intervention.

The "classic" halakhic "definition" of death (that is, the set of criteria accepted by virtually all Jewish legal authorities prior to the late 1960s) is based upon cardiopulmonary indicators: death is established by the complete and irretrievable cessation of heartbeat and respiration. This standard proceeds from Mishnah Yoma 8:6-7, [26] which declares that the saving of life supersedes the laws of Shabbat even when it is not certain that an individual's life is in danger or, for that matter, that he or she is still alive. Thus, when a building collapses upon an individual on the Sabbath, the halakhah permits all necessary labor to remove the debris so that it can be determined whether he or she is still alive. The Talmud (BT Yoma 85a)[27] verifies that we are obligated to assess his or her heartbeat or his respirations. The major codes rule that the cessation of

respiration is the determinative criterion for death. This does not mean that heartbeat is an irrelevant factor; later rabbis realized that the cardiac and respiratory functions are inextricably linked. Thus, R. Moshe Sofer, the "Chatam Sofer" (18th to19th century Hungary), established a threefold set of criteria for death: "when a person lies still as a stone [*i.e.*, absence of reflexes], with no discernible pulse, and then his respiration ceases, he is certainly dead."

We also find in the halakhic sources suggestions of a different "definition," namely that death is indicated by the cessation of neurological activity. Today the "Harvard Criteria," which established testing protocols for determining that all neurological activity (including that of the brain stem) has ceased, some halakhists have come to accept brain death as a proper indication of death according to Jewish law. This does not, in their view, contradict the cardiopulmonary standard as promulgated by Sofer: death is still indicated by the complete cessation of independent cardiac and respiratory activity. The difference is the introduction of diagnostic technology. At the time of the Sofer, death could be determined solely by the actual measurement of heartbeat and respiration. Today, we have conclusive testing procedures that can establish the cessation of all neurological activity and the patient can be declared dead. Since "brain death" is final and irreversible, and there is no possibility that autonomous respiration will begin anew if the respirator is removed from the patient." The fact that the organs of a brain-dead person are kept functioning by means of life support technology does not mean that the person is still alive, because with the cessation of neurological activity autonomous, independent heartbeat and respiration cannot be restored. Those Orthodox rabbis who accept brain death as an adequate indicator of death have ruled in favor of heart and liver

transplantation surgery, which require that these organs be retrieved from brain-dead donors. This stance, however, remains controversial within the Orthodox world; most noted halakhists continue to insist on the literal application of the "Chatam Sofer" standard: death occurs only when heartbeat and respiration have irretrievably ceased.(Meaning the person is off of mechanical ventilation for a period of time and therefore unable to be used as a viable organ donor)

Liberal halakhic opinion, accepts the brain death standard as a proper criterion for death. Since the determination of brain death signals that the body has terminally lost its ability to maintain cardiopulmonary functions on an independent basis, the brain death standard satisfies the requirements of both Jewish tradition and basic moral sense. When clinical tests establish beyond scientific doubt that brain activity has irretrievably ceased and that circulation and respiration are maintained solely through mechanical means, the patient is dead. It is then, and only then, that the body's organs may be removed for transplantation.

We should also note that this does not meet some Jewish individuals' standard of establishing death according to cardiopulmonary criteria. That standard, similar to the brain death standard, was meant to indicate that heartbeat and respiration have irreversibly ceased to function independently for the respirator.

Two to three minutes without the detection of a pulse are not sufficient to meet this test. Cardiopulmonary functions can return spontaneously or be restored through resuscitation during a much longer period, even up to ten minutes following asystole (cardiac arrest) It may be, of course, that physicians and family members have no

intention of resuscitating such a patient. That decision can be a proper one. As we have written, there are times when it is ethically permissible to withdraw most forms of medical treatment, to "allow nature to take its course" and to let the patient die without further "heroic" measures. It is for this reason that the "brain death" standard, which does testify to the irreversible cessation of autonomous heart and lung activity, meets the criteria for death as set forth in the sources of our Jewish tradition. Before the development of these neurological criteria, death was classically described as the cessation of circulation and respiration as the Sofer established. However, today mechanical ventilation and of methods for cardiovascular support presented new challenges for determining the end of life for patients with catastrophic cerebral injuries whose lives could be preserved by using these complex technological devices. Initial efforts to define death in this age of technological advancement included development of the Harvard criteria in 1968 by an ad hoc committee on brain death at Harvard Medical School. These criteria described determination of a condition known as "irreversible coma," "cerebral death," or "brain death". Since the initial introduction of these criteria, the Uniform Determination of Death Act, established in 1980 and supported by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, has served as a model statute for the adoption of state legislation that defines death. The act states: "An individual, who has sustained either irreversible cessation of circulatory and respiratory functions, or irreversible cessation of all functions of the entire brain, including the brainstem, is dead. A determination of death must be made in accordance with accepted medical standards." Much of this discussion is the result of the awareness of continuing

technological advances, neurological diagnostic developments, and clinical insight.

Although the concept of death determination continues to develop, clinical and scientific experts have discovered clinical practice guidelines for the diagnosis of brain death that are based in neuroscience. Experts continue to define brain death as irreversible cessation of all functions of the entire brain, including the brain stem. This definition remains consistent with the definition of brain death initially presented by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research

The Joint Report of the Council on Ethical and Judicial Affairs and Council on Science Affairs A-89 , Persistent Vegetative State or PVS and Decision to Withdraw or Withhold Life Support says that: "The definition of permanent unconsciousness is as follows , 'Consciousness has two dimensions: arousal and cognitive content of the aroused state. Arousal is a function maintained by deep brainstem- medial di-encephalic structures in the brain in contrast to learning, memory, self awareness, and adaptive behavior, all of which depend upon the functional integrity of the cerebral cortical mantle and its associated subcortical nuclei'.

People with overwhelming damage to the cerebral hemispheres commonly pass into a chronic states of unconsciousness called the vegetative state in which the body cyclically awakens and sleeps but expresses no behavioral or cerebral metabolic evidence of possessing cognitive function or of being able to respond in a learned manner to external events or stimuli. This condition of total cognitive loss can follow acute injuries causing coma or can develop more slowly as an end result of progressive structural

disorders, such as Alzheimer's disease, that in their end stages also can destroy the psychological functions of the cerebrum. When the cognitive loss lasts for more than a few weeks, the condition has been termed a persistent vegetative state (PVS) because the body maintains the functions necessary to sustain vegetative survival.

The distinguishing feature of PVS is chronic wakefulness without awareness. This can be accompanied by spontaneous eye opening, the utterance of unintelligible sounds, instinctive sounds such as grunting or screams or even brief smiles, and sporadic movements of the facial muscles and non paralyzed limbs. Although there is an alert appearance, observation and examination repeatedly fail to demonstrate coherent speech, or comprehension of the words of examiners to initiate or make consistently purposeful movements. Movements are largely confined to reflex withdrawals or any capacity to initiate or posturing in response to noxious or other external stimuli. Since neither visual nor auditory signals require cortical stimulate brief orienting reflexes, some of these patients may return the head or dart the eyes toward a noise or moving objects. However, they will not consistently follow objects with their eyes or show other than a startled response to noise. They blink as an involuntary reaction when air stimulates the cornea."

Cardiopulmonary activity, swallowing and digesting and other non- neurological vital functions usually are preserved to the extents that standard nutritional and supportive measures will sustain life indefinitely. The chance of regaining independence after being vegetative for three months is extremely small. Rare exceptions are claimed to have occurred but are a very low percentage of these cases.

One aspect of the debate about stopping treatment in PVS focuses on a concern that the patient will experience pain after the treatment is stopped. The person who is unaware cannot possibly suffer; contradicts physiology and suggests that suffering can remain when other unequivocal neurological signs and tests indicate profound loss of cerebral cortical activity.

In order to ensure that a patient truly would want life sustaining treatment to be withheld or with drawn, states have developed documentation that clearly states the person's wishes and desires concerning end of life care. These documents are referred to as an Advanced Directive, Living Will, and Health Care Proxy.

Please note that brain-dead patients, may be medically cleared for organ donation. Understanding the concept of brain death is an important factor that influences a family's decision to donate organs and tissues for transplantation. Families who are approached for donation without having all their questions about brain death answered may refuse to consent to donation. (Cahbalewski [1999]p.3)

When a situation arises in which it is permissible to withdraw treatment, the medical profession has a very specific and technical role. The attending MD will make the diagnosis of permanent unconsciousness, and in most states at least two MDs with no interest in the case must confirm the diagnosis. These MD are known as the prognosis board. Consultation with other MDs are desirable and appropriate. Once the diagnosis is made with or with out court involvement, withdrawal of life supporting measure can be implemented. Initial requirements for clinical determination of brain death include cardinal findings in brain death include coma or unresponsiveness, absence of cerebral

motor responses to pain in all extremities, absence of brain stem reflexes, and apnea.

In most patients with brain death, neurological imaging studies such as CAT scan, PET scan or MRI show abnormalities consistent with loss of brain and brain stem function. Clinical diagnosis of brain death is rare when findings on neurological imaging studies are normal. Occasionally, patients with a specific cerebral injury may have a normal brain presentation on neurological imaging, but does not mean that brain function is normal. Determining brain death in patients with coma of undetermined origin remains difficult but can be accomplished through prolonged observation and confirmation that the patient's condition fits clinical and diagnostic criteria. These criteria are as follows: cerebrally modulated motor responses of all extremities are absent in brain death. These motor responses should be absent after painful stimulation with pressure to the supraorbital ridge or the area above the eye socket and the nail beds. However, motor responses may occur spontaneously during apnea testing in the presence of hypoxia or hypotension. Muscle stretch reflexes in arms and legs, resulting in movements that resemble grasping or walking as well as assessment of neck muscle are assessed. In addition, use of neuromuscular blocking agents may inhibit motor testing in patients with brain death because of medication induced motor weakness. If this is use, other tests, may be required.

Brain stem reflexes are measures that evaluating pupilary reactions and eye movement. A patient's eye pupils are round. Oval or irregularly shaped pupils are compatible with brain death, and most pupils are midsize (4-6 mm). However, dilated pupils may occur even in the presence of brain death, because the nerve of the papillary dilator muscle may still be intact. The pupils may be unable to exhibit a light reflex in

brain death. Although many drugs can influence papillary size, the papillary light reflex remains intact only in the absence of brain death.

Both ocular movements both oculocephalic and vestibulo-ocular reflexes are absent in brain death. The oculocephalic reflex is elicited by rapidly and vigorously turning the head to 90 degrees laterally on both sides. The normal response is deviation of the eyes to the opposite side of head turning. In brain death, oculocephalic reflexes are absent, and no eye movements occur in response to head movements. The vestibulo-ocular reflex is elicited by elevating the head at a 30 degree angle and irrigating both tympanic membranes with 50 ml (milliliters) of iced saline or water. In brain death, vestibulo-ocular reflexes are absent, and no deviation of the pupils of the eyes occurs in response to ear irrigations. The patient should be observed for up to one minute after each ear irrigation, with a five minute wait between the testing of each ear. Several classes of drugs can diminish vestibulo-ocular reflexes, including sedatives, aminoglycosides, tricyclic antidepressants, and anti cholinergic, and anti seizure medications. Facial trauma involving the auditory canal and inner ear bone can also inhibit these reflexes. Facial, sensory, and motor responses are assessed by observing the corneal and jaw reflexes. These are absent in brain death. Corneal reflexes should be tested by using a cotton-tipped swab and gently touching the swab to the corneal area of the eye. Grimacing in response to pain can be tested by applying deep pressure to the nail beds, supraorbital ridge(above the eye), or temporal mandibular joint (the space where the jaw meets skull near the ear) . Severe facial trauma can inhibit interpretation of facial brain stem reflexes.

Both gag and cough reflexes are absent in patients with brain death. The gag

reflex can be evaluated by stimulating the posterior part of the pharynx with a tongue blade, but the results can be difficult to evaluate in orally intubated patients. Artificial ventilation is best used if the patient has a temporary condition that prevents adequate breathing, a breathing machine can be used until the patient recovers. The procedure involves placing a tube through the mouth or nose into the lung that is then connected to a breathing machine. When a patient is unable to breath on his or her own, they may benefit form the use of a breathing machine. This allows the body time to recover with the hopes that independent breathing will resume. However there are some disadvantages to intubation. For instance, the breathing tube is uncomfortable. Most patients require medicine to keep them comfortable while they are on the breathing machine .It may prolong a state of dependence in a medical setting that the patient finds not worth the discomfort and it may prolong dying. The cough reflex in an intubated patient can be tested by using bronchial suctioning. This is a procedure by which a small suctioning tube is passed through the mouth into the throat to produce a coughing response.

An essential component in clinical determination of brain death is detection of apnea. Apnea is the loss of breathing. Loss of brain stem function ultimately results in loss of centrally controlled breathing, which produces apnea.

The actual testing to determine brain death occurs over several days. Following is the actual procedure that is preformed in determining brain death.

1)Disconnect the ventilator

2)Deliver 100% oxygen at a rate of 6 l/min. .

3) Observe the patient closely for respiratory movement (abdominal or chest excursions that produce adequate tidal volumes. Measure Paco2 and pH after approximately eight minutes and reconnect the ventilator. In a neurologically functioning patient, the Paco2 level would rise and spontaneous respirations would occur. In the brain dead patient no respirations are noted during this test.

In clinical determination of brain death, persistent observation further confirms the irreversibility of the patient's condition. A repeat clinical evaluation of cardinal findings in brain death is recommended. Most experts recommend an arbitrary interval of six hours between initial and repeat observations for clinical determination of brain death in adults.

Although confirmatory tests are not mandatory in most situations, additional testing may be necessary for declaring brain death in patients in whom the results of specific components of clinical testing cannot be reliably evaluated. Clinical experience with confirmatory tests other than conventional electroencephalography, and transcranial Doppler sonography is limited.

Electroencephalograph, or EEG, consists of a 16- or 18-channel instrument and guidelines developed by the American Electroencephalographic Society are used to determine brain death. In patients with brain death, no electrical activity occurs during a period of at least 30 minutes of electroencephalographic (EEG) recording.

In the transcranial Doppler sonography, intracranial arteries are tested bilaterally (ie, middle cerebral artery through the temporal bone above the zygomatic arch which is above the eye). Some patients may have difficult to assess temporal windows. Therefore, initial absence of Doppler signals cannot be interpreted as consistent with

brain death. Findings consistent with brain death indicate a decreased blood flow to the brain associated with greatly increased intracranial pressure.

Testing for sensory, evoked potentials is done at the bedside with a portable instrument that provides bilateral stimulation of median nerves. In studies of patients with brain death, most patients had no response to tests for sensory and brain stem auditory evoked potentials. Both types of tests are less sensitive than previously mentioned confirmatory tests.

Having a clear understanding of how brain death is determined and being able to recognize that the criteria for neurological brain death differ from the cardiopulmonary criteria used to determine death are the first steps in eliminating the confusion often associated with brain death. Family members of patients with brain death need reassurance and accurate information. They may think that their loved one has a heartbeat and is therefore being "kept alive" by mechanical ventilation. They may also think that their loved one will get better through treatment or intensive rehabilitation.

As clergy members we must understand that first and foremost, brain death is irreversible. Patients who are brain dead have permanently lost the capacity to think, be aware of self or surroundings, experience, or communicate with others. The common pathological processes leading to brain death include massive head trauma, intracranial hemorrhage(bleeding in the brain AKA, CVA or stroke, and hypoxic ischemic(loss of oxygen to the brain tissue) damage suffered during cardiopulmonary arrest. These conditions rapidly produce marked brain edema and swelling, which increases brain volume and pressure. Because of the skull's fixed capacity, the increase in brain volume produces an inevitable increase in intracranial pressure causing two morbid events to

occur: (1) swelling due to infarction of the brain stem as it is forcibly displaced from its original location; and (2) loss of cerebral perfusion pressure as intracranial pressure exceeds the average arterial blood pressure. When cerebral swelling and pressure occurs the brain tissue starts to die due to loss of circulation which the pressure cuts off. However, if the patient has been maintained on a respirator, it also implies that circulation and oxygenation has been delivered to other organs of the body making organ donation a possibility. If the family does not give consent for donation, mechanical ventilation should be stopped, and the patient should be given post mortem care according to hospital protocol. Every patient's family has the right to be offered an opportunity for organ donation when their loved one meets accepted criteria. Regardless of the decision, the clergy members can best help families as they grieve the loss of their loved one by supporting them in their choice.

The saving of a life takes place over all but three halachic imperatives - murder, idolatry, and adultery. Accordingly no barriers exist to donation of the organs of the deceased if they are obtained in accord with halacha, which mandates the highest standards of respect for human dignity. Vital organs such heart and liver may be donated after the patient has been declared dead by a competent neurologist based upon the clinical and/or radiological evidence. This case is usually reviewed by the medical ethics board of the hospital prior to diagnosing the patient . In accord with the ruling of HaRav HaGaon Moshe Feinstein, z'tl, and of the Chief Rabbinate of Israel, brain stem death, together with other accepted neurological criteria, fully meets the standards of halacha for determining death.Since organs that can be life saving may be donated, the family is urged to do so. When human life can be saved, it must be saved. Even cornea transplants

that can restore sight to the blind are also treated in halacha as life-saving. The halacha therefore looks with great favor on those who facilitate the procurement of life-saving organ donations.

Today there are approximately 93,888 people waiting for organ transplants in the United States. Every 13 minutes another person is added to that list. In America at least thirteen people die every day waiting for an organ transplant in the United States. When a traditional Jew dies there is no question if there will be a ritual washing or a funeral. Judging by the programs at the Frisch School Rabbi Moses Tendler states in his article on organ transplant, " there soon may not be any question in the Orthodox community about the routine acceptance of organ transplantation. It may become just another part of Jewish ritual at death.". (Tendler, [1996]p1)All three of the major Jewish movements confirm that "pikuach nefesh," the saving of a human life, is the overriding value that permits the ordinarily- forbidden removal of organs from the body of the dead for harvesting of transplant organs. The significant and difficult halakic issue among the movements, is the determination of when death occurs and the harvesting of the organs begins. The determination of death is as follows: Rabbi Dr. Moses Tendler explains "dead motion is when blood circulation has been severed to a limb of the body, the organism can survive for a while, but brain tissue dies in about four minutes. Once a person is declared dead , a patient may be placed on a ventilator and then assessed for possible organ donation. It is halakically permissible to use the organs for transplantation. Now it is medical law that any patient who is considered brain dead and will be removed from life support, first be considered as a possible organ donor.(Tendler [1996] p.2) Rabbi Tendler also states that , "Human Life is identical. Jew or Non-Jew, chassid or secularist. Saving a life is

hallachically mandated so that we transgress the law of Shabbat to do so. If that law considering human life identical is violated, you've transgressed Torah law and endangered Jews through out the world." (Tendler[1996] p.2)

As cited from the Reform Responsa on *Live Liver Transplants* , it was stated that "nearly eighty percent of all transplanted in the United States are taken from deceased donors."(CCAR[5763.2]p.1) Since the patient has been diagnosed as dead one might think there would be no objection to this practice. Rabbi Joseph Prouser in his article on "The Mitzvah of Organ Donation from the Unit Synagogue Review explains," "the objections to this practice include prohibitions against nivul ha-met, hana'ah ha-met and halanat ha-met is over ridden just as the mandate to preserve a life take precedence over all other religious obligations." (Rabbi Joseph Prouser[1997]pp1-2)

The Reform Responsa on *Live Liver Transplants* continues , "Halakic authorities have come to recognize organ donation as an exception to each of these issues"(CCAR[5763.2]p.2-4) Reform Rabbis encourage their congregants to fulfill the mitzvah of organ donation . This is not to say that Reform Judaism does not follow the tradition of honoring and respecting the dead." Now that physicians and surgeons can save many lives with these procedures they have become an integral feature of the legitimate practice of medicine. Cadaver organ donation is included in this healing procedure of saving a life, which is a mitzvah, and it must not in any way be associated with the acts that our tradition condemns as disrespectful treatment of the dead."

The mitzvah of rescuing a person from mortal danger is cited in the Talmud BT Sanhedrin 73a [29] : "From where do we learn that if one sees his fellow drowning in the

river, attacked by wolves , endangered by robbers that one is obligated to save him?" "You shall not stand idly while your fellow's blood is shed."(Tanak, Leviticus 19:16)[30]

Jewish law forbids suicide and risking mortal danger to perform a mitzvah. This situation is most often examined in regards to live liver transplants and kidney transplants. Both transplants have been found to have manageable recovery periods. This does not mean that the procedure is not serious and the recovery is easy. The risk of a kidney transplant also places the donor in safek sakanah (possibility of danger), but it is now permitted since medical advancements have made this surgery somewhat routine.

In R. Epstien's , Aruk Hashulchan Chosen Mishpat 426, par.4, the poskim cite the Talmud Yerusalmi to the effect that "a person is obligated to risk his life in order to rescue his fellow. This passage has been omitted from the earlier codes, since the BT takes the opposite position. Each instance must be judged on its merits. One should weigh one's decision carefully and not protect himself more than is presented.. for when a person saves one Jewish life, it is as though he has saved an entire world."

The Shulchan Aruk teaches this point that "one should in any event weigh the situation carefully, to determine whether it is in fact Safek sakanah, and not to be overly strict (shelo ledakdek beyoter) in the matter. As we have seen elsewhere, one who is overly strict in insisting upon his own rights will one day lose the will to protect". (Bava Metzia 33a, SA Choshen Mishpat 264:1)[31]

The Reform Responsa, states that the preservation of human life as a mitzvah of the highest form and that we are required to protect ourselves from danger as well as

others. However if the act will pose mortal danger to our lives we are forbidden to attempt this mitzvah. How much more so must we be obligated to save a life through the death of a loved one.

The University of Pittsburgh Medical Center developed a set of guidelines, commonly referred to as the "Pittsburgh Protocol," to allow for "planned" organ retrieval. In the hypothetical case, a patient or the patient's surrogates make a legal and ethical decision to. The "Pittsburgh Protocol" specifies that organs may be retrieved once the patient meets the cardiopulmonary criteria for death, i.e., "the irreversible cessation of cardiopulmonary function," and it determines that "irreversible cessation" has occurred once the patient's pulse has stopped for a period of two minutes. To wait longer than two minutes would subject the internal organs to warm ischemia (damage caused by lack of blood flow) and possibly render them useless for transplantation. This presents a serious problem for those who only accept neurological criteria (brain death) as the determinative indicator of death. The Pittsburg Protocol meets the neurological criteria for death, irreversible loss of all brain functions." Indeed, since "no one would claim that two minutes of anoxia is sufficient evidence that the brain has ceased to function," a patient declared dead according to the Pittsburgh protocol may also need the advances of modern medicine which can accurately diagnosis brain death. A clear definition of brain death must be given and reinforced to the family in order to clarify any doubt that may be with them.

Advanced Directives

The topic of Advanced Directives may present itself at the beginning of an illness or at the end of one. When introducing the topic, inquire how familiar the patient is with advance care planning. Some patients may already have advance directives in the form of a living will health care proxy or durable power-of-attorney for health care. If this is the case, review the documents and amend them if appropriate. An advisory medical directive can be used to amend existing legal documents.

Physicians may disagree about the extent to which specific treatment preferences ought to be discussed, especially if such treatment will not help achieve the overall goals. As a rule, the discussion of general goals of care should precede the discussion of specific treatment preferences. Such conversations can begin like this, "Can we review our overall goals for your care?" "Let me tell you what I understand you want as we plan your care" . Make sure the pastoral caregiver and health care workers use language that the patient will understand (use a medically skilled translator if necessary), give information in small pieces, reinforce context in which the decisions will apply, stop frequently to check for reactions, to ask for questions, and to clarify misunderstandings, and concerns about discussion of specific treatments. This process can be an emotionally draining discussion. During these discussions, respond to patient and family's anxiety by acknowledging emotional content of this topic. Patients, families, and surrogates may be profoundly disturbed by subject matter being discussed. Parents, if the patient is a child, are likely to be very emotional and need support from the physician and other members of the health

care team including the clergy member .If the clergy member finds that emotions are too challenging, ask other colleagues to assist in establishing and implementing the plan. The next step may be as simple as planning to discuss the subject again at the next visit, or convening a family meeting to further discuss the proposed treatment plan.

Informed consent is a fundamental ethical principle that underlies today's medical care. Patients (parents if the patient is a child) deserve a clear, complete understanding of all therapies that are being proposed for them. Some will want to know all the details. Others will prefer not to know anything. Be prepared to describe in simple, neutral terms the aspects of each life-sustaining treatment in a manner that conforms to the principles of informed consent.

Before you begin the process, be prepared to explain the goals and the process that you recommend using to the patient or family. The clergy member may have literature for the patient to read. If you are using a validated worksheet of the hospital, give it to the patient to look over before the next discussion, explain the roles of other family members, or a proxy.

If a patient (or parent if the patient is a child) does not seem comfortable talking with you be supportive and provide information, but do not force the conversation. It may happen later when the patient is ready.

"In most states, every patient admitted to a hospital must be offered the option of filling out 'advanced directives,' commonly know as a living will, indicating their medical wishes in case the patient is not competent to express his or her desires at a

future time". A patient may also choose to establish a durable power of attorney or a health care surrogate , to be like to transfer legal authority to make medical decisions the patient can not. While Judaism may not have encouraged the writing of living wills and durable powers of attorney, it has begun to embrace the opportunity that these documents offer in the supporting and establishing Jewish law in end of life situations. The most direct argument for advanced directives is the recognition that if the patient has not indicated his or her wishes in advance, someone else will and that person may not have the same ethical concerns as the patient.

Agudath Israel and the Rabbinical Council of America have drafted model living wills and powers of attorney documents that are intended to incorporate the values of the Torah. Both The Union for Reform Judaism and United Jewish Synogoue have living wills and power of attorney forms on their websites for easy access. It is important to understand that advanced directives do not intrinsically require lack of treatment in cases of medical emergency. While one may legally choose to refuse life-sustaining treatment in cases of critical illness, one is also free to mandate that "everything" be tried. The Jewish person contemplating using a power of attorney may name his or her rabbi to be the his or her legal proxy, ensuring that any issues of Jewish law will be dealt with appropriately.

The crucial issue involved with a living will is whether the Torah grants the first legal principle concerning the duty of burying the entire body--- limbs , eyes, blood, etc... applies as a general rule. However, if it is evident that certain parts of the body are a remedy for a sick person who is in grave danger, then the necessities for healing would constitute an exception. Jewish law states that it is "forbidden for the living to derive any

benefit from the bodies of the dead." "This objection is often applied to the planned use of cornea and bones from a bone bank etc.., namely not to have benefit from a dead body. It is , therefore, necessary to go into the question of the legal status of healing, as to what may be used for healing". Freehoff continues "That if a patient is in danger then hesitation of using the dead person's blood is overridden for the sake of life."(Using The Blood of the Dead CCAR response # 83 Vol. LXXVIII, 1967, pp.78-81)

Far preferable to the living will is the durable power of attorney (often called a health-care proxy), which simply specifies a person-family member, friend, clergyman - empowered to make health care decisions on the patient's behalf in the event he or she is unable to do so for himself or herself. The power may in addition specify that all decisions shall be made in accordance with Jewish law and in consultation with a designated clergyman of the patient's choice. Sample forms - labeled somewhat inaccurately as "Halachic Living Wills" -have been prepared by Agudath Israel of America, This document ensures that decisions will be made consistently with the moral and religious beliefs that the patient holds dear.

Incapacitation and terminal illness are tragic situations. Let us remember, however, that we come from a tradition that has grappled with these questions and that approaches these issues with sensitivity, compassion, and understanding. Some of the decisions made will include the determining a health care proxy, durable power of attorney, Advanced Directive, and health care surrogate.

We may gain insight into the use of the power of attorney through a responsum written by Rabbi M. Feinstein. Rabbi Feinstein states , "if a pain-stricken terminally ill

patient were to prefer to die and it would be "proper not to treat him in any manner that would prolong the dying process", such as treating the second illness. Nevertheless, Rabbi Feinstein writes, that "this is a decision that the patient must make, and if the patient is incompetent, the doctor should consult the family regarding treatment, since they are closest to the patient. While the family's autonomy is limited by the same factors that limit the patient himself, we see that Judaism does recognize the concept of substituted judgment in such cases" (Tendler [1996]p2). A durable power of attorney is the easiest method of recognizing whom should be consulted if the patient is unconscious or incompetent. Patients frequently wish to minimize the decision-making burden for families. Clergy member should ask the patient to identify a possible proxy decision-maker who might act on the patient's behalf, to be involved in subsequent conversations. The health care proxy is someone the patient trusts - for example, a family member or close friend - to make health care decisions for the patient if he or she loses the ability to make decisions himself or herself. By appointing a health care agent, the patient can make sure that health care providers follow wishes. The agent can also decide how the patient's wishes apply to his or her medical condition changes. Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own. This person as health care agent, can have as little or as much authority as their want. This agent may make all of the health care decisions or only certain ones. The agent may be given instructions that he or she has to follow. This form can also be used to document for wishes or instructions with regard to organ and/or tissue donation organ viability. If the patient has not give consent for donation, mechanical ventilation should be stopped and the patient should be given post mortem care according to hospital protocol.

However, the best proxy decision-maker is not always a family member or significant other. Sometimes the decisions are too difficult for people close to the patient who may be overly influenced by their attachment or by burdens of care. Whether close or not so close, the proxy should be someone whom the patient trusts and who would be willing and able to represent the patient's wishes. The agent knows and understands the patient's wishes about his or her medical treatments. He or she can make decisions in situations that might not have anticipated. An agent has flexibility. He or she can talk with the patient's physicians about the patient's changing medical condition and authorize treatment or have it withdrawn as circumstances change. If the patient has prepared a living will, the agent can interpret it in situations that were not foreseen. The patient is to make clear in a living will that the agent should make decisions on how to interpret it or when to apply it. The agent should advocate for the patient. If health care providers insist on following the patient's wishes, the agent can negotiate with them and take any other necessary steps to see that the patient's wishes are honored. The living will, however, which attempts to spell out in advance which treatments should be employed and which should not be cold and impersonal of an instrument to accurately mirror the necessary value judgments of the patient. Keep in mind too that many patients such as those with advanced Alzheimer's or in comas may in fact not be suffering though their existence is undoubtedly a hardship to their families. It is almost impossible to spell out all situations in advance, making living wills incomplete almost by definition. There are legitimate cultural, ethnic, and racial differences in approaches to medical decision making and advance care planning. However make sure you are diligent in offering to discuss all situations on this topic for each and every individual patient.

The term advance directive describes two types of legal documents that enable the patient to plan for and communicate his or her end-of-life issues in the event that the patient is unable to communicate: A living will allows the patient to document his or her wishes concerning medical treatments at the end of life. A medical power of attorney (or health care proxy) allows the patient to appoint a person they trust as their health care agent (or surrogate decision maker), who is authorized to make medical decisions on the patient's behalf.

Advance directives are legally valid throughout the United States. While one does not need a lawyer to fill out an advance directive, your advance directive becomes legally valid as soon as it is signed in front of the required witnesses. The laws governing advance directives vary from state to state, so it is important to complete and sign advance directives that comply with the patient's state's law. Also, advance directives can have different titles in different states. Before the Living Will can guide medical decision-making two physicians must certify that the patient who is unable to make medical decisions and is in the medical condition specified in the state's living will law (such as "terminal illness" or "permanent unconsciousness"), other requirements also may apply, depending upon the state.

Before a Medical power of attorney goes into effect a patient's physician must conclude that they are unable to make their own medical decisions. In addition: if a person regains the ability to make decisions, the agent cannot continue to act on the person's behalf. Many states have additional requirements that apply only to decisions about life- sustaining medical treatments. For example, before the agent can refuse a life-

sustaining treatment on behalf of the patient, a second physician may have to confirm the first doctor's assessment that the patient is incapable of making treatment decisions.

Emergency medical technicians cannot honor a living will, health care proxy or power of attorney. Once emergency personnel have been called, they must do what is necessary to stabilize a patient for transfer to a hospital, both from accident sites and from a home or other facility. After a physician fully evaluates the person's condition and determines the underlying conditions, advance directives can be implemented. This is a very important step for those who are under the palliative care. The family should be fully aware of the procedures if they should call emergency personnel at the time of death.

One state's advance directive does not always work in another state. Some states do honor advance directives from another state; others will honor out-of-state advance directives as long as they are similar to the state's own law; and some states do not have an answer to this question. The best solution is if the patient spends a significant amount of time in more than one state, he or she should complete the advance directives for all the states he or she spends a significant amount of time in. It will be easier to have the patient's advance directives honored if they are the ones with which the medical facility is familiar. Advance directives do not expire. An advance directive remains in effect until the patient revises it. If the patient completes a new advance directive, it invalidates the previous one. The patient should review his or her advance directives periodically to ensure that they still reflect the patient's wishes. If the patient want to change anything in an advance directive once he or she has completed it, the patient should complete a whole

new document. Below you will find terms that you will be asked to have comfort with as you assist the patient in writing their Advanced Directives.

During this discussion on end of life issues many terms emerge that the most people are not familiar with. Below, I have provided a list of terms involved in making about end-of-life decisions. The following are excerpts from the glossary of Caring Connection: *Caring Connections A Hospice Glossary.*

Advance directive - A general term that describes two kinds of legal documents, living wills and medical powers of attorney. These documents allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity. Each state regulates the use of advance directives differently.

Artificial nutrition and hydration: Artificial nutrition and hydration (or tube feeding) supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluids through a tube placed directly into the stomach, the upper intestine or a vein.

Assisted suicide - Providing someone the means to commit suicide, such as a supply of drugs or a weapon, knowing the person will use these to end his or her life.

Benefits and burdens - A commonly used guideline for deciding whether or not to withhold or withdraw medical treatments. A benefit can refer to the successful outcome of a medical procedure or treatment. Outcomes can be medical (e.g. the heart beats again) or functional (e.g. the person is able to walk to the bathroom after being incapacitated by a stroke), or it supports the patient's values (for example, the patient is able to die at home as he wished). However, a benefit from one point of view can be experienced as a burden from another and might be viewed differently by doctors, patients and families. For example, if a patient is resuscitated and the heart starts beating again, this is a successful outcome from a medical point of view and a doctor may consider it a benefit. To the patient who is dying from a serious illness or disease, resuscitation may cause further injury and only contribute to the overall experience of suffering. This success, from the doctor's point of view, might actually be experienced as an additional burden by the patient. Discussions of the benefits and burdens of medical treatments should occur within the framework of the patient's overall goals for care.

Best interest - In the context of refusal of medical treatment or end-of-life court opinions, a standard for making health care decisions based on what others believe to be "best" for a patient by weighing the benefits and the burdens of continuing, withholding or withdrawing treatment. (Contrast with "substituted judgment.")

Brain death - The irreversible loss of all brain function. Most states legally define death to include brain death.

Capacity - In relation to end-of-life decision-making, a patient has medical decision making capacity if he or she has the ability to understand the medical problem and the risks and benefits of the available treatment options. The patient's ability to understand other unrelated concepts is not relevant. The term is frequently used interchangeably with competency but is not the same. Competency is a legal status imposed by the court.

Cardiopulmonary resuscitation - Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

Clear and convincing evidence - A high measure or degree of proof that may be required legally to prove a patient's wishes. A few states require clear and convincing evidence that an incompetent patient would want to refuse life-support before treatment may be stopped unless the patient has completed an advance directive authorized by the state's law.

Do-Not-Resuscitate (DNR) order - A DNR order is a physician's written order instructing health care providers not to attempt cardiopulmonary resuscitation (CPR) in case of cardiac or respiratory arrest. A person with a valid DNR order will not be given CPR under these circumstances. Although the DNR order is written at the request of a person or his or her family, it must be signed by a physician to be valid. A non-hospital DNR order is written for individuals who are at home and do not want to receive CPR.

Emergency Medical Services (EMS) - A group of governmental and private agencies that provide emergency care, usually to persons outside of health care facilities; EMS personnel generally include paramedics, first responders and other ambulance crew.

Euthanasia - The term traditionally has been used to refer to the hastening of a suffering person's death or "mercy killing". Voluntary active euthanasia involves an intervention requested by a competent individual that is administered to that person to cause death, for example, if a physician gives a lethal injection with the patient's full informed consent. Involuntary or non-voluntary active euthanasia involves a physician engaging in an act to end a patient's life without that patient's full informed consent. See also Physician-hastened Death (sometimes referred to as Physician-assisted Suicide).

Guardian ad litem - Someone appointed by the court to represent the interests of a minor or incompetent person in a legal proceeding.

Hospice care - A program model for delivering palliative care to individuals who are in the final stages of terminal illness. In addition to providing palliative care and personal support to the patient, hospice includes support for the patient's family while the patient is dying, as well as support to the family during their bereavement.

Intubation - Refers to "endotracheal intubation" the insertion of a tube through the mouth or nose into the trachea (windpipe) to create and maintain an open airway to assist breathing.

Life-sustaining treatment - Treatments (medical procedures) that replace or support an essential bodily function (may also be called life support treatments). Life-sustaining treatments include cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and certain other treatments.

Living will - A type of advance directive in which an individual documents his or her wishes about medical treatment should he or she be at the end of life and unable to communicate. It may also be called a "directive to physicians", "health care declaration," or "medical directive." The purpose of a living will is to guide family members and doctors in deciding how aggressively to use medical treatments to delay death.

Mechanical ventilation - Mechanical ventilation is used to support or replace the function of the lungs. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea). Mechanical ventilation often is used to assist a person through a short-term problem or for prolonged periods in which irreversible respiratory failure exists due to injuries to the upper spinal cord or a progressive neurological disease.

Medical Power of Attorney - A document that allows an individual to appoint someone else to make decisions about his or her medical care if he or she is unable to communicate. This type of advance directive may also be called a health care proxy, durable power of attorney for health care or appointment of a health care agent..

Palliative Care - A comprehensive approach to treating serious illness that focuses on the physical, psychological, spiritual, and existential needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering, by controlling pain and symptoms, and by enabling the patient to achieve maximum functional capacity. Respect for the patient's culture, beliefs, and values are an essential component.

Respiratory arrest - The cessation of breathing - an event in which an individual stops breathing. If breathing is not restored, an individual's heart eventually will stop beating, resulting in cardiac arrest.

Surrogate decision-making - Surrogate decision-making laws allow an individual or group of individuals (usually family members) to make decisions about

medical treatments for a patient who has lost decision-making capacity and did not prepare an advance directive. A majority of states have passed statutes that permit surrogate decision making for patients without advance directives.

(Caring Connections http://www.caringinfo.org)

One very important document which has not been mentioned thus far, but well known to Judaism is the ethical will. The tradition for leaving a spiritual will as well as a living will has it's roots in the Bible and the Talmud. Historically, Jews have made provisions to ensure their values will live on after their death. Jews have documented their beliefs and moral teachings through the use of ethical wills. It can be difficult for us to begin the process of writing an ethical will. First we must come to terms with our mortality. We must acknowledge that each one of has a finite number of days on this Earth. We do not know when, where or how that final day will occur. We just search for the right was to live our lives through the ethics of our tradition. " There is a story told about the tourist who came from America to visit the renowned scholar and saint who was known as the Chofetz Chaim. He came in, and he saw a bed a chair, a table, a cupboard, a closet and a bookcase. The tourist was shocked and asked the sage": "Where are your possessions?" The Chofetz Chaim replied: And where are your possession? The tourist said "what kind of question is that? I am a visitor here." The sage replied " I am too" Jews live with the awareness that we are all strangers and sojourners on this earth, we are visitors here."(Reimer & Stamfler,[1991}p. xxvi) This story presents us with the reality that we are just sojourners here on earth. It reminds us of the impermanence of our lives.The material items we work so hard to obtain for our families and our selves are really very immaterial to the grand scheme of life. We begin to face these issues when we begin to contemplate writing an ethical will. We then shortly learn that the ethical will

can be our voice in a world we no longer inhabit. Judah Godlin writes about meaning of the ethical will.: " The Hebrew ethical will is not a mere valediction but an audacious attempt at continuing speech from father in the grave to children in a reckless world. The teacher's absence is not the end of instruction. It was said along time ago, When the dead are quoted, their lips move." 'For I have singled him out, that he may instruct his children, and his household after him to keep the way of Adonai by doing what is just and right, in order that Adonai may bring about Abraham what Adonai has promised him.' (Tanak, Genesis 18:19)[33] This is one of many citations found within the Torah and could be considered an ethic will.

These documents "convey important information or advice to your family and future generations, your convictions, the valuable lessons you have learned, your hopes and blessings for the future and any personal statements you feel are necessary for them to know. During the Medieval period, ethical wills were written as attachments to wills. Since the Jews were dispersed over the Europe, these documents were ways in which to convey values and traditions. Due to the increasing mobility of our society, ethical wills are becoming popular once again. However, their contents have changed. The Talmud and the Torah primarily cite bedside blessings. Today ethical wills include more personal values of family history, values, and religious and ethical convictions. An ethical will has no specific length or style. The important thing is that you convey honestly about your deepest values.

By writing an ethical will, "we continue to teach by participating in this ancient mitzvah of leaving behind our values for our children." We have the opportunity

to leave behind our wishes about our own death, the love and hopes we wish for our children and to express the secrets we have learned through our lifetime. In preparing to write an ethical will, we ask ourselves questions such as, What values of faith and community of love and life do I want to share with the future generation? What legacy fro living can impart of those who know me? An ethical will represents and transmits the core values and structure of the true essence of the individual. In our Jewish heritage there is 'One of the most beautiful stories of ethical will writing comes from the Chasidic tradition. Reb Zuzsya's students came to see him while he was dying. They entered his room and found him trembling. "Why are You afraid?" To which Reb Zusya replied, " When I stand before the throne of judgement, I will not be asked, " Reb Zusya why were you not more like Moses?" I asked "Reb Zusya, Why were you not more like Zusya?"'p.)

Writing an Ethical Will at various time in your life will ensure that your values and teachings will live on for future generations. No on can predict when the time will come when you will need to have any of these issues conveyed to your loved ones. Since we have this knowledge of the Ethical Will our responsibility lies within ourselves to get the task done today.

In conclusion, as Jews each and every year we are reminded of our finite days on earth. Throughout the liturgy of the Yom Kippur service we are confronted with the ultimate judgment.. We acknowledge that only G-d knows who will live and who will die. Who will die by fire, drowning, plague, etc.. The topics presented in this paper will help prepare those facing their final days with healing, comfort and peace. The process

of pastoral counseling can be tedious and draining. Only through continual use of these tools can we master the skills of empathetic listen and true presence for those around us. By drawing on your own personal torah, one can begin to develop sensitivities needed for walking with another human being through their pain. Rich with answers to life's questions, our Jewish sacred texts have become the bases for all of our solution As Ben Bag Bag used to say . Turn it, and turn it, for everything is in it. Reflect on it and grow old and grey with it. Don't turn from it for nothing is better than it. (Pierke Avot 5:22)

1. במדבר פרק יג פסוק לג

וְשָׁם רָאִינוּ אֶת הַנְּפִילִים בְּנֵי עֲנָק מִן הַנְּפִלִים וַנְּהִי בְעֵינֵינוּ כַּחֲגָבִים וְכֵן הָיִינוּ בְּעֵינֵיהֶם:

2. תלמוד בבלי מסכת נדרים דף לט עמוד ב

אמר ריש לקיש: רמז לביקור חולין מן התורה מנין? שנאמר: +במדבר טז+ אם כמות כל האדם ימותון אלה ופקודת כל אדם וגו'. מאי משמע? אמר רבא: אם כמות כל האדם ימותון אלה, שהן חולים ומוטלים בעריסתן ובני אדם מבקרים אותן, מה הבריות אומרים? לא ה' שלחני לזה

3. תלמוד בבלי מסכת סוטה דף יד עמוד א

ואמר רבי חמא ברבי חנינא, מאי דכתיב: +דברים יג+ אחרי ה' אלהיכם תלכו? וכי אפשר לו לאדם להלך אחר שכינה? והלא כבר נאמר: +דברים ד+ כי ה' אלהיך אש אוכלה הוא! אלא להלך אחר מדותיו של הקב"ה, מה הוא מלביש ערומים, דכתיב: +בראשית ג+ ויעש ה' אלהים לאדם ולאשתו כתנות עור וילבישם, אף אתה הלבש ערומים; הקב"ה ביקר חולים, דכתיב: +בראשית יח+ וירא אליו ה' באלוני ממרא, אף אתה בקר חולים; הקב"ה ניחם אבלים, דכתיב: +בראשית כה+ ויהי אחרי מות אברהם ויברך אלהים את יצחק בנו, אף אתה נחם אבלים; הקב"ה קבר מתים, דכתיב: +דברים לד+ ויקבר אותו בגיא, אף אתה קבור מתים.

4. בראשית פרק יח

(א) וַיֵּרָא אֵלָיו יְקֹוָק בְּאֵלֹנֵי מַמְרֵא וְהוּא יֹשֵׁב פֶּתַח הָאֹהֶל כְּחֹם הַיּוֹם:
(ב) וַיִּשָּׂא עֵינָיו וַיַּרְא וְהִנֵּה שְׁלֹשָׁה אֲנָשִׁים נִצָּבִים עָלָיו וַיַּרְא וַיָּרָץ לִקְרָאתָם מִפֶּתַח הָאֹהֶל וַיִּשְׁתַּחוּ אָרְצָה:
(ג) וַיֹּאמַר אֲדֹנָי אִם נָא מָצָאתִי חֵן בְּעֵינֶיךָ אַל נָא תַעֲבֹר מֵעַל עַבְדֶּךָ:

5. תלמוד בבלי מסכת נדרים דף מא עמוד א

ר' יוסי בן פרטא אומר משום ר' אליעזר: אין מבקרין לא חולי מעיים ולא חולי העין ולא מחושי הראש. בשלמא חולי מעיים משום כיסופא, אלא חולי העין ומחושי הראש מ"ט? משום דרב יהודה, דאמר רב יהודה: דיבורא קשיא לעינא ומעלי לאישתא.

6. תהלים פרק מא

(א) לַמְנַצֵּחַ מִזְמוֹר לְדָוִד:
(ב) אַשְׁרֵי מַשְׂכִּיל אֶל דָּל בְּיוֹם רָעָה יְמַלְּטֵהוּ יְקֹוָק:
(ג) יְקֹוָק יִשְׁמְרֵהוּ וִיחַיֵּהוּ יאשר וְאַשַּׁר בָּאָרֶץ וְאַל תִּתְּנֵהוּ בְּנֶפֶשׁ אֹיְבָיו:
(ד) יְקֹוָק יִסְעָדֶנּוּ עַל עֶרֶשׂ דְּוָי כָּל מִשְׁכָּבוֹ הָפַכְתָּ בְחָלְיוֹ:
(ה) אֲנִי אָמַרְתִּי יְקֹוָק חָנְנֵנִי רְפָאָה נַפְשִׁי כִּי חָטָאתִי לָךְ:
(ו) אוֹיְבַי יֹאמְרוּ רַע לִי מָתַי יָמוּת וְאָבַד שְׁמוֹ:
(ז) וְאִם בָּא לִרְאוֹת שָׁוְא יְדַבֵּר לִבּוֹ יִקְבָּץ אָוֶן לוֹ יֵצֵא לַחוּץ יְדַבֵּר:
(ח) יַחַד עָלַי יִתְלַחֲשׁוּ כָּל שֹׂנְאָי עָלַי יַחְשְׁבוּ רָעָה לִי:
(ט) דְּבַר בְּלִיַּעַל יָצוּק בּוֹ וַאֲשֶׁר שָׁכַב לֹא יוֹסִיף לָקוּם:
(י) גַּם אִישׁ שְׁלוֹמִי אֲשֶׁר בָּטַחְתִּי בוֹ אוֹכֵל לַחְמִי הִגְדִּיל עָלַי עָקֵב:
(יא) וְאַתָּה יְקֹוָק חָנֵּנִי וַהֲקִימֵנִי וַאֲשַׁלְּמָה לָהֶם:
(יב) בְּזֹאת יָדַעְתִּי כִּי חָפַצְתָּ בִּי כִּי לֹא יָרִיעַ אֹיְבִי עָלָי:
(יג) וַאֲנִי בְּתֻמִּי תָּמַכְתָּ בִּי וַתַּצִּיבֵנִי לְפָנֶיךָ לְעוֹלָם:

(יד) בָּרוּךְ יְקֹוָק אֱלֹהֵי יִשְׂרָאֵל מֵהָעוֹלָם וְעַד הָעוֹלָם אָמֵן וְאָמֵן:

7. שמואל ב פרק יג

(ד) וַיֹּאמֶר לוֹ מַדּוּעַ אַתָּה כָּכָה דַּל בֶּן הַמֶּלֶךְ בַּבֹּקֶר בַּבֹּקֶר הֲלוֹא תַּגִּיד לִי וַיֹּאמֶר לוֹ אַמְנוֹן אֶת תָּמָר אֲחוֹת אַבְשָׁלוֹם אָחִי אֲנִי אֹהֵב:

8. 6#see

9. תלמוד בבלי מסכת נדרים דף לט עמוד ב

תניא: ביקור חולים אין לה שיעור. מאי אין לה שיעור? סבר רב יוסף למימר: אין שיעור למתן שכרה, אמר ליה אביי: וכל מצות מי יש שיעור למתן שכרן? והא תנן: הוי זהיר במצוה קלה כבחמורה, שאין אתה יודע מתן שכרן של מצות! אלא אמר אביי: אפי' גדול אצל קטן. רבא אמר: אפי' מאה פעמים ביום. אמר רבי אחא בר חנינא: כל המבקר חולה - נוטל אחד מששים בצערו. אמרי ליה: אם כן, ליעלון שיתין ולוקמוה! אמר ליה: כעישורייתא דבי רבי, ובבן גילו; דתניא, רבי אומר: בת הניזונית מנכסי אחין נוטלת עישור נכסים, אמרו לו לרבי: לדבריך, מי שיש לו עשר בנות ובן, אין לו לבן במקום בנות כלום! אמר להן: ראשונה נוטלת עישור נכסים, שניה - במה ששיירה, שלישית - במה ששיירה, וחוזרות וחולקות בשוה.

10. ר"ן מסכת נדרים דף לט עמוד ב

ובבן גילו - שנולד המבקר במזלו של חולה.

11. תלמוד בבלי מסכת נדרים דף מ עמוד א

ויאמר להו: לא כך היה מעשה? בתלמיד אחד מתלמידי ר' עקיבא שחלה, לא נכנסו חכמים לבקרו, ונכנס ר' עקיבא לבקרו, ובשביל שכיבדו וריבצו לפניו חיה, א"ל: רבי, החייתני! יצא ר' עקיבא ודרש: כל מי שאין מבקר חולים - כאילו שופך דמים. כי אתא רב דימי אמר: כל המבקר את החולה - גורם לו שיחיה, וכל שאינו מבקר את החולה - גורם לו שימות. מאי גרמא? אילימא כל המבקר את החולה - מבקש עליו רחמים שיחיה, וכל שאין מבקר את החולה - מבקש עליו רחמים שימות, שימות ס"ד? אלא, כל שאין מבקר חולה - אין מבקש עליו רחמים לא שיחיה ולא שימות. רבא, יומא קדמאה דחליש אמר להון: לא תיגלו לאיניש, דלא לתרע מזליה, מכאן ואילך, אמר להון: פוקו ואכריזו בשוקא, דכל דסני לי ליחדי לי, וכתיב: +משלי כד+ בנפול אויבך אל תשמח וגו', ודרחים לי ליבעי עלי רחמי. אמר רב: כל המבקר את החולה - ניצול מדינה של גיהנם, שנאמר: +תהלים מא+ אשרי משכיל אל דל ביום רעה ימלטהו י"י, אין דל אלא חולה, שנאמר: +ישעיהו לח+ מדלה יבצעני, אי נמי, מן הדין קרא: +שמואל ב' יג+ מדוע אתה ככה דל בן המלך בבקר בבקר וגו', אין רעה אלא גיהנם, שנאמר: +משלי טז+ כל פעל י"י למענהו וגם רשע ליום רעה. ואם ביקר מה שכרו? מה שכרו? כדאמר: ניצול מדינה של גיהנם! אלא מה שכרו בעוה"ז? +תהלים מא+ י"י ישמרהו ויחייהו ואושר בארץ ואל תתנהו בנפש אויביו, יי' ישמרהו - מיצר הרע, ויחייהו - מן היסורין, ואושר בארץ - שיהו הכל מתכבדין בו, ואל תתנהו בנפש אויביו - שיזדמנו לו ריעים כנעמן שריפו את צרעתו, ואל יזדמנו לו ריעים כרחבעם שחילקו את מלכותו.

12. תלמוד בבלי מסכת כתובות דף קד עמוד א

ההוא יומא דנח נפשיה דרבי, גזרו רבנן תעניתא ובעו רחמי, ואמרי: כל מאן דאמר נח נפשיה דר', ידקר בחרב. סליקא אמתיה דרבי לאיגרא, אמרה: עליוני' מבקשין את רבי והתחתוני' מבקשין את רבי, יהי רצון שיכופו תחתונים את העליונים. כיון דחזאי כמה זימני דעייל לבית הכסא, וחלץ תפילין ומנח להו וקמצטער, אמרה: יהי

רצון שיכופו עליונים את התחתונים. ולא הוו שתקי רבנן מלמיבעי רחמי, שקלה כוזא שדייא מאיגרא [לארעא], אישתיקו מרחמי ונח נפשיה דרבי. אמרו ליה רבנן לבר קפרא: זיל עיין. אזל אשכחיה דנח נפשיה, קרעיה ללבושיה ואהדריה לקרעיה לאחוריה, פתח ואמר: אראלים ומצוקים אחזו בארון הקדש, נצחו אראלים את המצוקים ונשבה ארון הקדש! אמרו ליה: נח נפשיה? אמר להו: אתון קאמריתו ואנא לא קאמינא.

see #2.13

14. תלמוד בבלי מסכת עבודה זרה דף יח עמוד א

אמרו: לא היו ימים מועטים עד שנפטר רבי יוסי בן קיסמא, והלכו כל גדולי רומי לקברו והספידוהו הספד גדול, ובחזרתן מצאוהו לרבי חנינא בן תרדיון שהיה יושב ועוסק בתורה ומקהיל קהלות ברבים וס"ת מונח לו בחיקו. הביאוהו וכרכוהו בס"ת, והקיפוהו בחבילי זמורות והציתו בהן את האור, והביאו ספוגין של צמר ושראום במים והניחום על לבו, כדי שלא תצא נשמתו מהרה. אמרה לו בתו: אבא, אראך בכך? אמר לה: אילמלי אני נשרפתי לבדי היה הדבר קשה לי, עכשיו שאני נשרף וס"ת עמי, מי שמבקש עלבונה של ס"ת הוא יבקש עלבוני. אמרו לו תלמידיו: רבי, מה אתה רואה? אמר להן: גליון נשרפין ואותיות פורחות. אף אתה פתח פיך ותכנס [בך] האש! אמר להן: מוטב שיטלנה מי שנתנה ואל יחבל הוא בעצמו. אמר לו קלצטונירי: רבי, אם אני מרבה בשלהבת ונוטל ספוגין של צמר מעל לבך, אתה מביאני לחיי העולם הבא? אמר לו: הן. השבע לי! נשבע לו. מיד הרבה בשלהבת ונטל ספוגין של צמר מעל לבו, יצאה נשמתו במהרה. אף הוא קפץ ונפל לתוך האור. יצאה בת קול ואמרה: רבי חנינא בן תרדיון וקלצטונירי מזומנין הן לחיי העולם הבא. בכה רבי ואמר: יש קונה עולמו בשעה אחת, ויש קונה עולמו בכמה שנים.

15. תלמוד בבלי מסכת ברכות דף ה עמוד ב

רבי יוחנן חלש, על לגביה רבי חנינא. אמר ליה: חביבין עליך יסורין? אמר ליה: לא הן ולא שכרן. אמר ליה: הב לי ידך! יהב ליה ידיה ואוקמיה. אמאי? לוקים רבי יוחנן לנפשיה! - אמרי: אין חבוש מתיר עצמו מבית האסורים. –

16. תלמוד בבלי מסכת קידושין דף כא עמוד ב

ר' יוסי דריש ריבויי ומיעוטי; ולקחת - ריבה, מרצע - מיעט, באזנו ובדלת - חזר וריבה, ריבה ומיעט וריבה - ריבה הכל, מאי רבי? רבי כל מילי, מאי מיעט? מיעט סם. אמר מר: המרצע - להביא מרצע הגדול. מאי משמע? כדאמר רבא: +בראשית לב+ הירך - המיומנת שבירך, ה"נ המרצע - מיוחד שבמרצעין.

17. דברים פרק ד פסוק טו

וְנִשְׁמַרְתֶּם מְאֹד לְנַפְשֹׁתֵיכֶם כִּי לֹא רְאִיתֶם כָּל תְּמוּנָה בְּיוֹם דִּבֶּר יְקֹוָק אֲלֵיכֶם בְּחֹרֵב מִתּוֹךְ הָאֵשׁ:

18. דברים פרק ל פסוק יט

הַעִידֹתִי בָכֶם הַיּוֹם אֶת הַשָּׁמַיִם וְאֶת הָאָרֶץ הַחַיִּים וְהַמָּוֶת נָתַתִּי לְפָנֶיךָ הַבְּרָכָה וְהַקְּלָלָה וּבָחַרְתָּ בַּחַיִּים לְמַעַן תִּחְיֶה אַתָּה וְזַרְעֶךָ:

19. טור אורח חיים סימן שכח

כל רפואה אסורה לעשות בשבת גזירה משום שחיקת סמנין אבל כל דבר שיש בו סכנה מותר הלכך כל מכה של חלל דהיינו באברים הפנימיים מן השיניים ולפנים מחללין עליה השבת בסתם אפי' אין שם בקי וחולה אינו

אומר כלום אבל כשיודעין באותו חולה שאין צריך לחלל עליו אין מחללין וכ"ש אם רופא אומר שאינו צריך וכן מכה שעל גב היד וגב הרגל מחללין אבל בשאר מכות בסתם אין מחללין עד שיאמר חולה או רופא שצריך: מי שבלע עלוקה מחממין לו חמין: מי שנשכו כלב שוטה או א' מזוחלי עפר הממיתין אפי' אם ספק אם ממית אם לאו עושין לו כל צרכי רפואה להצילו: החושש בשיניו מטילין לו סם שהוא ספק נפשות ומחממין לו חמין בין להשקותו בין להברותו ולא ספק שבת זו בלבד אלא אפילו ספק שבת אחרת דוחה כגון שאמדוהו שצריך לעשות לו רפואה זו ח' ימים והיום שבת לא יאמרו נמתין עד הלילה אלא יעשו מיד אע"פ שצריך לחלל עליו שתי שבתות ואין עושין הדבר ע"י קטנים וכותיים ונשים אלא ע"י גדולי ישראל וכל הזריז הרי זה משובח ומפקחין פיקוח נפש בשבת וא"צ ליטול רשות מב"ד וכל המקדים להציל הנפש ה"ז משובח אפי' אם מתקן עמו דבר אחר כגון שצריך להעלות תינוק מן המים וצד עמו דגים וכיוצא בזה היה החולה צריך לבשר שוחטין לו ולא יתנו לו בשר נבילה כדי שלא יצטרכו לחלל שבת בשחיטה כי השבת הוא אצלו כחול לכל מה שצריך ע"כ אין להאכילו בשר נבילה: מעלין אונקלי בשבת פי' רב אלפס פסאר אל מעדי"ה פדעתא פי' מכת חרב ענבתא פי' מורשא וסימטא ואישתא צמירתא על כולן מחללין עליהם את השבת מחללין על חולי העין כגון מאי אמר רב יהודה דמא ודיצא ורירא ודמעת עינא וקדחא ותחלת אוכלא לאפוקי סוף אוכלא דלא וזה לשון הרמב"ן ז"ל החושש בשתי עיניו או שהיה באחד מהן ציר או שהיו שותתות מהן דמעות מחמת הכאב או שהיה דם שותת או שהיה בהם קידחא ודיצא וכיוצא בהן הרי זה בכלל חולי שיש בו סכנה: והחום שמסמר הבשר מחללין עליו השבת וכן כל חולי שהרופאים אומרים שהוא סכנה אע"פ שהוא על הבשר מבחוץ מחללין עליה את השבת על פיהם וכן אם רופא אחד אומר צריך וא' אומר אינו צריך מחללין וכתב ר"י שא"צ מומחה דכל בני אדם חשובין מומחין קצת וספק נפשות להקל ואסור לאחר הדבר כדי לשאול אם הוא מותר דגרסינן בירושלמי הנשאל הרי זה מגונה והשואל הרי זה שופך דמים והרי הכתוב אומר וחי בהם ולא שימות בהם אמדוהו הרופאים שצריך לגרוגרת אחת ורצו עשרה והביאו לו כל אחד וא' גרוגרת כולן פטורין אפי' הבריא בראשונה אמדוהו לשתי גרוגרות ולא מצאו אלא שתי גרוגרות בשתי עוקצין ושלשה בעוקץ א' כורתין העוקץ שיש בו ג' אע"פ שאין צריכין אלא לב' כדי שלא להרבות בבצירה לכרות שתי עוקצים: כל צורכי חולה בדבר שאין בו סכנה הוא לא יעשה אבל אומר לא"י ועושה כיון שאין בו סכנת הגוף אפי' יש בו סכנת אבר אין מחללין עליו באיסור דאורייתא אבל מחללין באיסור דרבנן אע"ג דעביד מעשה אבל בחולי שאין בו סכנת אבר נסתפק א"א הרא"ש ז"ל אם מותר לחלל עליו בשבות דאית ביה מעשה דשמא לא התירו אלא אמירה לא"י אבל לא שבות דאית ביה מעשה אלא בסכנת אבר אבל הרמב"ם ז"ל כתב חולה שאין בו סכנה עושין לו כל צרכיו ע"י א"י ואם היו צריכין לדברים שאין בהן מלאכה עושין אותן אפילו ע"י ישראל לפיכך מעלין אזנים ומעלין אונקלין בשבת ומחזירין השבר וכל כיוצא בזה והרמב"ן חילק בדבר דבחולה שאין בו סכנה אפי' סכנת אבר אע"פ שהתירו אפי' שבות דאית ביה מעשה צריך שיעשנו בשינוי אבל בלא שינוי אסור אבל אם יש בו סכנת אבר מותר אפילו שבות דאית ביה מעשה בלא שינוי: אין נותנין יין לתוך העין או אפילו על גביו אם פותח וסוגר העין כדי שירד לתוכו דמוכחא מלתא דלרפואה עביד אבל אם נתן על גביו ואינו פותח וסוגר מותר ורוק תפל אפילו על גביו אסור דמוכחא דלרפואה עביד: שורה אדם קילורין מע"ש ונותן ע"ג העין בשבת שאינו נראה אלא כרוחץ ולא חיישינן משום שחיקת סמנין דכיון שלא התירו לו לשרותן אלא מע"ש איכא היכירא: מעבירין גלדין המכה וסכין אותה בשמן אבל לא בחלב מפני שהוא נימוח ואפי' בגמר מכה דליכא אלא צערא שרי אבל אין נותנין עליה שמן וחמין ולא ע"ג המוך שעליה אבל נותן הוא חוץ למכה ושותת ויורד לתוכה ונותנין חתיכות של בגדים וספוג יבשים וחדשים שאינן לרפואה אלא כדי שלא יסרטו הבגדים את המכה אבל לא ישנים שהן מרפאין והני מילי ישנים שלא נתנו מעולם על המכה אבל היו כבר על גבי מכה אפי' ישנים שרי ואין נותנין עליו גמי שהוא מרפא: רטייה שנפלה מעל גבי המכה על גבי הקרקע לא יחזירנה נפלה ע"ג כר או כסת יחזירנה ומגלה קצת הרטייה ומקנח פי המכה וחוזר ומגלה קצת השני ומקנחה ורטייה עצמה לא יקנח מפני שהוא ממרח פי' משוה אותה והממרח חייב חטאת אספלנית שפירשה מן האגד מחזירין אותה תחת האגד ע"פ המכה: המפיס מורסא בשבת אם לעשות לה פה חייב חטאת ואם אינו חושש לעשות לה פה אלא להוציא הליחה מותר לכתחלה: מי שנגפה ידו או רגלו צומתה ביין כדי להעמיד הדם אבל לא בחומץ מפני שהוא חזק ויש בו משום רפואה ואם הוא מעונג אף היין לו כמו החומץ ואסור: מי שנשמטה פרק ידו או רגלו ממקומו לא ישפשפנה הרבה בצונן שזהו רפואתו אלא רוחץ כדרכו ואם נתרפא נתרפא: ציפורן שפירשה רובה וכן ציצין שפירשו רובן כלפי מעלה שמצערות אותו ביד מותר להסירן בכלי פטור אבל אסור לא פירשו רובן ביד אסור בכלי חייב חטאת כך פירש רש"י דכל כלפי מעלה מצערות אותו על הא דאמר רבה בר בר חנה א"ר יוחנן והוא

שפירשו כלפי מעלה ומצערות אותו אבל מדברי הרמב"ם ז"ל משמע שהם ב' עניינים כלפי מעלה וגם מצערות שכ' אם פירש כלפי מעלה ומצערות אותו מותר ביד ואם אין מצערות אותו אסור ופי' כלפי מעלה שפירש כלפי הגוף וי"מ כלפי ראש אצבעות וצריך לחוש לכל הפירושים: החושש בשיניו לא יגמע בהן החומץ ויפלוט אבל מגמע ובולע או מטבל בו כדרכו: החושש בגרונו לא יערענו בשמן אבל נותן שמן הרבה לתוך אניגרון ובולע: גונח מכאב לב שרפואתו לינק חלב מן הבהמה מותר לינק בשבת ממנה ואם הוא מצטער מחמת רעבון אסור בשבת ומותר בי"ט: אין לועסין מסטכי ולא שפין בו השינים לרפוא' ואם מכיון לריח הפה מותר: כל אוכלין ומשקין שהן מאכל בריאין מותר לאוכלן ולשתותן לרפואה אעפ"י שהן קשין לקצת בריאים ומוכחא מלתא דלרפואה עביד אפ"ה שרי כיון שדרך בריאין לאוכלן ולשתותן וכל שאינו מאכל ומשקה בריאין אסור לאוכלו ולשתותו לרפואה אבל אם אוכל ושות' אותו לרעבו ולצמאו ואין לו חולי שרי: אין עושין אפיקטוזין פירוש גרמת הקיאה אפי' בחול משום הפסד אוכלין ואם מצטער מרוב המאכל בחול מותר אפילו בסם ובשבת אסור בסם ומותר ביד: החושש במעיו מותר ליתן עליהם כוס שעירה ממנה חמין אף ע"פ שעדיין יש בו הבל: מי שנשתכר שרפואתו לסוך כפות ידיו ורגליו בשמן מותר לסוכו בשבת כתב הרמב"ם ז"ל אין מתעמלין בשבת ואיזה עימול שדורסין על גופו בכח כדי שיגע ויזיע שאסור לחולה ליגע עצמו בשבת כדי שיזיע מפני שהוא רפואה ואסור לדחוק כריסו של תינוק כדי להוציא הרעי שלו שמא יבא להשקותו סמנין המשלשלים. מותר לכפות כוס על הטיבור כדי להעלותו: ולהעלות אזנים בין ביד בין בכלי ולהעלות אונקלי שכל אחד מאלו אין עושין בסמנין כדי לחוש לשחיקה ויש לו צער מהם: רוחצין במי גרר ובמי חמתן ובמי טבריה ובמים היפים שבים הגדול אע"פ שמלוחים קצת שכן דרך לרחוץ בהם וליכא הוכחה דלרפואה עביד אבל לא במים הרעים שבים הגדול ובמי משרה שהם מאוסים ואין דרך לרחוץ בהם אלא לרפואה ודוקא ששוהה בהם אבל אם אינו שוהה בהם מותר שאינו נראה אלא כמיקר: לוחשים לחישות נחשים ועקרבים ונותנין כלי ע"ג העין להקר והוא שיהא כלי הניטל בשבת: ועצם שיצא ממקומו מחזירין אותו:

20. מסכתות קטנות מסכת שמחות פרק א הלכה א

הגוסס הרי הוא כחי לכל דבר, זוקק ליבום ופוטר מן היבום, ומאכיל תרומה ופוסל מן התרומה, ונוחל ומנחיל, פירש ממנו אבר כאבר מן החי, בשר כבשר מן החי, וזורקין על ידו דם חטאתו ודם אשמו, עד שעה שימות.

21. שולחן ערוך יורה דעה סימן שלט סעיף א

הגוסס, א הרי הוא (א) כחי לכל דבריו. ב אין קושרין לחייו, ג ואין סכין אותו, ואין מדיחין אותו, ואין פוקקין את נקביו, ד ואין שומטין הכר מתחתיו, ואין נותנין אותו על גבי חול, ולא על גבי חרסית ולא על גבי אדמה, ואין נותנין על כריסו לא קערה ולא מגריפה ולא צלוחית של מים ולא גרגיר של מלח, ואין משמיעין עליו עיירות, ואין שוכרין חלילין ומקוננות, ואין מעמצין עיניו עד שתצא נפשו. ה וכל המעמץ עם יציאת הנפש, ה"ז שופך דמים. ואין קורעין ולא חולצין ולא מספידין עליו, ולא מכניסין עמו ארון לבית, עד שימות. ואין פותחין עליו בצדוק הדין, עד שתצא נפשו. הגה: ו וי"א דאין חוצבין לו (ב) קבר אע"פ שאינו עמו בבית, עד אחר שימות (ריב"ש סימן קי"ד). אסור לחצוב שום קבר להיות פתוח עד למחר שלא יקברו בו המת באותו היום, ויש סכנה בדבר (רבינו ירוחם בשם הר"י החסיד ז"ל). וכן אסור לגרום למת שימות מהרה, כגון מי שהוא גוסס זמן ארוך ולא יוכל להפרד, ז אסור להשמט הכר והכסת מתחתיו, מכח שאומרין שיש נוצות מקצת עופות שגורמים זה וכן לא יזיזנו ממקומו. וכן אסור לשום מפתחות ב"ה תחת ראשו, כדי שיפרד. אבל אם יש שם דבר שגורם עכוב יציאת הנפש, כגון שיש סמוך לאותו בית קול דופק כגון חוטב עצים או שיש מלח על לשונו ואלו מעכבים יציאת הנפש, מותר להסירו משם, דאין בזה מעשה כלל, אלא שמסיר המונע (הכל בהגהת אלפסי פרק אלו מגלחין)

22) ויקרא פרק יט פסוק יח
לֹא תִקֹּם וְלֹא תִטֹּר אֶת בְּנֵי עַמֶּךָ וְאָהַבְתָּ לְרֵעֲךָ כָּמוֹךָ אֲנִי יְקֹוָק:

23. תלמוד בבלי מסכת סנהדרין דף מג עמוד א

תו, הא דאמר רב חייא בר רב אשי אמר רב חסדא: היוצא ליהרג משקין אותו קורט של לבונה בכוס של יין כדי שתטרף דעתו, שנאמר +משלי ל"א+ תנו שכר לאובד ויין למרי נפש. ותניא: נשים יקרות שבירושלים היו מתנדבות ומביאות אותן. לא התנדבו נשים יקרות, משל מי? - הא ודאי מסתברא משל צבור, כיון דכתיב תנו - מדידהו.

See #14 .24

25. משנה מסכת יומא פרק ח

משנה ו
[ד] מי שאחזו בולמוס מאכילין אותו אפילו דברים טמאים עד שיאורו עיניו מי שנשכו כלב שוטה אין מאכילין אותו מחצר כבד שלו ורבי מתיא בן חרש מתיר ועוד אמר רבי מתיא בן חרש החושש בגרונו מטילין לו סם בתוך פיו בשבת מפני שהוא ספק נפשות וכל ספק נפשות דוחה את השבת:

משנה ז
[ה] מי שנפלה עליו מפולת ספק הוא שם ספק אינו שם ספק חי ספק מת ספק עובד כוכבים ספק ישראל מפקחין עליו את הגל מצאוהו חי מפקחין עליו ואם מת יניחוהו:

26. תלמוד בבלי מסכת יומא דף פה עמוד א

מי שנפל עליו מפולת וכו'. מאי קאמר? - לא מיבעיא קאמר: לא מיבעיא ספק הוא שם ספק אינו שם, דאי איתיה חי הוא - דמפקחין, אלא אפילו ספק חי ספק מת - מפקחין, ולא מיבעיא ספק חי ספק מת דישראל, אלא אפילו ספק נכרי ספק ישראל - מפקחין. מצאוהו חי מפקחין. מצאוהו חי פשיטא! - לא צריכא, דאפילו לחיי שעה. ואם מת יניחוהו. הא נמי פשיטא! - לא צריכא לרבי יהודה בן לקיש. דתניא: אין מצילין את המת מפני הדליקה, אמר רבי יהודה בן לקיש: שמעתי שמצילין את המת מפני הדליקה. ואפילו רבי יהודה בן לקיש לא קאמר אלא מתוך שאדם בהול על מתו, אי לא שרית ליה - אתי לכבויי. אבל הכא, אי לא שרית ליה - מאי אית ליה למעבד? תנו רבנן: עד היכן הוא בודק? עד חוטמו, ויש אומרים: עד לבו. בדק ומצא עליונים מתים - לא יאמר: כבר מתו התחתונים. מעשה היה, ומצאו עליונים מתים ותחתונים חיים. נימא הני תנאי כי הני תנאי, דתניא: מהיכן הולד נוצר - מראשו, שנאמר +תהלים עא+ ממעי אמי אתה גוזי ואומר +ירמיהו ז+ גזי נזרך והשליכי. אבא שאול אומר: מטיבורו, ומשלח שרשיו אילך ואילך. אפילו תימא אבא שאול, עד כאן לא קא אמר אבא שאול התם - אלא לענין יצירה, דכל מידי ממציעתיה מיתצר. אבל לענין פקוח נפש - אפילו אבא שאול מודי דעקר חיותא באפיה הוא, דכתיב +בראשית ז+ כל אשר נשמת רוח חיים באפיו. אמר רב פפא: מחלוקת ממטה למעלה, אבל ממעלה למטה, כיון דבדק ליה עד חוטמו - שוב אינו צריך, דכתיב כל אשר נשמת רוח חיים באפיו. וכבר היה רבי ישמעאל ורבי עקיבא ורבי אלעזר בן עזריה מהלכין בדרך, ולוי הסדר ורבי ישמעאל בנו של רבי אלעזר בן עזריה מהלכין אחריהן. נשאלה שאלה זו בפניהם: מניין לפקוח נפש שדוחה את השבת? נענה רבי ישמעאל ואמר: +שמות כב+ אם במחתרת ימצא הגנב. ומה זה, שספק על ממון בא ספק על נפשות בא, ושפיכות דמים מטמא את הארץ וגורם לשכינה שתסתלק מישראל - ניתן להצילו בנפשו, קל וחומר לפקוח נפש שדוחה את השבת. נענה רבי עקיבא ואמר: +שמות כא+ וכי יזד איש על רעהו וגו' מעם מזבחי תקחנו למות. מעם מזבחי - ולא מעל מזבחי.

תלמוד בבלי מסכת סנהדרין דף צח עמוד א

- מר ליה: אימת אתי משיח? - אמר ליה: זיל שיליה לדידיה. - והיכא יתיב? - אפיתחא דרומי. - ומאי סימניה? - יתיב ביני עניי סובלי חלאים, וכולן שרו ואסירי בחד זימנא, איהו שרי חד ואסיר חד. אמר: דילמא מבעינא, דלא איעכב. אזל לגביה, אמר ליה: שלום עליך רבי ומורי! - אמר ליה שלום עליך בר

ליואי. - אמר ליה: לאימת אתי מר? - אמר ליה: היום. אתא לגבי אליהו. - אמר ליה: מאי אמר לך? - אמר ליה: שלום עליך בר ליואי. - אמר ליה: אבטחך לך ולאבוך לעלמא דאתי. - אמר ליה: שקורי קא שקר בי, דאמר לי היום אתינא, ולא אתא! - אמר ליה: הכי אמר לך +תהלים צ"ה+ היום אם בקלו תשמעו.
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27. תלמוד בבלי מסכת סנהדרין דף עג עמוד א

גמרא. תנו רבנן: מניין לרודף אחר חבירו להרגו שניתן להצילו בנפשו - תלמוד לומר +ויקרא י"ט+ לא תעמד על דם רעך. והא להכי הוא דאתא? האי מיבעי ליה לכדתניא: מניין לרואה את חבירו שהוא טובע בנהר, או חיה גוררתו, או לסטין באין עליו, שהוא חייב להצילו - תלמוד לומר לא תעמד על דם רעך. - אין הכי נמי.

28. ויקרא פרק יט פסוק טז

לֹ֣א תֵלֵ֤ךְ רָכִיל֙ בְּעַמֶּ֔יךָ לֹ֥א תַעֲמֹ֖ד עַל־דַּ֣ם רֵעֶ֑ךָ אֲנִ֖י יְקֹוָֽק׃

29. שולחן ערוך חושן משפט סימן רסד סעיף א

מי שאבדה לו אבידה, ופגע באבידתו ובאבידת חבירו, אם יכול לחזור את שתיהן חייב להחזירם; ואם לא, יחזיר את שלו, א] שאבידתו קודמת אפילו לאבידת אביו ורבו, כדדרשינן מאפס לא יהיה בך אביון (דברים טו, ד). ואע"פ כן יש לו לאדם ליכנס לפנים משורת הדין ולא לדקדק ולומר: שלי קודם, אם לא בהפסד מוכח. ואם תמיד מדקדק, פורק ממנו עול גמילות חסדים וסוף שיצטרך לבריות.

30. תלמוד בבלי מסכת בבא מציעא דף לג עמוד א

משנה. אבדתו ואבדת אביו - אבדתו קודמת, אבדתו ואבדת רבו - שלו קודם. אבדת אביו ואבדת רבו - של רבו קודמת, שאביו הביאו לעולם הזה ורבו שלמדו חכמה מביאו לחיי העולם הבא. ואם אביו חכם - של אביו קודמת. היה אביו ורבו נושאין משאוי - מניח את של רבו, ואחר כך מניח את של אביו. היה אביו ורבו בבית השבי - פודה את רבו ואחר כך פודה את אביו. ואם אביו חכם - פודה את אביו ואחר כך פודה את רבו.

גמרא. מנא הני מילי? - אמר רב יהודה אמר רב: אמר קרא +דברים ט"ו+ אפס כי לא יהיה בך אביון - שלך קודם לשל כל אדם. ואמר רב יהודה אמר רב: כל המקיים בעצמו כך - סוף בא לידי כך.

31. בראשית פרק יח פסוק יט

כִּ֣י יְדַעְתִּ֗יו לְמַ֤עַן אֲשֶׁר֙ יְצַוֶּ֣ה אֶת־בָּנָ֔יו וְאֶת־בֵּיתוֹ֙ אַחֲרָ֔יו וְשָׁמְר֥וּ דֶּ֖רֶךְ יְקֹוָ֑ק לַעֲשׂ֥וֹת צְדָקָ֖ה וּמִשְׁפָּ֑ט לְמַ֣עַן הָבִ֤יא יְקֹוָק֙ עַל־אַבְרָהָ֔ם אֵ֥ת אֲשֶׁר־דִּבֶּ֖ר עָלָֽיו׃

32. טור אורח חיים סימן שכט

כל פיקוח נפש דוחה שבת והזריז הרי זה משובח אפי' נפלה דליקה לחצר אחרת וירא שתעבור לחצר זו ויבא לידי סכנה יכול לכבותה כדי שלא תעבור ואין הולכין בו אחר אחר הרוב כגון תשע עו"ג וישראל אחד לא מיבעיא באותה חצר דפשיטא שאם נפל שם עליהן שמפקחין דהוה ליה קבוע וכל קבוע כמחצה על מחצה דמי אלא אפילו פירש אחד מהם לחצר אחרת ונפל עליו שם מפקחין כיון שנשאר קביעות הראשון במקומו חשבינן ליה כמחצה על מחצה אבל אם נעקרו כולן ובשעת עקירתן פירש אחד מהם לחצר אחרת ונפל עליו אין מפקחין כיון שנעקר קביעות הראשון ממקומו אמרינן כל דפריש מרובא קא פריש: מי שנפלה עליו מפולת ספק חי ספק

מת ספק שם וספק אינו שם ואפילו אם תמצא לומר שהוא שם ספק עו"ג וספק ישראל מפקחין אף ע"פ שיש בו כמה ספקות ואפי' מצאוהו מרוצץ שאינו יכול לחיות אלא לפי שעה מפקחין ובודקין עד חוטמו ואם לא הרגישו בחוטמו חיות אז ודאי מת ל"ש פגעו בראשו תחלה או ברגליו תחלה ואפילו מצא עליונים מתים לא יאמר כבר מתו התחתונים אלא בודק עליהם שמא עדיין הם חיים: עו"ג שצרו על עיירות של ישראל אם באו על עסקי ממון אין מחללין עליהם השבת באו על עסקי נפשות או אפי' סתם יוצאין עליהם בכלי זיין ומחללין עליהם את השבת ובעיר הסמוכה לספר אפילו לא באו אלא על עסקי ממון מחללין עליהם את השבת וכן על הספינה המטורפת בים ונהר השוטף מצוה על כל אדם להצילן ולחלל עליהם וכן יחיד הנרדף מפני ליסטים מצוה להצילו והמצילין חוזרין בכלי זיינם למקומם:

33 .שו"ת אגרות משה חלק יו"ד ג סימן קלב

קביעת עת המוות בעה"י ה' אייר תשל"ו מע"כ חתני הנכבד והאהוב לנו כש"ת הרה"ג מוהר"ר משה דוד טענדלער שליט"א.

הנה בדבר ידיעת מיתת האדם מפורש בגמ' יומא דף פ"ה ע"א בנפל מפולת על האדם שמפקחין את הגל אפילו בשבת ובודקין עד חוטמו, ואיפסק כן ברמב"ם פ"ב משבת הי"ט ובש"ע או"ח סימן שכ"ט סעי' ד' שאם לא הרגישו שום חיות הוא בדין מת שהוא בבדיקת הנשימה, שאף אם הנשימה קלה מאד נמי הוא בדין חי שרואין זה ע"י נוצה וע"י חתיכת נייר דקה שמשימין אצל החוטם אם לא מתנדנד הוא בחזקת מת, אבל צריך שיבדקו בזה איזה פעמים כדבארתי באגרות משה ח"ב דיו"ד סימן קע"ד ענף ב' בבאור דברי הרמב"ם בפ"ד אבל ה"ה שכתב ישהא מעט שמא נתעלף שהוא זמן דאי אפשר לחיות בלא נשימה, והוא דוקא כשהסתכלו כל זמן זה בלא היסח הדעת אף לרגע קטן וראו שלא נשם כל העת, אבל כיון שאי אפשר לאינשי להסתכל אף משך זמן קצר בלא היסח הדעת שיש לחוש שמא נתחזק מעט ונשם איזה נשימות ונחלש עוד הפעם וחזר ונתחזק אי אפשר לידע אלא שיבדקו איזה פעמים ואם יראו שאינו נושם זהו סימן המיתה שיש לסמוך על זה ואין להרהר ועיין בחת"ס חלק יו"ד סימן של"ח שביאר באורך.

זהו בסתם חולים שנקרב מצבם למיתה ולא הוצרכו למכונה שיעזרם לנשום, אבל איכא חולים גדולים שלא יכלו לנשום והניחו הרופאים בפיהם מכונה שנושם ע"י זה, שע"י המכונה הא שייך שינשום אף שהוא כבר מת דנשימה כזו הא לא מחשיבו כחי, הנה אם לא ניכר בו בענינים אחרים ענין חיות שנראה כלא מרגיש בכלום אף לא בדקירת מחט וכהא שקורין קאמא כל זמן שהמכונה עובדת עבודתה אסור ליטול מפיו דשמא הוא חי ויהרגוהו בזה, אבל כשפסקה מלעבוד שנחסר העקסינזען /החמצן/ שהיה שם לא יחזירו לפיו עוד הפעם עד עבור זמן קצר כרבע שעה, שאם אינו חי כבר יפסיק מלנשום וידעו שהוא מת, ואם יחיה היינו שיראו שהוא נושם גם בלא המכונה אך בקושי ובהפסקים יחזירו המכונה עוד הפעם לפיו מיד וכה יעשו הרבה פעמים עד שיוטב מצבו או שיראו שאינו נושם בעצמו כלל שהוא מת.

אבל זהו באינשי שנחלו בידי שמים באיזו מחלה שהיא אבל באלו שהוכו בתאונת דרכים (בעקסידענט ע"י הקארס) וע"י נפילה מחלונות וכדומה שאירע שע"י התכווצות העצבים באיזה מקומות הסמוכים להריאה ולכלי הנשימה אינם יכולין לנשום וכשיעבור איזה זמן שינשומו אף רק ע"י המכונה יתפשטו מקומות הנכווצים ויתחילו לנשום בעצמם שאלו אף שאין יכולין לנשום בעצמן וגם לא ניכרין בהם עניני חיות אחרים אפשר שאינם עדיין מתים, וכיון שאתה אומר שעתה איכא נסיון שרופאים גדולים יכולין לברר ע"י זריקת איזו לחלוחית בהגוף ע"י הגידים לידע שנפסק הקשר שיש להמוח עם כל הגוף שאם לא יבא זה להמוח הוא ברור שאין להמוח שוב שום שייכות להגוף וגם שכבר נרקב המוח לגמרי והוי כהותז הראש בכח, שא"כ יש לנו להחמיר באלו שאף שאינו מרגיש כבר בכלום אף לא ע"י דקירת מחט ואף שאינו נושם כלל בלא המכונה שלא יחליטו שהוא מת עד שיעשו בדיקה זו שאם יראו שיש קשר להמוח עם הגוף אף שאינו נושם יתנו המכונה בפיו אף זמן גדול, ורק כשיראו ע"י הבדיקה שאין קשר להמוח עם הגוף יחליטו ע"י זה שאינו נושם למת.

וגם הערת דבאלו שלקחו מיני סם וכגון הרבה כדורי שינה שעד שיצא הסם מהגוף אינם יכולין לנשום, שלכן יש להצריך שהמכונה תהיה בפיו זמן ארוך עד שיהיה ברור שכבר אין הסם בגוף שיכולין הרופאים לבדוק זה בטפת דם שיוציאו ממנו, ואז יוכלו שלא להחזיר את המכונה לפיו עוד הפעם ויראו שאם אינו נושם כלל הוא מת ואם נושם אף רק בקושי הוא חי ויחזירו המכונה לפיו עוד הפעם. הכו"ח חותנך אוהבך בלו"נ, משה פיינשטיין.

.nal TextsAdditio

. רמב"ם הלכות רוצח ושמירת הנפש פרק ב הלכה ז

אחד ההורג את הבריא או את החולה הנוטה למות, ואפילו הרג את הגוסס נהרג עליו, ואם היה גוסס בידי אדם כגון שהכוהו עד שנטה למות והרי הוא גוסס, ההורג אותו אין בית דין ממיתין אותו.

. שולחן ערוך יורה דעה סימן שלה סעיף ג

המבקר את החולה לא ישב ע"ג מטה ולא ע"ג כסא ולא ע"ג ספסל, אלא מתעטף ויושב לפניו, שהשכינה למעלה מראשותיו. הגה: ודוקא כשהחולה שוכב על הארץ, דהיושב גבוה ממנו, אבל כששוכב על המטה מותר לישב על כסא וספסל (ב"י בשם הר"ן, וכן נוהגין).

שולחן ערוך יורה דעה סימן שלה סעיף ז

אומרים לו שיתן דעתו על ענייניו, אם הלוה או הפקיד אצל אחרים, או אחרים הלוו או הפקידו אצלו, ואל יפחד מפני זה מהמות.

שולחן ערוך יורה דעה סימן רמא

סעיף א
המקלל אביו או אמו, אפילו לאחר מיתתן, חייב סקילה אם הוא בעדים והתראה, אחד האיש ואחד האשה שקללו. במה דברים אמורים, שקללום בשם מהשמות המיוחדים, אבל קללם א בכינוי, אינו חייב אלא בלאו, ב כמו המקלל אחד מישראל. הגה: וכן המכה אביו או אמו, בחייהם, בין איש בין אשה חייבים חנק. ודוקא אם עשו בהם חבורה, אבל אם לא עשו חבורה אינו אלא בלאו, כמו מי שמכה אחד מישראל (טור).

סעיף ב
הכהו על אזנו וחרשו, חייב מיתה, שא"א שיעשה חרש בלא חבורה, דטיפת דם יוצא מבפנים באוזן ועל זה נתחרש.

סעיף ג
היה קוץ תחוב לאביו, לא יוציאנו, שמא יבא לעשות בו חבורה. וכן אם הוא מקיז דם, או רופא, לא יקיז דם לאביו ולא יחתוך לו אבר, אף על פי שמכוין לרפואה. הגה: בד"א, בשיש שם אחר לעשות. אבל אם אין שם אחר לעשות והוא מצטער, הרי הוא מקיזו וחותך לו כפי מה שירשוהו לעשות. (גם זה בטור ורמב"ם פ"ה מה' ממרים).

שולחן ערוך יורה דעה סימן שמה

סעיף א
המאבד עצמו לדעת, א אין מתעסקים עמו לכל דבר, ואין מתאבלין עליו, ואין מספידין אותו, ב (א) ולא קורעין ולא חולצין, אבל עומדין עליו בשורה אומרים עליו ברכת אבלים וכל דבר שהוא כבוד לחיים.

סעיף ב
איזהו (ב) מאבד עצמו לדעת, ג כגון שאמר: הרי הוא עולה לראש הגג, וראוהו שעלה מיד דרך כעס, או שהיה מיצר, ונפל ומת, הרי זה בחזקת שאיבד עצמו לדעת. אבל אם ראוהו חנוק ותלוי באילן, ד או הרוג ומושלך על גבי סייפו, הרי הוא בחזקת כל המתים, ומתעסקים עמו ואין מונעין ממנו דבר. הגה: ה מי שגנב וגזל ועל ידי זה נהרג בדין מלכות, מתאבלים עליו, אם אין בו סכנה מפני אימת המלכות, ולא מקרי מאבד לדעת (מהרי"ו סימן קי"ד).

סעיף ג
קטן המאבד עצמו לדעת, חשוב כשלא לדעת. וכן גדול המאבד עצמו לדעת, והוא אנוס ו כשאול המלך, אין מונעין ממנו כל דבר.

סעיף ד
ז מנודה שמת, דינו כמאבד עצמו לדעת; אין קורעין ולא חולצין ולא מספידין עליו, ומניחין אבן על ארונו. והני מילי באפקירותא, כשעובר על דברי תורה; אבל בממונא, כיון שמת, פטור מגזירתם, ואין מניחים אבן על ארונו, ומספידין אותו כראוי.

סעיף ה
כל הפורשים מדרכי צבור, והם האנשים שפרקו עול המצות מעל צוארם, ואין נכללים בכלל ישראל בעשייתם, ובכבוד המועדות וישיבת בתי כנסיות ובתי מדרשות, אלא הרי הם כבני חורין לעצמן כשאר האומות, וכן המומרים והמוסרים, כל אלו אין אוננים (ג) ואין מתאבלים עליהם, אלא אחיהם ושאר קרוביהם ח לובשים לבנים ומתעטפים לבנים ואוכלים ושותים ט ושמחים. הגה: הפורש מן הצבור ולא רצה לשאת עמהם במסים וארנוניות, מתאבלים עליו (תשו' רשב"א סי' תשס"ג) אבל אין שאר בני העיר צריכים לבטל ממלאכתן בשבילו לעסוק עמו (כן משמע בנ"י סוף מ"ק).

סעיף ו
קטן בן שנה או שנתיים שהמיר י עם אמו, ומת, (ד) אין מתאבלין עליו (ועיין לעיל סימן ש"מ סעיף ה').

סעיף ז
מי (ה) שנפל בים, או טבע בנהר, או אכלתו חיה, אין מונעין ממנו דבר.

סעיף ח
ארון העובר ממקום למקום, אם שלדו (פירוש השדרה וצלעותיה) קיימת, עומדין עליו בשורה ואומרים עליו ברכת אבלים ותנחומי אבלים, אם יש אבלים שמתאבלין עליו; ואם אין שלדו קיימת, אין עומדין עליו בשורה ואין אומרים עליו ברכת אבלים ולא תנחומי אבלים.

מסכתות קטנות מסכת שמחות פרק א הלכה ד

אין מעצמין את עיניו, הנוגע בו ומזיזו הרי הוא שופך דמים, רבי מאיר היה מושלו לנר שהוא מטפטף, כיון שנגע בו אדם מיד כיבהו, כך כל המעצם את עיני הגוסס, מעלין עליו כאילו הוא שומט את נשמתו.

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