University of Basel

"To Walk Between the Raindrops" The Role of Rabbis in Bioethical Decision-Making

Orthodox and Reform Jewish Practice in the United States and Israel

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Contents

List of Figures

Introduction

> A rabbi, a Catholic priest and a Protestant clergyman are being asked, when does life begin.
> The Catholic priest explains unhesitatingly that life begins at the time of conception.
> The Protestant clergyman does not quite agree and argues that it is not as simple as that.
> The rabbi thinks it over and finally opines: 'Well, life actually only begins after the kids have left the house and the dog has died.'

A joke remains a joke and should not be taken too seriously, even as an opener to the introduction of a dissertation. Nevertheless, as a point of departure, these lines provide reflection on the state of affairs in "Jewish" bioethics.

Bioethicist and professor of philosophy, William Ruddick, described three types of moral reasoning that one can find in medical ethics literature: the Protestant, the Catholic, and the Jewish ideal-type. The specific constellation of Protestantism, Catholicism, and Judaism not only inspires the imagination of smart alecks, but also assists in the classification of meta-ethical approaches to ethical case review. According to Ruddick, the Protestant approach is characterized by an emphasis on value conflicts and dilemmas, while Catholic moral reasoning is considered principle-based, and the Jewish method seemingly employs anecdotes from real or fictitious cases to ask questions and provide answers.[1]

It is astonishing that such classification coincides with the clergy's approaches to determining when human life begins: the Catholic priest's undoubted and pragmatic response, the Protestant's doubting answer, and the rabbi's witty anecdotal closure—all align with Ruddick's observation. In refraining from answering the question seriously, the rabbi of the joke avoids the problem of answering such a comprehensive question in one sentence for all Jews. This, perhaps, is not the worst strategy. However, his answer is not less convincing than the Protestant's, who merely points to the complexity of the question. Such complexity also exists when considering a possible all-encompassing Jewish position. It must be acknowledged that various Jewish sectors use different frameworks for evaluation. "Judaism" is often portrayed as a cultural monolith with "the"

[1] See Ruddick, "Teach and Test?"

Jewish way for this or that. Just as Judaism should not be understood as a religio-cultural whole, there is no single set of Jewish ethics, or a system of moral instruction that represents all of "Judaism." Various expert traditions have developed within contemporary Judaism, which run along the most prominent religious sectors: Orthodox, Conservative and Reform Judaism. As a result of Judaism's social and religious diversity, "the" Jewish answer to a specific ethical question does not exist. Furthermore, religiously motivated bioethics, whether discussed within Orthodox or liberal Jewish traditions of knowledge, do not necessarily coincide with the views of secular Jews, whose lifestyles and basic attitudes are not determined by religion. The various denominational insights as variations of a bioethics of Judaism cannot be tacitly transferred to non-practicing or secular Jews to form a bioethics of the Jews.

And yet, Ruddick is spot-on with his perception of the Jewish approach as anecdotal. The use of narrative text elements from traditional literature, such as the Aggadot from the Talmud and Midrash, are essential to Jewish discussion of medical ethical problems. The narrative character of Jewish bioethics, which Ruddick identifies as "anecdotal," is used in various ways. While Orthodox rabbis and bioethicists see the Aggadot as a narratively valuable framework for complementing halakhic (religio-legal) opinions, narratives in the Reform tradition are widely used to develop ethical points of view.

Of course, Jewish bioethics is more than just anecdotes of real and fictitious cases. The predominant approach in Jewish bioethics and the *modus operandi* of Orthodox scholars and authors of Jewish bioethical literature is halakhic in nature. Jewish law is the frame of reference within which religious authorities discuss, analyze and decide what may be otherwise known as an ethics case. Orthodox representation strongly dominates inner-Jewish discourse on medical ethics, thus adding to the impression that "Jewish bioethics" is equivalent to a halakhic evaluation of bioethical topics. This situation becomes clear upon closer consideration of American and Israeli publications on the topic. Orthodox authors who take part in the bioethical discourse from a Jewish perspective usually do so with reference to the medical halakhic framework. This approach to bioethical problem-solving is therefore called medical Halakhah or *halakhah refu'it* in Israel. In a narrow sense, medical Halakhah is not an ethical evaluation, but rather a religio-legal. This approach, however, does not apply to Jewish approaches from the liberal sectors, whose guidelines also correspond with Mordecai Kaplan's Reconstructionist concept in bioethical matters: "Halakhah has a voice but not a veto!"

It is against the backdrop of rabbinical discourse regarding bioethical issues and dilemmas that an interest in the professional practice of rabbis, which is notably absent from the literature, developed. Designed as a qualitative comparative study of Israel and the United States, the present

research project focuses on: rabbinical practice and its interrelationship with ethical discourse, the rabbis' social encounter with congregants and patients, and inter-professional and religious networks of rabbis and chaplains within specific national and institutional contexts. Based on empirical studies, the following pages analyze the practical relevance and processing of Jewish normative and formative ethics and Halakhah, ultimately resulting from the interaction among traditional texts, social relations, and religious structure.

Chapter one, *Preliminary Necessities: Literature Review, Methodology, and Theoretical Framework*, provides clarification on the study's methodology and theoretical framework. The first section reviews the relevant literature regarding Jewish bioethics and medical Halakhah. While Jewish expert discourse is accessible as a written discussion, this research project addresses the negotiation between religious ideals and the practical logic of bioethical decision-making in real life situations. Thus, the Bourdieuan concept of "the logic of practice" is used as the main theoretical framework within this study. The qualitative data was gathered during three research stays: one in New York (2010) and two in Israel (2011 and 2016). A total of 52 interviews were conducted in English, 49 of which were subsequently transcribed verbatim and analyzed. Interviews were conducted in Israel (mainly within Jerusalem) and New York City because these are the world's largest Jewish metropolitan areas, both in terms of population and religious diversity. Due to the abductive and context-sensitive process of the study, sampling in Israel was not congruent with that in the United States. Specifically, the denominational structure of the United States allowed for the inclusion of pulpit rabbis and healthcare chaplains of both Jewish sectors, the Reform Movement and Orthodox Judaism. Israel's contrasting organizational structure of religious institutions resulted in a different sample. The Orthodox sector yielded fewer pulpit rabbis, but more experts in medical Halakhah than in New York. Additionally, Israel currently lacks the professional equivalent of the United States' Jewish healthcare chaplaincy; *livui ruhani*, or professional spiritual care, is still evolving in Israel. The chapter's part on data and methods describes the study's sampling strategy and thematic analysis. The latter allows for a wide range of analytic options. Data was coded with Atlas.ti, a computer-assisted/aided qualitative data analysis software (CAQDAS). Coding is an integral part of the iterative qualitative data analysis process.

This empirical, context-sensitive study aims to show that Jewish moral spheres of action are always located at and realized within institutional, social, and cultural contexts. Description regarding social backgrounds and national idiosyncrasies is provided at length due to the fact that bioethical decisions do not occur within a socio-cultural vacuum. This dissertation is largely concerned with the contextualization of Jewish action and decision-making processes regarding bioethical problem analysis.

Chapter two, *American and Israeli Religious Cultures in Context: Idiosyncrasies in Communal Life and Spiritual Care*, describes the socio-historical development and current religious structures within Orthodoxy and the Reform Movement in the United States and Israel. These deliberations are crucial with respect to the impact of national and religious idiosyncrasies on the various social procedures in religious and medical settings, where rabbis and spiritual care workers, i.e. Jewish healthcare chaplains, pursue their professional duties. American Judaism, especially in New York, has developed from a synagogue-community into a community of synagogues within a multi-confessional Christian context, and was repeatedly shaped by waves of immigrants from Europe. Congregational structures and a denominational character, even when presently challenged by a post-denominational mood, are typical for American Judaism. In contrast, Israeli Judaism emerged within the Jewish nation state and its majority population of Jewish people. Furthermore, this dissertation pays substantial attention to the various models of Jewish pastoral care and *livui ruhani* as concepts relevant for the professional identity of rabbis and/or spiritual care workers, whose workplace is at the hospital.

Chapter three, *The Professional Practice of Rabbis and Chaplains at the Intersection of Discourse and Social Encounter*, addresses the project's main research interest. First, it evaluates the range of biomedical issues in the interlocutors' professional encounter with congregants and patients. While rabbinic sources, such as responsa literature and its corresponding rabbinic discussions of various biomedical and -technological issues, present a well-documented expert discourse, this chapter addresses their practical relevance. It is presumptuous to assume that topics elaborated upon within the literature coincides with a community's actual needs. Therefore, special attention is paid to respondents' reflection of their roles and rationalization of their professional persona. For example, what do rabbis think are the reasons that congregants and patients confide in them? Or why do the latter not confide in the former? Rabbis play a key role in the negotiation of religious tradition, ethical discourse, and an individual's needs. Their role reflection often entails a description of their professional network, which in turn is key for comprehending the structural differences regarding processes of authorization. Professional networks assist in understanding how rabbis deal with situations that supersede their competence (usually of halakhic nature) and how they process difficult cases.

One of these undeniably difficult cases is brain death and the issue of organ donation. In the first section of chapter four, *Dead or Dying? The Neurological Determination of Death (Brain Death) and Its Controversy in Judaism*, argumentative discourse analysis assists in describing the various positions on brain death and organ donation. The Orthodox brain death controversy particularly illustrates how production and governance of secular (also medical) and religious knowl-

edge depend on processes of legitimization within a specific interpretive community. The epistemological question of why there are such fundamental differences within a relatively small religious community that shares the same religious literature, religious law, hermeneutical methods, and practices, guides much of this chapter. While Ultra-Orthodoxy rejects neurological death as halakhically legitimate, the Reform Movement as well as a large segment of Modern Orthodoxy accepts the brain death criteria and supports organ donation. The second part of this chapter shows that opposing halakhic rulings can nevertheless co-exist in practice. In Israel, most medico-halakhic experts have tremendous respect for the opposing view on the matter. This leads to a solution oriented pragmatism that seems to work most of the time. However, working solutions are not necessarily enough to bridge the existing gaps and bury ideational differences, particularly when they exist between the medical establishment in public hospitals and the *haredi* community. In contrast to the prior medical protocol, the Brain-Respiratory Death Act (2009) is heavily infused with halakhic norms. An in-depth discussion of the rabbis' experiences with brain death cases shifts attention from discourse to practice.

Interview partners often shared their experiences by telling stories. These stories are fundamental for an illustration of rabbis and chaplains' professional practice and involvement in medical decision-making. By applying Pierre Bourdieu's theory of *habitus*, story-telling as part of the wider narrative epitomizes latent professional structures, religious rationales, and ways of thinking.

Thus, stories are an important part of chapters four and five. The fifth chapter of this dissertation, *Mitzvah or Murder? Organ Donation in Judaism*, explores the religious discourses, rabbinic experiences, and consequences of tensions that persist between legal, medical, and religious spheres of power and knowledge. From an Orthodox Jewish perspective the issue of organ donation is framed by two extremes: Does it constitute the "killing" of a brain dead individual or is it the ultimate *mitzvah*, a *matnat hayim* (gift of life), because it saves lives? The chapter also explores whether the Reform community is as accepting of organ donation as it is regarding brain death. The most relevant issues discussed include the interrelationship of guiding values or norms and rabbis' personal opinions or emotional struggles. Analysis tackles the question of how rabbis handle organ donation in their congregations and whether congregations are an appropriate place to address this issue. Mirroring the previous chapter on brain death, the last section of chapter five examines the Israeli Organ Transplant Law (2008) and its ethical rationales and implications for the religious community and general Israeli population.

This study contributes to the breadth of research that deals with bioethics and religious traditions. It specifically examines the Jewish practice of bioethics and medical Halakhah in congregations, religious networks, organizations, and hospitals. The study's comparison between the

United States and Israel attempts to address the question of how rabbinical discourse on bioethics and its practical application differs between countries in which a particular group represents either a minority or majority of the population. Although the results are embedded within their specific socio-cultural contexts, they may serve as a conceptual framework for further investigations on the role and narrative practice of religious experts within other religious traditions.

Addressing bioethical issues is also of great socio-political importance. The present, characterized by globalization and migration, brings with it a pluralization of lifestyles, which pose health policy challenges for societies. With its practice-oriented, empirical approach, this research project takes into account the social and institutional situation of bioethical decision-making processes at the interface of state, healthcare, patient and religious institutions. The study therefore provides sound support for current political decision-making processes and examination of legal regulations.

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Furthermore, chapter five consists of parts published in: Werren, Sarah. "Jewish Orthodox Perspectives on Brain Death and Organ Donation. Contested Knowledge between Scientific Determinations and Religious Normativity in Judaism." In: *Hirntod und Organspende aus interkultureller Sicht*. Ed. by Stephan Probst. Berlin: Hentrich & Hentrich, 2019, pp. 117–155.

Much of this dissertation was completed during the Corona pandemic. Consequently, lockdown of public life, work from home, and the inability to use some of the infrastructure so dearly needed could not have come at a worse time. Additionally, several libraries conducted major system changes during the last year that each required the return of all books. That made it impossible for me to access some publications in their original language or English translations; hence, I use German translations when I had access to them. Furthermore, I relied more heavily on online-resources and websites than I usually would due to the difficulty in obtaining monographs and chapters in anthologies.

This work was written on Aquamacs using XeLaTeX.

1 | Preliminary Necessities: Literature Review, Methodology, and Theoretical Framework

1.1 Literature Review

Bioethics as an interdisciplinary examination of dilemmas regarding all forms of life began in the United States of the postwar era. The human experiments carried out in the name of science during the Nazi regime and the accompanying acceptance of human suffering for the purpose of dubious medical progress were the main reasons for the establishment of an interdisciplinary bioethical discipline, supported by biologists, physicians, jurists, philosophers and theologians. At the same time, bioethics evolved into an academic discipline alongside medical ethics, the latter being considered to be the professional ethics of the medical profession. Bioethics is more interdisciplinary and ethically reflects upon biotechnological innovations on a broader level compared to medical ethics. Nevertheless, both academic fields have much overlap and affect discourses in the fields of healthcare ethics and the ethics of care.

As medical science advanced, medical interventions became increasingly technical and intellectual resources outside of the medical profession were pertinent to deal with new arising questions. Since issues of life, death, and social justice were questions long pondered by philosophers and theologians, their approaches to answering those unprecedented problems became an integral part of the new evaluation of medical practice.[1] For example, bioethics as an application-oriented discipline yielded Tom L. Beauchamp and James F. Childress' principled method, a highly regarded tool for moral argumentation. The ethical theory it is based on is known as principlism. The four principles are: respect for autonomy, beneficence, nonmaleficence, and justice.[2] The advantage of this approach is its compatibility with most social, individual and religious value systems.[3] In addi-

[1] See Jonsen, *Birth of Bioethics*.

[2] See Beauchamp and Childress, *The Principles of Biomedical Ethics*.

[3] Sharp critics of principlism reject this universal moral theory mainly because of the unsystematic and arbitrary composition of its principles. See Clouser and Gert, "A Critique of Principlism."

tion to more consistent moral theories such as utilitarianism or deontology, Jewish and Christian principles also had a decisive influence on bioethical theory formation. These include principles such as the sanctity of life and human dignity.

Thinkers and scholars from all branches of Judaism have long participated in intellectual and inter-religious exchange on the problematization of bioethical issues. This may not be surprising, especially since Judaism, as a religious and morally oriented order of knowledge, deals with questions of good living and "correct" behavior. Much of the documentation of these moral-legal arguments is undertaken from an emic perspective, which is ever shaped by religious norms and values that the Jewish author himself represents. Thus, the Jewish examination of bioethical issues is largely dominated by normatively oriented representations. Furthermore, scholars and authors who contribute to this interdisciplinary topic do so from a vast array of academic disciplines; more often than not, these contributions emerge at the cross-section of academic interest and practice, as well as religious identity. It is therefore quite common for this discursive field, to find religious agendas embedded within scholarly articles. This dissertation, however, is not based on theological or other normative assumptions that characterize the bulk of the literature on Jewish bioethics or medical Halakhah.[4] It is written from an etic perspective *(wissenschaftliche Aussenperspektive)*, maintaining analytical and critical distance from the subject matter.

With religious morality and virtues influencing bioethics, many of the challenging issues brought forth by the "new medicine" are also discussed within the scope of religious traditions. This is especially true when universal guidelines fail to meet the particular interests of religious communities and their normative frameworks, such as the religio-legal set up of Orthodox Judaism.

There are two basic approaches or legacies within the Orthodox discursive field. First, the legacy of Immanuel Jakobovits' approach of Jewish medical ethics, and the other of medical Halakhah. Immanuel Jakobovits (1921–1999), who was the Chief Rabbi of Great Britain and held a medical degree, pioneered the study of bioethics in Judaism with his fundamental work "Jewish Medical Ethics" (1959/1975).[5] His work includes perspectives from nursing, physician practice, and Jewish history, while covering a wide range of subjects, such as euthanasia, eugenics, and abortion. At the time of writing, biotechnology was advancing rapidly and Jakobovits' work highlighted

[4]Halakhah is the Hebrew term for Jewish law, though law is not exactly the exact translation of the word—and neither the precise concept. Halakhah is rooted in the Hebrew hlk which means as a verb "to go, to walk." In German, the term "Wegleitung" could be an appropriate translation of Halakhah, even though in practice Halakhah is indeed operated as a religio-legal system. Thus, other than in Christianity for example, Jewish religiosity is assessed on a scale of observance rather than in reference to faith and confession.

[5]See I. Jakobovits, *Jewish Medical Ethics*. Shorter articles based on his monograph are in I. Jakobovits, "A Brief Overview," "Some Letters."

the need for reflection on bioethical problems, laying the foundation for an inner-Jewish discussion of these issues. His method is a form of normative ethics, albeit not a positivistic religio-legal one. He focuses on moral problems raised by medicine and medical practice.[6] Nevertheless his approach is comparative and historical, as well as profoundly rooted in rabbinic literature, especially the Shulhan Arukh (Code of Jewish Law, 1565). As Alan Brill remarks, Jakobovits "employed a moral model in line with the Catholic model, believed that Jewish law must incorporate history and values, and rejected talmudic science."[7] Thus, Rabbi Jakobovits' perspective and method sharply contrasts with those of scholars and authorities in the Orthodox "field"[8] (e.g. Moshe Feinstein, Shlomo Zalman Auerbach, and Eliezer Yehuda Waldenberg), who represent a positivistic approach to Halakhah. The latter examine medical practices and possibilities within the religio-legal framework, where the objects of concern are not moral problems, but halakhic consistency that presumes morality and correct moral behavior.

As for the second approach of medical Halakhah, its main contributors include rabbis Moshe Feinstein ("Rav Moshe," 1895–1986), Shlomo Zalman Auerbach ("Minhat Shlomo," 1910–1995), and Eliezer Yehuda Waldenberg ("Tzitz Eliezer," 1915–2006). These three are generally considered to be the *posqim* (halakhic authorities) with the most substantial influence on medical Halakhah as it emerged at the time.[9] Moshe Feinstein and Eliezer Yehuda Waldenberg[10] have themselves written responsa on several important bioethical questions. Other authorities have not published their rulings, or at least not consistently. This is the case with Auerbach whose rulings and thorough halakhic evaluations were of crucial importance to the medico-halakhic discourse in its formative years. Although he published a few articles in periodicals and some of his rulings in his seminal work Minhat Shlomo, most of Auerbach's rulings were only rendered orally and never formally published.

All the more important are the contributions of the following two scholars of medical Halakhah who were both close disciples to Shlomo Z. Auerbach. First, there is Abraham S. Abraham whose three-volume handbook discusses bioethical case studies and is entirely based on the Shulhan Arukh: *Nishmat Avraham*. In contrast to Jakobovits, Abraham uses an intertextual approach

[6] See Brill, "Birth of Jewish Medical Ethics."

[7] Ibid., p. 347.

[8] The term and concept of field/s is introduced in the theory section of this chapter.

[9] Other halakhic decisors who influenced the field substantially are rabbis Joseph B. Soloveitchik (1903–1993), Joseph Shalom Elyashiv (1910–2012), Shmuel Wosner (1913–2015), Zalman Nehemiah Goldberg (1932–), Yitzchak Zilberstein (1934–), and Hershel Schachter (1941–), as well as responsa from various Chief Rabbis of Israel, such as Isser Jehuda Unterman (1886–1976), Shlomo Goren (1917–1994), Ovadja Josef (1920–2013), and Avraham Shapira (1921–2000).

[10] See Feinstein, Moshe (1961). *Sefer Igrot Moshe*. 8 vols. New York: Beth Medrash L'Torah V'Horaah (Hebrew) and Waldenberg, Eliezer Yehuda (1945–1996). *She'elot U'Teshuvot Tzitz Eliezer*. 21 vols. Jerusalem (Hebrew). A scholarly article on Waldenberg's medico-halakhic rulings has been provided by Brand, "Rulings of Rabbi Waldenberg."

in the style of commentary that is typical for traditional Jewish œuvres and problem analysis.[11] Second, the Israeli rabbi and doctor of pediatric neurology, Avraham Steinberg, created an important reference work with his Encyclopedia of Jewish Medical Ethics (2003).[12] Unlike A. S. Abraham, Steinberg's medical and bioethical topics are arranged alphabetically and contain, in addition to the halakhic assessments, definitions of terms, medical background information, and a historical and philosophical contextualization of nearly all bioethical issues. Both authors' contributions are central to the discourse of Orthodox Jewish bioethics, because they comprehensively integrate the responses of the *posqim* (halakhic authorities) into their presentations. Furthermore, Steinberg and Abraham can be credited for their integration of Rabbi Auerbach's halakhic decisions.[13] A summary of Auerbach's medico-halakhic decisions was published by Avraham Steinberg in Assia, a periodical on bioethics edited by the the Falk Schlesinger Institute for Medical-Halachic Research (Jerusalem).[14] Mordechai Halperin, the present director of the Schlesinger Institute, also published a review article on medical halakhic literature.[15]

Another circle of prolific scholars from the Orthodox sector who have made vast contributions to the field of Jewish bioethics are American-based rabbis Fred Rosner, Moshe Tendler, and David Bleich. Fred Rosner especially strives to reappraise the textual sources and historical contextualization of medical ethical conflicts.[16] The significance of Rosner's work lies in his successful collaboration with practically all participants in the halakhic discourse on bioethical topics—despite eventual differences in perspective and approach to Jewish medical ethics. Rosner translated the aforementioned Encyclopedia of Jewish Medical Ethics, which was originally published in Hebrew by Abraham Steinberg, into English. Furthermore, Rosner contributed to the accessibility of Israeli medical Halakhah to a larger non-Hebrew-speaking readership when he translated and edited "Medical Halachic Responsa" of Yitzchak Zilberstein, the *poseq* of Mayanei HaYeshua Medical Center in Bnei Brak (Israel).[17]

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[11] See Abraham, *Medical Halachah*.

[12] See Steinberg, *Encyclopedia of Jewish Medical Ethics*. An updated version, so far only available in Hebrew, was published in 2017. See Steinberg, Avraham (2017). הרפואה כהלכה: הלכות חולה, רופא, ורפואה מטרם יצירת האדם ועד אחרי מות: בתוספת הבהרות, הערות, והארות. Avraham Steinberg: Jerusalem.

[13] Another disciple who integrated Rabbi Auerbach's decisions on medical subjects into his multi-volume œuvre is Y. Neuwirth in "Shemirat Shabbat Kehilchatah," a halakhic work on Shabbat laws.

[14] See Steinberg, "Decisions of Shlomo Z. Auerbach." For Auerbach's end-of-life decisions see also Dienstag, "Auerbach on End-of Life-Care."

[15] See Halperin, "Milestones in Jewish Medical Ethics."

[16] See F. Rosner, *Medicine and Jewish Law*, *Biomedical Ethical Issues*; F. Rosner and Bleich, *Jewish Bioethics*; F. Rosner and Tendler, *Practical Medical Halachah*. A historical contextualization of Talmudic sources is further provided by Reichman, "The Halakhic Definition of Death in Light of Medical History," "Incorporation of Pre-Modern Scientific Theories," "Don't Pull the Plug," "Maimonides."

[17] Rav Yitzchak Zilberstein's "Medical Halachic Responsa" is noteworthy due to the authority Rav Zilberstein has gained within Ultra-Orthodox Judaism after the death of Rabbi Yosef Shalom Elyashiv in 2012.

Moshe Tendler, Moshe Feinstein's son-in-law, has published widely on various aspects of Jewish medical ethics. He is most famous for his postulation that "brain death is halachic death."[18] Much of the ambiguity that governs the question of legitimacy of brain death and organ donation from a halakhic perspective is due to some inconsistencies in Feinstein's definitive position within his responsa.[19] Both Rabbis Tendler and Rosner allow for scientific knowledge and practice to influence their normative Jewish deliberations on medical ethics. However, one of Tendler's vociferous opponents in the debate over the halakhic legitimacy of brain death is David Bleich, whose writings on all issues within the discursive field of Jewish bioethics continue to shape today's bioethical discourse from an Orthodox perspective.[20] Bleich publishes widely on bioethical topics and does so in close intertext with Talmudic sources and other rabbinic literature.[21] A trained biologist, Bleich differs in his approach from Tendler and Rosner. The former's approach is characterized by personal evaluations of Talmudic sources regarding bioethical issues and a tendency towards halakhic formalism.[22]

Similarly influential have been contributions from bioethicists and rabbis from the Conservative Movement. These include Elliot Dorff,[23] Louis Newman,[24] David Feldman,[25] Aaron L. Mackler,[26] Robert Gordis,[27] and David Teutsch[28] (of the Reconstructionist Movement).

Reform Judaism has its own umbrella organizations and experts to deal with bioethical decision-making. The Department of Jewish Family Concerns of the Union for Reform Judaism (URJ), which provides information material and textbooks for dealing with all bioethical issues,

[18]Tendler, "Organ Transplantation." The literature used to sketch the Orthodox rabbinic discourse regarding brain death and organ donation is part of chapter four of this thesis.

[19]Rabbi Tendler translated and edited some major parts of Feinstein's *opus magnum* Igerot Moshe in Tendler, *Responsa of Rav Moshe Feinstein*.

[20]See Bleich, "Establishing Criteria of Death," "Time of Death Legislation," "Cerebral, Respiratory, and Cardiac Death."

[21]See Bleich, *Contemporary Halakhic Problems*, *Bioethical Dilemmas*, *Judaism and Healing*; F. Rosner and Bleich, *Jewish Bioethics*.

[22]An informative example of different methods and presumptions regarding matters with no halakhic precedence is available in the scholarly exchange with Rabbi Ezra Bick on the matter of halakhic motherhood, published in the journal Tradition—the journal for Modern Orthodox thought. Bleich has authored countless articles and is the longstanding contributor to the journal's rubric "Survey of Recent Halakhic Periodical Literature." See Bick, "Ovum Donations"; Bleich, "Host Mothers," "Maternal Identity," "In Vitro Fertilization," "Maternal Identity Revisited."

[23]See Dorff, "A Methodology for Jewish Medical Ethics," *Matters of Life and Death*; Dorff and Crane, *Handbook of Jewish Ethics*; Dorff and Newman, *Jewish Ethics and Morality*.

[24]See Newman, "Jewish Theology and Bioethics," "Text and Tradition in Jewish Bioethics," "Ethics as Law," "Woodchoppers and Respirators."

[25]See Feldman, *Marital Relations*, "Matter of Abortion."

[26]See Mackler, *Life and Death Responsibilities in Jewish Biomedical Ethics*, *Jewish and Catholic Bioethics*.

[27]See Gordis, "Wanted."

[28]See Teutsch, *Bioethics*. The works of these authors are not further introduced, since Conservative and Reconstructionist normative ethics is not part of this dissertation.

follows an inclusivistic approach. The guides consist mainly of a compilation of texts from various Jewish denominations, amended with medical and legal information.[29] Reform Jewish positions on bioethical and biomedical issues have been published also in the form of responsa. In contrast to Orthodox Judaism with its many different interpretive communities and *posqim*, the Reform Movement's rabbinical organization has centralized the processing of *she'elot u'tshuvot* (responsa). The Responsa Committee of the Central Conference of American Rabbis (CCAR) regularly publishes Reform responsa, which are authored or edited by its chairman. The responsa of Solomon Freehof (1892–1990), Walter Jacob (1930–),[30] and Mark Washofsky (1952–),[31] each of whom once presided over the responsa committee, are therefore essential for the understanding of Reform Jewish bioethics, since aside from a few articles in the organization's own journal, the (CCAR Journal: The Reform Jewish Quarterly), not many Reform voices are part of the Jewish discourse. In Israel, Moshe Zemer (1932–2011), co-founder of the Israel Movement for Reform and Progressive Judaism, published on bioethical topics.[32] Additionally, Walter Jacob and Moshe Zemer coauthored essays and responsa of medical halakhic interest from a Reform Jewish perspective as a result of their collaboration in the international Solomon B. Freehof Institute for Progressive Halakhah.[33]

A decisive difference between Orthodox *posqim* and the Reform Jewish responsa committee is the differing authority attributed to these persons and their writings. A fundamental concept of liberal Judaism is autonomy, i.e. the concession to the individual not to place religious duty above personal power of decision. Thus, Reform responsa contribute to the elucidation of situational problems, but do not have the function of a binding and religio-legal instruction, as is the case with Orthodox *t'shuvot*. Though the method and framework of Liberal Halakhah fits with the purpose of responsa, it is not entirely relatable to the (non-)practice and lived-in world of Reform Jews.

While *posqim*'s rulings are the normative source for medical Halakhah, academic and contextual evaluations of these rulings on matters of bioethical relevance have been undertaken by several academic scholars. For example, Alan Jotkowitz, an Israeli professor of Jewish medical

[29]Unfortunately these guides have vanished recently from the organization's website. But since they have been used as information material for congregations and individuals interested in the topic, they are nevertheless considered in this study.

[30]See Jacob, *American Reform Responsa*, *Contemporary American Reform Responsa*, *Questions and Reform Jewish Answers*, *Medical Frontiers and Jewish Law*.

[31]See Washofsky, "Reform Jewish Bioethics," "Absence of Method," "The Woodchopper Revisited."

[32]See Zemer, "Determining Death."

[33]See Jacob and Zemer, *Death and Euthanasia in Jewish Law*, *Aging and the Aged*, *Fetus and Fertility*.

ethics and Jewish thought, focuses on the decision-making of Moshe Feinstein[34] and Joseph D. Soloveitchik.[35] Melanie Mordhorst-Mayer et. al employs comparative methodology when evaluating Waldenberg's and Feinstein's responsa and debate on abortion.[36] In their work, they capture the difference of opinion between the two *posqim* with respect to their individual halakhic argumentation and socio-cultural contexts.[37] Within gender studies, Ronit Irshai applies a feminist perspective to the discussion of the *posqim*'s rulings on abortion. Especially noteworthy is her monograph on feminist perspectives regarding fertility and Jewish law.[38] At the intersection of Jewish law and legal history, Daniel Sinclair examines a broad spectrum of biomedical issues. In his study on the legal and extra-legal dimensions of Jewish bioethics, Sinclair elaborates on the connectivity between Jewish law and Israeli law as well as the relationship between halakhic and aggadic text material in bioethical problem analysis. His apt description of bioethical subjects areas that are marked by strong differences within Orthodox Judaism sets his work apart from other Orthodox authors whose normative epistemological goal is accompanied by cascades of rabbinical text passages.[39]

In addition to emic and etic descriptions of halakhic perspectives on matters of bioethical concern, "aggadic approaches" (narrative approaches) are gaining scholarly attention. In his contributions, literary theorist and Reform rabbi William Cutter makes increasing usage of narratives for spiritual care and counseling.[40] As the founder of the Kalsman Institute on Judaism and Health, Cutter's concern is not primarily with bioethical reflection from a Jewish perspective, but rather with the spiritual dimension of patients and the physician-patient relationship in the medical setting. This "narrative turn" also includes story-telling and the narrative tradition in Jewish medical ethics. Jonathan Crane postulates a serious integration of stories for bioethical practice and speaks against the treatment of stories and the narrative approach as an orphan of legal (halakhic) reason-

[34]For an encompassing presentation of Feinstein's contribution to Jewish medical ethics see Jotkowitz, "Feinstein and Medical Ethics." For Feinstein's perspective on the role of autonomy in medical decision-making see Jotkowitz, "Feinstein and the Role of Autonomy," "Abortion and Maternal Need." The latter further includes a discussion of Feinstein's perspective on abortion.

[35]See Jotkowitz, "Soloveitchik and Medical Ethics."

[36]See Mordhorst-Mayer, *Responsen zum Schwangerschaftskonflikt*; Mordhorst-Mayer, Rimon-Zarfaty, and Schweda, "Halakhic Debate on Abortion."

[37]The inclusion of social factors into the evaluation of decision-making processes is a major concern of the present study as well.

[38]See Irshai, *Fertility and Jewish Law*.

[39]See Sinclair, *Jewish Biomedical Law*, "Patient Autonomy and Brain Death," "Legal History of Brain Death."

[40]See Cutter, *Healing, Midrash & Medicine*.

ing.[41] Alan Jotkowitz's scholarly articles focus on the interrelationship of narrative and normative aspects in Jewish medical ethics.[42]

Noam Zohar takes a fresh look at Jewish bioethics from a philosopher's perspective. In his "Alternatives in Jewish Bioethics," Zohar uses three ethical models (universalism, moral relativism, and pluralism) to consider whether there can be a specifically Jewish bioethics at all. He further approaches bioethical issues from a non-normative and nonjudgmental perspective and addresses them in a dialectical manner at the intersection of Jewish sources, principles and Western philosophy.[43] The discussion of ethical conundrums at the intersection of Western concepts and Jewish sources contributes to a broad foundation for a productive scholarly exchange on Jewish bioethics.[44]

Aviad Raz, Silke Schicktanz, and Carmel Shalev conduct cross-cultural comparisons employing empirical methods. Insights from their study on the dilemmas of genetic testing and euthanasia in Israel and Germany,[45] especially with regards to handling micro and macro aspects, were helpful for the present dissertation. Similarly, this dissertation deals with several comparative micro and macro levels of national and religious scope.

1.2 Data and Methods

The topic of this study is based on a distinctive contemporary research question: How do religious specialists, i.e. rabbis in different professional settings, conceive and negotiate religious—and therefore usually elitist—discourse as part of the macro structure of "tradition" regarding biomedical issues in their professional practice with congregants and patients? However, this study's approach relies on historicity and contextualization, since the relevant historical and sociocultural contexts are necessary factors in order to fully grasp the various styles of rabbinical practice and social encounter in the realm of bioethical decision-making.

The research design includes a comparison of rabbinical practice regarding biomedical questions involving two major sectors of Judaism: Orthodox Judaism and the Reform Movement. Focus is not on one denomination only, but instead provides a broader perspective and thus prevents a one-sided presentation of Jewish ethical-decision making in practice. Therefore, I sub-

[41] See Crane, *Narratives and Jewish Bioethics*. The author examines the different perspectives of bioethicists in their use of the story of Chananja ben Teradjon for end-of-life bioethical decision-making.

[42] See Jotkowitz, "Nomos and Narrative," "Stories."

[43] See Zohar, *Alternatives in Jewish Bioethics*.

[44] See Zohar, *Quality of Life*.

[45] See Raz and Schicktanz, *Comparative Empirical Bioethics*.

scribe to the postmodernist vision of deconstructing the "rhetoric of authority and [...] facilitate[ing] polyvocality."[46] Conservative perspectives are not included in the sampling primarily because another comparative layer was not feasible due to limited time and human resources. However, a comparison between Israel and the United States is relevant due to contextual differences of Jews being part of a majority or minority population. In fact, these differences seem to influence halakhic decision-making in some matters.[47] The conceptual advantage and the goal of this study is to highlight the complexity of bioethical practice in the rabbinate and hospitals. This complexity, with its irregularities, exceptions, systematic difference, and logic of real life, challenges the notion of ethical absolutes. Such complexity also has its share of disadvantages, such as a certain inconsistency or incommensurate categories for comparison. Thus, as elaborated in the following, I do not provide a 1:1 comparison of national, religious, and professional settings.

1.2.1 Sampling

The present study is based on empirical data, collected from altogether 52 interviews, 49 of which have been transcribed and analyzed.[48] Data was gathered during three research stays: once in the greater New York area (2010) for three months and twice in Israel (2011 (four months) and 2016 (three weeks); mainly in and around Jerusalem). Both locations are the world's largest Jewish metropolitan areas, in terms of population and religious diversity. Furthermore, Americans and Israelis predominantly make up the discursive field of Jewish bioethicists, medical Halakhists, and academia who are preoccupied with bioethical issues of religious, social, cultural and national importance.[49]

A literature review on Jewish bioethics and medical Halakhah informed the development of semi-structured interview guides, with probes for investigation of specific themes. Three semi-

[46] Seale, *The Quality*, p. 13 referencing Game, A. *Undoing the Social: Towards a Deconstructive Sociology*. Buckingham: Open University Press (1991).

[47] As for example Shlomo Zalman Auerbach's comments regarding the question of brain death and organ donation.

[48] Three interviews are not included in the study's evaluation: One interview was conducted with an independent Orthodox rabbi in Israel, who, in hindsight, did not meet any of the sample's criteria. Another interview is partially transcribed, but was conducted while the interviewee fulfilled her parental responsibilities. The interview occurred during two playground sessions and while walking, thereby not producing good data, especially due to the poor audio quality. A third interview was neither translated nor analyzed, having been conducted in Swiss German/German. The interviewee, who is one of the few spiritual care workers in Israel, was not interviewed in her professional function. A separate sample of Israeli spiritual care workers was not feasible during the remaining time of the study. Thus, the interview's content was used to contact experts in the field who set up the spiritual care movement in Israel.

[49] Although data gathered in 2010 and 2011 may seem outdated, its analysis focuses primarily on questions transcending technological aspects, such as role reflection and practice. Thus, the results remain valuable.

structured interview guides were devised in English—one for Orthodox pulpit rabbis, one for pulpit rabbis of Reform congregations, and one for rabbis and/or chaplains in hospitals. Both guides for congregational rabbis were also used with the Israeli sample, albeit slightly shortened. Between the research stays in 2010 and 2011 the focus of the interview questions became more defined, making a few questions no longer relevant, such as those regarding cloning and stem cell research.[50] Additionally, separate semi-structured guides were created for the expert interviews in Israel, depending on the expert's field of expertise. All interviewees were given the possibility to choose the location where to have the interview: workplace, family home, or public space (e.g. coffee shop). They signed a consent form, thereby confirming the author's right to use the collected interview material for her dissertation and further publication.

This study employed a mix of purposive-selective and snowball sampling. In purposive sampling, the purpose one wants informants to serve is decided and not, as in theoretical sampling, constantly readjusted in order to generate theory based on data.[51] Despite Sandelowski's assertion that all sampling, even grounded theory driven theoretical sampling, is purposeful, sampling in New York was based on the decision "to sample subjects according to a preconceived, but reasonable initial set of criteria."[52] The sampling method used for this study also meets Sandelowski's criteria of selective sampling, a subcategory of purposeful sampling.[53] In order to obtain the information needed to meet the study's goals, Orthodox and Reform Jewish pulpit rabbis were contacted. Initially, this target group did not consist of experts in Jewish bioethics, since information regarding rabbis' professional practice and experiences as contact persons for congregants/patients was sought. In the greater New York area, initial contact was made using a list of all Jewish congregations and organizations found on the internet. In order to be responsive to real-world conditions, especially due to the study's context-sensitive character, the research design and sampling strategy remained "sufficiently open and flexible to permit exploration of whatever the phenomenon under study offers for inquiry."[54]

After the first few interview requests, snowball sampling was added to the selective inquiry process, a technique used in studies of social networks.[55] A well-known advantage of "snowballing" is the enhanced positive response rate, since the stranger requesting an interview brings with her some credentials. In order to understand and describe the respondents role and place in the pro-

[50]The interview guides are part of the appendix.

[51]See Bernard, *Social Research Methods*, p. 176.

[52]Sandelowski, Holditch-Davis, and Harris, "Using Qualitative and Quantitative Methods," p. 302.

[53]See Coyne, "Sampling in Qualitative Research."

[54]Lincoln, Y. S. and E. G. Guba. *Naturalistic Inquiry*. Sage Publications: Beverley Hills, California (1985) as cited in ibid., p. 630.

[55]See Bernard, *Social Research Methods*, pp. 178–179.

fessional network, which is especially relevant within the Orthodox community due to its hierarchical structure regarding religious authority in halakhic decision-making processes, they were asked about their professional contacts during the interview. Not all respondents felt comfortable to name the people they interact with. However, some rabbis who were unavailable for an interview nevertheless named either someone they knew who was knowledgeable about the topic or revealed who they (would) contact in a case that supersedes their competence.

Snowballing and the "who knows who" effect led to the addition of another target group for sampling. Several pulpit rabbis indicated that they contact chaplains in hospitals or that chaplains are "the people you have to talk to." The healthcare chaplains of both denominations were more willing to be interviewed and fiercely shared their supportive professional network. In addition to their main duties as pastoral care givers, some Orthodox healthcare chaplains are responsible for hospital *kashrut* supervision and other specifically Jewish needs, primarily regarding Shabbat and holiday observance. Most chaplains, especially those of the younger generation, hold a degree in Clinical Pastoral Education (CPE), required by most hospitals today. All healthcare chaplains are ordained rabbis. Of the total sample, 38% consists of chaplains of both denominations and 59% of rabbis in congregations/organizations.[56]

The Orthodox sample consists of Modern/Centrist Orthodox and Ultra-Orthodox (*haredi*) interviewees. The Orthodox sample consists of 40% Ultra-Orthodox and 60% Modern Orthodox. With the exception of one, all interviewed *hasidic* rabbis are Chabad Lubavitch.[57]

In the United States, of 95 interview requests, 29 agreed to be interviewed. The response ratio of approximately 1:3 was consistent among Reform and Orthodox sub-samples. The New York sample consists of 31% Reform respondents, 41% Modern Orthodox respondents, and 28% Ultra-Orthodox respondents. Thus, the Orthodox sector comprises more than two thirds of all

[56]Rabbi Dr. med. Edward Reichman (i.e. 4% of the sample) does not count towards either professional samples, but is considered an expert for Jewish bioethics.

[57]56% of the interviews with interlocutors affiliated with the Reform Movement took place in Manhattan (22% in the Bronx and Westchester County, and 22% in Brooklyn). The interviews were conducted at the interviewees' workplace in 89% of the cases. Only one person, a chaplain working at a hospital in Manhattan (11%), wished to meet in a coffee shop.
In comparison, the Orthodox sample shows an equal institutional distribution between Manhattan, 40%, and Brooklyn, 40%, with an additional 5% each for the Bronx, Queens, Long Island, and Westchester County. If we differentiate between Modern Orthodox and Ultra-Orthodox, a clear cut distinction is noticeable: 58% of all Modern Orthodox interviewees are professionally Manhattan based, with 8% each for Brooklyn, Queens, Long Island, and Westchester County, while 87.5% of Ultra-Orthodox are Brooklyn based, and only 12.5% Manhattan based (0% in other boroughs). 85% of all interviews with Orthodox interlocutors were conducted at their workplace, 15% in family homes. Although this study does not draw conclusions from geographical data, the institutional distribution is still worth mentioning. Congregations and institutions of the *haredi* milieu are heavily Brooklyn-bound, while the majority of Modern Orthodox and Reform congregations and chaplains are located in Manhattan. Furthermore, all four chaplains who were employed by hospitals in Brooklyn are Orthodox (three *haredi*, one Modern Orthodox).

these interviews. While 29 interview requests were directed at Reform rabbis, 66 were directed at Orthodox rabbis. The reason for this inequality in initial requests is due to the fact that there are more Orthodox congregations and organizations than Reform ones. However, Reform congregations are much bigger in size. The largest congregation represented in the sample, though not the largest in Manhattan, has a membership of 1500 families (900 children in all programs). Though membership numbers were not consistently inquired, Orthodox congregations are smaller.

In Israel, a total of 23 interviews were conducted. Percentages of Reform and Orthodox (*dati/haredi*) interviewees are similar to those of the New York sample: two third Orthodox (65%) and 22% Reform.[58] The search for suitable interviewees resulted in a network of informants consisting of fewer "classical" Orthodox pulpit or local rabbis compared to the New York sample. This is due to the different structure of religious communitization in Israel. The country's Jewish majority leads to a weaker need for organizing into congregations. Therefore, participant recruitment in the Israeli setting proved to be rather challenging. These challenges, that are worthy of further analysis, will be addressed in the next chapter. Though religious structures of American Orthodox differ from that of Israeli *datim*, sampling of Reform pulpit rabbis in Israel is consistent with that done in New York. Reform informants were easily accessible and available for interviews, making purposive-selective sampling feasible. Of 19 inquiries made to potential Reform participants, five agreed to be interviewed. However, this strategy was not conductive to recruiting those from the Orthodox sector. Poor recruitment of Orthodox interviewees, i.e. the "non-existent pulpit rabbis," furthered the search for religious specialists who may be contacted by Jews or patients, i.e. non-congregants, in other places. Such people were contacted and available for interview. However, doing so changed the study's dynamics for comparison. Acknowledging these different social realities, with their consequences for bioethical decision-making, further enabled a context-sensitive analysis.

There are three major differences between the American and Israeli samples. First, the Orthodox interviewees who are not pulpit rabbis are experts for medical Halakhah. Second, in 2011, healthcare chaplaincy, or rather *livui ruhani* in Israel, was practically non-existent. By 2016, when another round of interviews was conducted, Israeli experts and pioneers of the Israeli spiritual care movement were contacted.[59] Third, instead of an established professional field for Jewish chaplains with rabbinical ordination, there are four "religious" hospitals in Israel where rabbis act as halakhic decision-makers. These rabbis decide on all halakhic matters that need to be set-

[58] Two interviewees were secular, one Conservative.

[59] Contrary to the sample in New York,the quality/quantity of the data that was collected in Israel in 2011 was not fully satisfactoy. To better understand some patterns and processes, additional interviews were necessary. In 2016, another short research stay Israel produced added another round of interviews.

tled in a hospital, ethically relevant issues included. As a variation to the religious hospital setting, one interview was conducted with a rabbi of a large hospital that is secular and not under *haredi* auspices.

Ten out of 52 interviews, i.e. 19.2%, were conducted at the respondent's family home. Of those who chose to be interviewed at home, 90% are Orthodox. The "lacking office" or preference to meet at home was remarkably high within the *haredi* sector. The rate of respondents who preferred to have the interview in their family home was almost three times higher in Israel than in the States (27.28% in Israel versus 10.34% in New York). Also four times more often the interview took place in a coffee shop or similar public space in Israel than in the States (18.18% versus 3.45%). Interviews at workplaces occurred at a rate of 54.55% in Israel versus 86.21% in New York. Thus, professionals in Israel open their family homes more often for professional meetings than is the case in the States. In many cases this added to a rather informal interview situation.

The matter of participant anonymization was greatly considered. Since interview content was by and large not sensitive, as is the case in studies with patients, consent forms did not mandate strict anonymization, except when explicitly expressed by the interview partner. However, respondents' real names are generally not used in order to protect the identity of those who are not experts, but were nevertheless willing to share personal and professional information that sometimes included unnamed patients. The names of experts, who feature more in the Israeli sample, are not pseudonymized. Interviewees who have passed away since being interviewed are not pseudonymized either. Pseudonymized interviewees are marked with a (p) in the footnotes, e.g. Mia Oppenheimer (p). All pseudonyms are fictitious. Any names resembling those of real people is purely coincidental. Family names are distributed randomly and are not informative of the interviewee's cultural background.

1.2.2 Methodology

1.2.2.1 Qualitative Research and Data Analysis

Qualitative data analysis (QDA) is a set of procedures and reflexive processes that a researcher runs through, using collected data in order to explain, comprehend, and interpret situations for the research question at hand. Data from respondents may be gathered via various methods, such as participatory observation, interview, and written discourses. QDA is based on interpretive sociology, applying a reflexive, analytical, and inductive strategy. The goal is to examine meaningful

and symbolic content to gain an in-depth understanding of human behavior and the reasons that govern it.[60]

A common critique of qualitative research questions the validity and reliability of its analysis. First, due to small sample size, results are not necessarily representative of the broader population. This is generally an argument brought forth by linking reliability to representation, best achieved via quantitative methods. However, the goal of small scale qualitative studies is not representation. Critics of small study samples also claim that it is difficult to deem results as authentic or to generalize them. However, generalizations are not the primary goal of qualitative research, especially since there are options to evaluate on the level of the concrete.[61] The strength of QDA is its "unrivaled capacity to constitute compelling arguments about how things work in particular contexts and qualitative research can produce very well-founded cross-contextual generalities."[62]

Second, another critique pertains to the issue of validity in qualitative research, especially when compared to quantitative studies: "In the case of qualitative observations, the issue of validity is not a matter of methodological hair-splitting about the fifth decimal point, but a question of whether the researcher sees what he or she thinks he or she sees."[63] As opposed to the natural sciences, social science is the exploration of a certain subject "not through one lens, but rather a variety of lenses which allows for multiple facets of the phenomenon to be revealed and understood,"[64] and thus contributes to a researcher's reflective process. Furthermore, the notion of an objective observer is untenable and the epistemological framework of QDA not compatible with positivist empiricism. Reliability of qualitative research is challenged also with respect to a persisting divergence between what people say and what they actually think and do.[65] In other words, how does one know whether a respondent tells the truth?

1.2.2.2 Thematic Analysis

As Vaismoradi et al. correctly note, "qualitative methodologies are not a single research approach, but different epistemological perspectives and pluralism have created a range of 'approaches' such as grounded theory, phenomenology, ethnography, action research, narrative analysis, and discourse analysis."[66] This list of options are only a few approaches to QDA. Though it proved chal-

[60] See Chowdhury, "Coding, Sorting and Sifting," p. 1136.

[61] See Weiss, *Learning from Strangers*, pp. 151–182.

[62] Chowdhury, "Coding, Sorting and Sifting," p. 1139 citing Mason, J. Qualitative Researching, 2nd ed., Sage Publications: London (2005).

[63] Kirk and Miller, *Reliability and Validity*, p. 21.

[64] Baxter and Jack, "Qualitative Case Study Methodology," p. 544.

[65] See Chowdhury, "Coding, Sorting and Sifting," p. 1137.

[66] Vaismoradi, Turunen, and Bondas, "Content Analysis and Thematic Analysis," p. 398.

lenging to decide upon a specific approach, it was clear from the outset that "methodolatry," strict epistemological commitments and methodological rigor, do not suit the present research design.[67]

Grounded theory was rejected in favor of thematic analysis in order to identify, analyze, and report repeated patterns of meaning, or themes, across the data set, e.g. interviews, focus groups, media, or texts.[68]

> Themes or patterns within data can be identified in one of two primary ways in thematic analysis: in an inductive or 'bottom up' way, or in a theoretical or deductive or 'top down' way. An inductive approach means the themes identified are strongly linked to the data themselves (as such, this form of thematic analysis bears some similarity to grounded theory). In this approach, if the data have been collected specifically for the research (e.g., via interview or focus group) the themes identified may bear little relationship to the specific question that were asked of the participants. [...] In contrast, a 'theoretical' thematic analysis would tend to be driven by the researcher's theoretical or analytic interest in the area, and is thus more explicitly analyst-driven.[69]

The strength of thematic analysis lies in the flexibility of the method that allows for a wide range of analytic options, while being basically independent of rigid theoretical and epistemological frameworks. Use of semi-structured interview guides enabled both inductive and deductive approaches of thematic analysis.[70] Deductive thematic analysis naturally followed from themes and specific probing questions that were integrated into the interview guide. Thematic analysis also comes with a choice of either essentialist/realist, contextualist, or constructionist epistemological paradigms.[71] Qualitative research within the broader disciplinary field of cultural studies does generally subscribe to constructivist epistemological approaches. Hence, such research "explores what it assumes to be a socially constructed dynamic reality through a framework which is value-laden, flexible, descriptive, holistic, and context sensitive; i.e. an in-depth description of the phenomenon from the perspectives of the people involved."[72] The present project's research design, theoretical framework and approach are therefore rooted in a contextualist-constructivist epistemological framework.

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[67]Methodological fetishism has also been fiercely rejected by Pierre Bourdieu, whose theoretical writings, informed by his empirical studies, are introduced in the next sub-chapter: "The sophistication of techniques of observation and proof can, if it is not accompanied by a redoubling of theoretical vigilance, lead us to see better and better fewer and fewer things." (Bourdieu and Wacquant, *Reflexive Sociology*, p. 28).

[68]See Braun and Clarke, "Thematic Analysis."

[69]Ibid., p. 12.

[70]The term "theoretical," preferred by Braun and Clarke, is exchanged in favor of "deductive" in order to refer to a top-down approach to data analysis. Reason being, there should not be a confusion with theory qua theory independent of methodology, e.g. practice theory or structuration theory.

[71]See Braun and Clarke, "Thematic Analysis."

[72]Yilmaz, "Quantitative and Qualitative Research," p. 312.

Thematic analysis was applied to 49 English transcripts. After an initial familiarization with the data while transcribing, re-reading, and generating ideas, the data was then coded with Atlas.ti, a computer-assisted/aided qualitative data analysis software (CAQDAS). Coding is an integral part of the iterative qualitative data analysis process.[73] The generation of initial codes is a process often referred to as tagging, a basic inductive way to link respondents' answers to concepts and categories and to sort data in order to prepare the material for analysis. Part of this process is the compilation of memos that may contain ideas, theory, or the research question that are then linked to the codes. Memos are an important means of analysis, because they allow for an early start of data evaluation in a creative and unburdened way.

The next phase requires searching the data for themes and is performed alongside coding.[74] What Clarke and Braun term as "themes" or "patterns" may be well identified with clusters, or code families in (CAQDAS). Themes were gradually formed and further revised, adjusted, and specified in the course of subsequent evaluation. Due to the large body of data, the process of sorting and grouping the material took place at an early stage of analyis. Thus, the emerging code tree was created and revised on multiple occasions.[75] A separate memo to track the development of the code tree was used. The following image illustrates the transition of a code family initially employing an inductive approach to one employing a deductive approach. It specifically notes the emergence of a theme addressed in the interviews that subsequently turned into two chapters of this dissertation: Rabbinical discourse and practice regarding brain death and organ donation.

[73]The coding was accomplished in the manner taught during the Atlas.ti workshop at the *Religionswissenschaftliches Seminar* at the University of Zurich in January 2017. Data analysis is based on the handbook for the software aided qualitative analysis with Atlas.ti.

[74]See Vaismoradi, Turunen, and Bondas, "Content Analysis and Thematic Analysis," p. 403.

[75]See T. Richards and L. Richards, "Using Hierarchical Categories," p. 89.

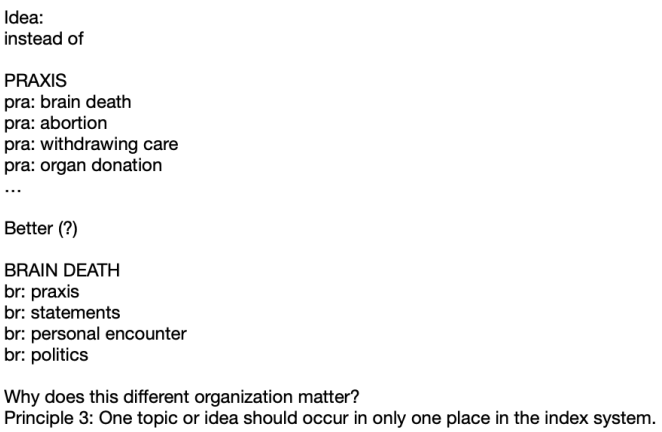

Figure 1.1: Screenshot of a memo in the code book.

Next, themes for an in-depth analysis were determined and the present chapters of this dissertation formed. Analysis with Atlas.ti included the word cruncher tool, code-document tables, and code-co-occurrence tables.

Inductive thematic analysis was applied to the theme of rabbinic role reflection and professional networks (chapter three), and deductive thematic analysis was used for the topics regarding brain death and organ donation (chapters four and five). These chapters employ an issue-focused code strategy. However, all chapters also draw from stories and single cases. Since thematic analysis may be understood to be a sub-category of narrative analysis, the shift of perspective away from codes towards story is compatible with the methodological framework of this project.[76]

1.2.2.3 Notes on the Text

Some of the abductive research process is displayed on a textual level. Rather than addressing research practical issues separately, it is captured within a gray box. This tool, which is sometimes adopted by ethnographers, integrates thoughts and reflections regarding the research process (or any other kind of research difficulties) into the running text without interrupting the narrative flow.[77]

Interview quotations contain the following signs: Omissions in the text are indicated by a square bracket with three dots [...]. Round brackets are used to indicate short (.), middle (..), and long (...) speech pauses. A long speech pause is understood to be an interruption of the speech flow for approximately seven or more seconds. Words in square brackets [word] are comments

[76] See Riessman, *Narrative Methods*.
[77] See Heilman, *When a Jew Dies*.

that were added by the author to improve text comprehension. /1/2/3/4 attached to an interview partner's name in the footnotes indicates whether the quoted passage is part of an interview's first, second, third, or fourth audio file. During some interviews the recording had to be stopped. Each restart generated a new audio file. Thus, a transcript may contain text from several audio files that each start at time stamp 00:00:00-0. For example, Bugsy Cohen/2 (p) at time stamp #00:00:08-4# means that the interviewee's name is pseudonymized and the quotation found in the second part of the transcript at time stamp #00:00:08-4#. The transcripts are part of the appendix.

1.3 Practice Theory

Just as thematic analysis permits methodological flexibility, Bourdieuan theory of practice allows for a theoretical flexibility.[78] Pierre Bourdieu's conceptions, particularly those of habitus, practice, fields, and capital, provide a useful lens for examining the Jewish "religious" field and rabbis' professional role. However, the present study is based on empirical findings, and therefore is not obliged to adhere to any grand theories.

In contrast to such social theory, Bourdieu's sociological program is rather an "invitation to (re)think Bourdieu by thinking along with him [...] Therefore an invitation to think with Bourdieu is of necessity an invitation to think beyond Bourdieu, and against him whenever required,"[79] as Loïc J. D. Wacquant concludes in their co-authored work "An Invitation to Reflexive Sociology." Michel Foucault similarly regards his own discursive interchange with primary sources, i.e. philosophers and mainly Nietzsche: "For myself, I prefer to utilize the writers I like. The only valid tribute to a thought such as Nietzsche's is precisely to use it, to deform it, to make it groan and protest. And if commentators then say that I am being faithful or unfaithful to Nietzsche, that is of absolutely no importance."[80]

Wacquant concisely describes Bourdieu's research style and its attraction for those who like to engage with their research at the intersection of empirical results and theoretical knowledge. Bourdieu's opposition to the "dogmatization of thought that paves the way for intellectual orthodoxies" is especially valuable for research questions—like that of the present study—whose inter- and trans-disciplinary alignment refute "intellectual orthodoxies." Bourdieu rejects the no-

[78] The theory of practice is compatible with thematic analysis for at least one major reason: the emergence of themes during coding and analysis is not a passive process, i.e. reviewing material until themes emerge, but an active one on the part of the researcher. Similarly, the theory of practice hypothesizes that objects of knowledge are constructed and not passively absorbed. (See Bourdieu and Wacquant, *Reflexive Sociology*, p. 121)

[79] Ibid., p. xi.

[80] Foucault, *Power/Knowledge*, pp. 53–54.

tion of a duality between individual and society. He maintains a methodological relationalism that informs his conceptualization of the dialectic of social and cognitive structures (i.e. *habitus*) and his comprehension of the ties between theory and empiricism.[81].

For Bourdieu, the interdependency of theory and empiricism is the cornerstone of his sociological and anthropological research practice and thinking. He criticizes scientific objectivism when models are projected onto social groups. During his field study in Kabylia, Bourdieu realized that marital behavior cannot be understood as a mere observance of rules and structures. Informants stated official, "honor-preserving" interests, and simultaneously concealed other reasons for a certain behavior. According to Bourdieu, there is a discrepancy between objective structures and motives for conduct. This discrepancy may be dissolved, if studies proceed from everyday behavior. Structures only emerge in practice.[82] This perspective is particularly relevant in the following chapters that detail the discrepancy between objective religious structures, such as Jewish Orthodox normative religio-legal frameworks, and the actual behavior (or rather the reported/reflected motives) of congregants. Such practical variation is also observable within Reform structures, albeit differently, whereby social behavior is not predetermined by religious law, but by objective structures relevant for the identity of Reform Jews.

Bourdieu's writings and concepts that are most relevant for the present study include "The Logic of Practice" and the "Outline of a Theory of Practice." Based on his field research in Kabylia, Bourdieu deepened his perspectives on structure and action theory by balancing the advantages and disadvantages of each and creating a synthesis of the two with his theory of *habitus*.[83]

> The habitus—embodied history, internalized as a second nature and so forgotten as history—is the active presence of the whole past of which it is the product. As such, it is what gives practices their relative autonomy with respect to external determinations of the immediate present. This autonomy is that of the past, enacted and acting, which, functioning as accumulated capital, produces history on the basis of history and so ensures the permanence in change that makes the individual agent a world within the world.[84]

Habitus generates strategies of behavior and tends to reproduce the objective conditions of production which in turn have led to its (i.e. the *habitus*) creation. Thus, Bourdieu's theory of practice assumes that objective structures are related to subjective structured dispositions in a dialectical manner and therefore "establishing an experimental science of dialectic of the internalizaton of externality and the externalization of internality, or, more simply, of incorporation and objectifica-

[81]See Bourdieu and Wacquant, *Reflexive Sociology*, p. xi.
[82]See Steiner, *Bourdieu lesen und verstehen*, p. 15.
[83]See Schmeiser, "Pierre Bourdieu," p. 170.
[84]Bourdieu, *Logic of Practice*, p. 56.

tion."[85] Bourdieu's main concern is not what he calls the *opus operatum*, the structured structures, but the *modus operandi*, the constitution of structures of practice. The theory of *habitus*, rooted in practice, thus contributed to the intellectual overcoming of the dichotomies of structure and agency, objectivism and subjectivism.

In "An Invitation to Reflexive Sociology" Bourdieu further emphasizes the main purpose of *habitus* as breaking with the intellectualist philosophy of action, which had become popular with adoption of rational choice theory. He therefore creates the concept of *habitus* to explain the actual logic of practice, "an expression in itself oxymoronic since the hallmark of practice is to be 'logical,' to have a logic without having logic as its principle."[86] It is a theory of practice that constitutes the product of a *practical sense*, or a socially constituted sense of the game.[87]

The metaphor of game is also relevant to Bourdieu's concept of "field:" He contends that to think in terms of field is to *think relationally*. A field is comparable to a game.

> Players agree, by the mere fact of playing, and not by way of a 'contract,' that the game is worth playing, that it is 'worth the candle,' and this *collusion* is the very basis of their competition. We also have *trump cards*, that is, master cards whose force varies depending on the game: just as the relative value of cards changes with each game, the hierarchy of the different species of capital[88] (economic, social, cultural, symbolic) varies across the various fields.[89]

A general property of fields is that they constitute relational systems that are independent of the populations which define these relations. Bourdieu uses the term "field" to remind social researchers that the essential object of social research is not the individual, despite the fact that a field is comprised of individuals, who, along with institutions, provide the necessary information for statistical analysis. It is the field that must be the focus of research. In highly differentiated societies, the social cosmos consists of a number of relatively autonomous social microcosms. Bourdieu highlights the economic, literary, artistic, intellectual, and religious fields. They are spaces of objective relations, subjected to a specific logic and necessity that are specific and irreducible to those that regulate other fields.[90]

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[85] Bourdieu, *Theory of Practice*, p. 72.

[86] Bourdieu and Wacquant, *Reflexive Sociology*, p. 120.

[87] Ibid., pp. 120–121.

[88] The concept of "capital" forms another important aspect of Bourdieuan theory of practice. The type of "capital" most relevant for the study's analysis is social capital, especially with respect to the role reflection and processing of bioethical issues in congregations and beyond. Social capital (as well as symbolic capital) is perpetuated within different structures of authority and relationships of trust. It influences the way people form, maintain, and profit from communities, e.g. congregations. For the religious field, another form of capital, namely spiritual capital, may be relevant. See Verter, "Spiritual Capital."

[89] Bourdieu and Wacquant, *Reflexive Anthropologie*, p. 98.

[90] See ibid., pp. 94–107.

Thus, when I use the term "religious field," I specifically mean the Jewish religious field. Bourdieu studies a specific field, such as the artistic or literary field, in respect to its interrelationship with other fields, such as the economic, and its position vis-à-vis the field of power. Thus, Wacquant asks how these differentiated fields interrelate when they have both invariant properties (general theory of fields) and varying properties rooted in their specific logic and history that requires a genetic (genealogy; Foucault) comparative analysis.[91] Within the present study, the religious field, which may be split along denominational lines, the scientific field, and, especially in Israel, the political field are often interrelated. However, in addition to what seems to me a claimed external field of power by Bourdieu, I believe such power structures reside within the fields themselves. As will be elaborated later in the following chapters, different fields have their specific power struggles, which at times are due to incompatible paradigms and epistemological aims (scientific knowledge, religious knowledge, political interests).

Bourdieu's concept of field is especially worth considering in its difference to other seemingly similar constructs, such as Althusser's concept of "apparatus" or Luhmann's system theory. In contrast to Althusser's functionalist perception of state apparatuses, such as schools, media, or the Church, which aim to describe the effects of ideology on individuals, a field's "agents and institutions constantly struggle, according to the regularities and the rules constitutive of this space of play (and, in given conjunctions, over those rules themselves)."[92] However, in certain historical circumstances a field may morph into an apparatus, like when totalitarian systems' or total institutions' (asylums, concentration camps) domination "are such that the struggle and the dialectic that are constitutive of the field cease."[93]

The difference between Bourdieu's field and Luhmann's conception of social systems results primarily because the notion of field excludes functionalism and organicism. Luhmann's theory of systems is based on biologistic assumptions. The centrality of self-referentiality or self-organization of a system that is characterized by common functions, internal cohesion, and self regulations, is incompatible with field theory. Fields form a system of differences and "distinctive and antagonistic properties which do not develop out of their own internal motion (as the principle of self-refrentiality implies) but via conflicts internal to the field of production."[94] Bourdieu differentiates between the two concepts by once again using the metaphor of game:

> Every field constitutes a potentially open space of play whose boundaries are *dynamic borders* which are the stake of struggles within the field itself. A field is a game devoid of inventor and much more

[91] See Bourdieu and Wacquant, *Reflexive Sociology*, p. 109.
[92] Ibid., p. 102.
[93] Ibid.
[94] Ibid., p. 103.

> fluid and complex than any game that one might ever design. But to see fully everything that separates the concepts of field and system one must put them to work and compare them via the empirical objects they produce.[95]

For this project, the concepts of field and system produce complementary results: For instance, Jewish Orthodox society may be conceived as a religious (sub)field as well as a religious system. The Bourdieuan "field" as a locus of relations of force and struggle is at least partially compatible with the notion of autopoiesis, or self-referentiality of a system. Halakhah is often conceived and practiced as an operative system that is self-referential. This is especially true regarding halakhic formalism. However, as a social practice halakhic decision-making involves "players" in a field primarily aware of their position, secondarily of how the game is played, and thirdly of "possessing a definitive configuration of properties," or symbolic capital, e.g. halakhic authority. Reproduction of the Orthodox social field is therefore correlated to a system of governance of knowledge on the premises of self-referentiality. Fields reproduce *habitus*, and it follows from the above that similar conditions of existence create comparable habitual structures. This in return leads to a homogeneity of *habitus*, a class *habitus*. Such homogeneity causes practices to be immediately intelligible and foreseeable without any problems by agents who possess the same class *habitus*.[96]

Contrary to his general theoretical writings, many sociologists of religion doubt that Bourdieu's writings on religion[97] contribute anything substantial to the sociology of religion, even though the "religious field" is of central importance to his work. In fact, his work on religion has not been applied widely.[98] With respect to Jewish religious cultures, an attempt at direct application of his models ultimately creates various flaws. The extrapolation and generalization of Catholic dispositions on top of Max Weber's classification and dynamics between religious specialists, i.e. priests, prophets, and magicians, is not necessarily applicable to Judaism. "The problem, put simply, is that Bourdieu perceives religion almost exclusively in organizational terms, exemplified particularly by a rather Voltairean image of the Roman Catholic church as an instrument of oppression and exploitation."[99]

This subchapter presents a wide theoretical framework of the study. Occasionally, I also include other theories when evaluating data. Since these theoretical writings are relevant for the comprehension of specific issues in the following chapters, I refrain from introducing them here, but do so where it is most relevant. This includes Hans-Georg Gadamer and Stanley Fish's inter-

[95] Bourdieu and Wacquant, *Reflexive Sociology*, p. 104.
[96] See Bourdieu, *Theory of Practice*, p. 85.
[97] See Bourdieu, *Rede und Antwort*.
[98] See Verter, "Spiritual Capital," p. 155.
[99] Ibid., p. 151.

pretive hermeneutics, Marcel Mauss' concept of "the gift," and Thomas Kuhn's work regarding paradigms.

2 | American and Israeli Religious Cultures in Context: Idiosyncrasies in Communal Life and Spiritual Care

Alaisdair MacIntyre claims that all morality is the result of tradition.[1] This ethical model, known as communitarianism, relies on the premise that human beings are social animals and not isolated individuals. In contrast to liberalism and a liberal understanding of personal autonomy, communitarian theory roots authentic virtue in the context of shared practices and coherent traditions. This divergence of approach to philosophical, political, and educational reasoning is not new at all and has various precursors, such as the Kantian and Hegelian divide. While the former emphasizes the sovereign moral agent, able to abstract from whatever historical peculiarities and idiosyncratic postulations that social groups make upon him or her, the latter insists on the relevance of received roles and obligations over the imperatives of autonomous reason.[2] Liberalism and communitarianism thus have made their impressions on bioethical reflection and shaped the directions of moral reasoning. Both moral concepts are mirrored in social and religious developments within Jewish history, at least since the age of emancipation: Freedom of the individual as moral agent and the striving for autonomy on the one side, and adherence to the tenets of Judaism, a historically grown conglomerate of communal, cultural, and religious manifestations and practice on the other. This chapter is conceptualized as a discussion of the social, professional, national, and religious contexts for the chapters that follow.

The first section elucidates upon the historical formation processes of American Judaism. Discussion of more than 350 years of Jewish settlement, beginning in the northeast and extending over time to the south and west of the continent, refers to a number of determinants that are relevant for the differentiation of the contemporary religious, structural and cultural character of contemporary Jewish communal life in the United States, especially New York City, the area where the interviews for this study were conducted. In section 2.2, considerations regarding the

[1] See MacIntyre, *After Virtue*.

[2] See Callan and White, "Liberalism and Communitarianism," p. 105.

Israeli Jewish spectrum reveal a concept of religion that is almost exclusively based on ritual observance and less integrative of the denominational model of religion as is the case in Western, and especially American spheres. Religion is still predominantly equated with Orthodoxy (*yahadut datit*). Thus, section 2.3 focuses on the two major differences between American and Israeli Judaism, which are relevant for the discussion of bioethical decision-making as a social process by religious agents. The intertwinement of "Jewish denominationalism" and "Jewish congregationalism" is key for understanding American Judaism. In contrast, Israeli religious realities unfold in what I call an "open structure of religious communitization," tensely operating within a religious-secular divide and a powerful, exclusively Orthodox, religious establishment.

The last section introduces the concepts of Jewish healthcare chaplaincy and spiritual care. Ordained rabbis who are engaged in congregations, religious organizations, and various other institutions, deal with issues of medical treatment and illness as part of their wider professional duties. However, the United States developed an inter-faith chaplaincy model that trains and certifies Christian and Jewish clergy to serve as pastoral care providers in hospitals and nursing homes. Jewish healthcare chaplains not only provide spiritual care to patients, family members, and staff, but sometimes also are involved in bioethical decision-making processes, while lacking normative authority of the pulpit. Additionally, Orthodox chaplains are often responsible for the correct service of all matters regarding Jewish ritual law in the hospital. Israeli reality differs considerably when it comes to spiritual care. Since it is a new phenomenon, its implementation into the Israeli healthcare system is only beginning and the system does not primarily rely on ordained rabbis.

2.1 American Judaism: Between Unity and Fragmentation

A recurrent topos of American Judaism has always been the tension between what can be described as unity of the Jewish people and the religious-structural difference that has emerged over time in the formation of different Jewish denominations. An important factor in this relationship has been the determination of boundaries. On the one hand, religious delimitation among Orthodoxy, the Conservative and Reform Movements, as well as Reconstructionism clarifies the different positions on various matters, which ever since the Haskalah (Jewish Enlightenment) had led to theological, ritual, and structural schisms. On the other hand it has been necessary to determine the boundaries to the non-Jewish environment and asking how to blend in and adapt to the new environment without provoking the loss of "Jewish identity" in a place with no previous Jewish social and cultural infrastructure. In his study on the Ultra-Orthodox milieu, Haym

Soloveitchik[3] claims that the loss of identity boundaries is answered by mixing, recreating old distinguishing features, or embracing other sources of distinctness. Much of American-Jewish history of the last 60 years is a result of the intertwinement of these conflicting reactions. Furthermore, major Jewish immigration shifts between 1840 and 1920, mainly from Central and Eastern Europe, presented a challenge to already existing structures. As a result, between eighty and ninety percent of American Jewry today has Eastern European roots.[4]

2.1.1 Beginnings

The colonization of the North American continent by Jews began in 1654, when a French frigate with 23 Jewish refugees from Recife[5] (Brazil) harbored in New Amsterdam, later to be known as New York. Although Jewish traders from the Netherlands used to settle in New Amsterdam on a short term basis, the history of the Jews in North America only begins with the establishment of a permanent settlement of these refugees, who did not seek to return to Europe after the Portuguese had reconquered Brazil from the Dutch. Scholars assume that the "23" intended to stay on the Caribbean Islands, where imposing Jewish communities evolved within the next decades. However, they anchored in New Amsterdam instead.

Contrary to European countries, where Jews have experienced religious coercion and persecution, there was no Christian denomination that established a lasting religious dominance over people of other religious heritages in North America. This was the case within the Dutch and British colonies as well as after the War of Independence and the foundation of the United States of America. Although Christian Protestant groups and the Calvinist mainstream outweighed the religious field, the religious set up was different to a state church. While Jews in other diasporas were often the only religious community in open dissent to a prevailing religious culture, in America they shared this status with other Christian minorities like the Huguenots, Baptists, and Quakers. However, among the Dutch colonialists and especially under Peter Stuyvesant, the governor of New Netherland, efforts were made to promptly expel the Jews who arrived in 1654 from Recife. For example, in a petition addressed to the directors of the Dutch West India Company, Stuyvesant, who felt entitled to establish moral order by means of introducing Calvinist Ortho-

[3] See H. Soloveitchik, "New Role of Texts," p. 208.

[4] See Thorwald, "Juden in Amerika," p. 187.

[5] The Jews in Recife were Sephardim, i.e. they were originally from Spain and Portugal. Under the reign of Isabella of Castile and Ferdinand II of Aragon, the "Reyes Catolicos," they were expelled from Spain in 1492 and finally, five years later under Manuel I, also from Portugal. A large part fled to Holland or to the Spanish and Portuguese colonies in the "New World," where both, openly practicing Jews as well as Jews who underwent forced baptism (*Conversos* (*Marranos*)), took up residence in order to escape the Iberian inquisition.

doxy to the colony, presents several arguments in favor of an immediate deportation of those Jewish refugees. First, he reports that these Jews, with their "usury mentality" and insidious way of trading with Christians, would have behaved repulsively towards the lower magistrates. Second, he argues that these newcomers would become a burden on deaconry the following winter due to their poverty. Third, he declares that this "deceitful race—such hateful enemies and blasphemers of the name of Christ—should not be allowed to further infect and trouble this new colony to the detraction of your worships and the dissatisfaction of your worships' most affectionate subjects."[6] The directors of the Dutch West India Company, however, did not comply with this petition and justified their position as follows:

> [...] but after having further weighed and considered the matter, we observe that this would be somewhat unreasonable and unfair, especially because of the considerable loss sustained by this nation, with others, in the taking of Brazil, as also because of the large amount of capital which they still have invested in the shares of this company. Therefore after many deliberations we have finally decided and resolved to apostille [note] upon a certain petition presented by said Portuguese Jews[7] that these people may travel and trade to and in New Netherland and live and remain there, provided the poor among them shall not become a burden to the company or to the community, but be supported by their own nation. You will now govern yourself accordingly.[8]

As is so often the case in Jewish history, Jewish trading relations, monetary bonds, and investments played a major role in the settlement policy of New Amsterdam by the Dutch West India Company. By granting the Jews settlement and the opportunity to trade, economic aspects were superordinated over the concerns of non-Christian religious affiliation, as was previously the praxis in Recife (and afterwards in the Caribbean colonies such as Curaçao, Surinam and Barbados). Thus, a minority-based society developed on "American" soil consisting of different, though not entirely equal,[9] religious cultures in a way unthinkable in Europe before the era of Enlightenment (and in many places thereafter). European Jews, even in countries such as Holland, where the circumstances of living were better than in most other countries, lived in social isolation under their synagogue and community leaders, with no prospect of political involvement.

[6] Mendes-Flohr and Reinharz, *Jew in the Modern World*, p. 501.

[7] This refers to the Portuguese Jewish community in Amsterdam.

[8] Mendes-Flohr and Reinharz, *Jew in the Modern World*, p. 502.

[9] For example the persecution of Quakers by Peter Stuyvesant or the prohibition issued by the company's directors for non-Calvinist religious groups to institutionalize, hire clergy, and publicly hold worship services ordered by the company's directors. Not even the Lutherans were granted the formation of a community and the appointment of a minister. Similarly, Jews were forbidden to build synagogues and publicly gather for prayer. Thus, religious activities were confined to private space.

After the Anglo-Dutch Wars, the takeover of the colony by the British entailed a number of positive changes. For example, Jews were permitted to be elected to public office henceforth.[10] Though it may seem that granting such rights points towards a transformation of society in the direction of liberal politics and tolerance, the perpetual linkage of economic success to the civil status of the Jewish population, portrays a contrary picture. Historian Howard B. Rock emphasizes:

> The British by the eighteenth century were so concerned with empire and mercantilism that, despite whatever anti-Semitic beliefs they yet harbored, they lifted all restrictions on Jews in order to ensure tranquility and to maximize profits in trade from their precious colony. Jews could not vote in England; they could in New York.[11]

At the beginning of the British colonialization, Jewish religious practice was still confined to the private sphere with no communal structures established. This finally changed at the turn of the 18th century. Although there is some evidence that an in-home synagogue existed as early as 1695, the first synagogue in British North America was erected between 1729 and 1730. It was located at Mill Lane, today's South William Street, in the very south of Manhattan.[12] The community that campaigned for the formation of this synagogue for decades, was called Kahal Kadosh Shearith Israel. In its pioneer role, Shearith Israel served as "mother synagogue" for the communities of Philadelphia, Newport, Charleston and Savannah.

Institutionalized religion and Jewish infrastructure was essential for many (but by no means all) immigrant Jews. The absence of these structures possibly imparts the importance of basic Jewish institutions to immigrants who were used to live a life with synagogues, *mikwaot*, Jewish schools, and kosher butchers. The following excerpts of a letter written by Rebecca Samuel to her parents in 1791 portrays such a life devoid of Jewish infrastructure.[13]

> When the Jews of Philadelphia or New York hear the name Virginia, they get nasty. And they are not wrong! It won't do for a Jew.[...] The whole reason we are leaving this place is because of [its lack of] *yiddishkeit*. Dear parents, I know quite well you will not want me to bring up my children like Gentiles. Here they cannot become anything else. Jewishness is put aside here. There are here in Petersburg ten or twelve Jews, and they are not worthy of being called Jews. We have a *shohet* here who goes to the market and buys *trefah* meat and then brings it home. [...] You can believe me that I

[10]Such progress was well prepared under Dutch rule. In 1657, after a series of petitions by Jewish traders, Jews were granted the Burgher right, the right to conduct retail and wholesale trade in New Amsterdam.

[11]Rock, *Haven of Liberty*, pp. 257–258. Niew Amsterdam was re-named into New York in 1664.

[12]See Sarna, *American Judaism*, pp. 11-12; Finkelstein, *American Jewish History*, pp. 33-34; Hershkowitz et al., "New York City," p. 196.

[13]Rebecca Samuel emigrated with her husband from Germany to Petersburg in Virginia. The letter, written in Yiddish, was addressed to her parents in Germany. Further correspondence indicates that the young family moved from Petersburg to Richmond in 1796, where a congregational life was existent at the time.

> crave to see a synagogue to which I can go. The way we live now is no life at all. We do not know what the Sabbath and the holidays are. On the Sabbath all the Jewish shops are open, and they do business on that day as they do throughout the whole week.[14]

This observation corresponds with Max Weber's suggestion that the necessity to be provided with kosher meat from a ritually punctilious *shohet* closeby was the reason why observant Jews ("korrekte Juden") usually did not seek to live isolated or in small communities, consequently furthering the "Zusammendrängung der rituell orthodoxen Juden in den grossen Städten"[15] in the United States until the 20th century. In the spirit of his study about the "protestantische Ethik und der Geist des Kapitalismus" Weber concludes that economical success was therefore granted to the Reform Jews who were, unlike their law-abiding co-religionists, able to pursue the profitable business of the "Bewucherung der Neger auf dem Lande."[16]

The difficulties described by Rebecca Samuel as having to renounce the community of like-minded people as an observant Jew reflect the heterogeneous social circumstances at that time. Even in larger cities, such as New York or Newport, negligence of traditional observance such as the compliance of dietary laws or the Sabbath and holidays were quite common. In contrast to the European countries from where Jews emigrated, there were no religious authorities in both colonial and post-colonial North America who could have decided on questions of Jewish law or advocate the strengthening of general observance.[17] Rabbis were missing from America. Interestingly, Rebecca Samuel also describes this lack of religious governance in the same letter written in 1791: "One can make a good living here, and all live at peace.[18] Anyone can do what he wants. There is no rabbi in all America to excommunicate anyone."[19]

In contrast, authority and governance were firmly established in economic matters: As long as the six-day week was in place, Sunday was considered the only day of rest. For the tycoons of the textile industry, where many Jewish immigrants found employment, Sunday was not negotiable. The standard response a worker received when asking for a day off from work is said to have read as follows: "If you do not show up for work on Saturday do not bother coming in on Monday."[20]

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[14] Mendes-Flohr and Reinharz, *Jew in the Modern World*, pp. 509-510.

[15] Weber, "Wirtschaftsethik," p. 1168.

[16] Ibid., p. 1168. Although this statement is a simplification of the social conditions Jews and non-Jews found themselves living in at the beginning of the last century, it is true that the trend towards a suburbanization of Orthodox Jews only set in after World War II.

[17] See Finkelstein, *American Jewish History*, pp. 39-40.

[18] She refers to the coexistence of Jews and non-Jews in Virginia. Further in the text she mentions that this is not the case in New York or Philadelphia.

[19] Mendes-Flohr and Reinharz, *Jew in the Modern World*, p. 509.

[20] E. Mayer, *From Suburb to Shtetl*, p. 70.

2.1.2 Religious Diversification in New York

The first type of official Jewish community emerging in North America was what historian Jonathan Sarna labels the *synagogue-community* model with a synagogue in each community that claimed overarching authority in Jewish life.[21] Kahal Kadosh Shearith Israel was, as briefly mentioned above, organized as a Sephardi community, since the founding families lived the tradition and culture of the Sephardim, i.e. those Portuguese and Spanish Jews who had come to America from other Dutch colonies in the south, the Iberian kingdoms or the Netherlands. In fact, every synagogue-community in America that came into being prior to 1795 followed the Sephardi *minhag* (custom). However, as early as 1730, Ashkenazi Jews outnumbered Sephardi Jews.[22] The community controlled synagogue services, Jewish education, regulated the supervision of *kashrut* (dietary laws), the cemetery and the *mikveh* (the ritual bath). The advantages of this community model become evident in the group solidarity that was created through communal structure, the teaching of Jewish tradition and education, and the maintenance of networks with other emerging synagogue communities (especially on the East Coast). This first synagogue community in New York saw itself as the only representative institution for the Jews living in the catchment area. It assumed responsibility regarding all aspects of religious life. This also holds true for the other synagogue-communities in the colonial era.

Contrary to the situation in Europe, where governmental power usually "enforced at least some of the decrees of the Jewish elders, because the Jewish community as such existed as a legal entity,"[23] this kind of manifestation of *kehila* (community) did not take roots in America. The different legal status of Jewish communities together with the lack of rabbinic authority in the New World—as indicated by the aforementioned statement of Rebecca Samuel—resulted in American Jewish individuals who did not face excommunication and "civil" vulnerability to the same extent as their European counterparts. Judaism in America evolved on a much more voluntary basis. This in turn must be evaluated in accordance with early forms of alternative affiliation that took place outside of traditional Jewish communal structures, as in the case of professional associations, *landsmanshaften*, or fraternities (e.g. B'nai Brith).

Shearith Israel and the concept of a single synagogue-community faced many challenges due to rapidly changing political, economic, and social changes. Historian Howard Rock contends that in 1760 New York's Jews were patriotic citizens of the British Empire. This condition started to change between 1765 and 1775, when the majority of the Jewish community "turned from loyal

[21] See Sarna, *American Judaism*, pp. 12–28; 52.
[22] See Blau and Baron, *Jews of the United States 2*, p. 502.
[23] Hertzberg, "The American Jew," p. 8.

Britons to rebellious Americans."[24] Tensions caused by a volatile economic situation and the approaching political power shift affected colonial society as a whole and the years leading up to the American Revolution, the Declaration of Independence in 1776, and beyond were conflict-laden. After the Declaration of Independence had been signed, New York's Jews had the choice between fleeing the city or staying and actively expressing their loyalty to the sovereignty of George III over the colony. The Jewish "rebellious Americans" left New York with their religious leader, *hazan* Gershom Mendes Seixas (1745–1818) in August 1776 in the wake of the approaching British forces advancing from Long Island. Seixas, himself a native New Yorker, and the other refugees did as many others from the southern communities of Charlston and Savannah, and fled to Philadelphia, which served as a kind of national gathering place for the Jewish self-exiled.[25] The ones who stayed in New York, whether they were complete "loyalists" or not, did so inter alia because they feared that their departure would cause the end of the synagogue. Thus, under British rule, synagogue service continued but most of the ceremonial objects "remained with their [the congregation's] patriotic protectors in exile, reassuring them, as it were, that the Torah stood on their side of the struggle."[26] The war split non-Jewish and Jewish Americans into two political camps, the Patriots and the Tories, with the majority favoring national independence and the minority opposing it. Among the so-called Tories were also Jews who left the United States by the end of the war.[27]

It becomes clear from these historical events that the involvement of Jews in the American project of independence had a transforming influence on American Judaism as a whole. In fact, one may see in the developments of this age what would constitute, at least conceptually, as American Judaism, later on: the inter-play between conservative, traditionalist, and liberal forces that stress progress, integration, and religious change. The political tug of war of nation building and Shearith Israel's intra-communal politics reflect the power struggle that emerges in early American republicanism. As much as the Jewish community was politically divided in 1800 with staunch liberals as well as staunch conservatives, there were Jews whom can be identified as political inde-

[24]Rock, *Haven of Liberty*, p. 71. Contributing to this trend were several laws enacted by the British government without the approval of the colonial legislatures that affected the colonial economy, especially in Massachusetts, New York, and Pennsylvania. The Sugar Act in 1764, subsequently followed by the Stamp Act in 1765 were both perceived by the colonialists as a violation of their colonial rights. The Stamp Act required the colonialists to pay taxes on domestic wares, such as newspapers, playing cards, and various other papers and documents. With the Townshend Acts of 1767/8 another series of laws of taxation were enacted, including a revenue tax on more than seventy consumer goods and only applying to imported products. Merchants and artisans, including the mercantile elite of the Jewish community reacted with increasing contempt; they were part of a conservative wing of the growing revolutionary movement.

[25]See Faber, "Preservation and Innovation," p. 30.

[26]Sarna, *American Judaism*, p. 34.

[27]See Sarna, "Jewish Political Conservatism," p. 117.

pendents in so far as they moved back and forth between the two. "This pluralism," as historian Jonathan Sarna observes "—this diversity of political positions within the Jewish community—is to my mind the most important legacy of the American Revolution."[28] During the years of the first party system, 1792–1824, Shearith Israel's leadership-style reflected both Hamiltonian and Jeffersonian political values. Alexander Hamilton and the Federalist Party advocated a strong central government, with a national bank and a strong industrial sector. Thomas Jefferson and the Democratic-Republican Party opposed a strong central government and national bank, supporting state governments and political egalitarianism. Both political programs, ideas, and values resonated within New York's Jewry, with members inclined towards both Hamiltonianism and Jeffersonianism.[29] Hamiltonian values might have had some indirect influence on the ratification of the synagogue's [30] new constitution in 1805—at least when contrasted with Jeffersonian ideals and Jefferson's followers, many of whom initially opposed the Constitution (of the United States).

The main force behind the congregation's revision of its constitution seems to have been the remittal of the "Act to Provide for the Incorporation of Religious Societies," passed by the Legislature of the State of New York in 1801.[31] In hindsight, this document hints at the rift that led to something like a "secession movement" starting in the mid-1820s when Ashkenazi members of Shearith Israel founded their own congregation, B'nai Jeshurun, in 1825. Some parts of this historical document shall serve as a textual starting point to discuss Jewish communal life in New York, its structure and struggles, during a time of radical change. This period gradually led to the institutional and social process elsewhere referred to as a transformation of "synagogue-community to [a] community of synagogues."[32]

The 1805 ratified constitution of Shearith Israel introduced a Board of Trustees; this change was mandated by the aforementioned Act of 1801 itself. The board consisted of six members, whom were eligible to elect a *parnas* (president) from amongst them. In §2, section 3 of the constitution, it explicitely states that the community's priorities regarding its basic needs are the following: "There shall always be a [Shohet, Hazzan,] and [Shamash] chosen by the congregation, to perform the services required of them in their several departments, subordinate officers to be chosen by the Trustees."[33]

[28]Sarna, "Jewish Political Conservatism," p. 119.

[29]See Rock, *Haven of Liberty*, pp. 116–126.

[30]We have to keep in mind that until 1825 there is still only one Jewish community/congregation in New York: Shearith Israel.

[31]See Blau and Baron, *Jews of the United States 2*, pp. 518–521.

[32]Sarna, *American Judaism*, p. 52.

[33]Blau and Baron, *Jews of the United States 2*, p. 518.

The extended base for lay community leadership, accomplished by establishing a Board of Trustees, concurrently reconfirms the absence of rabbinical authority in America. As in other early American republican Jewish communities, the synagogue life in New York took place without much scholarly wisdom and religio-legal advice, a condition that was very contrary to how rabbinical status and authority was revered in (Ashkenazi) Europe. Although the abovementioned Gershom Mendes Seixas is sometimes referred to as "Rabbi Seixas"[34] because he took on much of the role and professional function of a "rabbi," he was neither an ordained rabbi nor did he pursue halakhic authority as was required in Europe where legally recognized communities and chief rabbinates existed. The organizational and functional structure of the early American synagogue was such that it "lodged authority in prosperous male lay leaders who possessed the power to hire–and fire—rabbis and other religious functionaries, such a s cantors."[35] In fact, that describes exactly what Gershom Seixas was: the community's *hazan* (cantor), even though he was generally perceived as the congregation's religious leader. Furthermore, Seixas used to introduce himself as "minister," especially towards outsiders. This might have to do with a well-considered terminological alignment with Christian denominations to profess similarity over difference and reflects mainstream Protestantism's influence on Judaism, at least to a certain degree. The adoption of the sermon as a means to morally lecture the congregants is generally considered to be an example for a religious adaption of Christian origin. In §4 of the document, the *hazan's* professional function is denoted as:

> The fixed prayers the [Torah we-Haftaroth] shall forever be read in the Hebrew language, according to the [minhag Sephardim] but the Board of Trustees may on a public thanksgiving or other special occasion, direct the [Hazzan] or any other suitable person, to deliver an address, sermon, or moral lecture in English.[36]

Furthermore, the most detailed part of this document is to be found in the bylaws, where concise prescriptions of "solemnity and order" are given. In summary, the congregants were not allowed to sing "higher or louder" than the *hazan*, "umbrellas and canes, excepting canes carried by lame persons," had to be left at the door, and children under the age of three years were prohibited from attending synagogue services. Furthermore, "any person or persons leaving the Synagogue shall retire in a quiet and orderly manner [...] particularly during the reading of the [Torah] and [Haftarah]" in order not to disturb the service. In case of non-compliance the constitution states that such "persons [...] shall be considered as having committed an offence, and punished accordingly." It is worthwile noting that although §4 mentions that the *parnas* "may at all times cause

[34]See for example Rock, *Haven of Liberty*, pp. 137–149
[35]Dash Moore, *Urban Origins of American Judaism*, p. 8.
[36]Blau and Baron, *Jews of the United States 2*, 196. Constitution of Shearith Israel, 1805, 518.

any offender or offenders against this constitution, or any of the laws of this Congregation, to be punished in such manner as may thereafter be provided" such punishments for offensive behavior are not further described in the document. This greatly contrasts with the community's first constitution, issued in 1728, which enlists the exact amount of monetary fines for different offenses.[37]

Interestingly, order and decorum played a major role during the final stages of the rift within the community that led to the formation of New York's second congregation, B'nai Jeshurun, in 1825. As mentioned above and explicitly stated in §4 of the congregation's constitution, Shearith Israel followed the Sephardi rite, but Ashkenazi members quickly outnumbered their Sephardi co-religionists. In April 1825 intra-communal tensions peaked when the English-born Barrow E. Cohen refused to make the traditionally prescribed charitable donation when called to the Torah during service.[38] Only one month later, Cohen and the more traditionalist Ashkenazi members who were dissatisfied formally requested the use of the synagogue and "Sephorim" for an additional service "at an early hour on the mornings of Shabbat as well as on other mornings of the week before breakfast observing the same minhog that has always been observed in the congregation [...]."[39] The senders of the letter to the board of trustees of Shearith Israel perceived their request as a favour, one "to which there can be no grounds for refusal: as we have no doubt the trustees will cheerfully concur in the promoting of our zeal and attention to the worship of our holy religion,"[40] since this practice is "received by divine command."[41] The trustees, however, did see grounds for refusal and rejected the applicants' request.

In response to this rejection, the applicants initiated the secession from Shearith Israel, founding a religious society under the name of *Chevra Chinuch Nearim* subsequently developing into the second New York congregation of B'nai Jeshurun. All of a sudden Congregation Shearith Israel "no longer served as the cornerstone of Jewish existence."[42] From a relational perspective, this "secessionist act" and the formation of B'nai Jeshurun constitutes a very dense and transformative momentum in American Jewish history. The ever-increasing number of immigrants from Europe, beginning in the 1820s with immigrants from Central Europa, including German (speaking) Jews, raised the number of Jews of Ashkenazi origin. Furthermore, these immigrants were more observant and punctiliously followed Jewish law as compared to Shearith Israel's native members.[43] The

[37] See Constitution Shearith Israel, September 18, 1728 in Zola and Dollinger, *American Jewish History*, pp. 22–25.
[38] See Polland and Soyer, *Emerging Metropolis*, pp. 14-15.
[39] Blau and Baron, *Jews of the United States 2*, p. 541.
[40] Ibid., 205. The Opening Gun, 541–542.
[41] Ibid., 206. Constitution of *Chevra Chinuch Nearim*, 1825, 542.
[42] Rock, *Haven of Liberty*, p. 116.
[43] See Polland and Soyer, *Emerging Metropolis*, p. 14.

disparity between the native Sephardi structures and the changing social situation caused by an influx of immigrants, was further nurtured by the fact that the rich and powerful Sephardi families were in charge of synagogue business. Elitist structures, authority, and synagogue decorum in combination with religious laxity stood in stark contrast to the secessionists' striving to, somewhat pardoxically, combine a rather traditionalist Jewish lifestyle with egalitarian values and Jeffersonian ideology. Therefore, it is too simple to dichotomize Jews along the Ashkenazi–Sephardi dividing line.[44]

There were even a few prominent leaders of Shearith Israel who identified themselves with *Chevra Chinuch Nearim*, as was the case with Haym M. Salomon, son of Haym Salomon (1740-1785).[45] In a letter written on June 23, 1825 to the *parnas* and Board of Trustees of Congregation Mikveh Israel in Philadelphia, the younger Salomon requests the retrieval of a Sefer Torah "which my Father (olav hashalom) had imported at considerable expence, and which was lodged in the philadelphia Shule as our property" in order to have it repaired and therefore "prevent its becoming Pausul."[46] Salomon's response to the negative answer he received from Zalegman Phillips, Mikveh Israel's *parnas*, expresses not only his wish to have the scroll restored, but also, most likely, to use it for the services of the *Chevra*.[47]

B'nai Jeshurun dedicated its first synagogue, a former Presbyterian church on Elm Street, in 1826. From 1730 until 1824, Shearit Israel was the only Jewish community in New York. But after almost a hundred years the founding of B'nai Jeshurun marked the beginning of an era during which a speedy multiplication and diversification of the Jewish social and religious field took place. After initial division of the Jewish community into separate congregations, the process of institutional diversification quickly proceeded. German, Dutch, and Polish Jews left B'nai Jeshurun only four years after its founding and formed congregation Anshe Chesed. It was at this congregation where Max Lilienthal's installation was celebrated in 1846.[48] Lilienthal supervised three German-Orthodox congregations. In 1837, Polish Jews split from B'nai Jeshurun and Anshe Chesed in

[44]It is worth elucidating upon the "Shearith Israel-B'nai Jeshurun" division to include sociological theory regarding religious schisms. Interestingly, the division challenges Richard Niebuhr's conclusion, published in his seminal work, "The Social Sources of Denominationalism" (1929), that religious division is always the result of religious factors and social factors. While this is certainly true for the case at hand, religious as well as social factors were definitely not the sole factors. Borrowing from Phil Zuckerman's ethnographic study, "Strife in the Sanctuary–Religious Schism in a Jewish Community" (1999), the additional factor of ideology, i.e differing external political views or gender politics, contributes to the analysis. While in Zuckerman's research study antagonism was created by differing positions regarding Near Eastern politics, the "Shearith Israel-B'nai Jeshurun" schism that took place 170 years earlier, was provoked by the ramifications of the Hamilton-Jefferson divide.

[45]Haym Salomon was an influential member of Philadelphia's Mikveh Israel congregation and important figure during the Revolutionary War.

[46]Blau and Baron, *Jews of the United States 2*, p. 546.

[47]See 208. Haym M. Salomon to Zalegman Phillips, 1825 ibid., pp. 547–548.

[48]See Ruben, *Max Lilienthal*, p. 71.

order to set up Shaaray Zedek (today one of Manhattan's Conservative synagogues), which again lost members in 1845 who established Beth Israel. Then in 1839 and 1842 German Jews left Anshe Chesed to found Shaaray Hashamayim and Rodeph Shalom. A number of the original founders of B'nai Jeshurun founded Shaaray Tefilah in 1844, a congregation by and large consisting of English- and American-born members. The first Reform synagogue in New York was Temple Emanu-El, founded by German Jews in 1845.[49]

There were many reasons for the establishment of congregations: for example, the desire to worship among fellow Jews who shared the same cultural background, language, and *minhag*. Yet, this was not the only reason. Ohabey Zedek, a congregation that lasted only three months after its secession from B'nai Jeshurun, was founded because of a bridegroom's difficulties to obtain permission to have his marriage ceremony performed. In the case of the separation of Shaarey Zedek from Bnai Jeshurun, admission fees seem to have been the trigger. According to Hyman Grinstein, little information is available about the other secessions. However, the constant formation of new congregations, caused by secession or association of new immigrants, was "the common experience of New York Jewry"[50] before the Civil War (1861–1865).

In 1846 Isaac Myer Wise, one of America's Reform leaders at the time, visited New York and summarized concisely his impression of the landscape of New York's Jewish congregations. Even though he makes cutting remarks about pretty much every service and congregation he attended, his report imparts a vivid image of the Jewish institutional status quo in New York at the time.

> In 1846 there were seven Jewish congregations in New York, two communal schools, a number of Jewish mutual benefit associations, and two charitable societies—one German, the other English. The Portuguese congregation was the oldest, and the oldest Portuguese was a Polish Jew. Since my landlord, Friedman, was a member of this congregation, I went with him to the synagogue on Sabbath *Nach'mu*; but I found the Portuguese ritual just as antiquated and tedious as the German and the Polish, although more decorous, dignified, and classical. The next oldest congregation was the English-Polish, that had a handsome synagogue on Elm Street, and used the Polish ritual as it obtained in London [B'nai Jeshurun]. On the very first morning I visited this synagogue, I longed for the sight of a Hebrew book, and asked the *Shamash* whether I could obtain a volume of the *Mishnah*. That individual laughed so mockingly, that I readily perceived what a sign of "greenness" it was on my part to ask for an ancient Hebrew book in the New World, and that too in an orthodox synagogue. It was certainly not my fault, for I discovered only later the crass ignorance which ruled there. On Center Street, in the second story, was the Polish synagogue. I went there the next evening, and heard some individual sniffle through a bit of *Rashi* in so pitiably ignorant a manner between *Minchah* and *Maarib*, that I never went there again. Of the German congregations three were ultra orthodox. One of them worshiped on Henry [Ansche Chesed], the other two on Attorney Street [Rodeph Shalom].

[49] See Rock, *Haven of Liberty*, pp. 181–182.
[50] Grinstein, *Jewish Community of New York*, p. 53.

> Dr. Lilienthal had been chief rabbi of these three congregations for six months, and preached every Saturday in a different synagogue. On the first Sabbath (it was Sabbath *Chason*) I went to the synagogue on Henry Street to hear Dr. Lilienthal. The attendance was very large, the service according to the old German ritual. The congregation was orthodox, and just as ill-behaved as in Germany. The cantor had on a Christian gown, trilled like a mock nightingale, and leaped about like a hooked fish. After the selling of the so-called *mitzwoth*, I lost all patience with the intolerable sing-song with which the reader intoned the portion and read from the Torah and with the innumerable *Mi-sheberakh*. "Why is this nuisance tolerated in a metropolis?" I asked my neighbor. "I do not know," he answered; "but it takes place in all the synagogues of New York." At last the longed-for event took place. Dr. Lilienthal preached towards the close of the service. He pleased me very much, for he was an excellent and popular pulpit orator, used a glowing diction, and had a dignified carriage; but what he said about the season of mourning had long since lost all significance for me, and I was really and truly moved to mournful feelings, not for the destruction of Jerusalem, but for the disappearance of Judaism in the Polish-cabbalistical rabbinism and supernaturalism.
>
> The youngest congregation was the Emanuel congregation [*Temple Emanu-El*]. But very little was known of it in New York. On Sunday, the 10th of Ab (postponed *Tishah b'ab*), an acquaintance took me to the place where the beginnings of the temple were laid. We entered a small hall, a flight of stairs above the ground. There we found about fifty men and thirty women, the latter in a section partitioned off. A boys' choir, re-enforced by a few men's voices, and a cantor with a weak tenor voice, sang some compositions of Sulzer as poorly as in a village synagogue; but dignity and decorum ruled—the beginning of a better future—and I breathed easier. Dr. Merzbacher, of blessed memory, preached. There was nothing in his delivery to attract a stranger; but he spoke of the end of the *Galuth*, of the morning that was dawning also for the house of Israel. His words made me feel at home, although he did not treat the *Tishah b'ab* as drastically as I should have wished. Such was the status of the synagogues of New York in 1846. Outside of Lilienthal and Merzbacher, there was not one leader who could read unpunctuated Hebrew, or, with the exception of a few private individuals whom I shall mention later, had the least knowledge of Judaism, its history and literature. One of the most prominent individuals denied emphatically that Rashi had written a commentary to the Book of Samuel. [...][51]

This portrait of New York's Jewish community twenty years after the initial schism took place makes apparent how the synagogue-community of old had become somewhat incompatible "with a republican society in which Jews no longer had to seclude themselves around a plainly constructed sanctuary."[52] In fact, long before the onset of institutional diversification and the struggle over denominational orientation of American Judaism, New York's Jews had many options for affiliation other than membership in a congregation. Already before the turn of the 18th century, Jews could become members of different fraternal or professional societies, many of which admitted both Jews and non-Jews alike, as did for example the Freemasons or the Mechanics Society.

[51] Wise, *Reminiscences*, pp. 20-23.
[52] Rock, *Haven of Liberty*, p. 113.

The figure best illustrating what kind of manifold social opportunities were achievable (at least in theory) is New York's most famous Jewish citizen who portrayed himself as "citizen of the United States of America, late Consul of the said States to the City and Kingdom of Tunis, High Sheriff of New York, Counsellor at Law, and by the grace of God, Governor and Judge of Israel,"[53] and prominent leader, Mordechai Manuel Noah. Although most seats at High Holy Days were taken in the synagogues, the synagogue as "Jewish space" lost ground. Except for Rosh-ha Shana and Yom Kippur, many Jews went to synagogue in order to celebrate the life-cycle ceremonies only.

The second wave of mass immigration, beginning in the 1820, mainly brought Jewish immigrants from central Europe, particularly the German lands, to New York, while towards the end of the 19th century (after 1880), in a third wave, eastern European Jews constituted the majority. With the ever increasing influx of immigrants, new patterns of Jewish community, albeit more secular, developed. Alternative places such as social clubs, discussion groups, Jewish fraternities, libraries, hospitals, and philantrophic organizations drew a socially colorful picture within New York's neighborhoods. Eastern European immigrants established a broad network of what came to be known as *landsmanshaften*. These organizations, many of whom lasted well into the 20th century, were established in order to cater to immigrants' economic, cultural, and personal needs. Furthermore, the Yiddish press as well as the installation of a Yiddish theater, which made its debut in New York on August 12, 1882, played a role in acclimating the eastern European Jews to American life.[54]

Jewish immigrants of both "waves" hoped to find work and freedom, assets that seemed out of reach to them in their homelands. Furthermore, New York promised mobility, both social and residential. By 1881 most of the central European Jews who had lived in Lower Manhattan's Five Points and Kleindeutschland (or "Deutschländle") neighborhoods had resettled in Upper Manhattan as merchants. New York turned into a patchwork of Jewish neighborhoods ranging from areas of first immigrant settlements, such as the Lower East Side in Manhattan,[55] where Jewish

[53]M. J. Kohler, "Early American Zionist Projects," p. 107. This quotation is taken from Noah's "Proclamation to the Jews," where he openly declares his intention to establish an asylum called "Ararat," located on Grand Island in the Niagara River near Buffalo, New York in 1825. He refers to Ararat as a place of refuge"where Israel may repose in peace, under his 'vine and fig tree,' and where our people may so familiarize themselves with the science of government and the lights of learning and civilization, and may qualify them for that great and final restoration to their ancient heritage, which the times so powerfully indicate" (p. 107). Noah's proto-Zionist project served as an inspiration for Pulitzer Price-winner Michael Chabon's novel "The Yiddish Policemen's Union." Chabon locates the Jewish micronation Sitka on an Alaskan Island. Likewise Israeli author Nava Semel, who writes about Ararat in her alternative history novel "Isra Isle." The novelist wonders, how it would have changed the course of history, if Ararat really had been established and reached American statehood, therefore forestalling both the Holocaust and the State of Israel. See Rovner, *In the Shadow of Zion*, pp. 41–42.

[54]See Waxman, "America's Jews," p. 10.

[55]Regarding the representation of synagogues on the Lower East Side (corresponding roughly to the neighborhood borders of Kleindeutschland): Research literature seems to have shifted between near-exclusion and overem-

immigrants lived and worked in residential tenements that doubled as factories, Brownsville and Williamsburg in Brooklyn, and the East Bronx, to uppermiddle-class and even upper-class sections such as the Upper West Side, the Bronx's Grand Concourse, and Brooklyn's Eastern Parkway.[56] Of course, such shifts and re-settlements of congregations linked to social and economic developments took place even before the "central European" immigration wave. Congregation B'nai Jeshurun is a well documented example for "up-town mobility:" Contrary to Shearith Israel at that time, B'nai Jeshurun established its synagogue building closer to where most of its congregants lived. Hand in hand with the general "up-town" trend of the city's Jewish population, the congregation moved along—continuously northbound to Elm Street, then Greene Street, 34th Street, Madison Avenue and 64th Street, and finally up to the Upper West Side at 88th Street between Broadway and West End Avenue in 1918.

Geographic mobility and the sheer number of immigrants transformed New York into a socially, linguistically, and religiously highly diverse place. Additionally, the formation of Jewish denominations, infused with ideas of reformation, adaption of Judaism to American conditions, and the ever growing influence of secularism, were major factors in the process of shaping Jewish life in the growing metropolis of New York. The following parts focus on two "cultural products" that resulted from this transformative process: the Reform Movement and Orthodox Judaism.

2.1.2.1 The Reform Movement

Until the division of the Jewish community of New York, no self-identified Jewish denomination existed other than the cultural distinction between Sephardim and Ashkenazim. As was the case in Europe before the Haskalah and Jewish emancipation, Jewishness was a common denominator for a national identity in a pre-nationalistic era, since nations in the modern sense emerged in the course of the French Revolution. Jewish Enlightenment and Reform evoked the diversification of the "Jewish nation" into denominations, sectors, or identities, which differ from each other with respect to ritual observance, theological and anthropological perspectives, civil rights, and education. Orthodoxy, as much as Reform or Conservative Judaism, resulted from the historical processes and social shifts at the time. Thus, there was no such thing as Orthodox Judaism

phasis of synagogues on the Lower East Side of Manhattan. Historian David Kaufman, "Constructions of Memory," conceives of these extremes of representation as a reflection of broader questions regarding American Jewish identity. In his opinion, the "near-exclusion" of the immigrant synagogue in representations of the era of second-generation American Jewry (roughly 1920–1950) was due to the rise of a group identity that was largely based upon the ties of historic peoplehood and common culture. For the following era (1950–1980), identity rather was based on religious belief and (even if nominal) affiliation. This "re-orientation" also provoked a shift in the representation of the synagogue, which turned into the very symbol of group existence.

[56] See Polland and Soyer, *Emerging Metropolis*, pp. 1–43.

before the transformation of European Judaism at the threshold of modernity, even if religious traditional forces would seem to have created exactly such an impression of Jewish ahistorical continuity.

As early as 1825 Jews established the Society of Reformed Israelites in Charleston/South Carolina, the first Reform congregation in the United States.[57] The Society slowly emerged within the Kaal Kodesh Beth Elohim, the fifth American Jewish congregation, founded in 1750. The families and individuals who initiated the separation first attempted to bring about reform from within, since dissatisfaction with Beth Elohim's unchanged ritual did not meet the *zeitgeist*. Forty-seven individuals signed a petition, demanding moderate reformation of specific aspects in their congregational service: repetition of some of the Hebrew prayers in English, a weekly English "discourse" on essential texts and principles of the Jewish tradition, an abbreviated service, and abandoning the tendering of honors in exchange for contributions.[58] It is noteworthy that the Charleston Reform Society's early attempt to introduce change in religious practice took place the same year B'nei Jeshurun separated from Shearith Israel in New York, but for different reasons. In Charleston, a small group decided to base their congregation on enlightened liberal values, including certain ritual reforms; by contrast, B'nai Jeshurun's separation was mainly due to *minhag* and questions of decorum.

Dana Evan Kaplan argues that the Charleston Reform attempt presents "one of the most fascinating episodes in American Jewish history," and yet constitutes an "isolated phenomenon."[59] He considers the immigration of large numbers of central European Jews to be the prime factor for development of the Reform Movement in the United States. Thus, Reform Judaism in the United States took shape at the intersection of two distinct, but interrelated, social processes. German Jews who immigrated to the United States in the early 1830s introduced a theological superstructure and the core ideas of the Reform Movement. Trained Reform rabbinic leaders and ideologically motivated reformers joined lay groups to discuss theological subjects and to establish certain intellectual foundations. Intellectual stimulation for religious change went hand in hand with the desire of many congregations (or at least a part of its membership) to innovate and adapt synagogue service and certain customs. Michael A. Meyer, in his seminal monograph about Reform Judaism, concisely describes the distinction of the American Reform Movement:

> The rise of the Reform movement in America after the initial Charleston episode must be attributed to both Germanizing and Americanizing trends. Neither trend alone will explain it. Of the immi-

[57] According to M. A. Mayer, *Response to Modernity*, p. 229 the founding group called itself a society and not a congregation in order to indicate its "broader scope."

[58] See ibid., p. 228.

[59] D. E. Kaplan, *American Reform Judaism*, p. 10.

> grants who swelled the Jewish population from about 5,000 in 1825 to about 250,000 in 1875 the vast majority came from German-speaking lands.[60]

While there were congregations that exemplified an encompassing reformation of Judaism, including religious ideals, values, and principles, the majority of congregations focused on practical aspects rather than change of community life based on radical Reform.

Radical Reform and its ideologists were nevertheless crucial for the transformation of American Judaism. An example for radical Reform is the early formation of the Har Sinai *Verein*, founded in 1842, a small lay religious group of German immigrants in Baltimore who evolved into a congregation. They sang hymns from the Hamburg Temple prayer book, accompanied by an organ. Although men and women sat apart and the liturgy was mainly in Hebrew, these two aspects of communal life illustrate the change brought forth by the Reform Movement. The absence of gender segregation in seating and the use of English and other languages, such as German, in the service became tenets of the liberal branches in Judaism. A more radical group split from Har Sinai in 1954 and for the first time in America, a Shabbat service was conducted on Sunday. After the group reunited with Har Sinai, Rabbi David Einhorn (Diespeck/Bavaria, 1809–New York, 1879), one of the most influential American reformers, joined the congregation in 1855. Similarly, the above mentioned Congregation Emanu-El in New York, having emerged from a *Cultus Verein* consisting of Bavarian Jews, became the largest Reform congregation in America and took a leading role in the successful implementation of Reform Jewish innovations. In contrast to Har Sinai though, Emanu-El employed a spiritual leader from the start: Leo Merzbacher (1809–1856), who preached exclusively in German, but published, together with Samuel Adler, his successor, a prayer book in English—Seder Tefilah: The Order of Prayer for Divine Service.[61]

Although *Seder Tefilah* had some influence on American Reform liturgy, it was soon surpassed by the prayer books of David Einhorn and Isaac Mayer Wise. These prayer books are material testimonies to the religious development of Reform Judaism between radical Reform, represented by David Einhorn, and the more moderate approach of Isaac Mayer Wise (Steingrub/Bohemia, 1819–Cincinnati, 1900).[62] The latter represented a pragmatic approach to American Judaism and favored an effective response to changing societal trends over theological consistency.[63] The tension between the two approaches was remarkably territorial, with "theologically radical Reformers in the East" and "moderate Reformers in the Midwest."[64] However, Wise finally succeeded in

[60] M. A. Mayer, *Response to Modernity*, pp. 235–236.

[61] See ibid., pp. 236–237.

[62] Isaac Mayer Wise published *Minhag America* in 1857. David Einhorn published *Olat Tamid. Gebetbuch für Israelitische Reform Gemeinden* in 1858, followed by several English editions.

[63] See D. E. Kaplan, *American Reform Judaism*, p. 14.

[64] Ibid., p. 13.

establishing the main structural pattern of American Reform Judaism and is thus considered to be its institution builder *par excellence*. Wise urged congregational union since 1848 and postulated a union not only of Reform congregations, but a broad unity of "American Hebrew Congregations."[65]

> Although Wise had hoped to build a kind of American Judaism that included all American Israelites rather than just the more liberal elements, a moderate form of Judaism that combined some ritual reforms with traditional elements, this vision proved unworkable. The Reform movement, however, was the first Jewish religious movement in the United States to organize itself on a denominational basis.[66]

Moritz Loth, the president of Wise's Congregation Bene Jeshurun in Cincinnati, established the Union of American Hebrew Congregations (UAHC) in 1973. Its first assignment was to establish a rabbinical school. Again, it was thanks to Wise's engagement, that the first Jewish seminary for the training of rabbis in the United States was established in 1875: the Hebrew Union College (HUC). Today it is known as the Hebrew Union College–Jewish Institute of Religion with branches in Cincinnatti, Los Angeles, New York, and Jerusalem. Following the foundation of the UAHC rabbinical association, the Central Conference of American Rabbis (CCAR) was established in 1889. It deals with rabbinical issues, including controversial religious questions. The publications of its responsa committee testify to ongoing rabbinical debates on various aspects of life.

In terms of the history of Reform Jewish ideas, three events are of utmost importance to the development of the movement:[67] the Philadelphia principles, the Pittsburgh Platform, and the Columbus Platform. The formulation of the so-called Philadelphia principles took place as early as 1869. The twelve men who attended the meeting that led to the adoption of seven principles, almost exclusively belonged to radical Reform;[68] an exception was Isaac Mayer Wise who attended primarily because of his "unwillingnesss to risk exclusion from this circle."[69] David Einhorn's preliminary statements served as the basis for discussion. The conference adopted the following principles. First, the messianic aim of Israel is not restoration of the old Jewish state, but the union of all humanity. Second, the destruction of the second "Jewish commonwealth" was not meant

[65]Though Wise's vision of a broad congregational unity did not materialize in the long run, the Reform Movement's institutional pattern was considered the blueprint for other sectors of American Judaism (Conservative Movement, Orthodoxy, and Reconstructionism) which, as a result of various ideological demarcation processes, began to gain shape during the following decades.

[66]D. E. Kaplan, *American Reform Judaism*, p. 12.

[67]See Philipson, K. Kohler, and Mendes, "Rabbinical Conferences" for an encompassing description of the early rabbinical conferences.

[68]S. Adler of New York; J. Chronik of Chicago; D. Einhorn of New York; B. Felsenthal of Chicago; J. K. Gutheim of New York; S. Hirsch of Philadelphia; K. Kohler of Detroit; L. Mayer of Selma; M. Mielziner of New York; S. H. Sonnenschein of St. Louis; M. Schlesinger of Albany, N.Y.; I. M. Wise of Cincinnati.

[69]M. A. Mayer, *Response to Modernity*, p. 256.

as a means of punishment for the sinfulness of Israel, but the beginning of Israel's high-priestly mission to lead "the nations to the true knowledge and worship of God." Third, Aaronic priesthood and sacrificial cult of the temple era were "preparatory steps" towards "higher religiosity," expressed in sincere devotion and moral sanctification. For this reason, there is no mention in prayers of the Second Temple's destruction. Consequently and expressed in principle four, any distinction between the Jewish tribes is "inadmissible." The fifth principle strongly emphasizes the "selection of Israel as the people of religion" and the bearer of the highest idea of humanity. Six, belief in bodily resurrection is completely abandoned in favor of the idea of immortality of the soul. Seven, although cultivation of Hebrew is highly desirable, its unintelligibility to the majority of Jewish congregants should "give way in prayer to intelligible language."[70] In addition to these principles, the conference passed a number of resolutions regarding marriage and divorce. It also includes the decision that "the male child of a Jewish mother is, not less than her female child, in accordance with a never-disputed principle of Judaism, to be considered a Jew by descent, even though he be uncircumcised."[71]

Each of the Philadelphia principles includes affirmative and negative stances regarding central aspects of Reform Judaism. In contrast, the so-called Pittsburgh Platform (November 1885) focuses on what American Judaism should look like rather than what it ought not to be. At this conference, Rabbi Kaufmann Kohler (1843–1926), David Einhorn's son-in-law, dominated the proceedings. Content wise, the Pittsburgh Platform did not re-introduce a new doctrine, but confirmed the set course of minimized ritual and the emphasized Jewish moral values within a context of growing ethical universalism.[72] The Platform presents Judaism in its opening item as "the highest conception of the God-idea as taught in our Holy Scripture and developed and spiritualized by the Jewish teachers, in accordance with the moral and philosophical progress of their respective ages." In line with this claim, the platform's authors emphasize that "the modern discoveries of scientific researches in the domain of nature and history are not antagonistic to the doctrines of Judaism." It is necessary to perceive scientific knowledge this way in order for rabbis and Jewish pastoral care workers to comprehend ethics independently of a close attachment to religious content rooted in other historical and textual contexts, such as the Hebrew Bible or rabbinic literature. Similarly, the value of Halakhah for "modern" Jews is reduced to its impact in the realm of ethics and morality: "Today we accept as binding only its moral laws, and maintain only

[70]Philipson, K. Kohler, and Mendes, "Rabbinical Conferences," pp. 214–215.

[71]Ibid., p. 215.

[72]Especially relevant is Felix Adler's founding of the New York Society for Ethical Culture in 1876/77. Adler, the son of Temple Emanu-El's rabbi Samuel Adler, did not accept the concept of a theistic God nor the notion that the children of Israel were God's chosen people. Questioning particularism altogether, he argued in favor of a moral world on the basis of an eclecticism that draws from multiple religious traditions.

such ceremonies as elevate and sanctify our lives, but reject all such as are not adapted to the views and habits of modern civilization." Another distinctive factor of the Pittsburgh Platform lies in its abrogation of Jewish nationhood: "We consider ourselves no longer a nation, but a religious community, and therefore neither expect a return to Palestine, nor a sacrificial worship under the sons of Aaron, nor the restoration of any of the laws concerning the Jewish state."[73] The second part of the sentence recalls principle number three of the Philadelphia conference, as do several other points such as the rejection of bodily resurrection and the immortality of the soul. The last paragraph, added by Emil G. Hirsch, introduces social justice to the agenda.

The Pittsburgh Platform's written declaration may be understood as the foundational document of American Reform Judaism. Isaac Mayer Wise pointedly refers to the document as the Reform Movement's "Declaration of Independence."[74] However, as historian Jonathan Sarna points out, the Platform's ideas were already in circulation among Reform Jewish enclaves for generations:

> It not only spelled out what the movement considered to be 'self-evident truths,' it also marked its final break from Orthodoxy and from Wise's own exuberant dream of an American rite broad enough to encompass Jews of every stripe. While Reform Judaism never turned the platform into an ideological litmus test and always included members who disagreed with some of its planks (particularly the controversial fifth one concerning Zionism and Jewish peoplehood), the Pittsburgh Platform nevertheless remained the most important statement of Reform Jewish beliefs until it was superseded in 1937.[75]

The year 1937 alludes to yet another milestone, the publication of an authoritative text relevant for the Reform Movement. After fifty years of what is known to be the era of Classical Reform, most Reform rabbis felt the need for reorientation. A new general statement was demanded and finally passed: the Guiding Principles of Reform Judaism, better known as the Columbus Platform. It is subdivided into segments, namely a) Judaism and its foundations, b) ethics, and c) religious practice. In stark contrast to the Pittsburgh ideology, the Columbus Platform promulgates Jewish peoplehood and supports political Zionism. The fifth point of this declaration states that in "the rehabilitation of Palestine, the land hallowed by memories and hopes, we behold the promise of renewed life for many of our brethren. We affirm the obligation of all Jewry to aid in its upbuilding as a Jewish homeland by endeavoring to make it not only a haven of refuge for the oppressed but also a center of Jewish culture and spiritual life."[76] Until the 1930s Reform Judaism

[73] Philipson, K. Kohler, and Mendes, "Rabbinical Conferences," p. 215.

[74] The Pittsburgh Platform led to phenomena in the United States that occurred a generation earlier with German Reform: it divided the movement into a party that emerged on its right—Conservative Judaism.

[75] Sarna, *American Judaism*, p. 150.

[76] Central Conference of American Rabbis, *Guiding Principles*.

was officially opposed to political Zionism. David Philipson, who attended the Pittsburgh Platform, writes in one of his diary entries: "Had anyone told me twenty years ago that nationalism would make such inroads as to succeed in having the Zionist National hymn 'Hatikvah' incorporated into the hymnal published by the conference [CCAR], I would have thought him ready for the lunatic asylum."[77] However, as the interwar years culminated in the rise of Nazi Germany and the Holocaust, the Reform Movement further "veered away from its universalistic triumphalism toward a more ethnically based cultural identity."[78]

Main reorientation within Reform Jewry concerned congregational life and religious practice. A number of rites and rituals, abandoned or annihilated by Classical Reform, were reintroduced and their importance for Judaism underlined in the declaration. Surveys taken in 1928 and 1930 reveal that up to a quarter of Reform Jews lit Shabbat candles and recited *kiddush*. The Pesah Seder was carried out in a third of the Reform homes and Hanukkah lights kindled in about 40 percent. Additionally, about half of the respondents fasted on Yom Kippur. Furthermore, rabbis who participated in polls confirm that customs and rituals were an integral part of congregational service and family life of their congregants.[79] A major reason for the revival of Reform Jewish interest in religious rites and ceremonies is ascribed to the demographical shift that set in between 1881 and 1914, caused by the eastern European mass immigration to the United States. Most of these immigrants, who came from Russia, Lithuania, Poland, Romania, and other regions, did not relate to the Reform ideology and service, but joined Orthodox synagogues, if at all. However, after one or two generations, increasing numbers of Jews of eastern European descent joined Reform congregations, which slowly shifted towards traditional Jewish thought and practice.[80]

Contemporary Reform practice is extremely multifaceted, open for a multitude of approaches and styles of communal life and congregational expression. Ritual items that were abandoned by Classical Reformers, such as the *kippah*, *talit*, or *t'filin*, have been reintroduced. In some congregations, more women than men don them. While there is an increasing shift towards nondenominationalism and Jewish renewal in American Jewry, Reform Judaism's accessibility and adaptability are attractive features, especially in the post-secular age.

[77] David Philipson, My Life (Cincinnati, 1941, 423–24) as quoted in M. A. Mayer, *Response to Modernity*, p. 327.
[78] D. E. Kaplan, *American Reform Judaism*, p. 18.
[79] See M. A. Mayer, *Response to Modernity*, p. 322.
[80] See D. E. Kaplan, *American Reform Judaism*, p. 19.

2.1.2.2 Orthodoxy

The term "Orthodoxy" is problematic for a couple of reasons. First, on the grounds of terminology itself, and second, with respect to different cultural contexts. Within the academic field of *Religionswissenschaft* it is often stated that Jewish Orthodoxy (gr. orthós/right, gr. dóxa/believing) should rather be termed "Orthopraxy" (right behavior), since contrary to the Christian context, Judaism is preoccupied more with deeds than beliefs. Though this classification is not entirely wrong, it ignores "Orthodoxy" within its context of formation during the period of Jewish Enlightenment in 18th and 19th century Germany.[81] At some point Torah-observant Jews started to use the term Orthodox as an autonym (besides other expressions like *gesetzestreu* (law-abiding), and still do so, at least in German and English-speaking countries, where Modern Orthodoxy as religious self-identification is used more often as an autonym than Ultra-Orthodoxy. The equivalent term for the Ultra-Orthodox community in Israel, but also globally, is *yahadut haredit* and its adherents call themselves *haredim* (God fearing Jews). The terms Ultra-Orthodox and *haredi* are often used interchangeably, at least by outsiders. Insiders use the Yiddish emic expression *yid* (Jew) or, in lieu of *haredi*, the adjective *frum* (pious). Thus, Modern Orthodoxy and Ultra-Orthodoxy, sometimes used as emic terms, are terminological accumulations and often rough approximations to the lived-in world of observant Jews.

The emergence of Reform Judaism in America provoked an "Orthodox response." Again, before the competing doctrines put forth by Reform rabbis, there was no distinguished socio-religious concept called "Orthodoxy." Therefore, before the onset of the Reform Movement, Judaism (in America) is best labeled, for lack of a better term, as "traditional" in the Sephardi *minhag*.[82] Before the immigration of Russian Jews from the Pale of Settlement, beginning in 1869, traditional Judaism gradually became called Orthodoxy. Isaac Leeser (1806–1868), the *hazan*,[83] of Philadelphia's Congregation Mikveh Israel led this branch. He was born in Westphalia/Germany and immigrated to the United States in 1824, at the age of eighteen. Before Isaac Myer Wise be-

[81] See Blutinger, "Unwanted Label."

[82] See Waxman, *Social Change and Halakhic Evolution*. The formation of an Orthodox denomination or community is a socio-religious approximation or Weberian ideal type rather than a depiction of social reality. Furthermore, the many shifts, changes, and segmentation of the "Orthodox" field has led to myriad terminologies by historians and sociologists of religion.

[83] Leeser was not an ordained rabbi, just as most other traditional religious leaders in antebellum America. Absence of rabbinic leadership was common well into the 19th century, until the arrival of learned leaders from Germany. An Orthodox scholarly elite did not exist until the beginning of the 20th century. One reason for this condition is the relatively late establishment of a rabbinical school, although the JTS, the rabbinical school of the Conservative Movement, served a wider clientele than just the newly founded Conservative denomination.

came Judaism's driving force in the 19th century, Leeser was the epitome of an institution builder.[84] Chaim Waxman notes that "it is not much of an overstatement to suggest that he single-handedly stamped the basic character of American Judaism–certainly its traditionalist branch."[85]

The mid-1850s are an interesting era for the study of American Judaism. Attempts to settle obvious diverging religious tendencies existed and the unity of *klal israel* was not given up easily. As mentioned above, Isaac M. Wise's vision was to unite American Judaism, not divide it. He did not aim to establish a new movement with moderate Reform; thus, the intention was for the United American Hebrew Congregations (1873) to be the communal super-structure for *all* "Hebrew" congregations. Leeser and Wise shared the goal of unifying American Judaism, eventually organizing a conference, known as the Cleveland Conference (1855), which was attended by moderate rabbinic leaders. The assembly resolved, among other issues, that the Bible was the revealed word of God and that the Talmud contained "the traditional, logical, and legal exposition of the sacred Scriptures."[86] The state of Judaism at that time is pointedly reflected in Leeser's written statement after the conference:

> In explanation I urged that, however unpleasant the words *orthodox* and *reformers* might sound, and to no ears harsher than to mine, it was a deplorable fact that we were divided into two parties; and that unless something were done, and that speedily, it was to be dreaded that we should be hopelessly alienated from each other, and that we should then present *catholic* and *reformed* Israelites.[87]

As a matter of fact, "alienation" persisted. The three major Jewish denominations, one after the other, established their own rabbinical organizations and theological seminaries in order to shape their profile and serve their communities. Though not homogenous with respect to religious practice and ideological outlook, the Reform and Conservative movements each established common denominators at an early stage: "Once specific national denominational associations that set policies for its memberships were established, almost all Conservative and Reform congregations and their rabbis affiliated with these respective structures."[88] Ferziger notes that though the concept

[84]In addition to his communal work as minister at Congregation Mikveh Israel, Leeser's accomplishments include: the first English translation of the Hebrew Bible and subsequent publication in the United States (1853), translations of the Ashkenazi (1848) and Sephardi (1837/38) prayer books, the establishment of The Jewish Hospital in Philadelphia, the establishment of the Hebrew Sunday school, the Hebrew high school, and the first American Jewish seminary, Maimonides College in Philadelphia. The school opened in 1867 with the purpose of training future religious leaders. It closed its doors only a few years after Leeser's death. He also helped found the first American Jewish Publication Society and edited the first Jewish periodical, The Occident, for a quarter of a century from 1843–1868.

[85]Waxman, *Social Change and Halakhic Evolution*, 7, footnote 17.

[86]The compromise regarding the value and authority of the Talmud raised a debate in its own right.

[87]Leeser, "Cleveland Conference," p. 37. Italics are the editor's.

[88]Ferziger, *Beyond Sectarianism*, p. 4.

of denomination, or movement as he adds, can be applied to the Orthodox sector, though it better fits the Reform and Conservative branches of Judaism. Orthodoxy followed the same path of institutional structure and established the Orthodox Jewish Congregational Union of America[89] in New York 1898. Together with its theological seminary, the Rabbi Isaac Elchanan Theological Seminary (RIETS), and its rabbinical organization, the Rabbinical Council of America (RCA), Orthodoxy evolved into what came to be known as Modern Orthodoxy in the United States. Modern Orthodoxy has a positive attitude towards modernity and considers engagement with the broader American Jewish community to be a religious value.

> These are 'Torah-true' Jews who remain loyal to the formal doctrines and pattern of behavior associated with Orthodoxy but who reflect a practical and informal ideology that is something less than completely formed by the demands and expectations of the Torah. These are people who are both cosmopolitan and parochial.[90]

Modern Orthodoxy's development was considerably shaped by its most revered rabbinic leader, Rabbi Dr. Joseph B. Soloveitchik (1903–1993), known to his students and followers as "the Rav." Succeeding his father, Moshe Soloveitchik, as head of the RIETS at Yeshiva University in 1941, "the Rav" epitomized the possible synthesis of secular scholarship and Torah scholarship, a concept known as *torah u-madda*. Students worshipped Soloveitchik for this sophisticated style to teach and learn Talmud (Brisker method) as well as for his integrative Orthodoxy.[91] In contrast to traditional *yeshivah* education, Modern Orthodoxy favors the idea of a Jewish day school that includes secular studies, a model that continues with higher education, i.e. Yeshiva University. In 1937 Soloveitchik established the Maimonides School in Boston, which "was co-educational throughout, from kindergarten to high school, in all subjects, secular and religious, including the study of Talmud."[92] While Soloveitchik believed in the practicability and ideal of Torah study for everyone, he did not necessarily encourage students to choose the rabbinate as a profession. Consequently, this approach furthered "the development of a care of learned Modern Orthodox laypeople by enhancing their Jewish self-esteem and encouraging them to continue learning."[93]

In contrast to Reform and Conservatism, Orthodoxy's heterogeneity and culture of religious decentralization, combined with the constant influx of immigrants who either did or did not ac-

[89] Later renamed the Union of Orthodox Jewish Congregations of America, it is known as the Orthodox Union (OU).

[90] Heilman and S. M. Cohen, *Cosmopolitans & Parochials*, p. 209.

[91] Interviews conducted for this study include many stories, anecdotes, and legends about Rabbi Soloveitchik. In contrast to Rabbi Moshe Feinstein, whose published responsa and rulings on medical Halakhah are available to the public, Rabbi Soloveitchik's solutions are not. However, it seems that special cases, and especially those that include a moral surplus value, are transmitted orally within Orthodox circles.

[92] Waxman, *Social Change and Halakhic Evolution*, p. 16.

[93] Ibid., p. 17.

commodate to America's version of Modern Orthodoxy, ultimately created a "modern mosaic" of Orthodox religious cultures.[94] As described above, America's Orthodox community was heavily influenced by the immigration of eastern European Jews between 1881[95] and 1914, and then again after the Holocaust. Thus, essential to the description of American Orthodoxy is the relative position of Jews to American culture and their willingness to accommodate to it. Jeffrey Gurock, like many other sociologists and historians, identifies Jews, who are usually referred to as Modern Orthodox or Ultra-Orthodox,[96] as resisters and accommodators.[97]

An early effort to resist "Americanization" occurred in 1887 when the major eastern European synagogues in New York City created an organization called the Association of American Orthodox Hebrew Congregations.[98] The organization's main goal was to unite Orthodox congregations by way of designating and supporting a chief rabbi. As Jonathan Sarna notes, the respected communal Rabbi Jacob Joseph, who arrived in New York in 1888 from Vilnius, was expected to fulfill two tasks so conflicting with one another that the project of "Chief Rabbinate" was doomed to fail from the start. On the one hand, they expected him to "improve" the regulation of Kashrut, divorce, and marriage laws and by doing so prevent the advancing Americanization of Orthodox Jewry. On the other hand, he was supposed to accommodate to American conditions and "improve" Orthodoxy by means of combining of proper observance, enlightenment, and culture.[99]

> The whole effort failed, however, due to the opposition of non-Orthodox rabbis; the vehement opposition of Jewish radicals, socialists, and anarchists; the resistance of ritual slaughterers to abide by the regulation that Rabbi Joseph prescribed for the community; and the failure of the Orthodox synagogues to abide by their commitments to him.[100]

In 1902, the year Jacob Joseph died and four years after the founding of the Orthodox Union, a more successful example of Orthodox institution building was established: the Agudat Hara-

[94] See Ferziger, *Beyond Sectarianism*, p. 3.

[95] The year of the assassination of the Russian Tsar Alexander II and the subsequent wave of anti-Jewish pogroms.

[96] Synonyms for Ultra-Orthodox Judaism are sectarian Orthodoxy, Haredism/*haredi* Judaism, right wing, or the derogatory "black hatters." Labels for the various sub-groups are *yeshivah* world, the Torah world, *litvish-yeshivish*, and *hasidish*.

[97] See Gurock, *American Jewish Orthodoxy*. The focus on religious observance veils other factors relevant for the discussion of (Jewish) immigrants' identity. As specified in the next sub-chapter, instead of a strong theological/ideational superstructure and isolationist lifestyle, relevant definers for Jewish identity of *masorti* Jews in Israel include religious affiliation, cultural influences, and the practice of *mitzvot*: For example, Jewish communities with long-standing and unique traditions are the Bukharan (Central Asia), Mashadi (Iran), or Moroccan Jews.

[98] The name chosen for this Orthodox organization is undeniably similar to Wise's choice of Union of American Hebrew Congregations, which was renamed into Union of Reform Judaism in 2003.

[99] See Sarna, *American Judaism*, pp. 181–182.

[100] Waxman, *Social Change and Halakhic Evolution*, pp. 9–10.

banim, the Union of Orthodox Rabbis of the United States and Canada (OUR).[101] It served the Orthodox community of mainly eastern European immigrants in preserving an isolationist lifestyle. Charles Liebman, borrowing from Max Weber and German theologian Ernst Troeltsch, once described the relation between Modern Orthodox and the traditional (or Ultra-) Orthodox camp as one between church and sect. Isolationist, insular, or sectarian are terms commonly attributed to the *haredi* community. Though differing in their degree of acculturation, value attribution to secular education and economic success, as well as punctiliousness of religious observance, Liebman furthermore defines both camps as the "committed" Orthodox. In contrast, Liebman divides the category of "un-commited" Orthodox into "residual" and "non-observant." He describes the former as "remnants of the East European immigrants who remained nominally Orthodox more out of cultural and social inertia than out of religious choice."[102]

This classification has some resemblance to the one Samuel Heilman and Steven Cohen created twenty-five years later. They subdivide the Orthodox population in the United States into three types: the nominally Orthodox, the Orthodox of the center, and the traditionally Orthodox.[103] Heilman and Cohen identify traditional Orthodoxy with Ultra-Orthodoxy, while its counterpart is somewhat relabeled Centrist (modern) Orthodoxy. "Centrist" is not an etic term; it has been introduced in the early 1980s as an emic term by Modern Orthodox rabbis. "To close ranks, Orthodox Jews in the mainstream rebranded themselves as part of a 'Centrist Orthodox Movement.' Modern, then, was too far to the left."[104] Centrist Orthodoxy indicates the contemporary condition of an Orthodoxy that is neither seeking the isolation of the religious enclave, as does Ultra-Orthodoxy, nor is as "leftist" as what came to be known as Open Orthodoxy.[105]

Sociologists of religion have paid great attention to these sliding and shifting processes within American Orthodoxy of the last few decades in what has become to be termed the dynamic of "contrapuntalism."[106] Modern Orthodoxy has, by nature of its stabilized dualism due to the neologistic notions of *torah im derekh eretz* or its American version of *torah u-madda*, lived with a certain creative ambiguity ever since. Inherent to the religious behavior of Modern Orthodox Jews is what Heilman calls "compartmentalization" or a strategy to ignore "inherent conflicts built into their competing beliefs and practices."[107] This results in the acceptance of contradiction by ignoring it: "Both the compartmentalization and avoidance behavior so characteristic of

[101] This organization is not to be confused with the above mentioned OU, the Union of Orthodox Jewish Congregations of America.

[102] C. S. Liebman, "Orthodoxy in American Jewish Life," p. 31.

[103] See Heilman and S. M. Cohen, *Cosmopolitans & Parochials*.

[104] Eleff, *Modern Orthodox Judaism*, p. 348.

[105] See also Turetsky and Waxman, "Sliding to the Left?" for an analysis that includes Orthodoxy's slide to the left.

[106] See Heilman, *Sliding to the Right*.

[107] Ibid., p. 40.

the Modern Orthodox required a kind of endless cultural and instrumental shifting. I have called this dynamic of belonging 'contrapuntal.'"[108]

Samuel Heilman especially focuses on American Orthodoxy's general slide to the right since World War II. A major issue that accompanies this development concerns the increasing displacement of *minhagim ha-maqom* (original local customs) by using religious-legal codex literature. This process standardizes religious norms at the expense of local religious traditions, thereby favoring the importance of book knowledge over lived traditions.[109]

2.2 Israeli Judaism: Between Orthodox and Paradox

In their monograph about Israeli Judaism, pollsters Shmuel Rosner and Camil Fuchs describe a paradox: When asked whether they feel primarily Israeli or Jewish, most Israeli Jews first consider themselves Jewish. However, if interviewees are asked what qualifies a Jew as good, most Jews in Israel, i.e. 56 %, believe that living in Israel is essential for being a good Jew. The uniqueness of Israeli Judaism lies in the fusion of two identity traits:

> Jewishness and Israeliness are being fused into a new compound: Some elements belong exclusively to the religiously observant; others are strongest among those who are not observant. But there is much that is common to everyone, or nearly everyone. [...] A culture in which being 'a good Jew' means both 'observing festivals, rituals, and customs' and 'serving in the IDF.'[110]

Levy, Levinsohn, and Katz describe another paradox. A 2002 study on observance and religiosity in Israel resulted in a category of "not religious/observe somewhat." Therefore, people in this category are "subjectively disconnecting traditional observance from its religious roots."[111] In contrast to religious Jews, who perform *mitzvot* that have halakhic force, the non-religious choose to perform traditional behavior from the Jewish cultural heritage.[112] Interestingly, this category applies to the highest percentage of Jewish Israelis as compared to the other categories (see below).

Such "paradoxes" are described in most articles and monographs about Israeli Judaism or society. Contrary to the American Jewish religious field with its denominational structure (and non- or post denominational advocates), Israeli Judaism is quite a different "product"—largely due to its situatedness within the Jewish State.

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[108] Heilman, *Sliding to the Right*, p. 41.
[109] Heilman calls this process "When going by the book replaces living on the street."See ibid.
[110] S. Rosner and C. Fuchs, *Israeli Judaism*, p. 79; see also Kedem, "Dimensions of Jewish Religiosity," pp. 49–50.
[111] Levy, Levinsohn, and Katz, "Jewishness in Israel," p. 271.
[112] See ibid.

2.2.1 The Israeli State and Judaism

On July 18, 2018 the Knesset adopted the Nation State Bill, a controversial basic law that specifies the "nature" of the State of Israel as the nation-state of the Jewish people. Such controversy has brought the law under close scrutiny by the Supreme Court due to its supposedly discriminatory content. The undertone of the bill is not only nationalistic, but seizes Jewish symbols and Jewish "rights" for these purposes.[113] Implementation of this bill into Israeli law would legitimize extreme territorial expansion.[114] It also offers the latest concrete basis for heated discussions about the interrelationship of nationhood, religion, and Jewish identity in Israel. Contrary to this political stance and self-understanding, post-Zionists reject the self-definition of Israel as a Jewish state and demand to change it into a state of all its citizens. An alternative model to the "Zionist visionary state" is the "service state," one which primarily exists in order to provide material services to its citizens.[115]

Although the latest legal motion is an extreme expression of the interrelationship between the Jewish nation and the Israeli State, interdependence of nation and Jewishness is a unique feature of Israeli Judaism. Generally, Judaism or Jewishness either refers to a "national" identity, separate from statehood, designating Jews as a nation and/or culture, or as a "religious" identity. This relationship or the cultural prevalence of either definition has shaped Jews' and Judaism's identity in the diaspora. In contrast to other historical and geographical contexts, the Jewish aspect of nationhood in Israel has been determined by its integration with the nation state. The Declaration of the Establishment of the State of Israel very clearly emphasizes the connection between state and Jewish identity:

> Eretz Israel—the Land of Israel was the birthplace of the Jewish people. Here their spiritual, religious and political identity was shaped. Here they first attained to statehood, created cultural values of national and universal significance and gave to the world the eternal Book of Books. [...] The catastrophe which recently befell the Jewish people—the massacre of millions of Jews in Europe—was another clear demonstration of the urgency of solving the problem of its homelessness by reestablishing in Eretz Yisrael the Jewish state, which would open the gates of the homeland wide to every

[113] The three basic principles stated at the beginning of the bill convey such an impression: a) The Land of Israel is the historical homeland of the Jewish people, in which the State of Israel was established. b) The State of Israel is the nation state of the Jewish People, in which it realizes its natural, cultural, religious and historical right to self-determination. c) The exercise of the right to national self-determination in the State of Israel is unique to the Jewish People. (See *Nation State of the Jewish People*)

[114] Regarding Jewish settlement, the bill states: "The State views the development of Jewish settlement as a national value, and shall act to encourage and promote its establishment and strengthening." (Ibid.)

[115] See Don-Yehiya, "Israeli Civil Religion," p. 190. In contrast, Elbaum and Tremonti, ("A House Divided") argue that as soon as Israel realized most of its Zionist vision and its survival was no longer in any real danger, an identity and cultural vacuum formed, which seems to have attracted a return to a religious past, but in a religious revivalist way.

> Jew and confer upon the Jewish people the status of a fully privileged member of the community of nations.[116]

Prime minister David Ben Gurion, who proclaimed and broadcasted via radio the Declaration of Independence on May 14, 1948, was a defender of statism and regarded the modern state of Israel to be the legitimate successor of its ancient forerunner in Biblical times. A new kind of Israeli civil religion[117] developed after the Six Day War and even more so after the Yom Kippur War. Thus, traditional religious symbols were reinterpreted, pointing "the symbols away from God and toward the Jewish people, the Jewish state, and the particular needs of the state."[118] Ben Gurion's version of civil religion was called *mamlakhtiut* and "focused on the State of Israel as a source of loyalty and commitment and as the main unifying factor for the Jewish people."[119] These new national and concurrently civil religious symbols are diverse. Examples include visiting Masada and practicing specific rites, especially military ones, observing Holocaust Day (Yom ha-Shoa), Memorial Day (Yom ha-Zikaron), and the Day of Independence (Yom ha-Atzma'ut), as well as sacred places, such as the Western Wall (Ha-Kotel). The new civil religion succeeded in linking Jewishness with statehood.

As much as Israel is a Jewish state, it is also committed to being a democracy, whereby majority vote governs. However, tensions may flare between these two aspects. For example, religious Jews feel that Israel is constantly under threat of *hilun*, secularization. Meanwhile, the secular population feels religious coercion and fears a steady *hadatah*, religionization of Israeli society.

2.2.2 The Spectrum of Israeli Religiosity

Over decades, social and political researchers have analyzed Israeli Jewish society. These researchers take special interest in the construction and evaluation of categories regarding Jewish religious identity. Older surveys or anthropological studies seem to have operated with relatively few categories. In contrast, more recent surveys and classifications seem to be close-meshed when they try to accurately capture the "nature" of Israeli Jewishness or Jewish Israeliness—depending on the perspective. However, one thing seems clear: Israeli Jewish society has yielded, transformed, revived, and challenged all kinds of different religious, cultural, and national Jewish traditions.

[116] *Israeli Declaration of Independence (English).* For the Hebrew original see *Israeli Declaration of Independence (Hebrew).*

[117] See C. Liebman and Don-Yehiya, *Civil Religion in Israel.* The authors define civil religion "as a system that provides sacred legitimization of the social order" (p. 5). Although they contend that "traditional" religion provides this function as well, namely with reference to a super-natural being, civil religion focuses on society and its institutions.

[118] Sharot, "Sociological Analyses," p. 24.

[119] Don-Yehiya, "Israeli Civil Religion," p. 189.

It is therefore very difficult to decide along which line(s) one would like to approach Israeli Judaism, especially since it is not primarily organized into denominations, as is the case with American Jewry. Contrary to the American Jewish religious pattern, Israeli Judaism is much more diverse, one reason being the entanglement of religious and national/Zionistic identities.

To measure Israeli religiosity, in his article "Dimensions of Jewish Religiosity," sociologist Peri Kedem combines the results of three surveys, conducted between 1962 and 1985.[120] Collectively, he finds that 15 to 25% of the population define themselves as Orthodox (*dati*), 40 to 50% as traditional (*masorti*), and 35 to 45% as non-Orthodox (*lo dati*).

Such terminology highlights a number of issues. First, Kedem translates the Hebrew word *datiim* as Orthodox. However, such translation is problematic when comparing it with the categorization of surveys on Israeli religious identity from 1991 and 1999. In these surveys, types of religiosity are described as "religious," "traditional," and "nonreligious," with 40-50% belonging to the nonreligious segment, about 40% traditional, and between 15 to 17% religious.[121] The main issue here is that *dati* can be translated as either Orthodox or religious. Though *dat* and *dati/t* is usually translated as religion/religious, Kedem's translation is not wrong, but the result of social interpretation. Within the Israeli context, Jewish religion, or more specifically, the religious dimension of Judaism, correlates with Orthodoxy.

This observation leads to another matter. The non-Hebrew term "Orthodoxy" does not have a linguistic or cultural equivalent in Hebrew. Conceptually, Orthodoxy may well serve as an umbrella term to distinguish between those groups who are *shomrei torah u'mitzvot* from all other religious branches, i.e. denominations, as is the case with Reform, Conservative, or Reconstructionist Judaism. Consequently, Progressive Jews, i.e. all non-Orthodox "denominational Jews," are not conceived as "religious" Jews in Israel. This seems like another paradox for Westerners, simultaneously challenging euro-centric notions of religion. Thus, Israeli Jewish religiosity is generally measured against two extremes: totally secular and *haredi*. Religious minority groups, such as Reform Jews, do not fit into the "religious" spectrum, which ranges from *dati* to *haredi*, nor do they belong to the *masorti* (traditional) or *hiloni* (secular) Israeli population. Therefore, Jews who follow another "doxical system" are not included in most Israeli statistics on religious self-

[120]Kedem refers to studies performed by A. Antonovski. "Israeli political-social attitudes." In: *Amot* 64, 1979 (Hebrew); Ben-Meir, Y., and P. Kedem. "A measure of religiosity for the Jewish population of Israel." In: *Megamot* 2 (Hebrew), and C. Liebman and Don-Yehiya, *Civil Religion in Israel*.

[121]See Levy, Levinsohn, and Katz, "Jewishness in Israel." An extensive study performed by The Jewish People Policy Institute in 2017/2018 and subsequently published as a monograph (S. Rosner and C. Fuchs, *Israeli Judaism*) maintains the following distribution: *hiloni* (secular) 49%, *masorti* 19%, religious 31%. They explain that the *masorti*-segment seems to slowly loose its "members," either to the religious or to the secular segment.

identification, since in the Israeli context, *dati* basically means Orthoprax. The term "applies only to those who accept halakha as their source of authority and apply halakha to all their behavior."[122]

A major reason for the non-denominational development of Israeli Judaism is ascribed to the early waves of immigration to Israel by eastern European Jews, most of whom did not subscribe to the reforming movements. They divided into the broader categories of religious and secular instead, as was prevalent in eastern Europe.[123] The immigration of eastern European Jews to Israel/Palestine was not the only reason. If it was, American Judaism would have developed along the same lines. The establishment of Reform Judaism, other progressive streams and the denominational pattern in the United States preceded the mass emigration of eastern European Jews, who brought along Orthodox religious (and secular) cultures and ideologies. The impact they had on the already existing Jewish infrastructure was undeniably considerable, since the vast majority of the total 2.5 million eastern European Jews who left their countries between the 1870s and the mid-1920s immigrated to the United States. Whereas their cultural impact was influential, it was not as foundational as in Palestine, where the first four immigration waves consisted almost exclusively of Russian and eastern European Jews. For example, the second Aliyah between 1904 and 1914 was almost entirely made up of Russian Jews who started the Kibbutz movement. Their religio-cultural frame of reference was "Orthodox," even if these Russian Jews had a wholly negative approach towards religiosity and were mainly secular socialists or Zionists. These immigrants' goal was to create a new Jewish society that was built on revolutionary socialist and secularist principles.[124] Thus, it is not surprising that in 2018, 54 percent of the population categorized as "totally secular" are Ashkenazi, and only 17 percent are *mizrahi*.[125]

Interesting to note is the fact that *mizrahim* form an overwhelming majority of the segment labeled as *masorti*. From a post-secular perspective, current *masorti* Jews are an extraordinarily interesting group, because as a category of their own, they refuse to be allocated to either the secular or religious realm. Traditionism[126] therefore presents a category of "neither this nor that."[127] Traditionists value Jewish religious practice and stress that Jewish tradition has accumulated practices that are an integral part of Judaism. However, they feel that much of what they expect *datiim* and *haredim* to observe in full, can be neglected, because it seems not essential for the preservation of

[122]Levy, Levinsohn, and Katz, "Jewishness in Israel," p. 282.

[123]See Don-Yehiya, "Orthodox Jewry," p. 160.

[124]See Sharot, "Sociological Analyses."

[125]See S. Rosner and C. Fuchs, *Israeli Judaism*, pp. 123–124. It it not clear from the authors' description, as to which ethnic group the remaining 21% belong.

[126]Some, as Yaacov Yadgar, translate *masorti* as traditionist; others prefer the term traditionalist. Personally, I prefer Yadgar's translation, because traditionist specifically denotes *masorti*, while the terms traditionalist and traditionalism may also be used to describe other social dynamics.

[127]Yadgar, "Maintaining Ambivalence," p. 402.

Jewish historical continuity. Their observance revolves mainly around core practices like Kashrut, Shabbat, the festivals (especially Yom Kippur and Pesah), and life cycle events. Thus, they are criticized both by the secularist elite who tend to criticize traditionists for "not being able to distance themselves far enough from a religious lifestyle, symbols and rituals, which they, the critics, deem archaic, pointless and tasteless" and the Orthodox elite who dismiss "traditionist practice as a selfish preference of comfortableness and easiness over ideological consistency."[128]

To better understand their complex religious identity, scholar Yaakov Yadgar interviewed *masortim* and concludes:

> Many interviewees explained that they see the Jewish obligation as a matter of personal choice, and not as an externally imposed decree. This perception is a central component of the identity construct of those who view religiosity (i.e. Orthodoxy) as coercive, and wish to distance themselves from it. It allows traditionists to view themselves as fulfilling the (religious) obligation without being Orthodox.[129]

Religious practice is generally an important indicator for pollsters to measure and interpret Jewish religious identity in Israel.[130] Studies by Levy, Levinsohn, and Katz make use of a scale that combines two questions, namely the self-reported level of observance and self-defined religiosity, in order to capture Jewish religious identity in Israel. This scale enables them to "distinguish between different types of 'religious,' 'traditional,' and 'nonreligious' individuals according to the degree of their observance."[131] The category of religious observance is divided into four levels: Strictly observant, observant to a great extent, somewhat observant, not observant at all. The category of "self-defined religiosity" constitutes the following types: Ultra-Orthodox (*haredi*), religious–traditional (*masorti*), not religious, anti-religious. The resulting religious identity scale consists of eight types:

1. *Haredi* (5%)
2. Religious, strictly observant (7%)
3. Religious, observant to a great extent (4%)
4. Traditional, observant to a great extent (16%)
5. Traditional, somewhat observant (17%)
6. Not religious, somewhat observant (29%)
7. Not religious, totally nonobservant (18%)

[128] Yadgar, "Maintaining Ambivalence," p. 398.

[129] Ibid., p. 407. Yadgar observes that traditionism and its rejection of wider ideological models, while simultaneously validating religious practice, seems to offer an example for the Bourdieuan logic of practice.

[130] Again here too, progressive Jewish identification is not captured in a separate category, since "religious" denotes the range between *dati* and *haredi*.

[131] Levy, Levinsohn, and Katz, "Jewishness in Israel," p. 267.

8. Anti-religious, totally nonobservant (4%)

In their interpretation of the studies' (1991 and 1999) results, the pollsters noticed that while there has been practically no change in the self-reported level of observance of religious tradition,[132] there has been change in the self-definition of religiosity. Thus, there is a much higher reported level of observance than religiosity. About 50% describe themselves as not religious, but only about 20% describe themselves as not observant at all. Of the eight levels on this scale, the predominant type is "not religious, somewhat observant" with about 30%. The "modal Israeli Jew" is thus an epitome of not religious, somewhat observant.[133] Combining the nonreligious and *masortim* (both belonging to the type of "somewhat observant") totals to almost half of the sample. This explains why the level of observance does not necessarily drop, even if the religious self-identification changes from *masorti* to not religious. This finding largely corresponds to the fact that over half of Israeli Jews attend the Passover Seder (85%), fast on Yom Kippur (67%), and light Shabbat candles (51%).

To identify the "modal Israeli Jew" as "not religious-somewhat observant" is just one way of tagging the majority of Israeli Jews. Another term that was coined to typecast the largest segment of Israeli Jews regarding their religious identity is "Jewsraelis," a term that epitomizes the interrelationship between religious tradition and nationality in Israeli society. Pollsters Rosner and Fuchs reveal that an overwhelming majority of Israeli Jews, 55%, share a (constructed) identity, which is an amalgam of nationality and tradition. It is the only group that seems to gain in number and influence over the other groups, namely the "Jews" (17%), the "Israelis" (15%), and the "Universalists" (13%) (see below for further explanation). "Most Jews in Israel share a common denominator, a common tradition, and a common culture: A Jewsraeli culture: a compound of Jewish traditions from the past and Israeli innovations from the present."[134] Jewsraelis are those people "who consider both Jewish and Israeli rituals and customs and who espouse beliefs that combine Judaism and Zionism."[135] Thus, "Jewsraelis" observe festivals and value Jewish religious traditions and simultaneously consider service in the IDF (Israeli Defense Forces) to be an important factor of their Jewishness. They embrace both, religion and state.

In contrast, three out of four *haredim* belong to the category of "Jews." Their religious identity is made up by religious observance and is not necessarily having anything to do with living in Israel.

[132] 14% (1991)/16% (1999) are strict observers; 24%/20% are observant to a great extent; 41%/43% are somewhat observant; 21%/20% are not at all observant (Levy, Levinsohn, and Katz, "Jewishness in Israel").

[133] See ibid., p. 281.

[134] S. Rosner and C. Fuchs, *Israeli Judaism*, p. 45.

[135] Ibid., pp. 42–43. Further see Sharot, ("Sociological Analyses," p. 22) who contends that many Israelis observe a number of religious practices because they express a Jewish-Israeli national identity, and not because they believe in the divine origin of the commandments.

Traditionally, this segment would entail the anti-Zionistic religious layer of Israeli society—"yes" to Judaism, but "no" to state. Rosner and Fuchs identify "Israelis" being those who "can be found in the kibbutzim, and noticeably most of them are Ashkenazi (52%), almost all of them are secular, and a relatively high proportion are even atheists. Three in four (72%) identify as 'totally secular.' But they are Zionists. They are Israeli patriots. [...] They are the Jews for whom Israeli nationality has replaced Jewish religiosity."[136]

The last group consists of the "Universalists," a group that does not consider the state or religion to be important for their Jewish identity. They do not consider being Jewish important, but consider it to be a biographical fact and do not attribute cultural or intellectual significance to this circumstance. Almost half of this groups' members (47%) are of the opinion that there is a lot of religious coercion in Israel.

2.2.2.1 What's in a Label? Israeli Orthodox Religious Cultures

The rough classification of Israeli Jewish religiosity into three categories, namely *hiloni* (secular), *masorti* (traditional), and *dati* (religious), has been adjusted and refined multiple times. The Jewish People Policy Institute completed one of the most recent classifications. Instead of the "regular" three categories, they promote seven "levels of religiosity," of which only the religious subgroups will be presented as follows:[137]

First, there are the *haredim*. Key traits that identify the most traditionalist branch within the Jewish religious spectrum include Torah study and full commitment to Halakhah, comprehensive societal supervision of lifestyles, a conservative worldview, faith in the coming of the Messiah and rejection of the Zionist vision, physical and spiritual communal seclusion,[138] adherence to the community's special educational institutions, and external characteristics such as sidelocks, dress, and head coverings.[139]

For many outsiders, *haredim* may seem like a black and white monolith. However, this umbrella term serves as a generalization for a diverse group, mainly *hasidim* and *litvish/yeshivish* Jews,

[136] S. Rosner and C. Fuchs, *Israeli Judaism*, p. 43.

[137] See ibid., pp. ix–x.

[138] The two largest *haredi* enclaves in Israel are Bnei Brak, close to Tel Aviv, and the neighborhoods of Northern Jerusalem. They work like cities within cities and their residents are almost exclusively *haredi*. They emerged in reaction to the secular community surrounding them. This life-style is sometimes called rejectionist, contra-acculturalist, sectarianist, or fundamentalist.
Communities known as Anglo-*haredi* or cosmopolitan *haredi* or those termed as "mainstream intense" are found in Haifa, Bnei Brak, Har Nof/Jerusalem, or Modi'in Illit (Kiryat Sefer). See an insider discussion on *haredi* sectors in this forum: *Imamother*.

[139] See S. Rosner and C. Fuchs, *Israeli Judaism*, p. 135.

the latter often being referred to as *mitnag'dim*.[140] *Haredim* may also include the *haredi*-Sephardic sub-sector, which is a distinct Israeli novelty.[141] The contemporary *haredi* branches are further divided by loyalties to particular religious leaders and *hasidic* courts. The *hasidut* of Chabad Lubavitch is sometimes comprehended as a separate stream, differing from most other *hasidic* branches in many ways. Chabad set out as one of many *hasidic* dynasties in eastern Europe, but their sixth and especially seventh Rebbe, Menachem Mendel Schneerson, turned it into a global movement, with its headquarters in Crown Heights, Brooklyn, New York. Chabad is famous for its outreach and differs from other *hasidut* in how it permeates secular society. The intrinsic motivation behind this enterprise is to accelerate the coming of the Messiah and the day of redemption through their actions. In order to reach this goal, it is believed that Jews must keep the *mitzvot*. Thus, it is the purpose of the Chabad emissaries, the *shluhim*, to assist as many Jews as possible in performing *mitzvot*. Schneerson transformed this *hasidic* group into a highly sophisticated and well organized institution, which did not shy away from engaging with modernity and technology.[142]

A high proportion of *haredim* receive economic support and study in the *yeshivot* for several years:

> As a 'cloistered community,' unconcerned with making a living and often sheltered from the pressures of families and local communities, they develop a self-image of an elite of Torah scholars who lead the way in their emphasis on the necessity of the most stringent interpretations of the religious law.[143]

In this context it is worth mentioning Avraham Yeshajahu Karelitz (1878–1953), better known under his pen name Hazon Ish. He is regarded by many as the archetype of the learned Jew who studied Torah *lishmah*, or Torah for its own sake. He elevated halakhic stringency, or *humrah*, to the standard mode of religious operation, especially after he and his wife settled in Bnei Brak in 1933. The Hazon Ish can be thought of as a major figure in the transformation and radicalization of Orthodox Judaism. The destruction of the traditional communities of eastern Europe during the Holocaust left a vast social and religious vacuum. Ultra-Orthodoxy had to be rebuilt on the basis of voluntary communities, but much of the customs and traditions had been lost. Rupture of the living tradition created a sense of lack of confidence, and therefore the lived traditions and customs had to be reconstructed via written codes and book knowledge.[144] One might well argue

[140]Literally adversaries (against *hasidism*). The term was introduced during the culture clash between the two groups in the 18th century.

[141]S. Rosner and C. Fuchs, *Israeli Judaism*, p. 135.

[142]See Heilman and M. Friedman, *The Rebbe*. For the distinct messianism of Chabad see Berger, *The Rebbe, the Messiah*.

[143]Sharot, "Sociological Analyses," p. 27.

[144]See M. Friedman, "The Lost Kiddush Cup"; Heilman, *Sliding to the Right*; H. Soloveitchik, "Rupture and Reconstruction," "New Role of Texts."

that this is the result of a process that exchanges "practice" for "theory," or rather, a new practice with strong roots in theory.

With the triumph of book knowledge over life tradition came the emergence of the community's call for greater stringency. A notable example of a "new" tradition is that of *shiur* Hazon Ish. A *shiur* is a measure of volume, area, length, or width which is essential to the performance and correct observance of major precepts. Most frequently used measurements are *k'zait* (like an olive [145]), as a measure for the minimum amount of *matzah* one is obliged to eat on Pessah; *k'beitzah* (like an egg), which is the minimum amount of food mandating *birkat ha-mazon* (Grace) after meals; and *revi'it*, a volume to measure a liquid, like the amount of wine one has to drink for *kiddush*. These three measurements, two of which are based on products of nature, are set to a fixed ratio: one *k'beitzah* equals two *k'zayts*,[146] and a *revi'it* equals one and a half *k'beitzah*. The sages of the Talmud and the *rishonim* additionally used alternative descriptions and means of measurement. Rabbi Yechezkel ha-Levi Landau (1713–1793) was the first to perform experimental measurements, noting discrepancy and incompatibilities. He raised the possibility that today's eggs are only half as large as the average egg in Talmudic times. In order to rectify this situation, he invoked a phrase first used by the Tosafists albeit in another context: "Nature has changed."[147]

[145]Shulhan Arukh, Orah Hayyim, 486:1: שעור כזית יש אומרים דהוי כחצי ביצה—The measurement of a *kezayit: Some say it is half an egg.*

[146]According to Maimonides a dried fig is one third of an egg and an olive slightly smaller than a dried fig.

[147]The secondary literature I consulted did not specify, how exactly Landau came to the conclusion that eggs are half as large today as they were in Talmudic times. I did not understand which discrepancy was responsible for this extremely farfetched explanation on the basis of the "nature has changed" argument. I tried to comprehend and therefore played around with different online sources and calculators, eggs in my fridge (organic), and a Coca Cola can (330 ml) that has pretty much the size of a *log* (320 ml).
A Kiddush cup must hold a *revi'it*, a quarter of a log (1 *log*=0.32 liter), i.e. 82.5 ml (Shulhan Arukh 472:9). According to several passages in the Talmud, a log is also equivalent with six eggs, therefore, a *revi'it* is like one and a half eggs. In Pesahim 109a the definition of a *revi'it* differs: אמר רב חסדא רביעית של תורה אצבעים על אצבעים ברום אצבעים וחצי אצבע וחומש אצבע—Rav Hisda said: The *revi'it* of the Torah is two fingerbreadths by two fingerbreadths by the height of two fingerbreadths and one half fingerbreadth and one-fifth of a fingerbreadth. Rabbi Landau compared the volume of one and a half eggs (one *revi'it*) with the measure given in Pesahim 109a. They did not correspond, because the volume of the eggs was half as much as the result of the calculation with the measures given in Pesachim 109a. The ratio must have been roughly 75 ml (egg mass) to 149 ml. The latter result is based on a calculation if 2.4 centimeters are taken as the unit for one fingerbreadth. Obviously, a certain Rabbi Frank, one of Landau's students maintained that Landau set the width of a thumb at 2.4 centimeters (according to Rabbi Adin Steinsalz the unit "finger" gets measured at the widest part of the thumb) and concurrently emphasized that Landau himself was a tall man (see Finkelman, *How Big Is An Olive?*). Therefore 4.8x4.8x6.48 equals 149.3 cm3 which is well double the volume of the mass of a*revi'it* I calculated on the basis of my organic egg (medium size, I guess) from the fridge; it added up to 70.05 cm3. I proceeded with my experiment and measured my own thumb width which is obviously 2.0 cm; one could argue that average women's thumbs are smaller; but in fact it is exactly the measure Rabbi Avraham Chaim Naeh, a contemporary of the Hazon Ish, set for the width of a thumb, i.e. 2.0 cm. Utilizing this measure one yields a volume of 86.4 cm3. Furthermore, the 86.4 cm3 (86.4 ml) also correspond with the other 82.5 ml (quarter of a log). Thus, the difference between the two ways of measurement is pretty accurate, if one does not use the paws of a Torah giant for measurement. If the egg in my fridge would have been slightly bigger, I would have had identical measurements. But

The argument of *nishtanu ha-teva'im*, or "nature has changed," was adopted by the Hazon Ish who, unlike Landau, "declared axiomatically that 'today's eggs are smaller."[148] The revolutionary move taken by the Hazon Ish thus was not with respect to the idea itself— the idea was not even his, but Landau's. The difference is its translation into practice. This aspect frames Rabbi Karelitz's approach in general, since he laid emphasis on the practical application of theoretical conclusions.[149] Thus, based on the calculation of Rabbi Landau, the *shiur* Hazon Ish is almost double as big or voluminous as other standards:

> Previously, such disputes were essentially theoretical alone, argued purely for the sake of Torah study. In contrast, the Hazon Ish's stipulation was also of practical significance, as it created a new halakhic norm, the *shiur Hazon Ish*, which is accepted today by almost all Haredi society and even by some non-Haredi religious Jews. In most if not all Haredi homes, the volume of *Kiddush* cups (at least *revi'it*), the *kezayit* of matzo eaten on Seder night, and even the dimensions of the *tallit qatan* worn by men all conform with the *shiur Hazon Ish*.[150]

The *shiur Hazon Ish* is just one of many examples that describe the re-interpretation of life traditions by means of book knowledge. In addition to stringency in matters of Halakha, traditionalism and anti-modernism are traits telling of *haredi* Judaism and the culture that the Hazon Ish represented. He was critical of the learning style that was the most accepted in the *yeshivah* world at the time, i.e. the Brisker method. This analytical approach to studying the Talmud was developed by Hayym Soloveitchik, also known as Reb Hayyim Brisker.[151] The method includes conceptual creativity and innovation. Innovation, or *hiddush*, applies to two realms: halakhic ruling and the study of the Talmud (*lomdus*). Followers of the analytic movement adopted this method because it allowed "a student's intellectual powers full range of expression, and that was as

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it was this disproportionate result that made Rabbi Landau suggest that eggs were double as big in ancient times as they are now and the reason why *haredim* deal with giant imaginary olives and eggs today.

The "nature has changed" argument to this extent seems completely absurd, especially in light of other Talmudic passages. For example Yoma 80a states: רבי אבהו דידיה אמר מכל האוכל אשר יאכל אוכל שאתה אוכלו בבת אחת ושיערו חכמים אין בית הבליעה מחזיק יותר מביצת תרנגולת—Rabbi Abahu said himself: Of all the food which may be eaten. Food that you eat at one time. The sages estimated: The esophagus cannot hold more [than the volume] of a chicken's egg. Thus, if the eggs almost 2000 years ago were double as big as they are today, what does that make with the anatomy of human beings at that time? Rabbi Joseph D. Soloveitchik is reported to have answered to the question how big a *kezayit* is with the following answer: "*K'zayis*? How big is a *k'zayis*? I don't know. But I know a *k'zayis* is according to most *rishonim* is a *chatzi beitzah* (half and egg) and according to Rambam is one *shlish* of a *beitzah* (third of an egg), and I know that elephants don't lay eggs." (See as cited in Finkelman, *How Big Is An Olive?* See also Slifkin, *The Evolution of the Olive*).

[148]M. Friedman, "The Lost Kiddush Cup," p. 180.

[149]See Čejka and Kořan, *Rabbis of Our Time*, p. 95.

[150]M. Friedman, "The Lost Kiddush Cup," p. 180.

[151]See Stampfer, *Lithuanian Yeshivas* for the educational setting of higher Talmud institutions in Lithuania. On the analytic method see Saks, "Brisker Method"; D. Schwartz, *From Phenomenology to Existentialism*; Shapiro, "Brisker Method Reconsidered"; Solomon, *The Analytic Movement*.

demanding, as rigorous as any discipline the secular world had to offer."[152] Therefore, America's Modern Orthodox's Torah giant Joseph D. Soloveitchik, Reb Hayyim's grandson, felt that thanks to his grandfather, Torah has not been forgotten in Israel. Regardless of the veracity of such an assertion, the Brisker method was popular among most Lithuanian *yeshivot*, and its inventor was revered for his well thought *hiddushim*.[153]

However, the Hazon Ish is famous for having stated that "Hiddush is alien to my nature."[154] In his opinion "one should not innovate (*le-haddesh ha-devarim*) but search out (*le-vakkesh ha-devarim*)."[155] He favored a more text-centered and *p'shat*-oriented approach, which was typical for scholars who preferred the "traditional" way to study, as did Hayyim of Volozhin (see below), a student of the Gaon of Vilna, or Rabbi Naftali Zvi Yehuda Berlin (Netziv), *rosh yeshivah* at Volozhin from 1854–1892. "What is required is to study and review the text several times, even without any *hidush*, and to carefully examine matters in which the intellect, to being with, takes no pleasure, matters which, on the contrary, it finds burdensome."[156]

As Lawrence Kaplan points out, the Hazon Ish's opposition to the analytic method is linked to a fundamental ideological standpoint. Creativity and use of intellect concedes to the modern emphasis on the self and its intellectual autonomy. The goal of Torah learning is, according to the Hazon Ish, the in-depth analysis of the text and the student's submission to the authority of the text. "For if R. Soloveitchik is one of the great MODERN halakhic thinkers of our time, the Hazon Ish was one of the century's great ANTIMODERN halakhic thinkers."[157] Thus, while America has Joseph D. Soloveitchik, Israel has the Hazon Ish.

Stringency, submission to the authority of Halakhah and the respective communities' leaders, as well as the observance of social codes frame *haredi* life. *Haredim* try to weed out individualism from their communities. Thus, heteronomy is a structural trait of *haredi* society. In these social circles ethical decision-making in the medical setting does not have much in common with contemporary Western standards. As will be elaborated in the following chapters, hospitals run by *haredi* authorities have policies that differ from those of other hospitals. Thus, there are practical consequences due to the dissonance between biomedical ethics and medical Halakhah (*halakhah refu'it*). Four hospitals altogether operate under halakhic auspices in Israel, a phenomenon completely absent in the United States.

[152]L. Kaplan, "The Hazon Ish," p. 153.

[153]His only authentic work is *Hiddushe Rabbenu Hayyim Ha-Levi al ha-RaMBaM*.

[154]Hazon Ish, Shevi'it, Siman 7 as cited in L. Kaplan, "The Hazon Ish," p. 154.

[155]Hazon Ish, *Likuttei Sanhedrin*, Siman 22 as cited in ibid. One may wonder how the Hazon Ish could oppose all human creativity in the halakhic process that would lead to a *hiddush*, while simultaneously setting new halakhic norms, as was the case with the *shiur*.

[156]Qovez iggerot, 1:26 (letter 2) as cited in ibid., p. 156.

[157]Ibid., p. 154.

However, most religious Jews in Israel today do not identify with the *haredi* camp. Instead, many identify with the wider field of religious Zionism, *zionut datit*. This orientation is often used interchangeably with the category of *dati leumi* (or just *dati*), national religious. Religious Zionists, or *datiim*, base their religious self-conception on Zionistic ideology.[158] If one is to be pedantic, the three major branches can be distinguished as follows: liberal-religious (*dati liberali*), national-religious (*dati leumi*), and national-haredi (*dati torani*).[159] Thus, a widely accepted distinction between groups constituting the religious field in Israel is not necessarily determined by degree of observance of the commandments, but instead based upon attitudes toward Zionism and the State of Israel.[160] *Haredim* are generally non-Zionists, meaning that the modern national state does not serve as a point of reference for their identity, but rather *Eretz Israel*, or the Land of Israel. The most extremist groups of *haredim* in that regard are the anti-Zionist adherents of the Eda Haredit and Neturei Karta in Israel, as well as the *hasidic* Satmar community located in Williamsburg and Kiryas Joel, New York. Anti-Zionist groups and institutions do not receive money from the state for their religious institutions. *Haredi* antagonism toward Zionism is mainly due to their opposition to political activism before arrival of the messianic age and the objection to maintaining any form of cooperation with Jewish secularists.

This deeply contrasts with the approach of religious Zionists who try to adapt rather than reject or isolate themselves from secularization and modernization.[161] Rabbi Avraham Yitzhak Ha-Kohen Kook (1865–1935), a highly influential rabbinic figure within religious Zionism, was the first Ashkenazi Chief Rabbi in Mandatory Palestine. He is considered to be the spiritual father of the synthesis between Orthodox Judaism and modern secular Jewish nationalism. Although Kook did not live to see the establishment of the State of Israel, his influence was far reaching. According to his understanding, Zionism and the State of Israel represent sacred expressions of messianic redemption. As in many other realms of his theology, Kook attached religious value to a distinctly secular enterprise. Not only did he have a highly positive opinion of the Zionist

[158] *Zionut datit* could possibly be the Israeli equivalent religious concept of Modern Orthodoxy, although the interrelationship with "modernity" differs. Samson Rafael Hirsch's concept of *Torah im derekh eretz* and Yeshiva University's *torah u-madda* approach attempt to link the secular with the religious (or sacred) realm in a sort of positive dualism, while at the same time these realms remain distinct from each other. The model shaped by Rabbi Kook subsumes the secular within the realm of the religious. As Benjamin Ish Shalom points out regarding this so-called "third way:""Orthodoxy [...] is modern in the sense that it is engaged in a constant process of encounter, dialogue, and confrontation with Modernity—a process bound up with the internalization of modern values and with perpetual self-change." (Shalom, "Rabbi A. I. Kook as Authority Figure," p. 77)

[159] A category that S. Rosner and C. Fuchs, *Israeli Judaism* do not include in their classification of Israeli Judaism, but which somewhat borders the *haredi* camp, are the *hardalim* (*haredi dati leumi*), a group almost as religiously strict as the *haredim*, but also fervently Zionist.

[160] See Don-Yehiya, "Does Place Make a Difference?" Pp. 53–54.

[161] See Don-Yehiya, "The Book and the Sword," p. 266.

movement, but also identified with its political activity as well as Jewish resettlement in *Eretz Israel*. Furthermore, he maintained close relationships to both Torah scholars of the diaspora and people of the second Aliyah—atheists who rejected tradition and Halakhah.[162] It is difficult to describe Kook's thought processes, definitive positions, as well as the influence and intellectual location of non-Jewish culture and knowledge in his *weltanschauung*:[163]

> If we were to characterize the essential nature of Rav Kook's thought, its central element would be his refusal to be content with the ordinary, his untiring search for what is beyond, and his awareness that whatever is perceived is only one aspect of manifold reality, multidimensional and limitless. This quality creates the dialectical nature of his thought. It is reflected in his relationship to mysticism and rational philosophy and his unwillingness to forego either of them, from his understanding that no restricted approach to reality can satisfy the undefatigable demand for completeness.[164]

Kook's holistic perception of reality seemingly encompasses all realms that may be conceived as dichotomous. For instance, he repeteadly called for the fusion of Aggadah and Halakhah, arguing that the spirit of *nevuah* (prophecy), exemplified by such a fusion, must be part of the national revival.[165]

Compared to his father, Rabbi Zvi Yehuda Kook (1891-–1982) was more of a religious activist. As *rosh yeshivah* of the Merkaz ha-Rav Yeshiva (founded by A. I. Kook two years prior to his death) from 1952 to 1982, he was an important figure in securing religious Zionist education for the national religious. Merkaz ha-Rav was the first Zionist *yeshivah* and remains a flagship within national religious and *dati torani*, or national-*haredi*, circles. Today it is located in Jerusalem's Kiryat Moshe neighborhood. Additionally, as co-founder and spiritual leader of the Gush Emunim settlement movement, Rabbi Zvi Y. Kook furthered the expansionist response of Orthodox Judaism to modernization and secularization.[166]

One of the State's superstructures that epitomizes the struggle of sustaining a broad base of support within a pluralistic society and a democratic state, while retaining religious integrity as a Jewish institution, is the Israeli Chief Rabbinate, the *rabbanut rashit le'israel*. It has the sole control over personal status issues, such as marriage, divorce, conversions, and Jewish burial, a fact that creates constant frustration within the secular and non-Orthodox population because

[162]See Shalom, "Rabbi A. I. Kook as Authority Figure," p. 75.

[163]See Shatz, "Rav Kook and Modern Orthodoxy," pp. 110–115.

[164]Shalom, "Rabbi A. I. Kook as Authority Figure," pp. 60–61.

[165]See Shatz, "Rav Kook and Modern Orthodoxy," p. 100. Shatz also notes that in contrast to this worldview which values freedom and creativity of human action, obviously little is felt in matters of his *p'sak* (halakhic decision). Although he was not a halakhic formalist and called for an approach to Halakhah that would be infused with prophetic spirit, he used conventional methods in *p'sak*. This discrepancy and inconsistency led to Kook's perplexing legacy.

[166]See C. Liebman and Don-Yehiya, *Civil Religion in Israel*.

it does not allow for equivalent options outside this specific religious framework (see Reform below). Especially within the secular sector, this union of state and religion regarding life-cycle events is often perceived as religious coercion. Fourteen percent of Israelis feel that there is religious coercion of the highest degree, i.e. a ten on a scale of one to ten.[167] The fear or anger over the infiltration of religious values into Israeli society and culture is quite common. While the antipathy of the secular sector is quite self-evident, the Chief Rabbinate's rabbinic authority with regard to spiritual leadership and the specific area of *p'sak* seems to carry relatively limited weight even within the religious sector. Rabbi Aharon Lichtenstein, a former *rosh yeshivah* of Yeshivat Har Etzion, a *hesder yeshivah*[168] in the Westbank, pointedly critiques the Rabbanut:

> Secularists and *haredim* largely ignore it, while the non-Orthodox actively fight it. Its status in the *dati-leumi* community is more secure, but, even there, many offer it little more than honorific lip service, having recourse to it only at their convenience. Moreover, as it has become increasingly regarded as the virtual patrimony of a dominant faction, its base of support has narrowed, and the number of those who truly look to it for guidance has dwindled.[169]

Regarding the Chief Rabbinate's status within the *dati leumi* sector, Lichtenstein further contends:

> Rabbi Kook's dream related to the specifically national aspect of the Chief Rabbinate—to the dimension of *mamlakhtiut* so prized by religious Zionism. That dimension entails, however, a presumed relation to a broad social spectrum and the ability to speak for and to divergent cultural and ideological sectors.[170]

Due to this lack of connectedness some national religious figures have come to realize that the Chief Rabbinate fails to effectively address the needs of the pluralistic Israeli population, thereby fostering greater alienation. This phenomenon is not surprising when one takes into account the fact that most recent chief rabbis have had strong allegiances to the *haredi* community and less

[167] See S. Rosner and C. Fuchs, *Israeli Judaism*, p. 58.

[168] A *hesder yeshivah* is a *yeshivah*, or higher institution for Torah learning, which operates a program that combines *yeshivah* studies and active army service.

[169] Lichtenstein, "Israeli Chief Rabbinate," p. 131. The extensive critical voices against the Israeli Chief Rabbinate and its legitimacy bring to mind similar attitudes harbored against the status of the so-called crown rabbis in Russia (similar concepts were in place all over eastern Europe) during the 19th century. The authorities acknowledged two types of rabbis: crown rabbis and spiritual rabbis. According to the Russian Constitution of 1835, every community and district was supposed to have a crown rabbi, who had acquired at least a high school education and was fluent in the national language. He represented the community before the authorities regarding religious issues, was responsible for recording births, deaths, marriages, and divorces. Some crown rabbis had extensive rabbinic knowledge and were recognized as learned authorities in their communities, but many lacked education in a traditional *yeshivah*, e.g. Volozhin. It was due to the lack of traditional *yeshivah* training that they were often ridiculed and their authority not taken seriously within *yeshivah*-circles of the traditional brand. In contrast, spiritual rabbis were not recognized as having any official status. (See Gertner, *Rabbinate*; Stampfer, *Lithuanian Yeshivas*).

[170] Lichtenstein, "Israeli Chief Rabbinate," p. 136.

so with the *dati leumi* sector.[171] While both chief rabbis elected in 1983 were identified with the national religious camp, the following three elections in 1993, 2003, and 2013, did not benefit the Zionists.

> This change was due to the decline in the political fortunes of the National Religious Party (NRP) that supported the Religious Zionist rabbis and the increasing prominence within coalition politics of the *haredi* groups—particularly the Sephardi Shas party. The result was that after a period of hope that the state rabbinate would indeed become the center of national religious rabbinic activity the system reverted to its previous condition.[172]

In reaction, to stop further discrepancy and alienation between secular and religious sectors within Israeli society, various alternatives to the Chief Rabbinate emerged. One of the best known is Tzohar, an organization established in 1995. One of its co-founders, Rabbi Yuval Cherlow, explains: "We were five founders who, after our prime minister's assassination [Yitzhak Rabin], felt that there is a big, a huge gap between the secular, religious, and Orthodox groups and we're trying to bridge, to bridge it in all kinds of ways, this gap between secular and religious people."[173] Their vision, which is published on their website, is short and straight to the point: "A sustainable cohesive Israeli Jewish society."[174]

The founders of Tzohar are national religious rabbis, most of whom graduated from the Merkaz HaRav Yeshivah and served in the IDF. Their first initiative and core activity is in the performance of marriages for non-observant couples by trained "Tzohar rabbis," who are sensitive to the needs of their secular clientele. Furthermore, in contrast to *haredi* rabbis or rabbis from the Rabbanut, Tzohar rabbis most likely have more in common with most secular couples due to common experiences such as IDF service or popular culture. Another "feature" that facilitates the Orthodox marriage experience for secular couples is the fact that religious women, many of whom are wives of Tzohar rabbis, teach the laws of family purity (*taharat ha-mishpahah*) to the brides, an instruction that has absolutely no practical value in the lives of secular Israelis, but is required by the rabbinate before marriage. "Tzohar rabbis" are approved to perform wedding ceremonies by the Rabbanut, but are not employed through it. In 2005, Tzohar rabbis conducted ten percent of all Jewish weddings in Israel.[175]

Another service Tzohar offers is the "Ask the Rabbi" interface on their website. The rabbis who answer questions on the platform are specialists in a particular area of Jewish law. The amount

[171] The New York Times labeled both present Chief Rabbis Ultra-Orthodox. See Rudoren, *Israel's Chief Rabbis*

[172] Ferziger, "Religion for the Secular," p. 81.

[173] Interview with Yuval Cherlow, 13.6.2011, Petach Tikva. Quotation at time stamp #00:01:37-5#. Cherlow was interviewed as part of the research project due to his expertise and involvement in medical Halakhah.

[174] *Tzohar*.

[175] See Ferziger, "Religion for the Secular," p. 71.

of emails that reach Rabbi Cherlow is remarkable: "I think, there's approximately 50'000, 50'000 questions and answers that I've done through the years and those questions are very wide range issues."[176] One set of questions that Rabbi Cherlow fields is that of medical ethics. He is widely regarded as an expert in issues of medical ethics/medical Halakhah. As opposed to the Chief Rabbinate, Tzohar and similar organizations are interested in offering services to all of Israel's population, even if it means confronting the former. This was the case in 2007, when the rabbinate adopted a stringent policy regarding a *kashrut* matter with an agricultural impact (*heter mekhirah*). With the approbation of several of the country's leading national religious rabbis, Tzohar created an alternative kosher supervision framework and supported an appeal for an injunction from the Supreme Court against the Rabbanut's policy. The latter responded by threatening to annul the rabbinic ordination of any rabbi involved in this Tzohar-initiative.[177]

The frustration over the Chief Rabbinate's omnipotence regarding religious affairs seems to permeate all strata of Israeli society. One segment, which has been actively fighting it for a long period of time already, is the Israeli Reform Movement.

2.2.2.2 The Reform Movement in Israel

The institutional beginnings of Reform Judaism in Israel were laid in 1958 with the founding of the Harel synagogue in Jerusalem, followed by five congregations in the early 1960s. The World Union for Progressive Judaism moved its headquarters to Jerusalem in 1973 with the goal of "establishing Progressive Judaism's international presence in Zion and reflecting its commitment to help build a strong indigenous movement."[178]

The Reform Movement in Israel is generally conceived as a foreign product on the Israeli religious market, that does not seem to sell well: "There is only one American product in Israel that has not caught on—only one item actually denigrated as unauthentic because it is imported. That exception is non-Orthodox religion.[179]" All scholars of Israeli religiosity agree that in contrast to their success and dominance in North America, Reform and Conservative Judaism have failed to perform likewise in Israel due to a couple of reasons.

First, Israeli Jews are not familiar with a denominational pattern per se. And even if they are, they identify inconsistently with denominations. Pollsters Rosner and Fuchs conclude that some Jews might say in one survey that they are Reform and in the next that they have no denomination,

[176] Yuval Cherlow, 13.6.2011, Petah Tikva. Quotation at time stamp #00:03:59-0#.
[177] See Ferziger, "Religion for the Secular," p. 74.
[178] *Israel Movement for Reform and Progressive Judaism*.
[179] Tabory, "Influence of Liberal Judaism," p. 183.

but self-identify in both cases as secular. Thus, "most Israelis who self-identify as Reform or Conservative do not treat such identifications as a salient feature of their identity. In fact, when they have to choose between self-identifying as Reform *or* secular, a vast majority opt for secular."[180] With the following quote, Hebrew University's professor Shlomo Avineri pointedly captures the cultural pattern consisting of a combination of non-observant behavior and acknowledgment of the Orthodox frame of reference: "I won't go to a synagogue, but the synagogue I won't go to is an Orthodox one."[181]

Second, the early establishment of Orthodoxy, which holds the official monopoly on Judaism in Israel, prevents the Reform movement's fusion with the state's religious institutional framework.[182] This phenomenon, known as the status quo, was an agreement made between David Ben-Gurion and *haredi* leaders at the time of the founding of the State of Israel. "The secular government allowed the Ultra-Orthodox community to exist in its 'ghettos,' according to its own rules, and the Ultra-Orthodox were not supposed to exert their political power to introduce religious laws in addition to those already in existence.[183]" Thus, the religious authorities of the Conservative and Reform movements are not officially recognized and their institutions are not, with some minor exceptions, financially supported by the state.[184] After decades of struggle, the movements have made some progress. In 2012 the Israeli state has guaranteed to pay for Reform and Conservative rabbis' salaries the same way that regional councils do for Orthodox rabbis whom they employ. Nevertheless, a workaround was necessary to prevent things from going too far:

> The State held that the deal on Reform and Conservative rabbis will not be made via the religious council and will not be done via direct employment by the local authorities, rather via financial assistance. The Reform movement agreed to this. Financing will be the responsibility of the Culture and Sports Ministry and not the Religious Services Ministry.[185]

Another aspect of the status quo which is often at the center of public debate, is the exemption of *yeshivah* students from compulsory service in the IDF. The consequent rejection of *haredim* to serve in the Israeli army does not resonate well with most Israeli Jews, since, as previously pointed out, serving in the IDF is a major identity marker of Jewishness in Israel. 72% of Israeli Jewry believe that being a good Jew means raising one's children to serve in the IDF.[186] Reform Jews in Israel take

[180]S. Rosner and C. Fuchs, *Israeli Judaism*, p. 165; see also Sharot, "Sociological Analyses," p. 2.
[181]Don-Yehiya, "Orthodox Jewry," pp. 157–158.
[182]See A. Cohen and Susser, "Reform Judaism in Israel"; S. Rosner and C. Fuchs, *Israeli Judaism*; Sharot, "Sociological Analyses"; Tabory, "Influence of Liberal Judaism," "Market for Liberal Judaism."
[183]Elbaum and Tremonti, "A House Divided," pp. 613–614.
[184]See Sharot, "Sociological Analyses," p. 21.
[185]Ettinger, *Reform and Conservative Rabbis*.
[186]See S. Rosner and C. Fuchs, *Israeli Judaism*, p. 43.

issue with the third aspect of the status quo, namely the exclusive Orthodox authority in matters of family law.[187] The Orthodox establishment does not view *masorti* Jews or secular Jews, with their non-existent or limited inclinations towards Jewish religious heritage, as problematic. Instead, it is the Reform and Conservative movements that are problematic, because they challenge Orthodoxy on institutional grounds. But those who "only" neglect to practice the *mitzvot* are not dangerous, since they constitute a population theoretically available for *t'shuvah* (religious repentance) and for whom Orthodox practice and halakhic authority is a religious ideal. Progressive Judaism in Israel, however, constitutes an alternative Judaism which, at least in the case of Reform, systematically legitimizes religious laxity, i.e. individual decision-making.[188] Though *masorti* Jews have never established institutions, a religious elite, or educational infrastructure, Reform Jews have set up a religious structure that challenges Orthodox Judaism.[189] From this normative perspective, it is clear that granting the Reform Movement the right to be a part of the Israeli religious establishment would indicate approval for the values that Orthodoxy largely considers to be deviant.[190]

2.3 Different Models of Communitas: American Jewish Congregationalism and Israeli Judaism

The previous sections reviewed the cultural and religious contexts of Reform and Orthodox Judaism and their embeddedness in different national settings. Subject matter of the following section is the introduction of a network relevant difference between a "closed" and "open model" of religious communitization (*Vergemeinschaftung*). The fact that Israeli Jews do less "congregate" than American Jewry, had a lasting effect on the development of this research project. Thus, concepts that have emerged from the practical difficulties of the research process must also be evaluated in research practice.[191]

[187] Furthermore, the status quo extends rabbinic control to the realms of *kashrut*, its supervision, and certification, as well as Shabbat. On the Jewish day of rest public transportation is forbidden, most businesses are closed, and *haredi* neighborhoods shut to traffic.

[188] Sephardi Judaism has been characterized by considerable tolerance for religious laxity too.

[189] See Tabory, "Market for Liberal Judaism," p. 292.

[190] The rather aggressive attitude towards the Reform movement by the right-wing Orthodox segment in Israel was clearly communicated to me. One of the interviewees tried to cancel our meeting, after he realized that my sample consists of both Orthodox and Reform rabbis.

[191] "Begriffe, die aus den praktischen Schwierigkeiten des Forschungsprozesses heraus entstanden sind, müssen auch in der Forschungspraxis evaluiert werden." Bourdieu and Wacquant, *Reflexive Anthropologie*, p. 198. The text in the grey box describes a crucial step in the research process.

The insights as presented below were formed at an early stage of the project, during the first research stay in Jerusalem, after a two months' struggle of not finding the "right" interviewees. The paradox of my poor recruitment of Orthodox rabbis for the interviews in Jerusalem while my relative ease in doing so the previous year in New York, helped me address my research bias as well as challenge my perceptional parameters regarding the organizational structure of religious life in both places. An additional confounding variable was the fact that in contrast to the Orthodox rabbis I sought to interview, the rabbis of Reform congregations in Jerusalem were easily accessible and very willing to share their experiences. Since the local "reality" did not provide me with what I expected, I had to adjust my perception of the conditions, i.e. the social structure of Orthodoxy in Israel and Jerusalem especially. In the beginning, I assumed that I could proceed with my sampling more or less in the same fashion I had done in New York. However, at that point I did not fully grasp the difference in organizational structure of Orthodox Judaism in Israel as compared to European and American contexts.[192] Thus, I unconsciously tried to operate against the backdrop of a socio-cultural background that did not exist. I began to realize that despite my research design claiming to be context-sensitive, gaps remained. In reverse of Karin Knorr Cetina's postulation that "understanding knowledge societies will have to include understanding knowledge practices,"[193] I realized that to understand rabbis' (knowledge) practices regarding biomedical issues, I must first revise my understanding of Israeli Orthodox (knowledge) society.

2.3.1 The Closed Model: Community as Structured and Institutionalized in the United States

As contextualized above, religious traditions in the United States developed within the general setting of religious pluralism and legal toleration. Such religious diversity that informally existed almost from the beginning, was legally ratified by the Constitution in the late eighteenth century. Separation of religion and state, despite the latter's protection of religious organizations, is crucial for understanding the role of religious organizations in the United States.[194] American Jewish

[0] I am well aware of the difference between "European" and "American" Jewish communal structures. Especially in German-speaking countries Jews are often organized into so-called "Einheitsgemeinden," a form of congregation that assembles a large span of religiously diverse Jews, ranging from nearly secular to modern-Orthodox, especially in smaller cities. Other institutional models that are distinctly Ultra-Orthodox communities, Reform, or Conservative congregations may exist within larger urban areas as well. In large cities or metropolises with a high population density, such as New York, there is great diversity in the denominational and post-denominational "religious market."

[0] Cetina, "Objectual Practice," p. 186.

[194] See Ammerman, "Denominationalism/Congregationalism," p. 354.

religious culture, in its constant negotiation between immigrant heritage and Americanization, was protected–but not governed–by the state.

Organizational theorists delineate religious organizations in the United States into three broad categories: congregations, denominations, and religious groups with a special purpose (or "parachurch").[195] With regards to the congregational pattern of American religious life, Nancy Ammerman concisely states in her review of the literature on the topic, that "no matter what their official theology proclaims about the purposes of local assemblies and their prescribed mode of governance, in this country, religion is 'congregational.' Religious groups assume that they can voluntarily form, that they should govern their own affairs, and that their own participation and leadership are necessary for carrying on the religious tradition."[196] This so-called "de facto congregationalism" provides the typical pattern for local religious groups.[197] The congregational model is the American organizational template for religious communitization and is best explained with the existence of institutional isomorphism, i.e. the resemblance of similar organizations in their "field" by imitation and compliance with regulation. The higher goal of such institutionalization of religion is to preserve and transmit subcultural identity.[198]

Jewish congregations are no exception to this organizational blueprint. Right from the beginning, in a predominant but diverse Protestant environment, the establishment of communal structures secured Jewish "identity,"–even though "Jewish identity" has never been a fixed entity, but a subject of negotiation. Most important with reference to Jewish congregationalism is the inclusion of institutional aspects which are part of the congregation's socio-religious support system. For example, the installation, supervision, and maintenance of kosher meat and *sh'khitah* (ritual slaughter), the educational opportunities for the young, the intra-communal set up of *bikkur holim* groups and *hevrah kaddishah*, or the many other charitable networks were traditional cornerstones of Jewish synagogue-communities. After congregational and denominational diversification, largely influenced by mass immigration, Jewish congregations started to merge certain structures of common interests (i.e. schools), or were complemented by organizations that catered to special needs, like the Hebrew Immigration Aid Society founded in New York in 1881 or the UJA-Federation of New York, today's largest local Jewish philanthropic society worldwide.[199] Regarding the evolution of the "American synagogue" in its congregational habit, historians used

[195] See Ammerman, "Denominationalism/Congregationalism."
[196] Ibid., p. 357.
[197] See Warner, "Place of the Congregation."
[198] See Ammerman, "Denominationalism/Congregationalism," p. 357.
[199] The UJA Website states: "Felix Warburg, a Jewish investment banker and humanitarian, spearheaded a group of community leaders to launch a federation, a central organization that would reduce the duplication and competition among many local Jewish charities, and maximize what they could do together." (See *UJA Federation New York*).

different models to illustrate the stages of development. While Jonathan Sarna's research discusses the evolution from a synagogue-community to a community of synagogues, Abraham J. Karp's historical typology is more finely graded. Karp delineates among the following types:[200]

- Synagogue-community: One Jewish community like Shearit Israel prior to 1825.
- Rite congregation: The communal situation after 1825 when institutional diversification set in. Ritual congregations in this context mean different *minhagim*, as was the case when German, Polish, Dutch and Russian Jews started to found their own congregations, before the reform transformed American Judaism and added the "denominational layer."
- Reform Temple including the many drastic departures from traditional patterns, e.g. installation of organs in the synagogue, mixed seating, *minhag* America, ordination of women, etc.
- Orthodox Shul: In reaction to radical innovations initiated by the Reform Movement, Jewish Orthodoxy emerged as a denomination.
- Synagogue-Center in its urban and suburban settings: This type is also well known as "Shul with a Pool."

Furthermore, small size communal structures, which do not strictly correspond to this historical typology, include the *shtibl*, the *landsmanshaft* congregation, as well as the synagogues established by the Young Israel movement after 1920, and the *havurah* groups starting in the 1960s.[201] In lieu of the large formal synagogue service, the *havurot* adopted the anti-establishment ideals of the time:

> Egalitarianism, informality, cohesive community, active participatory prayer, group discussion, and unconventional forms of governance. Participants met weekly, biweekly, or monthly; sat in circles; dressed casually; took turns leading worship and study [...] Most havurot, in time, either disappeared, evolved into larger and more formal prayer groups, or became attached to neighborhood synagogues. But the havurah movement's countercultural ideals, counter-aesthetic values, and relaxed decorum lived on.[202]

From an organizational theoretical perspective, these societies most probably fit Ammerman's category of religious special purpose groups. However, her concept, developed against the backdrop of American Protestantism, is not fully compatible with the Jewish context, mainly due to the difference in the applicabiltiy of the concept of religion.[203]

[200] See Karp, "Synagogue in America."
[201] See Gurock, "Orthodox Synagogue."
[202] Sarna, *American Judaism*, p. 321.
[203] See Haussig, *Religionsbegriff*. The advantage of Haussig's study over systematical approaches is his context-sensitive albeit comparative analysis of the concept of religion (*Religionsbegriff*).

The term denomination on the other hand was spawned as a nonjudgmental term in Protestantism in the eighteenth century by leaders of the Evangelical Revival in Great Britain and the parallel Great Awakening in North America. It denotes particular theological traditions, clusters of practices or memories and symbols, or existing ecclesiastical (i.e. religious/congregational) groupings.[204] Denominationalism therefore mirrors the unique condition of religious tolerance in the United States and "the religious situation created in a land of many Christian churches and sects when none of them occupies a privileged situation and each has an equal claim to status."[205] It becomes clear why "denomination" is not just a synonym for church, sect, movement, religious group or tradition, stream, or sector, as Jacob Neusner has chosen to neutrally label Orthodoxy, Conservatism, Reform, and Reconstructionism.[206] "Sector" may seem a valid alternative label with the advantage of not originating within Christianity. Yet, the term excludes the unique and positive American historical-political context within which Jewish religious branches developed.

American Jewish denominationalism spawned a broad variety of trans-local organizations.[207] Thus, the intertwinement of "Jewish denominationalism" with "Jewish congregationalism" is key for understanding American Judaism, especially when comparing this national religious setting with another, in our case the Israeli. At the same time, it should be noted that non-denominational and post-denominational tendencies within American Jewry are on the rise. While non-denominationalist Jews decline to identify with a major denomination, post- or trans-denominationalists uproot the traditional denominational pattern, as is the case with those congregations that do not subscribe to one of the Jewish denominations at all.[208] In New York, seven congregations with no denominational affiliation are listed. Interestingly, two out of the seven are Anshe Chesed and B'nai Jeshurun, Manhattan's second and third congregations, which were formerly Orthodox. Congregation B'nai Jeshurun and the Southern Manhattan based Congregation Beit Simchat Torah explicitly cater to the LGBT-community, the latter operating with rabbinical interns and rabbinical staff from among the whole Jewish spectrum, most recently even with *haredim*.

[204] See Hudson, *Denominationalism*; Ammerman, "Denominationalism/Congregationalism," p. 362

[205] Sarna, *American Judaism*, p. 41.

[206] See Neusner, *Sectors of American Judaism*.

[207] For a historical contextualization, see above in this chapter. The main professional rabbinical association within Modern Orthodoxy is the Rabbinical Assembly of America (RCA). It is affiliated with the The Union of Orthodox Jewish Congregations of America (OU). The Reform Movement's rabbinical association is called Central Conference of American Rabbis (CCAR), which is affiliated with the Union of Reform Judaism (URJ), known as the Union of American Hebrew Congregations (UAHC) until 2003. Both denominations further established institutions for higher education.

[208] See S. M. Cohen, "Non-Denominational."

Within the ideological grounds of denominationalism, congregationalism is certainly an American tradition. This sharply contrasts with the Israeli situation.

2.3.2 The Open Model in Orthodoxy: Religious Communitization in the Jewish State

The separation of state and religion greatly influenced religious organization of Judaism in the United States. Accordingly, the non-separation of state and religion in Israel creates a much different socio-religious environment. Israeli law clearly illustrates the non-separation of state and religion within the country. Though its common law is secular, a major part of Israeli family law is based on or at least heavily infused with Halakhah (Jewish religious law). The Orthodox establishment's governance over marriage and divorce laws leads to many tensions and frictions in everyday life for secular Israelis:

> The whole religious establishment in Israel is funded by state budget. That includes building places of worship and salaries for rabbis, priests and kaddis, etc. Religion is a service that Israel provides, from the taxpayer's money. The government is involved in electing and appointing the chief rabbis and religious judges. The local politicians are involved in electing city rabbis and officials. They all perform duties according to Israeli law.[209]

When they speak of the "religious establishment," sociologists Kremnitzer and Fuchs equate "religion" with Orthodox/*haredi* Judaism. This conceptual implication indicates the majority's cultural self-conception: the religious field identifies with Orthodoxy. Though only a small percentage of Israeli Jews affiliate with other ideological and theological traditions, such as the Conservative (Masorti in Israel) and Reform Movement, these segments are in fact part of the religious field. However, they are not acknowledged as such. The religious establishment in Israel is equivalent to the Orthodox establishment–implicitly on a conceptual level and explicitly on a political one–meaning that denominationalism does *not* correspond with the Israeli context. Jacob Neusner's pragmatic use of "sector" probably fits Israeli socio-political conditions better, since "denomination" implies the equality of treatment of other religions or religious branches of Judaism by the state. This is certainly not the case in Israel. Therefore, the non-existence of the denominational pattern and the dominant position of Orthodox (infra)structure seem to constitute the foundation of what may be comprehended as an "open-structure model" for Jews who do not congregate and/or affiliate with a Jewish congregation. While this categorization holds true for many different segments of Israeli religio-cultural formations, including the *masortim*

[209] Kremnitzer and A. Fuchs, "Non-Separation," pp. 497–498.

and those *hilonim* dedicated to Jewish Renewal, the sector relevant for the analysis here is the Orthodox one in Jerusalem.

Jews religiously identifying with the Reform Movement or Conservative (Masorti) Judaism also "congregate" in Israel. The "closed" congregational community structure with a rabbi as religious/spiritual leader is practically the same in Israel as it is in the United States. Historically this comes as no surprise, since Reform and Conservative/Masorti Judaism are cultural imports from the U.S. The affiliation with a synagogue community and the congregational behaviour that goes with it seemingly turns Conservative and Reform synagogues into "ethnic' congregations of immigrants from English-speaking countries."[210] This observation, made by social researchers in the 1980-1990s, is only partially applicable to the contemporary situation of Reform congregations. Even if it may not be representative, three out of the four local Reform rabbis interviewed for this project are native Israelis, increasingly attracting families that are not immigrants from Western countries.

However, considering Nancy Ammerman's paper on congregationalism in the United States, the "voluntary nature of congregations makes them highly dependent on the willingness of participants to contribute their time, skill, and money to the collective work of the group." Of special interest is the aspect of the voluntary nature regarding financial contribution by congregants. Congregations produce and depend on social capital "as the basic resource that generates the monetary and human resources necessary for pursuing their goals."[211] This situation is the same for Reform congregations in both countries, but within a very different settings of religious power. Israeli Reform congregations are not financially supported by the Israeli State; this is in contrast to Orthodox institutions and organizations. In addition to being a cultural import, one could argue that Reform and Conservative congregationalism is probably the most effective means for a religious minority group to survive institutionally in the long run. Mia Oppenheimer, the Reform rabbi of a congregation with 205 families at the time of interview, shares her perspective.

> You feel like a religious minority. I'm not a person who looks back, I look forward. The fact is, Israel is not a democracy in the realm of religion, because Orthodoxy has monopoly. And not only that it has monopoly, it has money and power. The whole, the bond between religion and the state in this country is sickening; it's certainly not democratic. It will have to change, but politics will have to settle down before it changes, so I don't see any reason to really fight it. [...] There is no sense in crying 'We don't get money from the state, we don't get money from the municipality,' no, I want this place to be a beacon of culture, of knowledge, of spirituality. Let the others worry, if I don't get money, I'll get money from other places, ahm, so I look forward.[212]

[210] Sharot, "Sociological Analyses," p. 28.
[211] Ammerman, "Denominationalism/Congregationalism," p. 355.
[212] Interview with Mia Oppenheimer (p), 24.5.2011, Jerusalem district. Quotation at time stamp #00:11:08-3#.

Oppenheimer's comments mirror those of Ammerman's statement in making the point that congregations produce and depend on social capital. Sociologist Robert Putnam comprehends social capital to be (social) trust, reciprocity, and voluntary community.[213] Thus, social capital is the basic resource to generate monetary as well as human resources, both of which are invested into the congregation. The monetary aspect is especially important for Reform congregations in Israel, since they are not funded by the state. In comparison to the established and supported Orthodox sector, progressive Jewish congregations are far from being competitors to Orthodoxy on the religious market. However, generating money is not the only factor necessary for institutional survival. Reform congregations need to increase the number of their active members and supporters, who constitute their future social capital. Human and monetary resources are, as Ammerman holds, necessary in order to pursue goals. In the above passage, Oppenheimer clearly states her goal: She wants her congregation to be a "beacon of culture, of knowledge, of spirituality." This goal is the result and premise for generating social capital. Accordingly, she says, "So my dream is to build up this place. My dream is to see instead of 205 families last year to see 500 families."[214] Regarding social demography, Oppenheimer emphasizes that her congregation attracts more and more *mizrahi* families.

> We have many many Sephardic families, many.[...] So, we've really grown into parts of society where we are not the natural guest. Because, see, many Sephardic families, even if they're educated, are not egalitarian. The women are expected, as in very traditional societies, to be at the service of the family and to not always go out to work. So, naturally women would want to identify with the Reform Movement. But the men will not always be happy about it. So, it depends, but we've really broken a ceiling, a glass ceiling regarding what type cast of families we have.[215]

I suspect that if it were not for the congregational structure of the community, Sephardi families, or more specifically Sephardi/*mizrahi* women, would not actively seek to participate in a Reform congregation. Therefore, as Oppenheimer implicitly states, a neighborhood or small city-congregation provides support that transcends religious alignment despite congregants' lack of familiarity with Western *maskilic* thought traditions.

However, another Reform Rabbi, Bugsy Cohen, leader of a small Reform congregation in a city close to Tel Aviv, explicitly addresses the value of congregationalism as a measure to counteract

[213] See Putnam, *Making Democracy Work*.

[214] Interview with Mia Oppenheimer (p), 24.5.2011, Jerusalem district. Quotation at time stamp #00:11:08-3#.

[215] Ibid. at time stamp #00:05:52-4#. Tabory, "Market for Liberal Judaism," p. 307 confirms the statement that Jews from an Asian/North African backround feel alienated by the style of prayer in Reform synagogues and do not seek out a religious movement that emphasizes gender equality. It was therefore interesting to hear from Rabbi Oppeneheimer that this generalization, i.e. "these people" or "these Jews," seems to already have changed in *mizrahi* families–at least along the gender division line.

social alienation. He makes his point clear by re-telling the story of a widow whose husband held an important position within the congregation before he died. When it became clear that she was slowly becoming depressed due to grief and social isolation, since her children and grandchildren lived far away, the congregation resolved to entrust her with the same position previously held by her late husband.

> So she replaced him. She took his position. [...] And all the congregation was in favor, and she was so much touched by and it was tremendously important for her as a recognition of his value and of her value, that she is meaningful for people, that people care about her and the people want her to be part of the life of the congregation. So this is network. Modern life (..) there is a lot of alienation and what we do with the community, the community and education that's what we do. So community is one of the answers to the alienation. The other choice is that she is alone at home and she is a widow and she's alone at home and maybe, maybe she goes and play cards with another, like, but she doesn't have something in her life that is meaningful. And the children and the grandchildren live far away and here there is something that is across the street and she knows she can always come.[216]

In contrast to Israeli Reform, the "congregation-model" is a form of Jewish communitization that is less prevalent within Orthodox segments of Israeli society, ranging from *dati leumi* to non-*hasidic haredi*.[217] This does not suggest that Orthodox congregations do not exist, even though it is harder for an outsider to find them in Israel than in New York. If congregations are to be found, especially in a *haredi* dominated city like Jerusalem, they are most likely of the type or in the spirit of a Modern Orthodox congregation, often with rabbis of European or American background. Some perspectives view the lack of Orthodox congregational life as a disadvantage. For example, Gershon Elbaz, a young rabbi and teacher at a Modern Orthodox *yeshivah*, originally from Europe, raises several issues:

> Well, first I mention that there are very few rabbis of synagogues in Israel. It's a new thing, in the last few years it started to pay up a bit. It's a social issue, because when people came to the State of Israel they felt they didn't need communities. So, the idea of a Jewish community in Israel is very underdeveloped. It's incredible. Because everybody feels they're part of a wider community. So what that means, which is a major problem, is that people don't necessarily have close services. They don't necessarily have a local rabbi. They have the rabbi at, you know, where their own *yeshive* is [...][218]

Gershon Elbaz highlights multiple issues. First, the lack of Jewish communities, i.e. (in the style of) congregations due to a broader perception of what a "new" Jewish society should and could look like in the Jewish state, namely open and not modeled after the identity-securing and closed-off diasporic structures. Second, and as a consequence thereof, the lack of "local" rabbis, who have

[216] Interview with Bugsy Cohen/2 (p), 16.6.2011, Jerusalem. Quotation at time stamp #00:00:08-4#.
[217] *Hassidic* Jews on the other hand have a strong group specific identity.
[218] Interview with Gershon Elbaz/1 (p), 3.6.2011, Jerusalem. Quotation at time stamp #00:03:55-1#.

been serving as religious advisors, but also as contact partners for social matters transcending halakhic issues. Elbaz's assessment and observation sounds similar to what England's Chief Rabbi Immanuel Jakobovits bemoaned in the 1970s, despite not consistently referring to a specific cultural context. Jakobovits revisits a topic that has been the subject of intense debate in rabbinic journals and articles during the 1960s: namely, "the tendency to prefer 'pure' Talmudic research to the 'applied' pursuit of practical rabbinics,"[219] and the depreciation of "the rabbinate itself as an indispensable communal institution,"[220] represented by the local rabbi as the "custodian of Jewish law." He addresses five trends that he holds responsible for these institutional, professional and social changes. Jakobovits' enumeration and concise elucidation of these socio-religious rifts and shifts within Orthodox Judaism would further entail an in-depth analysis of Judaism's institutional transformation in the modern era, an issue that is beyond the scope of this project and to which can only be partially alluded.

1. "The denigration and usurpation of the role of practising rabbis by *yeshiva* deans had virtually eliminated the traditional place and functions of the rabbinate in the spiritual government of the religious community."[221]

Jakobovits envisions the solution to this development in the restoration of rabbinic authority: "Rabbinical authority, our Sages averred, derives from *communal appointment*, not from mere wisdom or learning."[222] Part of the problem, according to Jakobovits, lies in the "abuse of the rabbinical title," or generally in the post-modern misconception of *s'mikhah*. In his opinion, rabbinic ordination is the conferement of "power and responsibility to *exercise* rabbinical jurisdiction, as emphasized in its wording *yoreh yoreh*—'he shall surely give rulings,' " and therefore should only be awarded to candidates striving for the active rabbinate, "and not as a kind of higher yeshivah graduation diploma." He actively proposes the reintroduction of titles such as "*Morenu* and *Hechaver* as a mark of distinction for scholarship and piety," in order to make a qualitative distinction from the title and function of *s'mikhah*. The realization of these measures would contribute to the public respect for the rabbinate and restore the positive image of the rabbinate and the rabbi, who historically and halakhically "is an administrator of Jewish law, a spiritual guide and a communal leader."[223] The first to acknowledge this, he reckons, should be the *yeshivot*.
Furthermore, Jakobovits' views regarding the respective realms and responsibilities inherent in the positions of pulpit rabbis and *roshei yeshivah* are considered against the backdrop of profes-

[219] I. Jakobovits, *The Timely*, p. 320.
[220] Ibid., p. 321.
[221] Ibid., p. 323.
[222] Ibid., p. 324.
[223] Ibid., p. 325.

sional practice. His objections are targeted at a further shift leading to Jewish societies of "learning" and halachic stringency at the expense of communal responsibilities.

2. "The transfer of rabbinic jurisdiction from communal rabbis to academic scholars confined to *yeshivot* had severely limited the scope of contemporary Halakhah and caused substantial deviations from the traditional pattern in the methods used to determine Jewish law."[224]

As a consequence, this institutional relocation of religious power seemingly affects the approach to and practice of Jewish law. Jakobovits puts forth three desiderata, all including the prevalence of practice and commensurability. First, Jakobovits argues, "*Halakhah* must be, and appear to be, a guide to human progress, not a brake on it."[225] He is much concerned that "vast segments of our people are alienated from Torah life because they believe that *Halakhah* creates problems instead of solving them" due to "the emphasis in rabbinic rulings on subjects of little relevance to the average modern Jew rather than on the great moral, social and intellectual challenges troubling our age."[226] Furthermore Jakobovits advocates the perception that rabbis have to interpret or explain as well as adjudicate Jewish law "if they are to enjoy the fealty of the public." In his last requisite, namely tolerance, he speaks against "the present tendency toward ever more rigid uniformity, turning stringency into a fetish and branding all dissent as heresy." He adduces the example of Rabbi Moshe Feinstein's ruling on artificial insemination and the "violent agitation" it stirred, although the ruling was made by an "unimpeachable" authority.[227]

3. "These unprecedented developments had led to the displacement by *yeshivot* of *kehillot* as the institutional center of gravity in Jewish religious life."[228]

This aspect of a globally shifting Orthodoxy is intrinsically intertwined with the first issue pointed out by Jakobovits. Such structural change, briefly outlined in the essay, should be evaluated against the backdrop of the eastern European transformation of the Jewish educational system in general. The mere decrying of the process of relocation of power from the local *kehilot* to the *yeshivot*, including the slowly but steadily gaining importance of the *yeshivah* and the *roshei yeshivah* at the expense of the *kehilah* and the local/city rabbis, does not adequately pay attention to the historical process that set in around the time of the death of the Gaon of Vilna. Foundational changes precipitated by the Haskalah are responsible for Modern Orthodox and *haredi*

[224]I. Jakobovits, *The Timely*, p. 320.
[225]Ibid., p. 325.
[226]Ibid. In Jakobovits' opinion, these challenges are birth-control, juvenile delinquency, the use of leisure, the economics of automation, Jewish-Christian relations, and the place of religion in public life.
[227]See ibid., p. 326.
[228]Ibid., p. 320.

structures–but not exclusively. As historian Shaul Stampfer argues, the modal shift from a *kehilah* model to the *yeshivah* model has also contributed.[229] The establishment of the type of *yeshivah* set the educational standard for an institution that turned out to be a success story, including a new type of *homo religiosus*, namely the *yeshivish* Jew.[230] The *yeshivah* in Volozhin, also called *em ha-yeshivot* (mother of the *yeshivot*), established by Haym of Volozhin in 1803, a former student of the Vilna Gaon, came to be the new archetype of the modern *yeshivah*. The reason behind Haym Volozhin's motivation to found his yeshiva is unclear. The most probable hypothesis suggests that a crisis in traditional Torah study and the growing lack of sustainable places of Jewish traditional education was the main factor, although, according to Stampfer, sources containing complaints about the decline of Torah study should be taken into account with caution.[231]

In the second half of the nineteenth century, the link between Torah study and social rank gradually subsided and traditional study began to lose its status, especially among the wealthy. This change in values due to a social environment increasingly influenced by the Haskalah, secularism, and a changing economy, greatly changed the notion of *batei midrash* as traditional locations for study:

> Significantly, it was during the period that the *batei midrash* were disintegrating that yeshivas began to proliferate: in the second half of the nineteenth century, yeshivas were founded in Radun, Telz, Solobodka, Novogrudok, Slutsk, Ponevezh, Lida, Malech and elsewhere. This rapid growth seems to have been directly linked to the collapse of the *beit midrash* system in the face of modernity.[232]

Although these changes became socially transformative only after Haym of Volozhin put his *yeshivah* into service, the fact that Lithuanian *yeshivot* and their pre-eminent leaders, the *roshei yeshivah*, successfully restructured and "reformed" Jewish traditional education by basically reinventing it, must be understood within context. Though it is unclear why Haym of Volozhin chose to do it the way he did it, he nevertheless created a novel approach and set up what was to be copied dozens of times. It seems that Haym of Volozhin preferred his home town of Volozhin for personal reasons. As a matter of fact, were the *yeshivah* located in a bigger city, as was traditionally the case, and overlooked by the local rabbi of the community, it would not have been what Haym Volozhin intended to do: to reach a large number of students without himself having to pursue other duties (as was the case with the Gaon of Vilna, who never held a rabbinic

[229] See Stampfer, *Lithuanian Yeshivas*.

[230] The famous Polish *yeshivot* of the Middle Ages did not recover as a system of higher Jewish education after their extinction during the Chmielnicki pogroms. They were replaced by small *yeshivot*, *batei midrash*, and *kloyzim*. See ibid., p. 2.

[231] See ibid., p. 27.

[232] Ibid., p. 6.

position).[233] Consequently, this kind of centralization meant the "complete organizational and physical isolation from the local Jewish community:"

> In the past, yeshivas had been communal institutions, but the new type of Lithuanian yeshiva was independent of the community. It was not housed in a community-owned building, nor was it supported financially by the local community, but collected funds by means of itinerant emissaries.[234]

This detachment of the *roshei yeshivah* from rabbinic office led to a new kind of rabbinic authority. This shift therefore ushered in a shift from the validation of a knowledge-conglomerate that had a strong footing in practice, "reality," and custom to the validation of knowledge consisting of book wisdom. Therefore, in light of this case study in Jewish history, Rabbi Jakobovits' framing seems, though comprehensible and to the point, not well considered against the backdrop of historical events and processes.

However, no one has described this process and the consequences as precisely and elegantly as Haym Soloveitchik, a direct descendant of Rabbi Haym of Volozhin and himself a former *rosh yeshivah*:

> However, the power lost by the rabbinate did not have to accrue necessarily to the *roshei yeshiva*. It is their standing as the masters of the book *par excellence* that has given them their newly found authority. In Eastern Europe of the last century, the rosh yeshivah was the equivalent of a head of an advanced institute, distinguished and respected, but without significant communal influence. He was appointed because of his mystery of the book, and to the book and school he was then confined. This mastery now bestows upon him the mantle of leadership. And that mantle has become immeasurably enlarged, as the void created by the loss of a way of life (the *orah hayyim*), the shrinkage of a culture, manifests itself.[235]

Sociologist Samuel C. Heilman refers to this process as: "When going by the book replaces living on the street."[236] The issues raised by Chief Rabbi Jakobovits are valuable considerations made at a point in Jewish history when the *da'as torah* movement[237] and the denominational sliding to the right started to direct Orthodoxy steadily towards *haredi hashkafah*. What is of special interest here are the halakhic ramifications this shift involves, since it is not just confined to the borders of Israel or the United States, but rather a process that has a bearing on the Orthodox global village as a whole. Today, historians and sociologists identify the same problems and trends,

[233] See Stampfer, *Lithuanian Yeshivas*, pp. 30-31.
[234] Ibid., p. 3.
[235] H. Soloveitchik, "Rupture and Reconstruction," p. 94.
[236] Heilman, *Sliding to the Right*, p. 127.
[237] See L. Kaplan, "Daas Torah"; H. Soloveitchik, "Rupture and Reconstruction," "New Role of Texts."

as did Jakobovits in the 1970s already, and call it "Haredization of Jewish Orthodoxy" or "Bnei Braqism," a term coined by Rabbi Simha Elberg in the 1960s.[238]

The *rosh yeshivah*, wearing "the mantle of leadership," but without significant communal influence, seems to have contributed to the following two consequences that Rabbi Jakobovits takes issue with regarding the interrelation of rabbinate and *yeshivah*:

4. "The *yeshivot's* discouragement of rabbinical careers was directly responsible for the spread of mediocrity in the rabbinate and the growing scarcity of candidates for leading rabbinical positions."[239]

5. "*Yeshivot*, by tending to stifle rather than to promote a sense of commitment to the wider community, had been equally unsuccessful in raising a community-minded laity, so that public Jewish life became increasingly drained of rabbinical and lay readers [sic!][240] alike."[241]

In his criticism regarding the shifted relation between rabbis and deans or *kehilot* and *yeshivot*, we can identify one overarching concern or topic: practice. His major concern is not with the *yeshivah* per se, but with the relocation of religious power and the practical consequences thereof. Again in presenting a solution to the issue at hand, Jakobovits remarks in concise and witty fashion that "*yeshivot* are meant to make Jews, *kehillot* (congregations) to preserve them."[242] He clearly wishes for the old times or at least the *modus operandi* of organized Jewish life with all the other facets of communal activity including education, rabbinical courts, *mikvaot* and welfare services. Furthermore, he makes a crucial observation regarding the role of rabbis and *rashei yeshivot*: "The Yeshiva dean is remote from the community and its problems: he cannot enjoy the intimate, personal contact which a practicing rabbi has with his members and their concerns."[243]

[238]See M. Friedman, "Life Tradition and Book Tradition" on "Bnei Braqism." Surprisingly, in a cursory search, none of the most influential historians and sociologists who wrote on the topic, namely Samuel Heilman, Haym Soloveitchik, Menachem Friedman and Chaim Waxman seem to have taken notice of Immanuel Jakobovits' essay. This essay preceded the authors by twenty to forty years and even summarized many of the rabbinic discussions on this topic of the 1960s.

[239]I. Jakobovits, *The Timely*, p. 324.

[240]It should probably read "leaders."

[241]I. Jakobovits, *The Timely*, p. 324.

[242]Ibid., p. 327.

[243]Ibid., p. 322 What Jakobovits did not take into consideration at that point was the next step in the direction of communal disintegration: The model of the stand-alone scholar of the type of the Hazon Ish. Neither did the Hazon Ish serve as local rabbi, nor was he ever a *rosh yeshivah*. Like his great role model, the Vilna Gaon, the Hazon Ish was very much a private person whose authority was rooted in Torah wisdom alone. Lawrence Kaplan concisely points out that the Hazon Ish expressed his opinion or opposition purely on the basis of his own authority, consequently presenting his view as *da'as torah*: "He was the community." (L. Kaplan, "The Hazon Ish," p. 172) Lawrence Kaplan

This observation hints at what Gershon Elbaz, the above quoted neighborhood rabbi in Jerusalem, points out: If people, and that means men, like to discuss a certain issue, whether of medico-halakhic interest or something else, they turn to their *rosh yeshivah*, since they are neither affiliated with a congregation, nor do they usually connect with a "practicing rabbi" in the sense Jakobovits described above. Taking the Israeli disintegration of Jewish institutional structures into consideration,[244] certain consequences come to the fore. According to Rabbi Elbaz, the lack of communal structures results in the lack of social support for people. The fluidity of religious allegiance, which may bring many advantages, supposedly to the young, strong, and healthy, has its down side:

> There's no alternative system in the works like you have in America and England. And because people think 'Well I'm in the Jewish State, I don't need this,' that means a lot of their basic necessities are not being catered for. Because they're not used to supporting themselves or even organizing as a community. So, in many ways it's very nice, you know, young people they float around from one synagogue to another synagogue and it's all fluid, it's all this, on the other hand there's no support basis for people. At all. Beyond the state or the municipality there's no support basis and a lot of religious needs are not taken care of. Now, a lot of religious needs are taken care of so much better because it's Israel, you know, it's like, a lot of needs you don't need, like you don't need to show you're Jewish here, everyone's Jewish, right? At least in these areas, I'm not talking about Palestinians that's a separate issue, but I'm saying in a Jewish area everyone's Jewish, right, you know, there's no intermarriage officially, so you don't have an issue, but it's a real problem because a lot of needs are not catered to.[245]

Elbaz addresses several topics we shall briefly turn to. First, the "Well I'm in the Jewish state, I don't need this [a congregation]" attitude of Israeli Jews, who are used to a much more fluid approach of communitization, entails major problems in the realm of social support. On the one hand, Rabbi Elbaz mentions that beyond the state or the municipality "there is no support basis for people." Therefore there is a gap in providing a lot of basic necessities and meeting individual' needs, especially religious needs. On the other hand, he does acknowledge that some of those religious needs, like religious self-assurance do not need special attention, form, or negotiation, since "everyone's Jewish." However, another respondent, Rabbi Yaakov Weiner, a Ge'ula (bordering

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further points out that this historical process is symbolized by the transfer of the leadership role of the traditional Orthodox Jewish community from Rav Hayyim Ozer [Grodzinski] before the war to the Hazon Ish after the war. Although Grodzinski was a very learned Talmud scholar, his standing in the community was generated by his position as the communal *rav* and leader of the Jewish community of Vilna: "To put the matter another way, it was Rav Hayym Ozer's personal charisma and learning, FILTERED THROUGH and MEDIATED by his position of communal Rav, that was the source of his great authority. The Hazon Ish neither needed nor desired such a filter. His own authority was purely personal, was entirely individual."(L. Kaplan, "The Hazon Ish," p. 171.)

[244] Although Jakobovits does not refer to a special national context in his essay, he nevertheless considers Israel to be especially problematic, since "the concept of a *kehillah* as a focal point of religious activity and inspiration has all but disappeared completely." (I. Jakobovits, *The Timely*, p. 322)

[245] Interview with Gershon Elbaz/1 (p), 3.6.2011, Jerusalem. Quotation at time stamp #00:07:49-1#.

Mea Shearim) based Haredi Jew and the director of the Jerusalem Center for Research-Medicine and Halacha, approaches the issue from another angle. He values the perception that while Jews have developed a group cohesion for the purpose of securing their Jewish identity in the diaspora through congregationalism, this is not the case in Israel. Contrary to Elbaz, he does not seem to miss congregations, but admits that open forms of communitization have both advantages and disadvantages.

> Yaakov Weiner: You don't belong to communities here, which is good, which is bad. You don't belong to a community here, you live in a neighborhood and you go to the neighborhood synagogue, you have a few synagogues.
> I: Exactly, there is, the synagogues I could find, but it doesn't mean that something like a congregation or community evolved around this synagogue.
> Yaakov Weiner: You have, you have American immigrants, American *olim* who come here, they're starting that, they're starting that.
> I: Do you know perhaps why this is different? Because, you know, with my very Western, European background, I expected something to be here and it wasn't. So, how does it come that the Israeli setting is so different?
> Yaakov Weiner: Perhaps because abroad, in the diaspora you are amongst gentiles. You live amongst gentiles. You wanna belong to a community. 'I live amongst gentiles so I wanna belong.' Over here everyone is Jewish. Why should I belong to the community, I am part of the community here at large. Perhaps because of the mixture, (not understood 2 words) mixture with non-Jews.
> I: To strengthen the identity.
> Yaakov Weiner: To strengthen, right. Take, take, in Basel, Basel or in Zurich, there's community, you belong to this synagogue or this synagogue, it's community. But over here everyone is Jewish, so.[246]

Weiner's positive conception of the open neighborhood-community and its relation to the question of identity, appears to be rather straightforward. Prior social research on Israeli religious behavior notes that Israeli Jews "feel little need to affiliate with a synagogue in order to identify ethnically or nationally as Jews."[247]

Rabbi Richard Hirsch, the executive director of the World Union for Progressive Judaism, is of the opinion that many Reform members belong to Reform congregations because they offer "the most palatable, the most aesthetic, and the easiest way to be a Jew. In other words, I suspect that the most influential factor in building American Reform Judaism has not been theology, but sociology." Hirsch further contends that "for in Israel, there is no societal pressure or inner compulsion to join a synagogue in order to identify as a Jew. No Israeli Jew is subconsciously moved by the question 'What will the gentiles say'?"[248] However, for the Israeli *haredi* closed

[246]Interview with Rabbi Yaakov Weiner/1, 19.6.2011, Jerusalem. Quotation at time stamp #00:00:00-0#.
[247]Sharot, "Sociological Analyses," p. 28.
[248]Richard Hirsch as cited in Tabory, "Market for Liberal Judaism," p. 293.

congregational models of religious communitization outside Israel is a means to protect Jewish identity in a world of gentiles, a process we may term identity segregation. Hirsch's perception implies a process of identity adaption—an adaption resulting from the "subconscious" concern that the non-Jewish environment may think negatively of Jews and their religion. The Reform Movement values not only a less ritualistic version of Jewish practice but also adjusted decorum. And decorum has been a matter of concern for American synagogues. In contrast, in Israel there is no need to navigate Jewish identity among gentiles. Although congregationalism and a rather formal network of religious institutions is not prevalent in many Orthodox milieus, "open-structured" religious societies, as in Mea Shearim or other Ultra-Orthodox areas, nevertheless struggle over identity issues. This urban enclave and the seclusion that it seeks from the identity-threatening secular Jewish Jerusalem, not to speak of the Arab areas, has a great deal to do with securing Jewish identity.

Congregationalism is predominantly seen as a development brought to the country by "foreign" forces, such as American immigrants. Orthodox "pulpit" rabbi, Berel Wein from another neighborhood congregation in Jerusalem explicitly states:

> Berel Wein: Our congregation is pretty much an American congregation. It's mostly American retirees and it's modeled on the American style. It's not just a place to come to pray, it's a community, it has classes, it has tours, it has all sorts of things. So, you know, I find it very comfortable.
> I: Would you call it Orthodox? More towards the modern or centrist (answer Berel Wein)
> Berel Wein: We're an Orthodox congregation, but you can't say any labels, we are everything. Anybody that comes is pretty comfortable in it. The synagogue has no agenda. We're modern, we're *haredi*, we're whatever you want.
> I: It attracts people from the neighborhood (Berel Wein: Right), and it's mixed.
> Berel Wein: So that's the mix of the people in the neighborhood.
> I: So do you think that there are not enough places like this where people can go to?
> Berel Wein: You know, everybody is biased, you know, I think that Israel could benefit by imitating the United States Jewry, the type of rabbi, the type of congregation. I think, I can't say it's good for everybody but it certainly, it certainly would be helpful for a lot of people.[249]

Similar to Rabbi Elbaz, Rabbi Wein not only considers the type of community, i.e. congregation, worthy of imitation, but also the type of rabbi. As was elaborated above, this type of rabbi can be identified with the "local rabbi," a type or rabbi that is in close touch with the individuals of his congregation, a person to trust and relate to and well equipped not only with book knowledge, but with practical abilities as well.

The difference in communal outlook has an impact on the processing of bioethical issues. The open socio-religious structure does not operate in an institutionally formalized world with pul-

[249]Interview with Rabbi Berel Wein, 8.8.2016, Jerusalem. Quotation at time stamp #00:03:22-7#.

pit rabbis, presidents, executive boards, or other institutionally relevant committees, but rather within the world of prayer and study groups or institutions, as well as neighborhood and family networks. Such differences in the set-up of social and religious communitization generates different relationships of trust and networks for patients and their families if they seek religious assistance with medical issues.

2.4 Jewish Healthcare Chaplaincy, Spiritual Care, and *bikkur holim*: Three Culturally Influenced Concepts of Patient-Centered Care

Bikkur holim is the term for the Jewish concept for visiting the sick. On an interpersonal level it means the religious deed (*mitzvah*) of visiting people, Jews and non-Jews alike. Even though *bikkur holim* is not to be found as a Biblical commandment, later rabbinic scriptures and commentaries made sure to mention the importance of this type of loving-kindness. Thus, Talmud Nedarim 39b states: "It was taught: 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 reward is unlimited."

As a social institution, a *hevrah bikkur holim*, the association for visiting the sick, provided, and still does so in many contemporary congregations worldwide, (spiritual) care for Jewish patients. Within modern societies and national health care systems, the sick visit has been professionalized and more or less successfully implemented in the different healthcare systems. While the United States has the most advanced system of interfaith chaplaincy, professional healthcare chaplaincy is a fairly new phenomenon in Israel.[250] This might come as astonishing news for Westerners with traditions of pastoral care or even interfaith chaplaincy available within the respective medical settings. It might also come as a surprise for Jews living outside Israel who are used to the concept of *bikkur holim* religiously and socially; in light of this tradition one might expect that some sort of professional "pastoral" care has been made available for Israeli citizens.

This section elaborates on the conceptual relationship between the lay performance of *bikkur holim* and the professional practice of Jewish healthcare chaplaincy. Further, it questions how the American and Israeli models of healthcare chaplaincy differ from each other.

[250]The following deliberations do not elaborate on the European situation. Suffice it to say that most European countries operate with professional Christian chaplains who hold a degree in theology combined with the so-called "parochial model," which operates with parish-based clergy, i.e. religious specialists (e.g. rabbis, imams) provide pastoral care for their congregants.

2.4.1 The Tradition of *bikkur holim*

The Hebrew term *bikkur holim*, which literally translates as "the sick visit," means the *mitzvah* (good deed, duty) of visiting someone who is ill. Interestingly, no commandment for *bikkur holim* can be found in the Tanakh, the Hebrew Bible, even though commentators as influential as Rabbi Moses ben Maimon (Maimonides, 1135–1204) and Rabbi Moses ben Nachman (Nachmanides,[251] 1194–1270) maintain that this service is one of a set of deeds the rabbis mandated to fulfill the command to "love your fellow as yourself (Leviticus 19:18)."[252]

However, by ways of interpretation the rabbis traced back the theological foundation for this *mitzvah* to a well-known passage in Genesis 18:1–2; Abraham is visited by God (angels) while sitting by the terebinths in Mamre. Using proximity as an interpretive device they observed that Genesis 18 is preceded by the story of Abraham's circumcision. The Bible does not state a purpose for the visit, thus the rabbis concluded that God's visit to the patriarch was a divine sick call, even though Abraham's behavior isn't that much in accordance with what one may expect from a newly circumcised 99-year-old, e.g. sitting outside of his tent in the sizzling heat and sprinting to fetch water for his guests.[253]

Rabbinic literature offers a lot of sources from which one can learn how to approach a patient or sick person.[254] Whether it is the *midrashim* (interpretive writings), the halakhic texts (religio-legal literature) or certain prayers: they are the basis to understand and discuss spiritual care and the practice of visiting the sick in Jewish religious culture. The rabbis of the Talmud and later commentators "had high expectations for Bikkur Holim; they did not see it as a merely 'friendly visit,' instituted to pass away the time of the sick. The objective of Bikkur Holim was to offer a healing intervention."[255]

This healing intervention consisted of what can be best described as pragmatic and medically related services combined with prayer and active presence:

(i) Provision of the patient's needs: Most of what is important for the discussion of Talmudic statements concerning an ill person and the proper behavior as well as do's and don'ts can be found in the tractate Nedarim (esp. 39–41). Ned. 40a for example gives a concrete description of an action taken by one of the most famous rabbis of his time, Rabbi Ak-

[251] Nachmanides' work Torat ha-Adam deals with the sick visit, the laws of mourning and burial ceremonies. The Shulhan Arukh (Yoreh Deah 335–338), a code of Jewish law, adopted its content.

[252] Sheer, "Bikkur Holim," p. 107.

[253] See ibid., p. 106; Ozarowski, "Bikur Cholim," p. 17.

[254] Of course, there are many more resources that are used for Jewish spiritual care giving today. Besides written sources like Chassidic tales, life stories, or philosophic works (i.e. Martin Buber) chaplains also use other means of expression like art and music. See also Ettun, Schultz, and Bar-Sela, "Transforming Pain."

[255] Sheer, "Bikkur Holim," p. 102.

iba: "So, R. Akiba himself entered [his house] to visit him, and because they swept and sprinkled the ground before him, he recovered."

This means that an important duty of any visitor is to see to it that the patient is well looked after. The word *bikkur* not only means "visit" but also includes the meaning of "investigation." The purpose of the sick visit is to examine whether the bedridden person is well provided for. Is there enough food, medication, and money? The holistic approach of the Jewish *mitzvah* of the sick visit consists of lay nursing as well as any sort of assistance, spiritual assistance included.

(ii) Prayer: The second responsibility involved in visiting the sick is prayer. To stress the importance of healing, Jewish religio-legal literature states that a sick visit was not complete unless the visitor prayed on behalf of the patient. A special prayer for healing is known by its opening words, *misheberakh* (May the One who blessed). In this prayer Jews pray for a *refuah shlemah*, a complete healing.[256] The end of the prayer reveals what is meant by a complete healing: this is *refuat ha-guf*, the healing of the body, and *refuat ha-nefesh*, the healing of the spirit, the soul. The dual aspect of healing, that of cure (*refuat ha-guf*) and that of care (*refuat ha-nefesh*), the provision of therapy for the ailing body as well as the offer to care for the soul, is the Jewish key concept for a holistic approach to heal a person. Even if a patient won't recover from his illness, an Israeli spiritual caregiver once explained to me that, "to die a healthy death," to alleviate not only bodily pain but the suffering of the soul accordingly, is the ultimate goal of spiritual care. In the United States, Jews might even participate in a "Service for Healing, a special liturgy designed for those whose lives are touched by illness, pain, and loss."[257] Such services are provided by the programs and centers institutionalized by the Jewish Healing movement.[258]

(iii) Presence: Visiting a sick person doesn't have to imply an action. Listening to the patient's distress or relieving his or her anxiety by conversation, is equally important and should not be neglected. Ideally, the positive consequence of this interpersonal aspect of the sick visit would be the patient's state of *nahat ruah mehaveraw*, the peace of mind one receives by the presence of his friends. Accordingly, Talmud Nedarim 39b states: "Whoever visits the

[256] Additionally, this is the response to give if one is told that someone is ill. Instead of "get better/get well," a Jewish option to respond in Hebrew is "*refuah shlemah*."

[257] Flam, "Healing the Spirit," p. 492.

[258] The most influential institutions for Jewish Spirituality and Healing are: The Kalsman Institute on Judaism and Health, the National Center for Jewish Healing, Shine and Divine, and the Jewish Healing and Hospice Project of Los Angeles.

> sick takes away one-sixtieth of his distress," or in a slightly other version in Baba Metzia 30b: "A man's affinity takes away a sixtieth of his illness."

The sick visit is not restricted to close family, friends or medical professionals like doctors or nurses, but is a collective duty for all Jews in the community. Accordingly, *bikkur holim* is not only a religious and moral obligation but an important concept for social behavior. As a communal service, the "holy societies" for visiting the sick were established as early as the 14th century in Spain, Southern France, and Italy. Only in the 16th century was this communal service institutionalized in the rest of Europe and a few such societies existed in 17th century Germany. A *hevrah bikkur holim* usually paid for a physician, druggists, barber-surgeons, hospital attendants, midwives, and others. Additionally, care was not only provided for the poor, but all communal members could rely on the association for help.[259] However, bioethicist Michael Y. Barilan argues that religious idealism should not be confused with actual norms and social reality:

> Between the lines of the written sources, we may discern huge gaps between abstract norms and actual compliance. At times, communities would send sick vagabonds away in order to avoid the expenses of care and burial. Some of the regulations were quite cruel, like the prohibition against hosting deformed people on the Shabbat; these unfortunates had to stay in a public shelter.[260]

In many places these *hevrot bikkur holim*, the societies for visiting the sick, disappeared due to different historical events and their social, political, and cultural consequences. The Russian Revolution, the Holocaust, and two world wars contributed to the dissolution of traditional community structures in many parts of Europe and the mass immigration of *mizrahi* Jews to Israel emptied the Jewish communities in the Middle East and North Africa.[261]

On the other hand, still a lot of congregations maintain *bikkur holim* groups. Also, community-based *bikkur holim* may have a different outlook today: For example, the Satmar *hasidim* set up an organization that provides practical and emotional support services to the sick and disabled and their families within the *haredi* community in North London. Another solution for big cities are organizations that are specialized in *bikkur holim*-related services, Bikur Cholim Los Angeles as for example.[262] Besides visiting the sick they also organize blood drives and maintain a special program for Holocaust survivors.

[259] See Levitats and Efrati, "Sick Care," p. 544.
[260] Barilan, *Jewish Bioethics*, p. 61.
[261] See ibid.
[262] See *Bikur Cholim Los Angeles* and *Bikur Cholim of Greater Washington*.

2.4.2 The Professionalization of the Sick Visit: Jewish Healthcare Chaplaincy

The traditional Jewish sick visit, an obligation for all Jews, contains many aspects of professional spiritual care. Yet, their approaches and methodologies differ from each other.

In an enlightening description of how he became a chaplain, American rabbi and chaplain David Singer described well one of the main differences between the religious obligation of *bikkur holim* and his professional role as a chaplain.[263] At the beginning of his training he was convinced that pastoral care was identical with the commandment of bikkur cholim. Contrary to his supervisor's understanding, it was enough for him to know that visiting the sick was a *mitzvah*, and one he was reminded of every day due to its prominent placement in the morning service.

His change of perspective was brought about by the close reading and reflection on Martin Buber's I-Thou philosophy and a tale taught by Rabbi Nachman of Bratslav, a late-18th century *hasidic rebbe*. This story is about a prince who suddenly thought he was a turkey. He felt compelled to sit naked under the table, and instead of ingesting food in a normal manner he was pulling at bits of bread like a turkey. None of the doctors who were sent for by the king were able to cure the prince. In the end, it was a "wise man" who initiated the healing process. How? The man went to sit with the prince-turkey under the table, naked himself and pulling at pieces of bread as well. Asking questions like "Do you think a turkey can't wear a shirt?" or "Do you think a turkey has to sit under the table? You can be turkey and sit up at the table," the wise-man gradually but completely cured the prince.

This *hasidic* tale helped Rabbi Singer understand that illness can be a very lonely place, and as part of his role as chaplain he was "going to the place where the patient is and, if they want to be brought somewhere, helping them in that transition."[264] Thus, pastoral or spiritual care means reaching out to the patient at the place of his or her confinement.[265] By the end of his chaplaincy training, David Singer realized that in comparison to his earlier "Jewish" understanding of *bikkur holim*, "chaplaincy and pastoral care, though they fulfill the basic Jewish obligation of visiting the sick, are actually much more. They are a professionalized means of helping people—being with other human beings—in their most difficult and painful times."[266]

Professional spiritual caregivers repeatedly insist that the methodology to providing professional chaplaincy is key. Developing approaches to deal with such situations on an every-day basis as well as the development of coping strategies is an important goal of modern chaplaincy

[263] See Singer, "The Turkey."
[264] Ibid., p. 3.
[265] See Barilan, *Jewish Bioethics*, p. 53. This perspective and behavior holds true (or at least is the ideal) for patient-centered care personnel in general.
[266] Singer, "The Turkey," p. 3.

training and supervision. The fact that clinical pastoral education imparts tested methodologies that are universally applicable may leave Jewish (or any other religious community) chaplaincy trainees wondering how to implement the respective religious knowledge and how/if/when to use it. This process is a very individual one because it implies a search for linking established "eternal" knowledge and personal life stories, character, and experiences. The aforementioned story of Rabbi David Singer serves as an example of such an integrative process.

Concurrently, it is crucial to always focus on the patient's needs first, as Charles Sheer, an American Orthodox rabbi and experienced chaplain serving the New York area, states very clearly:

> Pastoral care should be driven by tested methodologies, not by texts. The principal focus of a trained practitioner is upon the patient, and a clinical response should be based upon the assessment of the patient's condition and need. That assessment, however, can be informed by the wisdom of our religious traditions that guide—but do not determine—pastoral care.[267]

2.4.3 United States: Healthcare Chaplaincy and Jewish Healing

In comparison to most European countries and Israel, North American healthcare chaplaincy developed the most comprehensive education for pastoral care and provides the best implementation of these services in the healthcare system. The approximately 10'000 certified chaplains belong to one of five major professional organizations: The Association for Clinical Pastoral Education (ACPE), the Association of Professional Chaplains, the Canadian Association of Pastoral Practice and Education, the National Association of Catholic Chaplains, and Neshama: Association of Jewish Chaplains (NAJC). In 2004 these organizations set up the Spiritual Care Collaborative (SCC) that defines pastoral care as a profession, which provides common standards for accountability and communicates unanimously with legislators and other official bodies.[268] Even before this official fusion they produced the white paper "Professional Chaplaincy: Its Role and Importance in Healthcare." A study about the extent of hospital chaplaincy service in the United States between 1980 and 2003 revealed that between 54% and 64% of hospitals had these services available.[269] Also, church-operated hospitals were much more likely to provide this kind of patient-centered care. According to Cadge's assessment this is a potential indicator for "different

[267] Sheer, "Bikkur Holim," p. 101.
[268] See Orton, "Transforming Chaplaincy," p. 122.
[269] See Cadge, Freese, and Christakis, "Hospital Chaplaincy," p. 628.

value commitments around religious/spiritual care and/or greater ease of finding and financially supporting chaplains."[270]

Of course, this finding is not surprising with historical hindsight: Anton T. Boisen (1876–1965), who graduated at Union Theological Seminary in the City of New York, is acknowledged as founder of the clinical pastoral movement. Boisen's primary intention was to establish pastoral care in psychiatric institutions and to provide clergy with clinical pastoral training.[271] As early as 1930 Boisen and his colleagues Elwood Worcester, Helen Flanders Dunbar, and Richard Cabot—the early leaders of the clinical pastoral movement—formed the Council for the Clinical Training of Theological Students. Encouraging interprofessional cooperation, they designed their programs according to the structure of the training of medical and social work professionals. The primary goal of this structural resemblance was the translation of the scientific method into the clinical training of the ministers. They worked with the case study method as the main teaching tool:

> In one sense, CPE [Clinical Pastoral Education] programs in the 1930s remained true to Boisen's vision of the minister as a scientist of religion and to his idea that knowledge about human personality was accumulated most effectively not through the reading of books but through the study of "the living human document."[272]

Another method, which was an important tool for most CPE supervisors, was the process of befriending patients. Called "therapeutic friendship," this pastoral technique was of special importance to many CPE supervisors. Obviously, for many educators, chaplaincy training in the healthcare setting was intended "to teach ministers how to deal with 'ordinary people in their own parishes.'"[273] To deliver lectures, case seminars, and supervisor-student conferences served those ministers to exercise their counseling and pastoral care skills.

The first Jew who was approved as CPE supervisor in 1958 by the predecessor of the ACPE was Rabbi Fred Hollander, an Orthodox rabbi at Bellevue Hospital in New York. Yet, comprehensive formal training for Jewish chaplains had not been developed and only a few Jewish facilities participated in CPE programs. Even after World War II, CPE programs were heavily influenced by Protestantism and limited to Protestant ministers and seminary students. On an organizational level this only changed in 1990 when the National Association of Jewish Chaplains (NAJC)[274] was

[270]Cadge, Freese, and Christakis, "Hospital Chaplaincy," p. 629. Other demographic and institutional characteristics revealed that smaller hospitals and those located in rural areas were less likely to have chaplaincy services than larger hospitals and those located in urban areas.

[271]See Hart and Div, "Present at the Creation," p. 540.

[272]Myers-Shirk, *Helping the Good Shepherd*, p. 48.

[273]Ibid., p. 57.

[274]The acronym NAJC now stands for Neshama: Association of Jewish Chaplains.

founded.[275] Today, the American interfaith chaplaincy system generally, but not exclusively, operates with clergy that has been thoroughly trained in clinical pastoral care and underwent clinical pastoral education. This holds also true for Jewish healthcare chaplains, whether they are Orthodox, Reform, Conservative, or Reconstructionist.

The number and visibility of chaplains in hospitals increased when the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) changed policies in the 1990s and stated that hospitals must demonstrate respect for pastoral counseling. However, these changes have not increased the fraction of hospitals that employ chaplains.[276] Lauren Vanderwerker et al. conclud that, although the extent of chaplaincy services stayed more or less the same between 1980 and 2003, "the role of chaplains had been expanding in the U.S. and elsewhere. [...] For instance, chaplains counsel staff members, conduct community outreach activities with local clergy, sit on ethics committees, and participate in medical and nursing education programs."[277] Considering this development, Vanderwerker et al.'s study also evaluated the lengths of visits with patients in order to determine whether today's chaplains have less time at the bedside. Interestingly, this is not the case and chaplains seem to be adjusting to the increased demands by improved screening processes, referral protocols through staff members, and the assistance of volunteers.[278] This expanded role differs from the "solo practitioner" of earlier times who visited and prayed with patients and family. According to chaplain Martin W. Feldbush there was minimal interaction with the patient care process and the medical staff.[279]

In the 1930s, clinical pastoral education became "part of a larger movement among liberal Protestants of the period who were attempting to make an explicit connection between Protestantism and healing, whether physical or mental."[280] This connection was promoted in mainstream Protestantism as well as in Christian Science via "the mind could heal the body" principle, or in the Lutheran Church of America which supplied their community hospitals with chaplains to visit the sick.

Similarly, in the early 1990s Progressive Judaism, which includes the Reform Movement (America's largest Jewish denomination), the Conservative movement, as well as Reconstructionism, and the Jewish Renewal Movement, developed its own theologically founded approach: Jewish spiritual healing. This movement yielded the National Center for Jewish Healing as well as different local Jewish healing networks. Another very important promoter and turntable for different

[275] See Tabak, "Jewish Health-Care Chaplaincy."
[276] See Cadge, Freese, and Christakis, "Hospital Chaplaincy," p. 630.
[277] Vanderwerker et al., "Chaplaincy in the New York City Area," p. 14.
[278] See ibid., p. 21.
[279] See Feldbush, "Healthcare Chaplaincy."
[280] Myers-Shirk, *Helping the Good Shepherd*, p. 56.

themes on Judaism, health, and spirituality is the Kalsman Institute on Judaism and Health of the Hebrew Union College Jewish Institute of Religion. The Institute describes the reason for the emergence of the Jewish healing movement as follows:

> The work was spearheaded by professionals and lay leaders who came to realize that, as a consequence of modern life, many Jews no longer had easy or meaningful access to the spiritual and communal supports that had sustained previous generations of Jews through difficult times of illness and loss.[281]

The Jewish healing movement equipped itself with a language that combines therapeutic language with Hebrew expressions and a vocabulary common for groups that offer tools in the realm of spirituality, meditation, and mindfulness. The strong promotion of the link between religion and health thus seems to mirror some of the concepts already put forward by the early clinical pastoral educators within liberal Protestantism.

2.4.4 Terms and Their Contexts

One of the leaders of the Jewish healing movement is American Rabbi Dayle A. Friedman, the author of the seminal handbook "Jewish Pastoral Care: A Practical Handbook from Traditional & Contemporary Sources," who suggests to use the Hebrew term *hitlavut ruhanit* or *livui ruhani* (spiritual accompanying) to describe the Jewish tradition and way of spiritual care: "The root of this term, lvh,[282] is used in biblical and rabbinic texts to refer to one who 'walks with' another. Ministering angels, God's presence, friends, priests, and peers all are described as lvh, accompanying people as they go on their path."[283]

It's interesting to note that the Hebrew term for funeral, *levayah*, derives from the same root. When someone dies, a community of mourners escorts the dead person to the burial site, an act that stresses the meaningful coherence of Jewish social practice and language. It is a consoling thought that the concept as well as the social act of accompanying (lvh) a human being who suffers from illness and pain continues by means of escorting (lvh) the body after death has occurred.

Rabbi Friedman's hope that "*hitlavut ruchanit* [*livui ruchani*] or other terms that practitioners may coin can come to serve as alternative, organically Jewish labels for this work"[284] became true: The term *livui ruhani* became essential for the spiritual care movement in Israel and has been adopted by most of Israeli spiritual caregivers. They are called and introduce themselves as *melavah ruhanit* (fem.) or *melaveh ruhani* (masc.). Alternatively, the term *t'mikhah ruhanit*

[281] *Kalsman Institute on Judaism and Health.*
[282] In Hebrew letters the root is לוה.
[283] D. A. Friedman, "Hitlavut Ruchanit," p. xiii.
[284] Ibid., p. xx.

(spiritual support) is used.[285] Interestingly, *t'mikhah* (support) was a common term to name associations that performed different kinds of *g'milut hasadim* (acts of loving-kindness). Several examples from pre-Holocaust Vienna testify to the existence of groups such as Tomchei Jeschurun (Support for the Jewish People) or, most relevant here, Temicho uwikur Cholim (Supporting and Visiting the Sick, founded 1920).

However, both terms (*livui/t'mikhah*) and their derivations focus on interpersonal relationships. On a conceptual level this is more in sync with the main purposes of modern interfaith chaplaincy and Jewish spiritual care than the term "pastoral care." Pastoral care is traditionally understood as the clergy's religious role in a situation of taking care of the other, including a thorough reflection of the self. The "pastoral" refers to his role of providing a religious service for the patient, his professional duty. From the Latin term pastor, he is "the first shepherd" of his congregation or faith community and devotes his flock with whatever religious practice (sacrament, prayer, Kashrut) is indicated. Chaplaincy and pastoral care are terms connected to concepts that refer to ideas and practices from within the Christian tradition of caring for the "other's soul." Together with the term spiritual care, which has been employed increasingly in the last twenty years, they are often used interchangeably. This shift in the usage of the term occurred in the 1990s. Interestingly, although the rate of English-language journal articles about pastoral care is much higher than the one for spiritual care, there is a steady decline in articles about pastoral care since 1996.[286] Thus, spiritual care seems to be the new pastoral care for multi-ethnic, multi-religious, and secular societies. Due to the many possible or obvious reasons for this development, suffice it to say that the lack of the term's coherence (or because of it), spirituality serves the concept of patient-centered care better since "pastorality" is interlinked with religion, religious institutions, rituals, and ideology while in general "people are much happier with the language of spirituality rather than religion."[287]

2.4.5 Israel: The Novelty of Spiritual Care

Until a few years ago spiritual care was basically non-existent in Israel. The process of its institutionalization has been started about twelve years ago with the support of the NAJC, the organization and certifying body for Jewish chaplains in the United States, local support from JDC-Eshel, an NGO dedicated to the development of services for the elderly in Israel, and financial support

[285] Accordingly, a spiritual care provider is called *tomekhet ruhanit* (f.) and *tomekh ruhani* (m.).

[286] See Harding et al., "Spiritual Care, Pastoral Care," p. 99.

[287] Mike Gartland, Anglican priest and psychotherapist leading a multi-faith mental health chaplaincy and counseling service in West Yorkshire, as quoted in Barton, *Medicine's Spiritual Roots*.

from the UJA-Federation of New York.[288] But only in 2014 the Association for Spiritual Care in Israel was founded in order to serve as the body responsible for certifying spiritual care coordinators and spiritual care educators as well as reviewing the training programs for spiritual care coordinators.

Rachel Ettun, one of the association's co-founders, mentioned in a personal communication to the author in August 2016, that they considered whether to adopt the American healthcare chaplaincy model or the Jewish Healing Center model (see above). The former involved the setup of a new profession, including training and supervision possibilities, the latter a group oriented cooperation between rabbis and social workers. They chose the first option and decided to create a profession. But unlike in the United States, in Israel most spiritual care providers are not rabbis. They come from other backgrounds like nursing, counseling, psychotherapy, social work, and education.[289] On the one hand this circumstance explains, at least to a certain extent, why there was no professionalized spiritual care in the medical setting, while on the other hand this absence of clergy is the very reason for the present development and outlook of the Israeli model.

First, apart from the fact that the rabbinate has its own history of professionalization, the job description of Israeli rabbis who are employed in healthcare facilities does not include the duty of visiting patients for the purpose of providing spiritual support. Furthermore, these rabbis also do not call themselves chaplains. They are charged with such activities as ensuring that the hospital is following halakhic standards and policies. This includes dietary laws, Shabbat observance and festivals, and many other areas that are subject to rabbinic scrutiny. In some of the so called "religious" hospitals, the rabbi in charge even has decisive power in the realm of ethical decision-making. Even though most of these rabbis wish they had more time for *bikkur holim*, the performance of pastoral care is not a role-inherent duty of a rabbi, at least not for the Orthodox rabbi in Israel. This image suits the Christian role model for clergy way better.

Second, this religious reality bears an important impact on the development of the Israeli spiritual care movement. The fact that Orthodox rabbis and Orthodoxy, the only Jewish (religious) denomination[290] in Israel that possesses religious/political power, did not provide this service systematically, made it possible for the movement to create a clergy-independent spiritual care model.[291] That's not to say that religion or more specifically Orthodoxy, is against spiritual care in the medical setting. Of course, there are many who belittle the importance of this service or

[288] See B. M. Kinzbrunner and B. D. Kinzbrunner, "Spiritual Care in Israel," p. 2.

[289] See Tabak, "Jewish Health-Care Chaplaincy," p. 102.

[290] The term denomination is used *faute de mieux*. Jewish Orthodoxy, especially in Israel, is very heterogeneous.

[291] There are chaplaincy training programs for rabbinical students of the Conservative Movement, carried out at the Machon Schechter in Jerusalem, for example. Most other programs offer training for all professionals or health care professionals.

try to ignore the ongoing processes of implementation in the different healthcare facilities (as do many head nurses and social workers out of fear for their "professional territory"); but by and large people who identify themselves as religious (*dati*) or traditional (*masorti*) are more willing to accept a chaplain compared to patients who are secular and "not spiritual."[292]

The secular clientele was allegedly another main reason why spiritual care in Israel did not adopt the "religion-clergy model." Linking religious practice and spiritual care would be problematic due to the tensions among Jews in Israel, "where the religious and secular publics are polarized and the secular shy away from anything that may be interpreted as religious coercion."[293] This has major consequence for the development of spiritual care in Israel: "Out of awareness of this concern regarding the relationship between spiritual care and religion, spiritual care in Israel has intentionally been built not on a religious framework, in contrast with some other parts of the world."[294]

Leaders of the Israeli spiritual care movement as well as social scientists and health policy researchers agree that there are still many obstacles to overcome in order to achieve a successful and sustainable long term implementation of spiritual care in the Israeli healthcare system:

> Firstly, spiritual care should get official credentialing as a new health care profession. Secondly, decision-makers should be given a full and detailed introduction to the new profession, thereby raising its profile. [...] At the same time, in order to attain professional recognition from the Ministry of Health, the profession should continue to develop at grassroots level.[295]

The histories of healthcare chaplaincy have always been influenced by cultures, shaped and transformed by societies and religious traditions. The American pastoral care model, including Jewish chaplaincy, has been developed within and along mainstream Protestantism. Thus, most certified chaplains in healthcare facilities are clergy (priests, rabbis, vicars). Additionally, communal care or supra-communal care of the sick, i.e. *bikkur holim* groups and organizations, successfully provide such services too.

In Israel, however, the chosen name *livui ruhani* says it all: as has been described above, the root לוה (lvh) in traditional Jewish texts means (spiritual) accompaniment provided by all kinds of people or even non-human beings like angels or God, not only ordained rabbis. This concept seems to be the Israeli vision of healthcare chaplaincy, namely the implementation of trained spiritual care providers albeit with different professional backgrounds. Even though it will still take a long time to establish a coherent system of professional spiritual care in Israel, which will be

[292] See Schultz, Lulav-Grinwald, and Bar-Sela, "Cultural Differences," p. 5.
[293] Bentur, Resnizky, and Sterne, "Attitudes of Stakeholders," p. 16.
[294] Schultz, Lulav-Grinwald, and Bar-Sela, "Cultural Differences," p. 2.
[295] Bentur and Resnizky, "Spiritual-Care Training," p. 775.

financially independent from American philanthropic institutions, the first steps that are often the most difficult, have been successfully taken.

2.5 Conclusion

As a sociologist of religion, Max Weber states in his seminal work "Wirtschaft und Gesellschaft" that we do not deal with the essence of religion, but with the conditions and effects of a certain kind of communal action: "Allein wir haben es überhaupt nicht mit dem Wesen der Religion, sondern mit den Bedingungen und Wirkungen eines bestimmten Art von Gemeinschaftshandeln zu tun."[296] As much as ethical considerations and abstract moral philosophy are necessary intellectual preconditions to understand ethical discussions regarding medical cases, this study's approach follows Weberian logic—at least to a certain degree. The description of historical contexts, social conditions, the structure of religious communitization, and professional settings of American and Israeli Jews—especially rabbis—greatly contribute to the intellectual embedding of religious ethics as social practice.

Thus, this extensive chapter provides the necessary contextualization of the communal and ideological settings within which the following rabbinic discourses, ethical considerations, and medico-halakhic decisions take place. America's denominational and congregational structure of religious communitization produce a unique social and religious reality; one that adapts to ever changing historical and social conditions. Various shifts and slides, to the right and to the left, processes of diversification and separation, as well as the seemingly ubiquitous struggle between unity and fragmentation, produce various social and professional networks that provide consistency for its rabbis and congregations. Thus, Modern Orthodox rabbis who immigrate from the States to Israel miss such communal structure that is absent in the Jewish democratic state. Used to being approached by congregants regarding all aspects of life, including medical and medico-ethical issues, this rabbinic role seemingly befits *roshei yeshivah*, rabbis in hospitals, and specific and/or specialized religious networks that are usually supralocal. Though the Orthodox establishment predominantly serves the religious sector, the political powerlessness of liberal Jewish branches prevent considerable influence on the wider public regarding matters of ethical and religious concern. Nonetheless, the Reform and Conservative movements, in cooperation with mostly secular professionals, are the major driving force behind implementation of spiritual care in Israel.

[296] Weber, *Wirtschaft und Gesellschaft*, p. 245.

3 | The Professional Practice of Rabbis and Chaplains at the Intersection of Discourse and Social Encounter

This data-driven chapter explores key aspects of rabbis' professional practice with respect to bioethical or medico-halakhic issues at the intersection of rabbinic discourse and the social encounter with congregants or patients. Analysis examines interviewees' reflections and rationalizations that combine concrete individual cases with religious structure. The following premises that a) rabbis and chaplains, as agents, recourse to ethical values and norms in the counseling situation, that b) their positions and perspectives are influenced by being involved in the cases, and c) such social and practical-ethical interaction in turn affects bioethical normativity in Jewish religious cultures. To a certain degree, this process is already inherent in the halakhic system, which includes the operational tool of responsa literature. The first sub-chapter thus recapitulates the main aspects and differences between Orthodox and Reform conceptions and practices of Halakhah. With respect to the Reform Movement, liberal Halakhah is a means to perpetuate the tradition of responsa, even though pulpit rabbis and researchers dispute their practical value.

In contrast to 3.1 and its description and contextualization of Halakhah within Orthodoxy and Reform Judaism, 3.2 focuses on the frequency, nature, and intensity of questions regarding biomedicine and ethics, as reported by the rabbis and chaplains interviewed for this study. Chapter 3.3 evaluates interviewees' impressions and reflections regarding congregants and patients' expectations or motives for talking with them about biomedical and ethical issues. Rabbis' accounts reveal whether, and in what cases, people expect clear statements, halakhic advice, or moral guidance, or when they seek a rabbi's personal assessment or validation as a confidant. Cursory discourse analysis of the interviews reveal that some rabbis describe congregants and patients' motives, while others give an account of their personal role and function. The latter are most often chaplains who excel at self-reflection due to their clinical pastoral education.

The last section examines the professional embeddedness of the rabbi, halakhic expert, and chaplain in his professional network and religious hierarchy. Two types of networks are relevant for halakhic and ethical decision-making in the realm of medicine. The cluster-like distribution of expert networks are present in Israel and the structured network type occurs in the United States.

3.1 Rabbinic Discourse on Bioethical Issues: The Technical "How"

3.1.1 Orthodox Halakhic Reasoning and Approaches

Within the Orthodox context, evaluation of a problem that otherwise can be called an ethical issue is genuinely dealt with in a religio-legal framework. The word "ethics," in the way practical philosophy uses it, does not have an equivalent in classical Hebrew. Jewish Orthodoxy does not primarily focus on questions of moral behavior per se, but rather on questions of whether and under what circumstance a certain action or deed is *assur* (forbidden), *mutar* (permitted), or *hova* (mandatory). For example, a medico-halakhic question would entail whether and how a patient is allowed to use an electrically operated nebulizer on Shabbat, assuming that its use is physician-directed in the case of a strong allergic reaction to pollen, to prevent adverse events, like congestion of the lungs or asthma. Although this case exemplifies Orthodox Jews' idiosyncratic needs, due to their observance of Jewish law, it is approached just as any other question of ethics within the realm of practical ethics. Whether or under what circumstances is it legitimate to withdraw medical care from a dying patient, use donor sperm for artificial reproduction, or endorse organ donation? All questions regarding medical technology, medical treatment, or the role of the physician are part and parcel of medical Halakhah. By contrast, Jewish bioethics describes a field of interest that deals with all subject matters that are relevant for the general academic field of bioethics and excludes those issues that are caused by the idiosyncrasies of a certain religious field or system, e.g. halakhic questions regarding the use of a nebulizer on Shabbat.

In general, the classic and notably formalistic halakhic approach to solve problems is that of analogy with an existent halakhic ruling.[1] Furthermore, as Rabbi Hershel Schachter (1941–), the *rosh yeshivah* of RIETS at Yeshiva University in New York, states, a *poseq* "juxtaposes the partic-

[1] See Bick, "Ovum Donations," p. 28. This article is a discursive response to an article by David Bleich that was published two years earlier in the same journal. The authors, both Orthodox rabbis, state their methodological approaches as part of their respective halakhic discussion of maternity. For that matter see Bleich, "In Vitro Fertilization," "Maternal Identity Revisited."

ulars of his own case and various halakhic precedents and principles, and thereby decides into which category his case falls. Then he must apply these precedents and principles to the situation at hand."[2] For example, halakhic decision-making regarding assisted reproduction technology and its various methods is anchored in the positive commandment of "Be fruitful and multiply" (*p'ru ur'vu*, Gen 1:28).[3] Thus, consensus generally exists among the majority of halakhic authorities on the permissibility of using these technologies. Controversies do exist, but only with respect to individual aspects of treatment, such as in the dissent on legitimate obtainment of male ejaculation for artificial insemination.[4]

In contrast, the lack of a similar "basic" consensus on the matter of neurological death is due to the absence of such a distinct source. Hershel Schachter states that the halakhic case of a brain dead individual is exceptional and "never has anything comparable existed in earlier generations."[5] This statement refers to the difficulty inherent in the halakhic evaluation of brain death, since this medical situation may be "too unique" to fulfill the basic criteria to render a *p'saq halakhah* according to the aforementioned rules. Strict adherence to these rules is called halakhic formalism and is a process of seeking a precedent, no matter how remote, in order to find a halakhic answer to a certain issue. This means that the halakhic system, perceived as a flawless system that has been revealed to Moses and Israel on Mount Sinai, offers a normative response to any situation and question without reference to anything outside itself.[6] From a formalistic point of view, Halakhah is an autopoietic system.

There is, of course, respectable critique concerning halakhic formalism, from within and without the Orthodox community. Rabbi Daniel Gordis from the Conservative Movement frames a critical response to halakhic formalism, especially when applied in the context of ethical decision-making: "To pretend to find any precedent for this type of issue destroys the meaning of the original case, and, in many instances, stresses a non-essential trait which the cases share in common at the expense of never addressing the new ethical agenda at hand."[7] Gordis' assessment expresses the concern that halakhic formalism and the forced search for analogous passages in the Talmud

[2]Schachter, "Determining Death," p. 32.

[3]Halakhic decision-making is of course much more complex and involves many other discussions of Talmudic passages and rabbinic literature. Each case is evaluated individually with the inclusion of the necessary medical information.

[4]Extra-halakhic factors that influence halakhic reasoning identifies the approach of Rabbi Eliezer Yehuda Waldenberg in his opposition of artificial reproductive technologies. His argumentation against IVF involved moral reasoning roots in religious ideology, or *hashkafah*. He justifies his opposition by referring to the high level of artificiality during IVF, which, in his opinion, involves "changing the order of Creation" (Brand, "Rulings of Rabbi Waldenberg," p. 505).

[5]Schachter, "Determining Death," p. 32.

[6]See Roth, *The Halakhic Process*.

[7]Gordis, "Wanted," p. 29.

inevitably miss the ethical issue at hand. Even moderate Orthodox scholars are sometimes at odds with the conventional method. Rabbi Ezra Bick, an Israeli Orthodox rabbi and teacher at Yeshivat Har Etzion in Alon Shvut, states a similar frustration in a debate with Rabbi David Bleich on the issue of maternal identity in the era of assisted reproduction technologies. Bick maintains: "If conventional halakhic methodology fails, the result should not be desperate attempts to preserve a semblance of halakhic reasoning. There may be questions to which conventional halakhic methodology provides no sources, no solutions."[8] Bick thus proposes addressing the issue of maternal identity by challenging the Talmud's concept of conception.

Furthermore, Daniel Gordis raises another important objection against the classical approach: "Another danger of the approach to text that mandates that every case must be answered by means of precedent is that the search for such a precedent will often lead to unnecessarily and unacceptably conservative results."[9] This statement indicates that strict adherence to precedents in a context where new scientific knowledge and practices must be analyzed in addition to other scientific paradigms, as inherent in the Talmud and commentaries, can lead at least to partially opaque and unintelligible halakhic reasoning.

3.1.2 The Jewish Legal Tradition in the Reform Movement

Halakhah as the normative framework for case law, whether formalistic or conceptual, has never been very highly regarded in Reform Judaism—neither by its laity, nor by its leadership. However, since World War II there has been increased interest in rabbinic answers and a renewed emphasis on Halakhah. The Movement's *posqim*, Solomon B. Freehof, Walter Jacob, Mark Washofsky, and Moshe Zemer in Israel have been widely engaged in the development and integration of (liberal) halakhic reasoning in Reform Judaism.

The promotion of "progressive" Halakhah within a Reform setting is by no means self-explanatory. In the latter half of the 19th century Radical Reform rejected any form of submission to Halakhot and Talmudic authority, including the notion that rabbis are possessors of religious authority. Reform Judaism's ideological legacy is this renouncement of religious heteronomy for the sake of autonomy as one of the guiding principles in religious Jewish life. Although the vast majority of American Reform rabbis were not "radical" but moderate, establishing a halakhic framework within the movement proved to be difficult. For instance, to achieve liturgical consistency within the Reform Movement, between 1904 and 1906 a committee of the CCAR drafted

[8] Bick, "Ovum Donations," p. 32.
[9] Gordis, "Wanted," p. 30.

a manual of life cycle rituals. The committee presented the draft at the convention in 1906, reporting that President Kaufmann Kohler and HUC Professor Gotthard Deutsch were previously requested to add "a number of Halakot or laws, which should serve as a guidance for Reform Rabbis."[10] According to the committee's report, these *halakhot* were understood to be guidelines only, and not mandatory decisions. However, the term *halakhot* triggered a wave of indignation. The situation was resolved during the next year's convention with the establishment of a responsa committee. The proceedings entail the following statement of Rabbi Schulman, who fiercely opposed introducing the *halakhot*:

> I deem it necessary to explain, that there is a distinction between sending out a Ministers' Handbook with Halakot as a new Shulhan Aruk and that which we are about to do if we adopt this paragraph. Our recommendation is that if any of the younger men [i.e. professionally unexperienced young rabbis] are in doubt upon a question of practice they should do what has been done from time immemorial in Israel: write to older men and men of learning and experience for an answer, and, of course, they will be guided in their conduct with due deference and reverence for such authority and such information; and as such answers may be valuable, it is thought that they should receive some form of permanence in our Year Book. Moreover, such responsa are in accord with principles of Reform; they do not become crystalized; they remain traditional. According to my interpretation of Reform, it is impossible for Reform to write a new Shulhan Aruk [...].[11]

The CCAR thus adopted a bottom up approach of *she'elot u'tshuvot* rather than issue a guideline resembling a code of law. Furthermore, chairman David Philipson claimed that the responsa were "simply the responsa of an individual, or of some committee of three,"[12] in order to prevent involving the entire conference. He argued that a decision made by the conference would give the impression of an authoritarian religious structure. However, the question of religious authority has always been a challenge for Reform Judaism. Although, some seventy years later Walter Jacob argued the opposite when he stated in the introduction to American Reform Responsa that "autonomy and freedom have limits and there has been less concern about autonomy than with the danger of chaos. The books of guidance which the Central Conference has published indicate that mandates are very much desired by many in the American liberal community."[13] To express his position, Jacob states that the volumes of responsa literature, which are published under his auspices as president of the responsa committee, are organized "to follow the pattern of the Shulchan Aruch wherever possible."[14]

[10] Central Conference of American Rabbis, Yearbook 16, 1906, p. 58 as cited in J. S. Friedman, *Guidance not Governance*, p. 8.

[11] Schanfarber, Hirshberg, and Stolz, *Yearbook of the Central Conference of American Rabbis*, pp. 121–122.

[12] Ibid., p. 123.

[13] Jacob, *Contemporary American Reform Responsa*, pp. xix–xx.

[14] Jacob, *American Reform Responsa*, p. xiii.

As Joan S. Friedman notes in her study on Reform responsa, the adopted vehicle of responsa as a means for rabbinic exchange on the basis of case law had a somewhat slow start. Many of the questions "gathered" under Kaufmann Kohler were not even submitted as such, but presented Kohler's own "exposition of issues that would have been included in the 'Halakot' section of the proposed Minister's handbook."[15] Some of the responsa, such as those of Rabbi Jacob Lauterbach, show a preference for implementing rabbinic literature and quotations from the Talmud. However, other responsa, such as the answers of Israel Bettan, are "extremely light on citations from rabbinic sources and heavy on appeals to Reform principles and ideology."[16] Yet another subset of authors draw from the spirit of the *Wissenschaft des Judentums* or refer to Jewish history and other sources of knowledge. Reform responsa, even if they rely on Talmudic passages and other religio-legal works, nevertheless differ from those issued by Orthodox *posqim*, as Israel Bettan concisely states in the final passage of his responsum on Euthanasia in 1950:

> Of course, we liberal rabbis have always claimed the right, in the interest of a progressive faith, to modify Rabbinic law and to remove what we regard as an obstacle in the advance of the spirit. And, indeed, we have eliminated many an old restriction which, though meant to safeguard Judaism, proved to obscure its essential nature. But we have never sought to nullify an effective Rabbinic implementation of a vital spiritual principle. The Jewish ideal of the sanctity of human life and the supreme value of the individual soul would suffer incalculable harm if, contrary to the moral law, men were at liberty to determine the conditions under which they might put an end to their own lives and the lives of other men.[17]

Rabbi Salomon B. Freehof developed a clear methodology for Reform responsa, classifying the questions that he received into three categories. First are questions that only require a brief response including a reference to a halakhic source in the codes. Second are issues that need a more extensive investigation of the sources and a thorough summary. Third are questions that demand a "specifically Reform" answer. In the third case a divergence of practice from codified law has already taken place or was likely to happen on the basis of Reform values. Such Reform responsa would elucidate "the ethical purpose behind the Halakhah [...]"[18] and support the decision's contemporary nature. Furthermore, Freehof emphasizes the importance of finding the most liberal halakhic opinion possible; one that is feasible and conforming to the realities of life. During his period as chairman, Freehof received a wide range of questions on matters of medical treatment and bioethics.

[15] J. S. Friedman, *Guidance not Governance*, p. 10.
[16] Ibid., p. 17.
[17] Bettan, "Euthanasia (1950)," p. 263.
[18] Salomon B. Freehof in an interview with Kenneth J. Weiss, 1978, as cited in J. S. Friedman, *Guidance not Governance*, p. 215.

Freehof's successors, i.e. Walter Jacob and Mark Washofsky, who both publish responsa, scholarly articles, and essays, repeatedly highlight the relevance of Halakhah for Jewish Reform responsa. The Reform *posqim* also emphasize the importance of Halakhah to Reform Judaism as a religious community:

> Our Jewish conversation on issues of personal morality and social justice, in which we attempt to apply Jewish values to construct our responses to the challenges we encounter in the marketplace, in medicine, in politics, and in world affairs, is based upon a discourse that is anchored in the Rabbinic literature and is suffused with references to halachic texts. Halachah, it turns out, is all around us in Reform Judaism, giving structure, meaning, and context to our community's ritual practice and our religious life.[19]

Halakhic reasoning for Reform responsa literature is undoubtedly relevant in the realm of rabbinic elite discourse. The question that remains is whether this kind of halakhic reality shows any interdependency with the concrete social behavior of Reform Jews. Washofsky is aware of this discrepancy and addresses it in his introduction to "Reform Responsa for the Twenty-First Century:"

> Do we not define ourselves as a 'non-halachic' or 'post-halachic' movement? Reform Jews, it is often said, do not tend to consult traditional Jewish law when making their religious decisions. And even when they do, they are likely to find its conclusions and methodologies strange and off-putting.[20]

The progressive legal approach in study and religious practice seems to correspond with the "theoretical interests" of a minority group within Reform Judaism. In his review essay of the anthology "Re-examining Progressive Halakhah" (2005) by Moshe Zemer and Walter Jacob, Rabbi Martin Lockshin expresses his disappointment regarding the practical usefulness of halakhic reasoning within a Reform Jewish context.

> I had been hoping to find here some critical discussion of what it means for Reform Jews qua Reform Jews (and not just qua academic scholars) to write about Halakhah. Generally the halakhic system is premised on the assumption that there exists a community of observers who feel that they must suppress their own autonomy to the authority of an obligatory religious system and must rely on rulings of Torah scholars. My sense in reading these essays is that the authors do not assume the existence of such a community for the writings of progressive Halakhah. Therefore it is not clear what audience they are addressing.[21]

Interviewees of this study confirm Lockshin's conclusion that Reform Jewish responsa do not actually have an audience to address. However, Reform responsa may appeal to rabbis who want

[19] Washofsky, *Reform Responsa 1996–1999*, p. xvii.
[20] Ibid., p. xv.
[21] Lockshin, "Re-examining Progressive Halakhah," p. 379.

to learn about Reform Judaism's stance regarding a certain halakhic issue. They are also a valuable source for "official" positions. Contrary to Orthodox responsa and their implementation and discussion within their respective interpretive communities, Reform responsa do not have the same standing within the religious milieu that relies on them. The experienced pulpit rabbi of a small Reform congregation in Brooklyn, Michael Loeb, confirms Lockshin's assessment and reveals that Reform responsa are of no practical importance to his community. [22]

> Michael Loeb: The people who write them are writing in the theory. [...] They're in the theory of it and it's meaningful to them, but Reform Jews like us (.) it's not that much interest, you know. It doesn't pertain to us, it's not gonna impact our decision. We may be curious and wanna know, maybe I would be more curious than, now as being a rabbi, you know, maybe I'd be more curious, but she's [i.e. Marcy Simmons] is very practical, she's going to make a decision according to what she thinks is in the best interest.
> Marcy Simmons: You know me rabbi, I don't ask anybody anything. I just do. (Michael Loeb laughs)
> Michael Loeb: That's my pal. [...] Yeah, they[23] like to think of themselves as being really halakhic Jews of sorts, even though they're Reform, you know, they think that way. You see, when the instructions are given in the books that I would read, like for funerals, it's always according to what the Orthodox would do. But then, I don't tell you they do it that way, they give you options.[24]

3.2 Subject Matters of Concern in Practice: The "What"

It is worthwhile to consider the frequency and nature of bioethical issues that rabbis deal with in their various professional settings. Different factors such as religious orientation of the congregation, its size and location, average age of the congregants and other demographical aspects impact the quality and quantity of questions that are discussed with Jewish clergy. Rabbis in large congregations and *rashei yeshivot* are more likely to be confronted with a wide spectrum of bioethical or medico-halakhic issues, since all life-stages are represented. This holds true also for experts on bioethical issues and rabbis or chaplains in hospitals, as long as these hospitals do not specialize in a certain field of medicine, e.g. cancer treatment or geriatric medicine.

Examination of rabbis' professional practice with respect to questions of medical Halakhah and bioethics reveals that there are some issues that are more salient than others. For example, end-of-life issues are pre-dominant. Since this area includes many different medical conditions,

[22] After a while into the interview Rabbi Loeb (p) had the idea to "test" some of the questions with his secretary and congregant, Marcy Simmons (p). The interview was not planned as a group interview. However, some of their discussions turned out to be very revealing, especially because both were comfortable with each other.

[23] I.e. the rabbis of the responsa committee and "progressive" halakhists.

[24] Interview with Rabbi Michael Loeb/3 (p) and Marcy Simmons/3 (p), 9.6.2010, Brooklyn, N.Y. Quotation at time stamp #00:31:59-8#.

intervention, care and treatment, the following is merely an overview based on the study's coded data.

Rabbi Bryan Epstein, a Reform rabbi in a Brooklyn-based congregation and former chaplain at NYU Medical Center in Manhattan, classifies the various questions regarding end-of-life matters into three categories. First are issues that deal with the aftermath of acute and life threatening incidences, such as strokes, heart attacks, or traumatic brain injuries. These cases create a situation where a person becomes dependent on life-support. Second are conditions and therapies of cancer patients that are related often to questions regarding palliative and hospice care. A whole set of decisions pertain to the question of whether or when to end treatment and prepare for the inevitability of death. Third are long-term illnesses that include aspects of care and decision-making of patients with chronic illnesses and/or old age, particularly involving the consequences of dementia and Alzheimer's disease.[25] An Orthodox colleague of Epstein's, Rabbi William Lapin, who holds a medical degree and serves as a contact for less experienced pulpit rabbis on questions about medical Halakhah, gives a similar account:

> The most common questions deal with either end-of-life care or emergency, acute situation care, some of which are end-of-life, some of which are not. But mostly dealing with end-of-life care, dealing with how aggressive to be or not to be in the care of a family member, issues that are related to ventilator support or withdrawal, issues related to feeding tubes, issues related to 'Do not resuscitate' orders, DNR, those are the most common.[26]

It is noteworthy that, while issues regarding cancer treatment and care are brought up equally by the Reform and Orthodox samples, other subjects indicate different distributive patterns. In Orthodox settings, a major concern that cuts through all of the aforementioned end-of-life "categories," is DNR, the "Do not resuscitate" order. It implies ethical and halakhic considerations and creates multiple intersections with legal, medical, and ethical issues in end-of-life decision-making. DNR symbolically presents the negotiation that exists between the principle and ideal of (patient) autonomy, however relational, and the heteronomy of halakhic normativity. Orthodox rabbis' and chaplains' narrative reflection of DNR is often related to the question of halakhic authority and an individual's "free choice" regarding the withholding of treatment and other interventions. Orthodox chaplain Yosef Ungar, who is employed in a hospital in Manhattan, reveals his approach to situations when the "Western" notion of autonomy conflicts with the Jewish limited conception of it:

> A person is not allowed to damage himself. A person is really obligated to do, which is best for him. That sometimes flies with the Western conception of autonomy. Here we have to respect patients'

[25] See interview with Rabbi Bryan Epstein (p), 25.5.2010, Brooklyn, N.Y. Time stamp #00:02:05-8#.
[26] Interview with Rabbi William Lapin (p), 3.6.2010, Queens, N.Y. Quotation at time stamp #00:03:26-8#.

> autonomy. I can't say 'Well, Jewish law says you must do this,' you know. Sometimes, and this is where it comes up a lot, is situations where there's no real clear-cut remedy: do I do an extra chemotherapy or not? (.) So, there are different arguments amongst rabbinic scholars about whether one has to take the chemotherapy or not. My rabbi (rabbis?) says that, 'Unless, if there's no clear-cut remedy which works all the time or most of the time, if it's like a 20% chance or 30% chance and there're significant side effects and there's less than a year left for recovery, it's really up to the patients to make that decision.' That's kind of the intersection between Orthodox Judaism and Western autonomy. It intersects over there. [...] The questions that get to me aren't extreme questions of autonomy, they're usually at the intersection.[27]

Jewish bioethicist David Bleich notes that halakhic Judaism recognizes freedom and liberty as values, but defines them in a unique way. Bleich comprehends freedom as the absence of restrictions that prevents a person from achieving his or her potential. In contrast, the laws of the Torah intend to support the efforts of human beings to fulfill the divine plan inherent in creation. Bleich thus considers the rejection of these laws not as an act of freedom, but the anti-thesis of it.[28] However, "significant side-effects," i.e. pain and suffering, are major factors to take into account when seriously considering a patient's wish to discontinue treatment. A difference between Reform and Orthodox accounts regarding end-of-life situations concerns the issue of withholding and withdrawal of treatment or life-sustaining therapy. Orthodox rabbis address cases and considerations that include these specific ethical and halakhic dilemmas more than four times as often as their Reform colleagues. The difference hinges upon ascertainment of when prolonging life becomes "unneccessary" prolongation of the death process.

Sources, which serve as a textual basis for general orientation, illustrate an actively dying person in pre-modern times. The relevant passage and key source to legitimize "nature taking its course" is found in the Sefer Hasidim, a text written in the 13th century: "If a person is dying, and near his house someone is cutting wood so that the soul [of the dying person] cannot escape, someone should drive out the woodcutter from there."

Rabbi Moshe Isserles' (16th century) commentary on the Shulhan Arukh further explains:

> If there is anything which causes a hindrance to the departure of the soul such as the presence near the patient's house of a knocking noise such as wood chopping or if there is salt on the patient's tongue; and these hinder the soul's departure, then it is permissible to remove them from there because there is no act involved in this at all but only the removal of the impediment.[29]

These texts clarify that a *goses* (actively dying person) must not be disturbed in his dying process; it is even permissible, or advised, to remove those elements that prevent death from occurring. Let-

[27] Interview with Rabbi Yosef Ungar (p), 1.6.2010, Manhattan, N.Y. Quotation at time stamp #00:11:39-9#.
[28] See Bleich, "Behandlung des Patienten," p. 61.
[29] Quotation as in F. Rosner, "Jewish Attitude Toward Euthanasia," p. 281.

ting a person die by refraining from life-prolonging measures, if further treatment only prolongs the dying person's period of suffering, is thus permitted. Though there has been much scholarly attention to this passage, rabbis involved in every day situations with patients have their own experiences and ideas regarding the text's relevance in contemporary healthcare. For instance, Rabbi Ann Kornblum, who works as a Reform chaplain in a retirement home in New York, realized the meaningfulness of the "wood chopper's" analogy when noise from a construction site nearby had become an issue for the residents and staff:

> I had an interesting experience once. There is a famous text, which I've never understood, about when someone's dying and there's a wood chopper outside. (I: Ah, yeah, yeah the wood chopper.) And I've never understood that text. What's the answer from that text? Is it good to hear the wood chopper, is it bad to hear the wood chopper, do you tell the wood chopper to stop? And we have had these buildings under construction and you hear the construction and sometimes I've been in a patient's room, a resident's room, trying to talk to that person; we can't really hear each other 'cause bang, bang, bang, there was construction going on outside. And so, for the first time the text came alive to me in all of its nuances. So, we can't have a conversation, they can't have peace during the day, you know, during the construction from 8.30 to 5.30 or whatever the hours are of the construction. There's no peace in their room. And yet, that's the reality of the outside world. Should they continue to be engaged with the reality of the outside world? We can't make the world perfect. I don't think it has an answer.[30]

Kornblum further remarks that she convinced the workers to stop the construction work during Rosh ha-Shana and Yom Kippur services. She argues that no "sacred service" could be accomplished under these circumstances. However, Kornblum doubts that the instruction given in the Sefer Hasidim and its commentary correctly describes the interrelationship between the dying process and outer world:

> Because they're focusing on the noise, so they're distracted from the natural process in their body, then they still have life inside them. If you take away the noise, then you think they're gonna go,'Oh, I'm gonna die?' You know, now, it doesn't make sense to me. I don't know what (.) what was the intent of the text?[31]

Although the Sefer Hasidim's instruction theoretically seems to be a good orientation guide, its implementation into contemporary medical reality is questionable. Furthermore, as rabbis and medical professionals agree, every case is different. There exists a tension between two ends: the wish to protect life and the wish to not prevent death at all costs, especially if pain and suffering are an issue. Within this halakhic and human gray zone, the halakhic agent is given the "autonomy"

[30]Interview with Rabbi Ann Kornblum (p), 18.5.2010, Bronx, New York. Quotation at time stamp #00:27:20-8#.
[31]Ibid. at time stamp #00:31:21-1#.

to make his own decisions. It is in this realm of the human struggle with finitude that the Talmudic statement לב יודע מרת נפשו (the heart knows its own bitterness) halakhically supports "autonomous" decision-making: the sentence is generally understood to mean that a person knows best how much s/he suffers. This is especially true in cases where "withholding" treatment may be preferable over continuation of treatment. For instance, there are cancer patients who do not feel that they can endure another cycle of chemotherapy, surgery, or radiation, when a previous round of treatment did not cure the disease. However, a Brooklyn-based *hasidic* chaplain, Yehuda Leib Danziger, suggests that there are rare cases when a conscious patient will favor living with pain over dying at any cost. He is the only one who states that suffering may be a means to "reprimand myself from my sins."

> A religious person, who devotes himself to the service of God, to Ha-Shem, will not measure the quality, 'cause he knows, 'I'm here for a cause. I came into this world to serve the Almighty. And therefore, if this is what he wants from me, you know, I'm suffering, this is the way I can maybe reprimand myself from my sins and replenish and cleanse myself,' you know, so he'll never say 'quality of life,' you know. But if somebody is terminally ill and is already out of it and not conscious, if we, the outsiders, should go and say 'Prolong him,' that's a different situation. But as long as a person is conscious and could say a *b'rakha* or whatever, do the deed or do a *mitzve*, *shakel* a *lulav* or put on *t'filin* or whatever it is, we will help him along even though the quality is poor.[32]

Danziger's assessment corresponds well with the general "dogma" within Orthodoxy, especially in *haredi* circles, to apply heroic measures whenever possible and as much as possible, in order to make sure that one is not liable of having shortened life (*karev kitzur*). In fact, practically all Orthodox rabbis mention that they receive questions pertaining to withdrawal of life-sustaining support from patients. "To pull the plug" or "remove the ventilator" are common expressions used by the interviewees to semantically refer to this area of decision-making in the clinical setting. It is noteworthy that Ultra-Orthodox and Modern Orthodox rabbis agree about the necessity to differentiate between withholding versus withdrawing therapies. While not starting treatment may be indicated under certain circumstances, Orthodox agents do not condone the cessation of ongoing therapy, including the removal of ventilators. A common thought pattern among Orthodox respondents is their perception of the medical field as being "generally" in favor of "rushing" to remove life-support. Thus, often they describe their own role as one of intervention when they suspect such processes of shortening patients' lives. Unless they are chaplains, Reform rabbis do not regularly deal with this specific issue. Instead, they often deal with questions regarding hospice care, dementia, and the care of cancer patients in their congregations.

[32]Interview with Yehuda Leib Danziger/3 (p), 8.6.2010, Brooklyn, N.Y. Quotation at time stamp #00:16:08-1#.

Rabbis' answers regarding the question of which issues are the most complex and difficult to handle depend on various factors, such as their experience, position in the religious network, and professional context. A few interviewees from the Orthodox sector feel that brain death cases are the most difficult to handle. This may be due to the controversial nature of the topic in Judaism, i.e. Orthodoxy. Rabbi Itamar Neman, a rabbi who is employed at a public hospital in Jerusalem, states that the complexity is caused by the density of the situation and the difficult decisions family members have to make within a short amount of time.[33] Additionally, Rabbi Neman classifies refusal of treatment as among the most difficult situations to handle.[34] Although the issue of neurological death, i.e. brain death, entails a myriad of difficult decisions, other rabbis do not consider it to be the most complex issue. For example, Rabbi William Lapin,[35] the aforementioned Orthodox pulpit rabbi in Queens, feels that brain death constitutes an important subtopic of end of life care, but is trumped in complexity by other questions: patients who suffer from advanced dementia and face subsequent complications; end stage situations due to septic shock, organ failure, and infections; patients after heart attacks and strokes, who may or may not transition into brain death; and people in persistent vegetative states or other unconscious states.[36]

> From my perspective in terms of the care that you do or don't provide to a patient, independent of the issue of organ donation, [a brain dead patient is] actually an easier type of patient to manage halakhically, I believe—if once one resolves the issue of definition of death. But the management of such a patient, I think is actually more straight forward halakhically than those who are not brain dead, which is the larger population, who have, you know, compromised levels of consciousness or other cognitive impairments, other complications, other aspects of terminal illness or hopeless illness. [...] Oftentimes patients who had a certain level, a base line of quality of life and then kind of spiral down and it's not always clear whether they could ever retain that earlier quality of life or some semblance of it, which makes the issue of how aggressive to treat or not more complicated; somebody who's brain dead we know exactly what is and what will not be.[37]

Rabbi Richard Address, the director of the URJ's Department of Jewish Family Concerns at the time of the interview, perceives that the most difficult questions he receives are not about death *per se*, but about the years leading up to it: "Care giving and issues that concern quality of life. I

[33]Especially in Israel, religious Jews may object to brain death diagnosis qua diagnostic tool. Thus, besides having to establish whether the family factually agrees to brain death or not, staff must further address the sensitive topic of organ donation while the family is likely in shock, and inquire whether to remove the life-sustaining therapies or treat the patient as if s/he is alive.

[34]See interview with Rabbi Itamar Neman/3 (p), 17.8.2016, Jerusalem. Time stamp #00:03:34-4#.

[35]Lapin (p) is somewhat of a second degree contact person in the area of medicine and Halakhah (see later in the chapter) and is contacted by chaplains and other neighborhood rabbis for his halakhic advice.

[36]See interview with Rabbi William Lapin/1 (p), 3.6.2010, Queens, N.Y. Time stamp #00:13:27-3#.

[37]Ibid. at time stamp #00:18:52-3#.

would say that's really been in my work what has jumped up in the last five, six years more so than anything else."[38]

Difficult bioethical decisions also arise regarding the beginning of life and assisted reproductive technologies. Various questions and uncertainties exist regarding pregnancy, childbirth, and fertility treatment. Beginning of life issues that are most often discussed with rabbis involve IVF or PDG (prenatal genetic diagnosis), storage of eggs for later use, egg donation or the use of donor eggs, surrogate motherhood, (intrauterine (IUI)) insemination with donor sperm, and the halakhically correct retrieval of a husband's sperm for insemination. In addition to the many practical halakhic aspects of reproduction technology, the issue of abortion frequently comes up. The cases and questions presented to rabbis include many different medical and social situations. One Reform rabbi reports having received the question as to whether selective reduction after IVF is morally acceptable or not. Practically all rabbis of the Orthodox sample feel that the evaluation of a case, which may lead to a premature termination of pregnancy, should be discussed with rabbinic authorities who are experienced in medical Halakhah. Melanie Mordhorst-Mayer et al.'s analysis of Eliezer Yehuda Waldenberg's and Moshe Feinstein's halakhic rulings on abortion suggests that the latter approaches the issue from the perspective of the unborn child and therefore generally rules in favor of the child—as long as it is not considered a *rodef* (pursuer).[39] In contrast, Waldenberg considers the matter from the mother's perspective, often ruling leniently on abortions.[40]

The hospital rabbi of a religious hospital in Israel recalls one aspect of his professional encounter with Rabbi Waldenberg in relation to pregnancy termination. Hospital rabbis of religious hospitals in Israel are authorized to decide over patients' treatments in halakhically delicate issues such as abortion. Their position in the hospital is a safeguard for maintaining the hospital's religious policies, which are under the auspices of greater halakhic authorities.

> Abortions I won't do here because in [hospital name][41] I have to sign for it; also I won't sign something that's against my conscience. But I told you before, people with that answer came crying to me, I tried speaking to them and then it seemed clear to me that they want to go through it and I told them to go to the Tzitz Eliezer. [...] Today we don't have the Tzitz Eliezer, unfortunately, but I did send them to him. By the way, people should know, everybody calls the Tzitz Eliezer that he permitted abortions relatively easier than other *rabbonim* [rabbis], which is true. However, he did not allow any fertility treatment, people should be aware of that, so when you go according to a *rav*, you're supposed to look at the entire picture and people are very good at saying 'The Tzitz Eliezer allowed abortions,' but I don't hear them saying 'He didn't allow IVF, he didn't allow IUI.'[42]

[38]Interview with Rabbi Richard Address/2, 23.6.2010, Manhattan, N.Y. Quotation at time stamp #00:25:03-#.
[39]During a difficult birth an unborn child may be turn into a *rodef*, a pursuer, who threatens its mother's life.
[40]See Mordhorst-Mayer, Rimon-Zarfaty, and Schweda, "Halakhic Debate on Abortion."
[41]The hospital demanded that neither the interviewee's nor the hospital's names be disclosed.
[42]Interview with Rabbi Doron Blaufarb/1 (p), 25.5.2011, Israel. Quotation at time stamp #00:26:25-6#.

The termination of pregnancy is a complex area that also may touch upon other ethical issues. Orthodox interviewees repeatedly point out that premarital genetic testing is a promoted means to prevent the birth of seriously ill children. Dor Yeshorim, an organization that offers a unique service to the community, is widely adopted by the Orthodox sector. The goal is to eradicate fatal and debilitating recessive genetic disorders that are most prevalent in Ashkenazi Jewish circles by establishing easily accessible premarital genetic testing. For that purpose, Dor Yeshorim conducts mass screening drives at high schools, *yeshivot*, and colleges. Pairs considering marriage then exchange ID numbers and birth dates, and call Dor Yeshorim's hotline to request a compatibility check. This highly sophisticated procedure is confidential and well-tailored to fit *haredi* marital customs. The result only states whether a couple is "compatible" or not. It does not give information as to whether one is a carrier of a certain genetic disorder. If only one person is a carrier for a recessive disease, both parties are informed that they can proceed with matchmaking.[43] If the parties are both carriers, then they are informed that they are genetically incompatible, which means that they have a 25% chance to give birth to a child having one of the nine genetic disorders (including Tay Sachs) for which the organization currently screens. Recently, Dor Yeshorim added on a Sephardi standard panel that includes sixteen genetic disorders.[44] Thus, exchanging ID numbers has become an integral part of the matchmaking process in Orthodox Jewish, particularly Ashkenazi, circles.[45]

It is inventive to have the results of screening tests linked to dating customs of Ashkenazi Jews who won't invest more time and feelings into a marital project that likely turns out to end in a tragedy. Furthermore, although there are *posqim* who rule leniently on abortion in cases of such severe and lethal defects, the goal of these screening programs is to prevent such cases from the start. Though there are other possibilities to give birth or raise healthy children, such as using PDG to screen the embryos for a certain genetic disorder, adopting, using donor eggs or donor sperm, the most halakhically unproblematic, convenient and inexpensive way to prevent major pitfalls in building a family, is by way of not coupling two carriers of the same disorder. While this may work for those Jewish milieus where people find their partners by means of traditional *shiddukh*, it is practically irrelevant for Reform Jews. Not feeling attached to Halakhah and religious authorities who take the decision for them, Reform Jews make their own decisions when it comes to abortion—whatever the reason. Thus, they do not consult their rabbis regarding these decisions.

[43] See Dor Yeshorim, *Process*.

[44] See Dor Yeshorim, *Sephardi/Mizrahi Panel*.

[45] For an international and cultural comparison of the mass screening projects as Dor Yeshorim for Jewish couples and the Cyprian program for testing thalassaemia see Prainsack and Siegal, "The Rise of Genetic Couplehood?"

However, rabbis involved in bioethical decision-making do not necessarily consider the complexity of a medical problem an issue for decision-making. Rabbi Avraham Steinberg shares that, for him personally, the most complicated issues are those that involve a new situation: cases that he and *posqim* are not able to answer *ad libitum*, but require further investigation and study of relevant sources. Even if the question is complex, Steinberg believes it is "easy to answer," as long as it is a question that comes up repeatedly.[46] He still acknowledges that while an issue may present itself as a simple one to an expert, it may nevertheless be hard or difficult to bear for the patient and family members.

Finally, Orthodox rabbis in various professional settings also receive questions that belong to the realm of medical Halakhah, but are without bioethical relevance. It is interesting to note that these questions constitute a considerable part of Orthodoxy's preoccupation with medical issues from a halakhic perspective. Congregants often contact their rabbis to clarify if certain medications, medical treatment, or actions are prohibited, allowed, or mandatory on Shabbat and festivals. Especially on Passover, rabbis receive questions concerning ingredients of medications, supplementary nutrition, or vitamins that may contain *hametz*. Also common are issues related to *taharat ha-mishpahah* (family purity laws), and childbirth. Rabbi Shalom Rabinowitz, a young pulpit rabbi in South Brooklyn, states that his congregants sometimes feel that they should follow Talmudic medicine rather than modern medicine or that they should not receive any treatment: "I think sometimes people are a little bit misguided in their faith and they go the opposite way and think that they can't use the methods out there for treatment, because that's supposed to just throw their faith in God and one is not a contradiction to the other."[47]

Frequency cannot adequately analyze rabbinical involvement in decision-making processes regarding specific questions. Thus, the next section addresses the network positions of various actors, who are involved in halakhic, ethical, or spiritual decision-making. The chapter's last section will consider the role reflection of rabbis and chaplains. The interviewees were asked what they think congregants and patients expect from them. Is it a clear statement? Or should the rabbi provide a personal assessment, advice, or just an ear to listen? For congregants who want to familiarize themselves with "the Jewish" view on a certain topic, do they request general clarification or *their* rabbis' perspective? Or do congregants seek a rabbi's halakhic evaluation of their case?

[46]Interview with Rabbi Avraham Steinberg/2, 9.8.2016, Jerusalem. Quotation at time stamp #00:00:42-2#.
[47]Interview with Rabbi Shalom Rabinowitz (p), 9.5.2010, Brooklyn, N.Y. Quotation at time stamp #00:55:24-3#.

3.3 "It's not What You Know, it's Who You Know": Professional Networks, Hierarchies, and the Relational "Where"

The role of rabbis and chaplains in various professional settings is influenced by the rabbi-layman relationship as well as by respective religious structures and professional networks. The practical aspects of the rabbis' involvement in bioethical decision-making can only be fully grasped if the relevant professional relationships and co-dependencies of network(s) are comprehended. Thus, the aphorism "It's not about what you know, but who you know" serves as *leitmotif* for the following section on biomedical case discussions and professional networks within Jewish communities.

Sociology's network model, as outlined by Tobias Müller-Prothmann, differentiates between four kinds of network actors and their respective roles.[48] The model is based upon knowledge management and operations research. Since the present study is not strictly network analytical, Müller-Prothmann's descriptions serve as a rough framework.

First, experts possess specialist knowledge and professional experience within a certain domain of knowledge. They hold a central position in a network, usually with a high amount of external links. Second, knowledge brokers know which person in a certain corporation or community possesses what kind of knowledge ("who knows what"). They build bridges between various subgroups and network clusters, which otherwise would not be connected—or if connected, then only indirectly. Third, contact persons take an intermediary position, connecting with experts without having expert knowledge themselves, or without communicating such knowledge. They are intermediary because they hold a position that is between central and peripheral agents in the network. Fourth, knowledge consumers seek out expert knowledge and therefore occupy a peripheral network position.

Applying this position-focused approach to Jewish communities assists with understanding how relevant agents support congregants and patients in bioethical decision-making. Congregants or other persons who seek contact to religious and spiritual care professionals, i.e. rabbis or chaplains, are knowledge consumers. In both Orthodox and Reform contexts, (local) neighborhood rabbis who are employed in a congregation serve as contact persons or agents. In general, they are not experts for biomedical ethics or medical Halakhah, and are not expected to be so. An experienced Chabad rabbi in Crown Heights, Brooklyn/New York, compares such a rabbi's position with that of a general practitioner:

[48] See Müller-Prothmann, *Communities of Practice*.

> Today in Jewish law also: There are specialists in various fields. While all rabbis go to a basic course of training, they're not specialists in a particular field. They may be like the general practitioner of old, you know, that you want to talk to about all your problems; but what you expect of the rabbi is, at least he should know who to refer you to. And people will appreciate you for that [...].[49]

The bridging function of this agent within the network mirrors his social role. He is not the ultimate authority, but the first link in a chain. This trend is more applicable to the Orthodox sector than the Reform Movement. Though as rabbis Reich and Greenspan state, Reform pulpit rabbis may contact the chairman of the CCAR responsa committee to hear his opinion on a specific case or subject matter, they do not refer or send congregants to other rabbis. Most often, American and Israeli Reform rabbis contact their own colleagues in order to get another opinion or discuss an issue and to "bounce it off the other rabbi, to make sure I'm on the right course."[50] *If* Reform congregants seek to talk to their rabbis, they do so because they are interested in a moral *hekhsher* (kosher stamp) of their actions or because they are curious as to whether their decision is the "right one" from "the Jewish" perspective. However, it does not necessarily mean that they indeed follow the rabbi's advice.

The remaining two positions in the network are a bit more complex: knowledge brokers and experts. Knowledge brokers can be described as agents "somehow between worlds,"[51] who are "well placed to resist the 'dogmas' of the domains they are eventually meant to bring together."[52] Such resistance accompanies a marginal or peripheral position in the network. Furthermore, knowledge brokers are bridge builders, but at the same time tend to operate somewhat invisibly. To a certain degree, chaplains serve this professional function within the Jewish network. Such framing is more applicable to an American pastoral care giver who traditionally earns a rabbinical degree, and less so to an Israeli spiritual care worker. The position of knowledge broker resembles Rabbi Yosef Ungar's metaphor for his professional role:

> There are different schools of thought and the main thing what I do is I'm trying, you know, help Orthodox patients who are turning to me to find a super-duper rabbi, you know, a big rabbi that they can ask and consult. And sometimes I play switchboard operator, get them speak to them themselves.[53]

Ungar's position does not seem to differ fundamentally from the one of a contact person, i.e. congregational rabbi. However, there is one major difference with respect to the professional domain:

[49] Interview with Rabbi Uriel Kagan/2 (p), 1.6.2010, Brooklyn, N.Y. Quotation at time stamp #00:22:14-5#.
[50] Interview with Rabbi David Reich (p), 3.5.2010, Manhattan, N.Y. Quotation at time stamp #00:28:32-7#.
[51] Meyer, "Knowledge Broker," p. 122.
[52] Ibid.
[53] Interview with Rabbi Yosef Ungar (p), 1.6.2010, Manhattan, N.Y. Quotation at time stamp #00:14:05-8#.

a chaplain's workspace is within the healthcare setting, while that for a pulpit rabbi is within the communal setting of his congregation or organization. Though there is some overlap between the two professions due to their intermediary status within the greater network, chaplains are more invisible in the network than pulpit rabbis because the former do not claim a normative position in the Jewish world. In contrast to congregational rabbis, chaplains in American hospitals generally have extensive knowledge in Jewish bioethics, but do not have the authority, religious status, or job description to exert it.

Thus, it is important to recall the key aspect of Bourdieu's theory. The social practice of halakhic decision-making involves "players" who are aware of their field position, the rules of how to play the "game," and the symbolic capital involved, e.g. halakhic authority. Reproduction of the Orthodox social field therefore correlates to a system of knowledge governance that is structured around self-referentiality. Fields reproduce *habitus*, and similar conditions of existence create comparable habitual structures. Such homogeneity due to class *habitus* causes practices to be immediately intelligible and foreseeable by agents in the field.[54] It is thus important to include factors of authority and normativity in our determination of network positions.

As knowledge brokers, healthcare chaplains are indeed peripheral within the religious normative network and view themselves as a spiritual resource for others. Additionally, healthcare chaplains may play "switchboard operator" for Jewish families and patients, when necessary. They possess lists with names of *posqim* and experts in the field, whom they may contact. Interestingly, their peripheral status in the "pecking order" of the religious network sharply contrasts with their central position as knowledge brokers at the intersection of religious and medical communities of knowledge. According to Morgan Meyer, "knowledge brokers produce, enable, and facilitate movement, and they themselves are in movement. They move back and forth between different social worlds."[55] Social mobility and the capability to engage in a positive way with these various social and religious worlds is of essential importance to healthcare chaplains, especially in culturally diverse places, like New York City. Thus, knowledge brokers, e.g. pastoral care givers, not only move back and forth between social worlds, they also facilitate communication between people who would otherwise not be connected with each other.[56]

Religious communitization and network analysis are major aspects to consider in the organization of care, support, or referral of patients and families, particularly with respect to the Orthodox community. As elaborated in the previous chapter, a major difference between the United States

[54]See Bourdieu, *Theory of Practice*, p. 85.

[55]Meyer, "Knowledge Broker," p. 123.

[56]There are of course other job descriptions besides healthcare chaplains that fit the position of knowledge broker, as elaborated below. This holds true for American and Israeli contexts.

and Israel has to do with: a) the institutional existence or absence of Orthodox congregations as social containers for religious Jews in Israel, b) the implementation of certified Jewish spiritual care workers who are ordained rabbis of all denominations in the United States, which contrasts with Israel's multi-professional and non-clergy oriented approach, and c) the existence of an Orthodox (religious) establishment, which contrasts with denominationalism and various Jewish sectors' equal footing.

These cultural differences influence the position of a knowledge broker in relation to the network. While the healthcare chaplain serves this role in the United States, at least two other positions serve this role in Israel.

Difficulty in recruiting suitable Orthodox interviewees in Israel made me realize the necessity of changing my perspective of the network within the Israeli context. As mentioned in chapter 2.3, my preconception of Israeli Orthodox communitization as (more or less) congruent with that in the United States caused me to seek "contact persons" in the wrong place, i.e. (non-existing) congregations. I realized that I would have to investigate at the "consumer's" level, assuming institutional "non-affiliation" of Orthodox Jews to be common. However, the study is not set up to investigate the "story" of the consumer, i.e. congregant or patient. Gradually, certain patterns and names emerged: One name in particular, mentioned by interviewees and others I spoke with, was that of Rabbi Elimelech Firer, a Belzer *hasid* from Bnei Brak and the most prominent figure within the Israeli medical referral network.

Medical referral is the epitome of knowledge brokering within the healthcare setting. Many people seem convinced that any question in the realm of medicine, whether it is a medical or medico-halakhic question, may be directed at Rabbi Firer. He started the non-profit organization Ezra le-Marpeh (help to the healer) in 1979. This voluntary organization, with Firer as its "main human resource," helps sick people find the best hospitals, physicians, and treatments available for their conditions. An autodidact with no formal training in medicine (or any other science) he not only refers patients to the best medical professionals, but also interprets medical data; by doing so, Firer continues to flabbergast the medical world.[57] This kind of rabbinic involvement in medical cases, including discussion of medical data with surgeons and other physicians, is what makes

[57]See Siegel-Itzkovich, *Don't Call Him Doctor*. In addition to several honorary doctorates, Firer received Israel's highest civilian honor, the Israel Prize for his life work in 1997. There are other medical referral services led by *Haredi* rabbis. For the Jerusalem area there is Magen Lacholeh (shield of the sick), directed by Rabbi Benjamin (Benny) Fisher. This institution was founded by Rabbi Shlomo Zalman Auerbach, the Yerushalmi *poseq* who issued many medico-halakhic rulings. For Auerbach's role regarding the question of brain death in Judaism see chapter four of this dissertation. Furthermore and noteworthy with respect to international medical referral is Rofeh, an organization established by the Bostoner Rebbe, Levi Yitzhak Horowitz (1921–2009; Boston *Hasidut*).

Rabbi Firer unique. However, rabbis who engage in medical referral serve the roles of knowledge broker and first contact person, much like the pulpit rabbis or chaplains in the States who are contacted either because a relationship of trust already exists or they are available to discuss the moral or spiritual dimensions of hospital care. Shuper et al. assert the following:

> Seeking out the chaplain for comfort or moral support when conventional medicine fails, for instance near the time of death of a patient, is common practice worldwide, and many care facilities now include chaplains on the medical team for this purpose. In Israel, however, for decades we have witnessed a unique phenomenon wherein rabbis, usually from the ultraorthodox stream, are actively consulted by patients or their families for help in making basic medical decisions in the acute care of emerging problems, such as which physician, hospital, or treatment should be chosen for a specific disorder. Rabbis' advice is not sought in regard to the moral, ethical or spiritual appropriateness of a specific testing or treatment for particular conditions but in regard to the appropriateness of medical-professional decisions.[58]

It is noteworthy that rabbis' advice is sought with respect to medical-professional decisions rather than the moral, ethical, or spiritual dimensions of a particular condition. However, this pattern does not consider the socio-religious context of the consumer of such knowledge. It may be suggested that *dati* and *haredi* Jews who contact a medical advisory service to discuss their options may nevertheless seek to talk to a halakhic authority or medico-halakhic expert to determine whether a certain medical decision is appropriate.

Lastly, an expert's position is defined by his specialist knowledge and his centrality within the network. Two kinds of experts are relevant for Jewish decision-making at the intersection of medicine and religion. There are *posqim*, who are halakhic authorities situated high within the religious hierarchy, and experts for medical Halakhah, who are simultaneously trained as rabbis and physicians.

Reform *posqim* are usually not directly involved in the decision-making process of other rabbis' congregants. Pulpit rabbis may contact them to discuss a case, but just as Reform Jews do not contact their rabbis for a halakhic decision, Reform *posqim* do not exert rabbinic authority in matters of medical decision-making. However, the *posqim* within the Modern Orthodox and *haredi* milieu do exactly that. As halakhic experts, they possess the relevant knowledge and experience, as well as status that is necessary to be accepted by the wider community. In the case of Rabbi Moshe Feinstein, who was known to be the *gadol* (greatest) of his generation, this acceptance came from within the whole Orthodox spectrum. *Posqim*'s position in the network is such that they deal with the new and halakhically complicated questions. They are at the top of the ladder and possess the necessary "broad shoulders" to decide whether a certain procedure is

[58]Shuper et al., "The Paediatrician and the Rabbi," p. 441.

halakhically acceptable or not. Thus, the Rabbinical Council of America (RCA) explicitly states "that all end-of-life issues and questions should be presented to a Halachic authority, preferably, when possible, before they become urgent or emergency decisions."[59] Due to the decentralized structure of the Orthodox community, at any time there are multiple halakhic authorities who can be considered *poseq*.

The person named most often by Modern Orthodox as well as *haredi* rabbis is Brooklyn based David Cohen (b. 1932).[60] Dovid Feinstein (1929–2020; Lower East Side, New York) is mentioned often as well, but some respondents only say that they *would* turn to Feinstein, and not that they actually do. Rabbi Yisroel Belsky (1938–2016, Brooklyn) and Rabbi Chaim Pinchas Scheinberg (1911–2012) are mentioned among the *litvish-yeshivish* milieu. Interestingly, only American interviewees in Jerusalem named the latter, who was born and raised in the United States but immigrated to Israel in 1965 to establish a *yeshivah* in Jerusalem 's Kiryat Mattersdorf. Hershel Schachter and Mordechai Willig are considered Modern Orthodoxy's *poskim*. The *hasidic* world name Rabbi Gavriel Zinner (Nitei Gavriel, Brooklyn), Yechezkel Roth (Karlsburger Rav, Brooklyn), Binyomin Landau (Tosher Dayan, Brooklyn), and David Twersky (Skverer Rebbe, b. 1940, Brooklyn). One of the Brooklyn-based *hasidic* chaplains said he would turn to Shmuel Wosner (1913–2015), one of the most influential halakhic authorities in Israel.[61]

In Israel there are even more *posqim* who *pasken* (halakhically rule) on medical issues. Some of the most often mentioned include: Yosef Shalom Elyashiv (1910–2012, Jerusalem), Yitzchok Zilberstein (b. 1934, Bnei Brak),[62] Yehoshua Neuwirth (1927–2013, Jerusalem), Aharon Yehuda Leib Shteinman (1914–2017, Bnei Brak), Asher Zelig Weiss (b. 1953, Jerusalem),[63] Zvi Thau (b. 1937, Har Hamor), Nissim Karelitz (1926–2019, Bnei Brak), Chaim Kanievsky (b. 1928, Bnei Brak), Zalman Nechemia Goldberg (1931–2020, Bnei Brak), Shmuel Wosner (s.o.), Moishe Sternbuch (b. 1928, Jerusalem), Yitzhok Tuvia Weiss (b. 1926, Jerusalem), and Arye Stern (b. 1944, Jerusalem).[64]

Though *posqim* are halakhic experts and rank highest in the religious hierarchy, they work closely together with physicians and rabbis who have a medical education. These latter experts are immensely important to the field of medical Halakhah due to their dual education and training in

[59] See America, *Halachic Guidelines*. The document is also part of the appendix.

[60] The following are a merging of names that were mentioned by the interviewees. Many of the *poskim* on this list have died in the meantime.

[61] The list is not a complete list of halakhic authorities theoretically available. It is based on the statements given by the interviewees for this study. Some respondents named rabbis that may not be widely consulted, but nevertheless are part of their network: these are Chabad rabbi Uriel Vigler, New York; Chaim Shaul Grainemann, New York; Rabbi Yehoram Ulman, Sydney/Australia; Aaron Glatt, New York; Rabbi Yekutiel Farkash, Jerusalem.

[62] Rabbi Zilberstein is the official halakhic authority of Mayanei Hayeshua Medical Center in Bnei Brak.

[63] He is the official halakhic authority of Shaare Zedek Medical Center in Jerusalem. Some of his medico-halakhic responsa are published in Minchas Asher.

[64] Arye Stern is the Ashkenazi Chief Rabbi of Jerusalem.

both communities of knowledge. While *posqim* are essential because of their authority, experts on medical ethics are involved in many cases. One reason is because the latter are far more accessible than the former. *Posqim* are not necessarily easily, if at all, approachable by outsiders, even if these "outsiders" are themselves Orthodox Jews with special competencies in medical Halakhah. For example, Rabbi Yigal Shafran, the director of the Jerusalem Rabbinate's Department of Medicine and Halakhah, explains that he would hardly be able to approach Rabbi Chaim Kanievsky:

> כן, זה בוודאי אוטוריטה חשובה מאוד. ואנחנו בוודאי משתדלים לראות אם הוא כותב דברים וללכת גם לפי דבריו. בוודאי. אבל הקושי הוא בעניינים היום יומיים. אצל הרב קנייבסקי אי אפשר לשאול שאלות ככה, כמו שאת יושבת איתי שעה ולדבר. אבל קרה שהיה פעם צורך, אז דרך הרב זילברשטיין אני שמעתי את הרב קנייבסקי.—Yes, he is certainly a very important authority. And we certainly try to see if he writes things and follow his words as well. For sure. But the difficulty is in the daily matters. It is not possible to ask Rabbi Kanievsky questions like this, as you sit with me for an hour and talk. But it happened once when there was a need, so through Rabbi Zilberstein I heard Rabbi Kanievsky for example.[65]

Rabbi Shafran's explanation reveals an important social aspect of *p'saq*. The aforementioned RCA guideline on end-of-life decision-making, which instructs rabbis and the wider Orthodox community, states that a halakhic authority should be contacted. Regardless of the definition of "halakhic authority," access to such authorities is not a given; it must be "gained" through the network from the bottom to the top.

One of the most interesting experiences during my research stay in New York was my desperate attempt to interview Rabbi Yisroel Belsky, the *rosh yeshivah* of Torah voDaas and a *poseq* in Brooklyn. An Orthodox chaplain gave me his number. After two additional interviewees mentioned Rabbi Belsky to me, I was determined to meet the man so that at least *one poseq* would be part of my sample. Despite some thirty calls to him, requesting an interview, Rabbi Belsky did not tell me directly that he cannot, does not want, or social code forbids him from "sitting with me an hour to talk." In contrast, other potential interviewees either accepted or refused my invitation. Eventually he explicitly, but very kindly, explained that he needed to know "who I was." Essentially, I needed a *hekhsher* from an Orthodox rabbi. After providing him with a respective phone number in Switzerland, I finally met Rabbi Belsky in his home office in Brooklyn's Kensington neighborhood.

Thus, knowledge brokers such as chaplains, medico-halakhic specialists, and Israeli hospital rabbis hold important positions within the socio-religious network of medico-halakhic decision-making. These specialists are "technical" experts and knowledge brokers due to their accessibility

[65] Interview with Rabbi Yigal Shafran, 15.8.2016, Jerusalem, p. 30.

(to outsiders) and central position within the network. Other than Rabbi Shafran, Israeli experts of this kind include Abraham S. Abraham, Mordechai Halperin, director of the Schlesinger Institute for Medical-Halachic Research at Shaare Zedek Medical Center, and Avraham Steinberg at Shaare Zedek Medical Center in Jerusalem. Both Dr. Abraham and Dr. Steinberg are contacted by Rabbi Lapin (Queens, N.Y.). Although this medically trained pulpit rabbi has local contacts, such as Hershel Schachter and David Bleich, he prefers to discuss complicated cases first with the Israeli experts. Comparable figures in the New York area include rabbis Moshe Tendler, David J. Bleich, Dr. med. Edward Reichman,[66] and Dr. med. Fred Rosner.

Another human resource in the Israeli context is the hospital rabbi. Similar to the ordained chaplain in the United States, these rabbis are employed in the hospital and are often the initial contact person for patients and families who need to make a decision. Berel Wein, an American born congregational rabbi who made Aliyah as soon as he retired, notes:

> Most of the people abide by the hospital rabbi. They are the experts, you know, we live in an age of specialization, right? And the doctors are specialists, everybody is, so the rabbis also become specialists. The congregational rabbi is like the family doctor. But if there's really something serious, then people go to specialists.[67]

A context-sensitive evaluation of the knowledge broker's position reveals two distinct realities: Hospital rabbis in Israeli religious hospitals[68] epitomize the existence of religious power *inside* the medical context, while medico-halakhic decision-making in the American Orthodox network must happen *outside* of hospitals due to chaplains' non-normative function. In other words, rabbis in Israeli religious hospitals counsel or assist people with decision-making, but those decisions must be congruent with Jewish law; otherwise the rabbi can overrule the wishes of the patient or family member. They are even instructed to go against physicians' assessments, if halakhically necessary. Rabbi Tzvi Weinheimer, the hospital rabbi of a religious hospital, clearly states the hospital's religious policy:

> Over here in this hospital everything is decided by the rabbi. Every ethical question has to be answered by the rabbi, every doctor or every nurse who comes to work or every person who comes to work in the

[66]For example, Rabbi Dr. med. Edward Reichman, who is a physician and author of scholarly articles on Jewish bioethics in New York, also serves the network as a knowledge broker. He is well connected to other experts and *posqim*, especially in the Modern Orthodox sector. He is also one of Rabbi Margalit's (p) contacts, whenever he is overwhelmed with a certain issue. Margalit may be identified as a "contact person," since he is a neighborhood rabbi in Manhattan.

[67]Interview with Berel Wein, 8.8.2016, Jerusalem. Quotation at time stamp #00:13:19-9#.

[68]These are Shaare Zedek Medical Center (Jerusalem), Bikur Cholim Hospital (Jerusalem), Laniado/Sanz Hospital (Netanya), Mayanei Hayeshua Medical Center (Bnei Brak).

> hospital has to be interviewed by me and I explain him that this hospital was built and is maintained only to be according to Jewish Halakhah, Jewish law.[69]

It is unthinkable for clergy, regardless of religious tradition, to disrespect patient autonomy or go against a patient's will in the American context. However, despite deciding medico-halakhic and ethical matters, Israeli hospital rabbis are always submissive to halakhic authorities. This system benefits the Orthodox world by enabling urgent decisions to be made quickly, either by the on-site rabbi or through him by *posqim*. The daily routine of such hospitals is unthinkable without the on-site rabbi:

> It's a full time job. It's 24 hours a day, it's seven days a week. Because even let's say on Shabbat, somebody comes, they don't know whether to resuscitate or not to resuscitate. So they have to ask me even on Shabbat, so I live next door to the hospital and they come to ask me. And then, if I'm not home, let's say I go away, I very rarely go away but I have to go away sometimes to breathe, so I have somebody instead of me, I have a substitute. There is no situation that the hospital should be without a rabbi even for one second.[70]

Itamar Neman, hospital rabbi at one of Israel's largest public hospitals in Jerusalem, is also available around the clock as a contact person. Although he does not expect people to call him to evaluate every situation according to halakhic standards, as is the case with Rabbi Weinheimer, he makes himself available for support of any kind.

> My phone number is open for everybody. Everyone can ask daily, night, even in the middle of the night if he has his own problem. Because when a man, it's not a shop that you want to buy something, even food. Here you have a problem, you have a problem now. If it's in the middle of the night, you don't bring the problem, you have the problem.[71]

However, compared to reknown experts like Steinberg, the authority of local hospital rabbis does not emanate from their knowledge at the intersection of medicine and Halakhah. Afterall, they are not trained physicians. Though they are able to understand medical reports, the uniqueness of their position in the network is because of their local halakhic sovereignty. They represent a certain local practice. In this respect the hospital rabbi is the *mara de-atra*, the master of the locality. This concept "refers to the local rabbi in his capacity as the sole halakhic authority of the locality in which he serves."[72] Rabbi Doron Blaufarb, who works at a second hospital, underscores this point:

[69]Interview with Tzvi Weinheimer/1 (p), 20.6.2011, Israel. Quotation at time stamp #00:00:00-0#. For a case description that exemplifies the extent of his authority see the following section in this chapter.

[70]Interview with Tzvi Weinheimer/1 (p), 20.6.2011, Israel. Quotation at time stamp #00:07:21-9#.

[71]Interview with Rabbi Itamar Neman/2 (p), 17.8.2016, Jerusalem. Quotation at time stamp #00:18:28-9#.

[72]Kirschenbaum, "Mara de-atra," p. 35.

> It's my opinion that if a person wants to know what to do in a hospital, they should ask the, or in any place, they should ask the *rav* of the place. If someone would ask me from a different hospital or from a different community what to do, I would not answer, I don't answer out of principle. I tell them to ask the *rav* in the place, whether it's a *moshav*, a *kibbutz* or a hospital, I would tell them the *rav* there probably knows the *metziut*, the situation, better than I do. I cannot educate the whole world. If someone asks a different rabbi, they can ask a different rabbi, I don't even have the time to find the other rabbi and ask him why he would answer in such a way.[73]

In conclusion, two models emerge, representing each national context, but not necessarily mutually exclusive. In New York, there are strong communal structures, i.e. congregations and locally organized communities, religious normative decisions concerning medical issues pass from the consumer to a contact person such as a family rabbi or the rabbi of an affiliated congregation s/he is affiliated with. These congregational rabbis have contacts to specialists within the various areas of Jewish law (*kashrut*, outreach, business, medicine, etc.). They may discuss a case with a *poseq* with whom they already have an established connection, such as David Cohen, Hershel Schachter, or any other of the above listed rabbis.

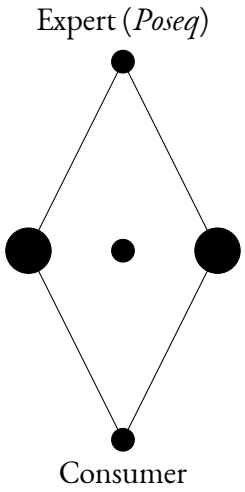

Figure 3.1: Network model for Jewish decision-making processes in New York City.

Haredi neighborhood rabbis most often describe this direct link to *posqim*. Younger Modern Orthodox pulpit rabbis seem to contact first their predecessors that hold similar positions to themselves or who have retired from the pulpit, call their *rebbis*, contact other senior rabbis with more experience and connections, or call medico-halakhic specialists. There are also those who directly contact Yeshiva University's *posqim*. For example, Rafael Margalit (p), a young Modern Orthodox

[73] Interview with Rabbi Doron Blaufarb/1 (p), 25.5.2011, Israel. Quotation at time stamp #00:24:32-5#.

and Manhattan-based neighborhood rabbi says he has three contacts that he calls, if there is the need for discussion or clarification. Margalit emphasizes that it is important to always have several contacts, if one or another are temporarily unavailable: One of his contacts is William Lapin, the medically trained pulpit rabbi in Queens. Lapin is Margalit's first choice, because he is also a congregational rabbi. If Lapin does not know the answer, he in turn would contact either Avraham Steinberg or A. S. Abraham in Jerusalem to discuss the matter.[74]

Another contact is Edward Reichman, a practicing emergency medicine specialist at Montefiore Medical Center in the Bronx, who discusses decision-making processes in detail:

> This morning I get from a rabbi who has a congregant, and the congregant approaches him, he may not be familiar with Jewish medical ethics approaches, so I will speak to the rabbis very often like the younger generation of rabbis, they don't have education in Jewish medical ethics, they don't have the medical knowledge, they don't necessarily know how to integrate the information that's being fed to them either by the family or by the physician, so they call me to serve as an interpreter, you know, to help them and help the families. I, in some cases I'll be able to do that for them and in some cases, you know, it's, a real life or death issue may require consultation with another rabbinic authority.[75]

Margalit's third option is Yosef Ungar, a chaplain in a Manhattan hospital. From the "consumer's" perspective, the need for a halakhic decision may arise after hospitalization. In many instances, healthcare chaplains are able to refer patients or family members to religious authorities who are most likely to be helpful, especially when there is no existing contact with a family or pulpit rabbi:

> There was a big question about a pacemaker and the patient's 94, 95 whatever it was, so I called up my rabbi, Rabbi Hershel Schachter who's one of the biggest rabbis in America and I put him on the phone with this person and he was just, he very appreciated that I had the ability to do that. He [Hershel Schachter] basically said 'Go ahead, put the pacemaker' and the patient is still, his last check's a couple of months ago, he was still living, so that's very good and that's very important.[76]

In general, chaplains refer Jewish patients back to their "own rabbis" for a halakhic discussion of their case. Basically there are two options for congregants and patients in the American model: First, they either defer to their own rabbi who may know the answer, e.g. Lapin, or when the rabbi does not know the answer, e.g. Margalit, they contact an expert for medical Halakhah or a *poseq* with which they have an established connection. Second, they ask the Jewish chaplain at the hospital for help, if there is no family rabbi available or they do not *want* to ask their own rabbi.

[74] Lapin (p) also mentions that he might contact rabbis Hershel Schachter or Bleich, both teachers of his at Yeshiva University.

[75] Interview with Rabbi Dr. med. Edward Reichman, 10.6.2010, Bronx, N.Y. Quotation at time stamp #00:03:51-5#.

[76] Interview with Rabbi Yosef Ungar (p), 1.6.2010, Manhattan, N.Y. Quotation at time stamp #00:14:05-8#.

Either way, the decision-making process follows a relatively predetermined pattern of religious authorization in the various Orthodox religious communities.

The second model of networks is prevalent in Israel, where congregations are not as widespread as within the diaspora. When Jewish identity is not centered around the synagogue and leads to a different organization of religious life, then bioethical decision-making is also organized differently. The "local" rabbi may have a slightly different connotation in the Israeli cultural sphere, as becomes evident from Prof. Avraham Steinberg's answer regarding the options for Israeli Jews:

> So there are different ways to solve problems. If it's an inpatient in a hospital then it's easier, then the whole system helps it, but if it's in the community, so either they turn to their local rabbi who can be the rabbi of their city, not necessarily their community. In every city there is a rabbi (I: Yes, the city's chief rabbi.), there is a chief rabbi of a city, right, so they can turn to the chief rabbi or to the rabbi of their synagogue and supposedly if they [the rabbis] don't know, they know who to turn to, the rabbis. So that is one way.[77]

The main difference concerns the consumer's "entry" level into the halakhic, ethical, or spiritual decision-making or deliberation process, which may involve different network actors.

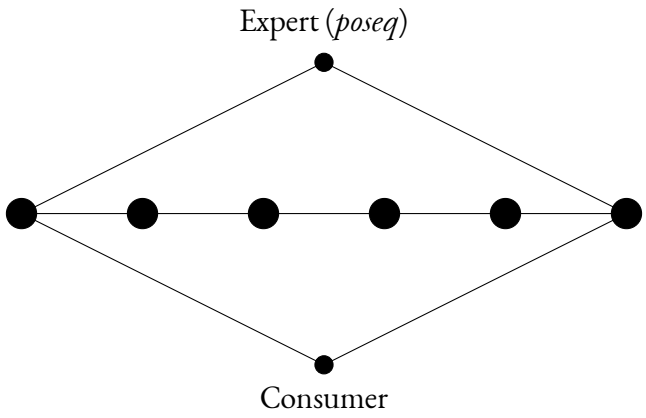

Figure 3.2: Network model for Jewish decision-making processes in Israel.

Furthermore, Israeli culture is more informal and it is thus not astonishing "that people have friends and friends have friends and they know who directly to ask rather than go through a local rabbi."[78] Steinberg further explains that they often skip the stage of contacting a congregational or city rabbi and directly contact experts such as himself, Rabbi Mordechai Halperin, or Rabbi

[77] Interview with Rabbi Prof. Dr. med. Avraham Steinberg/1, 9.8.2016, Jerusalem. Quotation at time stamp #00:10:47-3#.

[78] Ibid.

Shafran. The latter confirms that he is usually flooded by emails and phone calls of people with questions. Yet another option is to call a medical referral organization:

> Consultants on medical issues like a Rav Firer or Rav Fisher. So that is more on the medical aspect, who is the best doctor and what hospital should they go to, but sometimes they also ask them, 'And if they tell me I need an abortion should I do it?', so that is how they start the conversation and then they either turn to me or to someone who they feel is appropriate to answer such questions. So there is always ways to get the further one. So either the first answers it or they go through people to a further one or they go directly to a further one.[79]

Furthermore, Rabbi Yuval Cherlow highlights that a fair share of the 50'000 questions that he answered as Tzohar rabbi had to do with medical ethics.[80] Thus asking a question via a specific website or email also constitutes a popular means for finding answers to pressing medical and halakhic questions, even if the informal nature of this kind of contact is non-binding.[81]

3.4 "Being a Rabbi is Like Being a Decathlete:"[82] The Rabbi's Role and the "Social How"

Analysis of rabbis' description of their role in bioethical decision-making resulted in 94 in-vivo codes. Additional codes were generated from rabbis' deliberations regarding their congregants'[83] intentions and motives to discuss bioethical issues. The following figure (see next page) captures the main dynamics of social exchange between rabbis and congregants and best frames the complex professional role of rabbis and chaplains.

The strength of this model lies in its function-oriented arrangement, which does not begin with denominational and national distinctions. However, this is not to say that the model does not include these contexts. Relational experiences that arise due to specific structural conditions are addressed when the differences impact actors' understanding of their roles. For example, a social encounter that takes place at the normative-authority intersection is relevant for the Orthodox sector due to the importance of Halakhah in the decision-making process. This relational sphere is depicted in the figure's upper right area. To the left of this area is the spiritual-authority

[79] Ibid. at time stamp #00:12:35-0#.

[80] See interview with Rabbi Yuval Cherlow, 13.6.2011, Petah Tikva, time stamp #00:03:59-0#.

[81] It is very likely that the online "ask the rabbi" approach as well as the contact to a medical referral organization is also common in the United States, although no interviewee said so.

[82] Interview with Rabbi Yosef Ungar (p), 1.6.2010, Manhattan, N.Y. Quotation at time stamp #00:02:06-9#.

[83] In the Israeli sample such descriptions with regard to actual congregants are relatively few.

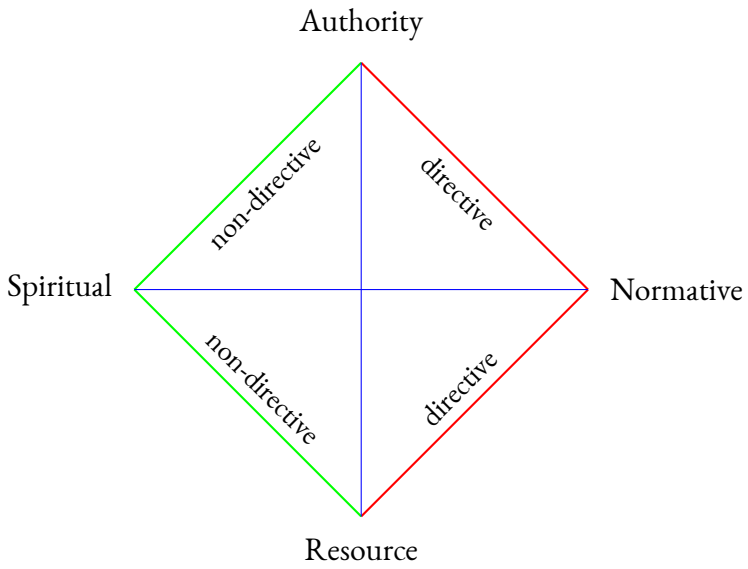

Figure 3.3: Figurative typology of rabbinic role.

intersection, a range of social exchange that is not as normative as Jewish law, but makes use of a rabbi's moral or spiritual authority. The epitome of this realm, i.e. upper-left quarter, is for a congregant to receive a "moral *hekhsher*"[84] from his/her rabbi. The main difference between the two upper quarters concerns the social processing of issues of bioethical relevance: the right quarter is directive via halakhic advice or *p'saq*, while the left quarter is non-directive when a congregant (subconsciously) asks for a rabbi's approval.

The spiritual-resource intersection, represented by the lower-left area of the figure, also includes non-directive social exchange. This area describes the roles of healthcare chaplains and spiritual care workers. The resource node, which is a "counterpart" to the authority node, expresses a social domain where relationships focus exclusively on the patient. The role of rabbis and chaplains, whose professional self-perception strongly identifies with patient-centered care, refrain from bringing normative language or concepts into the patient-pastoral care provider relationship.

The normative-resource intersection includes directive social exchange that provides some sort of religious guidance, but without authoritative power. It may include exchange between a "knowledge broker" who refers a "consumer" to a halakhic authority for case discussion. The medical referral services that Rabbi Firer offers fall into this category of religious or normative-resource; Israelis turn to him for all sorts of questions, whether medical, personal, or halakhic in

[84] A *hekhsher* is a Kashrut certificate, which is imprinted or depicted on product packages, mainly edibles.

nature. Additionally, a couple of Orthodox chaplains say that they provide patients' family members with necessary ritual objects, e.g. if they stay over Shabbat, or provide them with information about the local religious infrastructure.[85]

This model is not an unerring representation of reality, but an approximation of interviewees' shared explanations, experiences, and role descriptions. It is therefore important to keep in mind that there are also intersections between the domains, which are compartmentalized for the sake of manageability and visual clarity. For example, *bikur holim* provides a social network that offers spiritual and material resources for patients and families. The same holds true for social interactions that are part of a religious tradition's spiritual heritage, such as prayers. Though this dissertation focuses on the social encounter between rabbis and patients, future research should consider applying network theory to this constellation.

Furthermore, there are certain actors, such as Orthodox chaplains, who move around in almost all four areas, depending on the situation and need. Just as a chaplain's core competency is "listening" and helping patients process their feelings or assist them with decision-making in a non-judgmental way, a congregational or family rabbi with whom a person has established a trusting relationship may do the same. Such relationships of trust are an important part of the Jewish network in bioethically relevant matters. Similarly, Orthodox pastoral care providers may be asked for halakhic guidance. In practice, these areas overlap. This reality is typified by one interviewee's comment:

> [...] There are no simple answers. So it's kind of weird to do a chaplain's work. We work kind of in the gray zone where (.) many times patients in the hospital are turning to us for like real answers but to, kind of, [we are] dealing with three dimensions, the aftermath of all this two-dimensional scholarship.[86]

3.4.1 Normative Authority

This three dimensional reality of practice is also inherent in the halakhic decision-making process, which takes different forms depending on religious and institutional contexts. A rabbi's role varies according to his professional environment, training, relations, and position in the religious hierarchy. Furthermore, much of halakhic decision-making regarding medical issues occurs in a field of tension between religious authority and individual autonomy. In fact, most of halakhic decision-making takes the individual's situation as well as his/her wishes into account. Interestingly, secular

[85] Some hospitals that are located outside of the big cities, such as in Westchester County, or Long Island, have guest rooms in a separate building.

[86] Interview with Rabbi Yosef Ungar (p), 1.6.2010, Manhattan, N.Y. Quotation at time stamp #00:30:05-8#.

professionals as well as Reform and Conservative rabbis often believe that the typical Orthodox rabbi-congregant, relationship is one-sided and purely instructive: "They go to the rabbi and he tells them what to do." Non-Orthodox Jews further assume that the questioner then complies with the rabbi's instructions. However, the halakhic process often results in a recommendation (*Handlungsempfehlung*) rather than an order (*Handlungsanweisung*). Depending on the social context and setting, both "cultures of *p'saq*" are practiced.

The social encounter between rabbi and patient, which relies heavily on rabbinic authorization of patients' decisions, is most relevant in Israeli religious hospitals, which represent stringent *haredi* standards of care. The rabbis' competency to overrule a patient's will or the medical assessment of a physician is unique but characteristically paternalistic. The paternalistic model of physician-patient relationship is also called the "parental" of "priestly" model and integrates well into this socio-religious setting: "Ultimately, it is assumed that the patient will be thankful for decisions made by the physician, even if he or she would not agree to them at the time."[87]

Emanuels' description coincides with the position of hospital rabbi Tzvi Weinheimer, who is under the auspices of three *posqim* with medico-halakhic expertise. Consequently, Rabbi Weinheimer's authority is over patients and medical professionals.[88]

> They [*posqim* of the hospital] decide exactly, you know, how to go. 99% of the people, who come here, know that and most of them are happy. By the way, even a lot of the doctors are very happy that they don't have to make these decisions, the hard decisions. And they really are not qualified to, you know, to decide on ethical questions. Because they don't learn ethics, I mean they learn ethics, but not Jewish ethics in medical school and they are very happy that when we tell them, you know, how to do and what to do and what not to do. 95% of the families are also very happy because they know big rabbis and the other five percent are divided between non-religious people who say 'We don't care what the rabbis say but ah,' not many, a lot of non-religious people also don't mind, you know, that the rabbi should make the decision.[89]

Weinheimer's statement is noteworthy for a couple of reasons. First, the rabbi believes that many physicians are relieved not to have to make difficult decisions. The interviewee seemingly does not consider the possibility of non-paternalistic paradigms that delegate decision-making to or share it with a patient and his/her family.[90] Second, the assumption or conviction that physicians are "happy" to defer difficult decisions to the rabbi does not necessarily correspond with statements and impressions, of both rabbis and physicians, gathered during this study. Often

[87] E. J. Emanuel and L. L. Emanuel, "Physician-Patient Relationship," p. 2221.

[88] There are differences between the various Jewish religious hospitals in that regard. Not all rabbis in religious hospitals are granted that much authority over patients and medical staff as Weinheimer.

[89] Interview with Rabbi Tzvi Weinheimer/2 (p), 20.6.2011, Israel. Quotation at time stamp #00:02:32-5#.

[90] The other three models of physician-patient relationship, as described by E. J. Emanuel and L. L. Emanuel, "Physician-Patient Relationship" are the informative, interpretive, and deliberative models.

there is a clash of ideologies between medical and religious establishments rather than physicians' appreciation for exemption from professional responsibility and autonomy. The next chapter will further address the issue of overstepping professional boundaries.

Rabbis and chaplains of all Jewish denominations counsel their congregants when they struggle with ethical dilemmas and emotional ambivalence in decision-making. However, in the realm of extreme "halakhic heteronomy," such counseling is not part of the rabbi's role. Instead he is to be a guardian of Jewish law, as long as it does not explicitly contradict the law of the state, e.g. performing surgeries without consent:

> We will never not treat a patient because the family doesn't want it. If the Halakhah says we have to treat the patient, we treat the patient, even if the family doesn't want. If it's an operation, no, we can't do anything because according to the Israeli law, if we do, if we do an operation without the agreement of the sick person or the family you can be sued for attack.[91]

Halakhic influence on the patient is substantial, as is evident from the following case description:

> There is a lady, 42 years old, she's married and has five children. [...] She has five children and she had four cesareans (I: Oh.) and now she's having her fifth. And she wants to tie the fallopian tubes, so she won't have anymore children. So, according to the Jewish law you are not allowed to do that, you're not allowed to make anything, any, you're not allowed to make sterile, you know what I mean? (I: Yeah) Not a man, not a lady, even not an animal either. You're not allowed to make sterile. Only, you know, if it's life-saving or close to that. So here, she had already four cesareans and so, sometimes it's dangerous. At the beginning the doctors were saying, 'We'll see, we'll open, and see if there is a lot of trouble inside,' so I said, 'Ok, no problem, you can do it.' But now she says, 'I want it in any case.' So I have to think about it, you know, I have to make a decision. So over here they can't do without my, you know, a special, you see, *tofes* [form] *ishur ha-beit holim* [hospital permission]. That means this is a special paper which needs to go to the *rav*, and the rabbi has to decide what to do.[92]

This case description follows Weinheimer's deliberations on the aforementioned concept of לב יודע מרת נפשו, the heart knows its own bitterness. Though a decision was not rendered at the time of the interview, the framework for his decision-making is recognizable. There are arguments in favor of a halakhic prohibition of sterilization as well as considerations in favor of a procedure based on a concept that considers the impact of suffering of the individual. Cases like this show that settings under strict surveillance of *haredi* authorities do not allow patients to get involved in the halakhic decision-making process. The momentary rabbi-patient exchange at the bedside (or a rabbi's office) is set within a shared *haredi* socio-religious background, resulting from society's

[91]Interview with Rabbi Tzvi Weinheimer/2 (p), 20.6.2011, Israel. Quotation at time stamp #00:02:32-5#.
[92]Interview with Rabbi Tzvi Weinheimer/3 (p), 20.6.2011, Israel. Quotation at time stamp #00:17:04-4#.

establishment of religious structures in the medical context. However, outside the hospital there is no pre-existing relationship between rabbi and patient.

This social fact leads one to ask whether this constellation creates tension and conflict between rabbis who have an existing relationship of trust with a patient and the hospital rabbi, who is the *mara de-atra* (master of the locality) of the place. In a closed model of communitization, such as in the United States, this would likely be an issue. In contrast, and due to the more open structure of Israeli Orthodox communitization, a *rosh yeshivah* or family rabbi would defer to higher authorities because of the latter's expertise in medical Halakhah. In theory, conflicting opinions suggest rabbinic dissent; in practice, it does not challenge the established power structure:

> Yes, that's a very good question. It's a very good question. The answer isn't so simple as the question, I'll tell you, I'll tell you. [...] So over there we have a problem, we try to, we try to convince the people as much as we can. There's some people, maybe two percent of the people who come here they have their own rabbis and they don't want to listen to our rabbis. I'm here 16 years and it happened once, it happened once. Since he was a rabbi and it wasn't such a big thing, ok, do what your rabbi says. 'Cause he was a, and otherwise I try to convince the rabbi, sometimes I phone the rabbi and tell him 'Look, we,' 'cause not all rabbis really know exactly all the medical ethics and you know, they don't deal with it every day, they don't. So it's not so hard usually to convince, but, there is no, one, clear cut answer for that question you asked.[93]

The question does not evoke a clear cut answer because there is an inherent conflict to the concept of *aseh lekha rav* (make yourself a rabbi). In his article on rabbinic decision-making in medical practice, Rabbi Berel Wein concludes that the centralization of rabbinic power to only a few figures represses individual rabbinic decision making (*p'saq*). Wein immigrated to Israel after having been a rabbi in Miami Beach and the New York area for 34 years. During his rabbinical career he realized that people have stopped consulting their local rabbis—not only with respect to medical questions. He believes that a major cause for this development was ease of access to Rabbi Moshe Feinstein to discuss questions over the telephone at all times. "Rabbi Feinstein once told me in frustration, 'I would do anything if I were able to destroy the telephone.'"[94] Thus, Wein holds that the Jewish community's lack of *aseh lekha rav* is responsible for the development of a "form of leadership and counseling bankruptcy in the Jewish world in general and in the Jewish professional world in particular."[95]

> It is necessary in the post-Feinstein era to restore the proper rabbinic problem-solving balance. Our sages teach us to 'make for yourself a rabbi (*aseh lecha rav*.) Has this teaching been forgotten? Is it purposely being ignored? [...] One must choose a rabbi, whether one who wears a knitted skullcap

[93] Interview with Rabbi Tzvi Weinheimer/2 (p), 20.6.2011, Israel. Quotation at time stamp #00:02:32-5#.
[94] Wein, "Rabbinic Decision Making," p. 50.
[95] Ibid.

> or one who wears a black hat. One must remain with and loyal to that rabbi and consult him for the solution to problems.[96]

Considering the religious history of Orthodox Judaism (see chapter 2), the telephone certainly is not solely responsible for diminished halakhic loyalty and the general state of affairs in rabbinic leadership. Wein states that due to the expert's status of hospital rabbis in Israel, the "congregational rabbi is removed from these situations,"[97] at least to a certain extent. Though Wein perceives such "counseling bankruptcy" as a major disadvantage to the community, American Orthodoxy gives primacy to the pre-Feinstein culture of *p'saq*. Orthodox interviewees, whose position in the religious network is that of a contact person, often describe the rabbi-congregant relationship as one of trust and thereby instrumental for medico-halakhic decision-making.

Such rabbinical decision-making, or profound counseling, is uncharacteristic for rabbis of Israeli religious hospitals. However, several congregational rabbis throughout the Orthodox spectrum, especially in the United States, describe their role and encounter with congregants as Rabbi William Lapin does, emphasizing the importance of being sensitive to the needs of the congregant as a person:

> [...] So there's a halakhic component for sure, but it's not just a straight halakhic opinion that they need. Sometimes based on what they explicitly elicit, sometimes just implicitly, it's clear and in my own approach I think that one has to kind of provide an answer that is kind of encompassing of both the technical halakhic as well as some of the emotional and pastoral aspects associated with these issues.[98]

These pastoral aspects of the rabbinic role coincide with the kind of encounter that American Jewish chaplains have with hospital patients.[99] He wants to facilitate the decision-making process and to be someone "who guides them through because they are overwhelmed with emotions, technical aspects and Halakhah."[100] Rabbi Lapin also says out that some people have very straightforward, specific, and concrete questions that are clearly halakhic, and therefore expect his halakhic opinion. Yet he maintains that this is not the primary motivation for congregants to

[96] Wein, "Rabbinic Decision Making," pp. 50–51.

[97] Interview with Rabbi Berel Wein, 8.8.2016, Jerusalem. Quotation at time stamp #00:12:39-1#.

[98] Interview with Rabbi William Lapin/1 (p), 3.6.2010, Queens, N.Y. Quotation at time stamp #00:05:04-7#.

[99] Israeli public hospitals generally do not employ professional "chaplains" who are clergy. A hospital rabbi is responsible for the implementation and control of the halakhic dimension in the hospital: Kashrut, Shabbat, the festivals, services, etc. He usually is available for shared decision-making and does *bikur holim* as much as time allows. However, these rabbis are not certified pastoral care providers. Reportedly there are difficulties to implement *melavim ruhanim* (spiritual care givers) in public hospitals due to resistance from nursing staff and social workers who forbid uncertified staff, e.g. music therapists, to work with patients in their wards. The Israeli model is currently implementing accredited spiritual care givers, but the processes are still very new. There are also aspirations to start training programs for Orthodox spiritual care givers. See chapter 2.4.

[100] Ibid.

contact their rabbi: "I would say either together with that or aside from that, largely it's guidance and help and then work out the issues and helping them better understand so that they can come to an appropriate decision."[101] Another young Orthodox rabbi in South Brooklyn, Shalom Rabinowitz, has a congregation that includes many Russian Jews from the former Soviet Union. In his experience, the majority of the questions he receives is of the kind, "Work with me rabbi, if you can, advising us how we should handle this medical issue."[102] Thus, the quality of the interrelationship between the congregation and their rabbi is also influenced by the social demography of the members. Rabbi Rabinowitz also stresses that halakhic decisions without basic counseling does not work for his religious community:

> I'll be clear that I'll answer the questions specifically to this congregation. I would say it's more advice. While I would say in many other synagogues it's more straight out Jewish law, as if going to a judge, not necessarily a rabbi. [...] But in other synagogues there are certain people, they just give yes and no answers, rabbis that get those kind of questions, and they answer just either 'yei' or 'nei.' It's not, 'Oh let's sit with the whole family and discuss this' or, 'How do you feel about using a different doctor.' It's sometimes just a question 'Am I permitted to do this or not.'[103]

Paul Vilner, who is the rabbi of an Upper West Side congregation made up of a demographically diverse group, expresses a similar view. He says that some congregants are interested in straightforward halakhic case discussion and clear response, while others see Halakhah as only one aspect of a broader conversation: "Let's say more often it's a question of guidance, 'Can you help us understand the issues that are relevant here, here is the situation we're thinking about how to make a particular decision, Paul Vilner could you help us?'"[104]

American Modern Orthodox rabbis in New York City, especially Manhattan, serve a heterogeneous crowd of people. Their deliberations show that they need to be extremely versatile in their role. As described below, much of their professional job description includes emotional support, pastoral help, or being available to just talk. The Modern Orthodox rabbis in this sample must be able to negotiate religious, including halakhic, ideals and the realities of their congregants' lives in their professional practice. It is especially important to keep in mind that American Orthodox Jewry not only consists of Modern and Ultra-Orthodox, but also nominally Orthodox Jews; the latter do not live in Borough Park, but prefer a Modern Orthodox synagogue. Striking the right balance between maintaining a congregation's basic halakhic orientation and being open to the needs and concerns of people outside these religious guidelines may be challenging for Modern Orthodox halakhic decision-making.

[101] Ibid.
[102] Interview with Rabbi Shalom Rabinowitz (p), 9.5.2010, Brooklyn, N.Y. Quotation at time stamp #00:36:48-3#.
[103] Ibid.
[104] Interview with Rabbi Paul Vilner (p), 27.5.2010, Manhattan, N.Y. Quotation at time stamp #00:03:27-9#.

Several interviewees report difficulty in following standard rabbinic decision-making processes when congregants eventually do not observe the *p'saq*. This is especially true when the rabbi reaches out to a higher authority or makes a referral. Rabbi Shimon Burstein, who serves a Southern Manhattan congregation, describes that his congregants generally do not consult him and decide for themselves. If Burstein formally contacts a *poseq* for a halakhic decision in a weighty matter, he has to make sure that it is followed through on the consumer's side. Since this seems unrealistic in his congregation, he tends to discuss the issues informally or confide in one of his contact persons, but without initiating formal halakhic processes:

> I'll give you an example: So for instance this beginning of life issue, you know, the way they were describing to me, the procedure they were doing, you know, I happened to just informally discuss with Rabbi [Dovid] Feinstein, you know, about in a general sense, in a theoretical sense, and it sounded what they were doing was completely inappropriate, but so, that sort of puts me on the spot, you know, if I'm gonna say something, you know, then I have to be proactive, but I'm not gonna do that, not gonna do that. But they were desperate to have children, so they do what they have to do.[105]

Rabbi Lapin, who is also Modern Orthodox, says that many times families cannot implement Halakhah, as they have been advised, due to the overwhelming nature of the situation. For example, they may implement aggressive treatment, even if they have been halakhically advised that it is not necessary. The general Orthodox notion of the value and preservation of life is the basic framework for many families to solicit an opinion that is in favor of applying heroic measures. Furthermore, Lapin feels that the reason for such perseverance is "because they have perhaps trouble pulling back for understandable reasons."[106] He further observes that the family's decision is many times congruent with the respective halakhic opinion, "but often times, not uncommonly for sure, families make a decision differently in one direction or the other than what perhaps a rabbi may have suggested or advised."[107] Especially regarding end-of-life matters, Lapin experi-

[105]Interview with Rabbi Shimon Burstein/3 (p), 12.5.2010, Manhattan, N.Y. Quotation at time stamp #00:03:48-0#. Rabbi Joshua Hershberg (p), a chaplain at a major hospital on Long Island also brings up an example of a seemingly complicated situation in the halakhic process. He recalls a case where a family rabbi asked him to support his halakhic opinion regarding a certain medical treatment of the rabbis congregant. Hershberg, who generally does not like to share his halakhic advice if there is a rabbi who knows the family and can better discuss the case with them, gains the impression that "part of it [the issue] in this case actually was that he [the family rabbi] almost didn't want to give them an exact halakhic ruling, because based on what they were saying he felt like they won't gonna follow it." (Interview with Rabbi Joshua Hershberg/1 (p), 2.6.2010, Long Island, N.Y. Quotation at time stamp #00:12:03-9#.)

[106]Interview with Rabbi William Lapin/2 (p), 3.6.2010, Queens, N.Y. Quotation at time stamp #00:09:25-2#. A Reform Jewish chaplain, Rabbi Ellis Benda, believes that many Orthodox Jews mask their emotions by using Halakhah as an excuse not to have to think about their struggle: "It's all about conversation and there're some people where you can't even have that conversation because they make such a distance between, behind religion, and that's just kind of, it's safe to hide behind." (Interview with Rabbi Ellis Benda/1 (p), 3.6.2010, Manhattan, N.Y. Quotation at time stamp #00:23:51-6#.)

[107]Interview with Rabbi William Lapin/2 (p), 3.6.2010, Queens, N.Y. Quotation at time stamp #00:09:25-2#.

ences families who press for heroic measures, even if they are halakhically advised not to, and those who stop treatment, even though they should still provide aggressive treatment. Hence, if halakhic advice does not correspond with the family's emotional situation, they likely decide in favor of their gut feeling: "That's what they feel and it is important and necessary what the patient would want or what's best for the person."[108] It is against the backdrop of this rabbinic experience of how to integrate Halakhah in the broader decision-making process that Lapin concludes that "the family's decision isn't really a halakhic decision, it's a personal decision."[109]

American *haredi* counseling is a bit different. As Rabbi Uriel Kagan states, he advises families to "try to do everything you can, so please afterwards you would not have any regrets."[110] He justifies this approach by explaining that he has supervised many cases where "people later have thoughts, apprehensions. 'Maybe I didn't do, maybe I should have tried this, maybe we should have tried this, maybe I didn't do the right thing, you know.' If you did everything you can (..) there's no place for you to have any thoughts afterwards or to have some guilt that maybe you didn't do the right thing."[111] Although rabbis from the *haredi* sample relentlessly stress that preservation and saving of life is the ulterior motive for Jewish action, no matter how poor "the quality" may seem, in practice, many times, they rule leniently, if they can. Since the general rule in Halakhah is that one may not be stringent with others but only with oneself, halakhic deciders take families' emotional stress into consideration.

One Ultra-Orthodox rabbi, Moshe Katznelson, was provoked by the interviewer who claimed that the principle of sanctity of human life invariably seems to be interpreted as keeping a person alive as long as possible, even in the event of a hopeless situation.[112] *Haredi* rabbis, and especially *hasidic* rabbis, generally defend the ideal of the preservation of life and say something like, "As long as the soul is in the body, we have to make sure that that lives on."[113] However, Rabbi Katznelson argues otherwise:

> I don't completely agree with that. I think the issue has to be dealt with from the perspective of the relative, of the child. What are they allowed to do or not do in terms of ending someone's life. I don't think that the goal is preservation of life no matter what the cost. I think that it's being careful not to do the wrong decision, which would either result in a parent vegetating or God forbid ending life

[108]Ibid.
[109]Ibid.
[110]Interview with Rabbi Uriel Kagan/1 (p), 1.6.2010, Brooklyn, N.Y. Quotation at time stamp #00:09:25-1#.
[111]Ibid.
[112]The exact word used was "vegetable," which is a repetition of Rabbi Katznelson's previous wording.
[113]Interview with Rabbi Yehuda Danziger/3 (p), 8.6.2010, Brooklyn, N.Y. Quotation at time stamp # 00:15:22-9#.

> prematurely. And I think that the question has to be dealt with from the perspective of the child, not necessarily a generic goal of preserving life at all costs.[114]

Katznelson understands his role as one of helping people with decision-making, because they are "bombed out, they're very nervous when a parent gets sick and they have to make decisions about treatment."[115] He feels that such decisions cannot solely focus on the quantity of a patient's life span, but must also address the emotional world of an individual who must live with a decision's consequences. Chaplains and rabbis frequently address guilt and its reduction when involved in familial decision-making processes. Yet, Rabbi Katznelson's perspective is not in opposition to the general trend of extending life as long as possible. Instead it aligns with other assessments of *haredi* rabbis who fervently adhere to this principle, if a patient has the potential to regain some abilities, even when permanent dependence on others is probable.[116] Many situations demand balancing the application of "heroic measures" with the perspective that "nature is taking its course." In this way the normative framework of Halakhah legitimizes the individual, or surrogate, to decide according to his/her own will. Though these cases often happen with respect to cancer treatment and palliative care, they also occur with other medical conditions. Admor Mayer Horowitz, the Bostoner Rebbe in Jerusalem, recalls that it was difficult for him to accept the fact that even a *hasidic* rebbe eventually may have to step back and let others make difficult decisions for themselves. His father, the Bostoner Rebbe Levi Yitzhaq Horowitz (1921–2009), taught him this lesson. The elder Horowitz was a tremendously important figure for the international medical referral scene. He established Rofeh, the international medical referral network with its headquarters in Boston/Massachusetts.[117] The elder Bostoner Rebbe was also in close contact to *posqim* who ruled in matters of medical Halakhah, such as Shlomo Zalman Auerbach and Yosef Shalom Elyashiv:

> I don't wanna mention who, but one of the great rebbis of Israel was in Hadassah Hospital, he was in his late nineties, in his late eighties or maybe early nineties, he had a high temperature and they had brought in a specialist from Boston. My father had been instrumental in getting him to leave all of his patients and come to Israel to treat this man, because no one could figure out what it was. [...] He [the doctor] was the was the head of Harvard in infectious diseases and the rabbi had a high fever. The doctor said they had to operate otherwise he would die and the family was hesitating back and forth and I called the Rebbi z"l my father and I said to him, 'Call them up and tell them they have to

[114]Interview with Rabbi Moshe Katznelson/1 (p), 26.5.2010, Brooklyn, N.Y. Quotation at time stamp #00:05:44-7#.

[115]Ibid. at time stamp #00:03:41-6#.

[116]A state of permanent loss of consciousness, i.e. PVS is however evaluated differently from the state of brain death.

[117]Rofeh also maintains and supports local *bikur holim* groups and many other social services. See *Rofeh International.*

> do this!' He told me, 'You have to learn sometimes that the family has to make the decision, the family has to make that decision, you can't make it for them.' And it was a very long lesson I learnt from that. They did the operation, what the doctor thought it was he could not prove that that's what it was. After the operation the fever went away, the rabbi recovered, but the family never accepted that there was a need for the operation. They had decided to go ahead but since the doctor couldn't prove, 'cause he didn't find what he wanted to find, even though the patient survived and got better.[118]

Horowitz's story refers to a dimension of decision-making that is tremendously important—that of experience.[119] For Rabbi Yisroel Belsky (1938–2016),[120] the *rosh yeshivah* of Yeshiva Tora Vodaas and *poseq* in Brooklyn, "the value of experience makes all the difference in the world."[121] As a *poseq* of a community that heavily relies on the advice and instruction of its religious leaders, Belsky's is highly in tune with his followers' needs, highlighting the significance of social skills for halakhic decision-making:

> People ask for, people ask for all kinds of things. The main thing is you have to have patience, you have to listen and you can't let your personal emotions play a role. You have to be a good researcher, a good listener and get everything and teach you everything carefully before you issue a decision. You know, snap decisions, decisions made that are effected by anger or arrogance or anything.[122]

Aside from experience, empathy, and accuracy in halakhic decision-making, the *poseq* stresses the importance of benevolence, especially with respect to evaluating "quality of life" in medical Halakhah: "So you can't just apply a blank situation to quality of life. It's a personal and subjective thing, the decision has to be made by people who are interested in the welfare of the patient and at the same time have standards and experience, know the Halakhah, know the medicine."[123]

A rabbi's role can be directive, supportive, or discursive, depending on the socio-religious context, within which the rabbi and congregant or patient meet. A relationship of trust, often indicative of connections to a local or family rabbi, assists American Orthodox Jews in making difficult decisions. Healthcare chaplains repeatedly explain that they always try to refer patients to their "own" rabbis in all matters of halakhic decision-making. This is also the case in the Brooklyn-based hospital which is located in the midst of a *haredi* neighborhood. The local *hasidic* chaplain does not consider himself to be the *mara de-atra*, even though he knows medical Halakhah better

[118]Interview with Admor Mayer Alter Horowitz, 29.6.2011, Jerusalem. Quotation at time stamp #00:57:46-0#.

[119]In this context it is interesting to note that Levy Yitzhaq Horowitz as well as his sons studied at Torah Vodaas in Brooklyn.

[120]Yisroel Belsky was not considered a *poseq* specifically for medical Halakhah, as Rabbi Reichman points out, but was nevertheless consulted as an authority on all matters of Jewish law by the *yeshivah* community and rabbinic colleagues in Brooklyn. Rabbi Belsky's halakhic expertise was in the realm of Kashrut.

[121]Interview with Rabbi Yisroel Belsky/2, 25.6.2010, Brooklyn, N.Y. Quotation at time stamp #00:02:54-0#.

[122]Ibid. at time stamp #00:09:35-9#.

[123]Interview with Rabbi Yisroel Belsky/1, 25.6.2010, Brooklyn, N.Y. at time stamp #00:25:07-8#.

than many other rabbis: "But since I want them to have a comfort level, the families, so I prefer it comes from their rabbi, which they have a long standing association."[124] The reality for at least some of the Israeli *haredi* population is different due to: a) an open-structured religious society that is not based on local, i.e. congregational rabbis, and b) halakhic authorities act as binding deciders within religious hospitals.

Einat Ramon, a Conservative rabbi and spiritual care supervisor in Jerusalem, confirms the national, cultural, and social influence on decision making when she states that it "has a psychological element that they've [patients] contacted a person that they trust and the person told them what to do. But if you're not in that kind of cultural framework, whether you're a secular or observant, then you don't have an address in Israel to guide you through these dilemmas."[125]

3.4.2 Spiritual Authority

In contrast to normative religious authority that includes guidance and instruction, the rabbinic role within the field of spiritual authority is primarily, though not exclusively, based upon deliberations of Reform rabbis. Reform congregants, *if* they seek to talk to their rabbi, are often interested in obtaining what has been termed a *hekhsher* (kosher stamp) from *their* rabbi. Congregants consult because they want to reassure themselves that their decision is "right in a Jewish way." They neither seek a process culminating in a clear decision, as in halakhic guidance, nor unfiltered information.

> What they really want is to know that the decisions they want to make are OK. In a Jewish way. And that they have a *hekhsher*, you know what I mean (I: *Hekhsher*, yes.), that they have a *hekhsher* from their rabbi. That's what they really want, they want an emotional, spiritual, moral *hekhsher*. And most times I can give it to them. Because most people make the right decision. I think.[126]

This suggests that the rabbi's approval or assessment is important within the context of one's own religious culture. Aside from allegoric usage of terms such as *hekhsher*, rabbis throughout the Reform sample, regardless of national context, feel that patients and congregants expect "reassurance," "consent," or "confirmation" from their rabbis. Rabbi Bryan Epstein, who was a chaplain at NYU Langone Medical Center before he took over a Reform congregation in Brooklyn, confirms Reich's experience almost identically when he states that congregants seek "validation:"

> It's a counseling situation, you know, they're not meeting with the medical ethicist at the hospital, they're meeting with their rabbi, so (.) you both want to lay out the facts for them at the same time that

[124] Interview with Yehuda L. Danziger/2 (p), 28.5.2010, Brooklyn, N.Y. Quotation at time stamp #00:03:50-8#.
[125] Interview with Einat Ramon/1, 16.8.2016, Jerusalem. Quotation at time stamp #00:40:49-2#.
[126] Interview with Rabbi David Reich (p), 3.5.2010, Manhattan, N.Y. Quotation at time stamp #00:05:50-8#.

> you wanna sensitively listen to them, to help them understand themselves which path they'll choose, you know. So (..) it's a kind of a mutual relationship in terms of the listening that goes on in that situation. [...] And so, what they're also looking for is validation. They wanna know in general that what they're going through is OK, that the decision-making process they're engaged in is inherently a good one. And they want the approval of the religious authority figure, irrespective of you know what Judaism might say, they also just want a kind of human approval of their own set of decision making processes.[127]

As a spiritual, or moral, figure, the rabbi occupies a central position in this social constellation. As Epstein explains, the rabbi is perceived as a "substitute for higher power." Likewise, Rabbi Adonolem says rabbis are the "symbol of the Jewish religion." Validation of an "ethical decision" is not sought from a medical ethicist, but from *their* rabbi. The rabbi is an authority figure and a person whom congregants trust. Epstein underscores that congregants not only seek the "Jewish answer," the values, moral guidelines, or ethical norms, but also legitimization of their actions, a kind of "human approval." Congregants are not looking up answers in a book, but instead seek an authority figure's validation. In the same vein, a rabbi involved in halakhic decision-making does not answer a question, but rather the one who asks the question. This truism stresses the social aspect of *p'saq*. Epstein is the only interviewee who believes that the desire of a congregant to be validated by his/her rabbi is consistent across all of the Jewish denominations, despite different orientations: "If the rabbi says it's ok, it's ok. That's part of the experience." [128]

It is rare for such insights to come from non-Orthodox Jews, who usually believe the Orthodox rabbi-congregant relationship consists of halakhic instruction without any expectation of struggle or autonomy on the part of a congregant. However, congregations with a high amount of nominally Orthodox congregants, as is the case with Shimon Burstein's community in Manhattan, have similar rabbi-congregant patterns to those of Reform congregations. Rabbi Burstein feels that the motivation for many people to talk to a rabbi relates to having a "conscience." Most rabbis, whose role description aligns with the category of spiritual/moral authority, describe congregants' motivation as a wish to do "the right thing," "do it right," "do it right in the Jewish way," "make a proper decision," or "have the right approach." Though a rabbi's validation does not necessarily include direct normative action, interest in a normative epistemic goal underscores congregants' motivation to talk to their rabbi about bioethical matters:

> I think it's conscience, there's something weighing on their conscience, you know, they may decide to do on their own anyway, but they just wanna know for themselves did they do the right thing or the wrong as far as Halakhah is concerned. It's, clearly, they're, something's bothering them inside (.) and

[127]Interview with Rabbi Bryan Epstein (p), 25.5.2010, Brooklyn, N.Y. Quotations at time stamps #00:09:50-2# and #00:06:25-3#.

[128]Ibid. at time stamp #00:06:25-3#.

> they've talked about it, but whether they're gonna actually do (.) directly what the Halakhah would require is a different story.[129]

Brooklyn-based Chabad Rabbi Uriel Kagan is the only *haredi* interviewee who describes his congregants' approach with the same allegory as the Manhattan Reform rabbi. Unlike Reich, who generalizes the motives of his community members, Kagan bases his explanations on a case study of life-sustaining measures:

> I also have somewhat, see, when a person comes to me with a question about this, end of life, it's really putting me in a predicament. The family or the relatives are (.) hoping (.) that I will say, you know, finish you off. And this way their conscience wouldn't bother them, they spoke to the rabbi, the rabbi agreed, so that's, we have already the approval. We have, it comes together (clapping hands) with a stamp, with the insignia of the rabbi, so (I: The *hekhsher* from the rabbi.), yeah, so what do you need more?[130]

Whether it is a "*hekhsher*," rabbinical insignia, "validation," or "reassurance," congregants or patients want to know that an action is legitimized within Jewish tradition and/or assurance that their relative "moral representative," to use Alasdair MacIntyre's phrase, approves of their decision. According to MacIntyre, a "moral representative" falls into the category of "character," which differs in some essential aspects from the other social forms of "role" and "individual" within a particular culture.[131] "Characters" are "moral representatives" of their culture because it is through them that moral and metaphysical ideas and theories acquire an embodied existence in the social world.[132] "A character is an object of regard by the members of the culture generally or by some significant segment of them. He furnishes them with a cultural and moral ideal. Hence the demand is that in this type of case role and personality be fused."[133] MacIntyre argues that the gap between role as social and individual as psychological type of a person often leads to varying degrees of doubt, compromise, interpretation, or even cynicism in mediating between role and individual. Divergent aspects of role and individual are fused into unity as a "character," which is why the latter morally legitimizes a particular type of social existence. This legitimation also occurs due to the fact that the demands on a "character" are forced upon it from the outside.

[129]Interview with Rabbi Shimon Burstein/1 (p), 12.5.2010, Manhattan, N.Y. Quotation at time stamp #00:07:33-0#.

[130]Interview with Rabbi Uriel Kagan/1 (p), 1.6.2010, Brooklyn, N.Y. Quotation at time stamp #00:09:25-1#.

[131]See also Mauss, "La Notion de Personne" for the development of a category of *personne*.

[132]MacIntyre, *After Virtue*, pp. 26-28.

[133]Ibid., p. 28.

3.4.3 Spiritual Resource

Receiving a "*hekhsher*" is a major motivation for congregants to consult a rabbi. The rabbi as a moral representative of the Jewish religion is perceived to be a role model for just behavior and "the right" life choices. With the title comes the aura of wisdom, says Rabbi Joel Gross, a chaplain at a Manhattan special clinic.[134] However, this "aura" does not correspond with the professional self-image of healthcare chaplains who perceive themselves to be non-normative spiritual resource for patients and their relatives. Charles Sheer, a Modern Orthodox chaplain with decades of professional experience, contrasts his role with the one of a rabbi who gives his "*hekhsher*."

> But I must admit, if I'm playing the role as a chaplain, I discuss it with patients and I have to, you do not project your own position to the patient you're dealing with whether he's Jewish or non-Jewish, you, as I said before, you help them process their own feelings, their own thoughts about something, you never end up giving, you know, your *hekhsher*, saying this is ok, this is not ok, but there are occasions when your patients will say just very very cavalierly 'I can't have my mother exist like this, I told the doctor to withdraw,' and they say it to me and I say 'Oh I see, well as long you came to your decision I won't really venture an opinion.'[135]

In contrast to rabbis in congregations or medico-halakhic specialists, American healthcare chaplains' role descriptions are very reflective and eloquent. Often they are interspersed with deliberations over what their role and function does *not* include: giving unsolicited advice, stating their opinion or influencing decision-making processes, proselytizing, or using normative language in their encounter with patients. As chaplain and rabbi Levi Meier states in his article "Visiting the Sick–An Authentic Encounter," the last thing a person in agony wants to hear are clichés, trite statements, and theological truths, since they reduce the I–Thou[136] relationship to an I–It encounter.[137] Healthcare chaplains should prevent patients from making such reductions. These professionals excel at stating clear boundaries, their work methods, and practical difficulties that arise in their job. Among the most relevant aspects that healthcare chaplains, or spiritual care workers, provide in the hospital when they visit patients include: listening and eventually reflecting back, comforting, giving emotional support or support in decision-making, providing basic counseling, offering therapy with a touch (holding hands or giving a hug), engaging in conver-

[134] See Interview with Rabbi Joel Gross (p), 17.5.2010, Manhattan, N.Y at time stamp #00:13:13-5#.

[135] Interview with Rabbi Charles Sheer, 10.6.2010, Westchester County, N.Y. Quotation at time stamp #01:43:48-9#.

[136] It refers to Martin Buber's concept of I-Thou (*Ich und Du*). The concept is based on the idea that human beings form their identity primarily in relation to what surrounds them: Only the encounter with a human counterpart, the "You," or with the material world, the "It," makes it possible to differentiate the "I" from its environment.

[137] See Meier, "Visiting the Sick."

sation, and empathizing. Ellis Benda, a young Reform Jewish chaplain who works in a palliative care unit, provides a concise description that illustrates the chaplain's self-image:

> My role is to help support, help explore, sometimes help re-frame if it's necessary ahm, but it's done in a very supportive and very loving way where I may disagree a thousand percent with the decision that somebody is making but that's going on inside, it doesn't come out and I'm, my training helps me be aware of what's going on internally for me and to make sure that that does not play a role in how in helping somebody decide because that is their decision, it's not mine.[138]

In contrast to many congregational rabbis who assist their congregants with halakhic or non-halakhic decision-making, Benda stresses the importance of communicating to the patient that to *not* decide is also a valid option. Another important aspect of chaplaincy work includes the skill of "holding space." This expression describes a chaplain's compassion or listening presence (see 2.4). Israeli therapist and pioneer in the spiritual care movement, Rachel Ettun pointedly refers to this "ability of the spiritual care provider to be there with no answers."[139] Ettun observes that learning the mode of not answering, i.e. giving advice, is a challenge for people with rabbinic personae:

> Be able to be there and not to fix it. And this is something that is very similar to doctors and to rabbis. They want to go to the bottom line to say yes or no, healthy or sick, kosher or not kosher, like in slang, 'Cut the bullshit,' let's go. And we, the spiritual care givers, want to be there in that space that is gray; you have to hold it and not to answer anything and just to help to create the space for the person to find his own answer, eh, and it's hard, and it's hard for the system also to accept this kind of a language. So to bring the language of being in a place of 'doing' is a big challenge. But this is what we want to create here [in Israel].[140]

This description differentiates between two kinds of professional persona and their respective use of language. Analysis of interviewees' role reflection suggests that clinical pastoral education helps a rabbi shift his persona from one of "authority" to one of "resource." Generally, certified healthcare chaplains are aware of the difference between their professional persona and their self, i.e. role and individual. This profession requires supervision, which helps to reinforce such distinctions. Chaplains who are not certified and do not have formal clinical pastoral education (CPE) eventually break professional character. In this study, only Orthodox chaplains admit to such behavior, especially in situations that trigger their desire to moralize or state their halakhic opinion. For example, Rabbi Frank, a part-time chaplain with no formal CPE, shares how he once lost his temper.

[138]Interview with Rabbi Ellis Benda/1 (p), 3.6.2010, Manhattan, N.Y. Quotation at time stamp #01:16:33-7#.
[139]Interview with Rachel Ettun, 17.8.2016, Jerusalem. Quotation at time stamp #01:06:02-5#.
[140]Ibid.

> Here[141] [at the hospital], you don't know them, they don't know you, they don't respect you (.) You know, there was a time, when a situation, it was a question of when to make the funeral. And there were family you know at this funeral, the family. And I, you know, I took one of the brothers and I, I let him have it. I shouted at him. You know, and what happened was, when I opened my mouth he couldn't believe what was going on over there. But that's what he needed. He needed someone to hit him over the head. And that, I mean, you know, that was needed at that time, and thank God I was able to do it and then he realized that he made a mistake.[142]

Breaking character may occur, even though chaplains do not proselytize, influence, or give their normative opinion, unless they are asked to do so. However, there are various types of chaplains in that respect. There are those who do not disclose their personal perspective or opinion at all, because they do not see themselves as an "answerer of questions."[143] There are chaplains who do not give unsolicited advice, but state their opinion or give religious advice when explicitly requested to do so. There are also those who would like to be more normative, but are aware that they cannot. Finally, there are chaplains who actively include religion in their counseling.

While the American healthcare chaplaincy system works with CPE-trained clergy, the Israeli model operates with spiritual care workers, who do not hold a rabbinical degree; and if they do, the association's bylaws prohibit the individual care giver from introducing himself/herself with a title. The spiritual care movement's pioneers firmly believe that patients, as vulnerable persons, may be intimidated by a title. Additionally, titles may scare people who are either secular or assume that titles come with an agenda that they are either not interested in or opposed to. Einat Ramon, a spiritual care supervisor at the Machon Schechter in Jerusalem says that secular Israelis have issues with allowing religious or spiritual resources to be part of a "healing intervention." Though American secular patients may refuse to see a pastoral care giver for the same reasons, Ramon believes that the Israeli "consumer" of spiritual care must be approached differently:

> Why would they [secular Americans] seek a chaplain at the hospital? To sort them out. They do have autonomy, but they are not sure as to what they wanna decide. They're much more conscious of the dilemma and I think that's culturally, I think that's great, but I think this is consciously embedded in our [American] culture. But I'm not sure that this is culturally embedded in the secular Israeli culture.

Healthcare chaplains and spiritual care givers are not the only professional groups that provide spiritual and emotional support as part of their professional engagement. Pulpit rabbis also offer pastoral services, though within restricted time frames due to their many other obligations. In

[141] As opposed to the position of a family rabbi who knows the congregant and his/her family.

[142] Interview with Rabbi Gabriel Frank (p), 1.6.2010, Brooklyn, N.Y. Quotation at time stamp #00:33:22-2#.

[143] Interview with Rabbi Fay Trachtenberg/1 (p), 7.5.2010, Westchester County, N.Y. Quotation at time stamp #00:14:17-1#.

contrast to healthcare chaplains, pulpit rabbis have existing relationships of trust with their congregants. As a social resource, such relationships facilitate the guiding process of congregants in times of crisis. Rabbi Mia Oppenheimer, a Reform rabbi near Jerusalem, established a group of congregants known as *yad b'yad* (hand in hand), which is part *bikur holim* and part social service, to support her own pastoral work:

> I have a frailty [for visiting the sick] and I do much of what can be done by others myself, then I see, visiting the sick and escorting people emotionally as part of my rabbinate, so I don't always turn to them but in times of bereavement I do call the group and I tell them, 'Listen, this family is in bereavement and we need one of you to go over and see what happens and how things are going.' [144]

3.4.4 Normative (Religious) Resource

The model's realm of normative, or religious, resource includes various supportive networks and forms of social encounter that have been described either in the last chapter's section on *bikkur holim* or in this chapter's section on professional networks.[145] For example, religious referral may be considered a resource within a specific normative, or religious culture, with knowledge brokers who help patients find an expert or religious authority. People such as Edward Reichman or Yosef Ungar (p), the occasional "switchboard operator" (see above), are normative resources for patients and their family, because they know the "right" people to talk to, without being themselves an authority. Likewise, people such as Rabbi Firer in Israel offer a network that provides the necessary normative knowledge that is either medical or religious in nature.

Thus, this model's sphere is a conglomerate of different networks, services, and social constructs to support patients and families. While a professional spiritual care worker in his/her role enters a professional relationship that focuses on the individual, the normative-resource draws support from the traditional, but not necessarily spiritual heritage of Judaism. For instance, Jewish chaplains and rabbis in hospitals, both in the United States and Israel, are a normative resource for families and staff in their role as educators. They teach staff how to become aware of the religious differences that they experience with their patients. They do it "in order for them [staff] to make it more helpful and easier to administer to the needs of the patients and the family members, so that they shouldn't offend them inadvertently."[146] Eight chaplains or hospital rabbis explain

[144] Interview with Mia Oppenheimer (p), 24.5.2011, Jerusalem district. Quotation at time stamp #00:14:55-7#.

[145] One may consider *bikkur holim* a special case of social encounter that intersects between the two lower realms of the model. The patient care of laypeople definitely involves spiritual and religious resources. Listening presence, household tasks, and prayer combine actions that have been discussed separately with respect to "role" within this model which focuses on professionals.

[146] Interview with Rabbi Yehuda Leib Danziger/4 (p), 8.6.2010, Brooklyn, N.Y. Quotation at time stamp #00:05:10-1#.

that they educate medical staff or social workers in Jewish bioethics, Halakhah, and Jewish rituals and social behavior. Interestingly, one American chaplain states that he sometimes has to "educate" patients and their families about hospital "life," i.e. explaining that the kindling of Shabbat candles is forbidden due to the hospital's safety restrictions. Similarly, the role of rabbis in hospitals may also encompass encouragement or raising awareness. Rabbi Doron Blaufarb, one of the rabbis in a so-called religious hospital in Israel, tries to "encourage all the staff," to practice the *mitzvah* of *bikkur holim*.

> Anybody who comes or anybody who works at the hospital has the chance of doing tremendous *hesed*, tremendous good; it could be a nurse, it could be a volunteer, it could be a doctor. For the same money they could be doing a *mitzve*, or not. In other words, if they approach the patient with a smile and they're nice to them and all, they're getting a *mitzve*, both of *bikkur holim*, of *hesed* and I even think that it probably helps for the healing process. It's not the patient's fault if the nurse or the doctor had an argument with his wife or husband that morning, if their car broke down and if there were other problems in the house, right? [...] And that's what I try to encourage all the staff, when they're starting and when I speak to them along the way also that it's for their benefit to try to be nice and to understand that the patients didn't choose to come here, that they'd rather not be here. It's probably the last place they wanna be and they should take it into consideration.[147]

A major role of rabbis in all professional settings and networks is one of "bridge-builder," a position that is multi-faceted and fulfills various purposes. It fits this dimension of normative religious resource because it connects people within or between objective structures, without exerting authority. For example, *haredi* chaplain Yehuda Danziger understands this part of his role as a "vehicle, a conduit for them between the medical physicians and the rabbinical community."[148] He is the intersection between the medical and the religious worlds. Another, Modern Orthodox, chaplain describes a situation where he reunited a family with their congregational rabbi during the time of a family member's hospitalization.[149] Similarly, Fay Trachtenberg, a Reform chaplain highlights the notion of interfaith chaplaincy, as practiced in New York's hospitals, saying that "one of the roles of a chaplain is to be a bridge between the patient and the patient's clergy."[150] Rabbi Itamar Neman, the rabbi of a public hospital in Jerusalem, also uses the bridge metaphor. Contrary to religious hospitals, Neman is not under direct auspices of halakhic authorities: "Rabbi Blaufarb [pseudonym; rabbi in religious hospital] can take the questions, he has to bring the answers from the mentors. I have to solve the problem and put it before the mentors

[147]Interview with Rabbi Doron Blaufarb/3 (p), 25.5.2011, Israel. Quotation at time stamp #00:08:20-8#.

[148]Interview with Rabbi Yehuda Danziger/2 (p), 8.6.2010, Brooklyn, N.Y. Quotation at time stamp #00:00:04-5#.

[149]See interview with Rabbi Joshua Hershberg/1 (p), 2.6.2010, Long Island, N.Y. at time stamp #00:12:03-9#.

[150]Interview with Rabbi Fay Trachtenberg/1 (p), 7.5.2010, Westchester County, N.Y. Quotation at time stamp #00:16:45-6#.

like a decision." Rabbi Neman's job consists of networking within the religious world and serving as kind of "religious PR-person," advertising the hospital's advantages.

> [I] put the bridges between the hospital and the *haredi* people and the religious people, go to the mentors of them, to the medical mentors, to the rabbis, to the *admorim* [*hasidic* leaders] to sell the hospital, to sell the hospital because they have to know that they have the answers they need. So you have to deal with all kinds of religious people, here in Israel two men are three religions, you understand me, everyone has it's own vision, everyone is more smarter than the other one and you have to deal with all the people, to speak with them in their own language. Not the language that you talk, the language that they feel. [151]

In this role, Neman is less of a resource for patients and families, yet more of an intermediary between the hospital and religious communities. Israeli rabbi and expert in medical Halakha, Yuval Cherlow, perceives some of his own engagement intersecting religion and politics. He is a member of several ethics committees, which expect from him, as *dati leumi* rabbi, an opinion that "will be a kind of a bridge between something that the Halakhah and also the democratic State will be able to live with."[152]

A typical resource, but one that intersects with spirituality, is prayer. Chaplains and sometimes Israeli spiritual care workers pray with patients. In this role they understand themselves to be a "rabbinic resource for other chaplains" who periodically ask them to see Jewish patients. Upon request, Fay Trachtenberg uses "Jewish liturgy, the Jewish prayer for healing, or the Jewish prayer that one says or has someone say on one's deathbed."[153]

3.5 Conclusion

Chaim Reines writes in his article on the "Self and the Other in Rabbinic Ethics" that Jewish ethics seeks to guide the individual in his relationships with his fellow man.[154] This chapter illustrates how ethical decision-making is perceived as a social process that is based on social interaction within the context of short- and long-term relationships between Jewish congregants/patients–rabbis/chaplains. As such, ethics is not understood to be an individual's guideline *for* his relationship with fellow people. Instead, it conceptualizes Jewish ethics as a relational ethics that situates ethical action explicitly *in* relationship.

[151] Interview with Rabbi Itamar Neman/2 (p), 17.8.2016, Jerusalem. Quotation at time stamp #00:18:28-9#.

[152] Interview with Rabbi Yuval Cherlow, 13.6.2011, Petah Tikva. Quotation at time stamp #00:07:54-1#.

[153] Interview with Rabbi Fay Trachtenberg/1 (p), 7.5.2010, Westchester County, N.Y. Quotation at time stamp #00:07:59-6#.

[154] See Reines, "The Self and the Other in Rabbinic Ethics," p. 172.

Rabbis and chaplains are "decathletes" due to their versatility in the social encounter with congregants and patients: They provide emotional support, halakhic guidance, counseling, assistance, and advice. Analyzing the network positions and roles of rabbis and pastoral care givers can be understood as a relational mapping of care and ethical decision-making processes within Reform and Orthodox Judaism. Within the model, habitual structure is best identifiable within the area of "spiritual-authority." Alasdair MacIntyre's categorization of moral representative best describes the rabbi's role, or character, for congregants seeking validation and assurance from a figure who represents and embodies the ethical, normative, and cultural framework of Judaism.

The theory that undergirds this aspect of role and simultaneously integrates relational ethics is that of *habitus*. Bourdieu's theory of practice suggests that objective structures are related to subjective structured dispositions in a dialectical manner. It is against the theoretical backdrop of this dialectic of internalization of externality and externalization of internality that we conceive the role of rabbis and chaplains in their different professional contexts. External, or "objective," structure was described in this chapter's first section regarding the religio-legal framework of the relevant religious cultures. Different halakhic "styles," i.e. formalistic, conceptual, liberal, indicate that halakhic decision-making is, as Reform theologian Mark Washofsky claims, not primarily dependent on methodological correctness, but rather the authority of an interpretive community that legitimizes action.[155] This notion of *habitus* is the foundation for the next chapter's deliberations on the concept of brain death.

[155]See Washofsky, "Absence of Method."

4 | Dead or Dying? The Neurological Determination of Death (Brain Death) and Its Controversy in Judaism

At the core of the issue about the religious acceptance or rejection of the brain death concept(s) lies the question of whether an irreversibly brain damaged person is already dead or dying according to the respective Jewish religious culture. Scholars and thinkers within different Jewish denominations must find answers and solutions to these ethical challenges created by technological and medical developments. While respective elite discourses within Reform and Conservative Judaism[1] are pretty much in accord with the brain death criteria and allow for organ donation, there is more of a debate within the Orthodox camp. It is interesting to observe how the demarcation line for or against the halakhic (religio-legal) acceptance of brain death coincides with the socio-religious boundaries that exist within Jewish Orthodoxy. On a global scale, Ashkenazi Ultra-Orthodoxy rejects the concept, while Sephardi *haredim*, at least on the level of its leaders, by and large accept it. American Modern Orthodoxy is divided on the issue. In contrast, the national religious camp and Chief Rabbinate of Israel accept brain death as halakhic death since 1986.

It is somewhat astonishing that there can be such fundamental differences regarding the determination of death in modern times within a relatively small religious culture that largely shares the same religious literature, religious law, hermeneutical methods, and practices.[2] The Orthodox debate and halakhic search for "the right answer" in the matter continued for decades until a difference of opinions became acceptable—at least to many of the involved experts. However, one may argue that presuming unanimity misjudges the social and cultural diversity of Jewish Orthodoxy from the start. Talmudic dialectic and traditional Jewish learning are very disputatious in

[1]Reconstructionist, Reform, and Conservative Judaism are often subsumed under the umbrella term Progressive Judaism. Their members have in common not organizing their lives according to halakhic rules (except the Conservatives to a certain degree).

[2]According to a survey conducted by the Pew Research Center Survey of U.S American Jews, 10% of the Jewish population in the United States are Orthodox with roughly two thirds self-identifying as *Haredi* and one third as Modern Orthodox. See Pew Research Center Survey, *A Portrait of American Orthodox Jews*.

nature. Disputes are a means of reflection and dissent or contradiction systematic ways of reasoning. The *mahloqet*, the dispute, is the main characteristic of the two Tannaitic sages Hillel and Shammai and their "houses" or schools. They were in constant disagreement about matters of religious law (Halakhah) and practice. Thus, different results in analyzing Halakhah are expected and rabbinic discord is certainly a common occurrence.

Rabbi Joseph Dov Soloveitchik, one of American Modern Orthodoxy's most revered religious leaders and philosophers alludes to the Jewish dialectic as a kind of polemic (gr. *polémis*/dispute) dialectic compared to Western philosophical traditions of the 18th century:

> Judaic dialectic, unlike the Hegelian, is irreconcilable and hence interminable. Judaism accepted a dialectic consisting only of thesis and antithesis. The third Hegelian stage, that of reconciliation, is missing. The conflict is final, almost absolute. Only God knows how to reconcile; we do not. Complete reconciliation is an eschatological vision.[3]

Collectively, a rabbinic culture of dissent, lack of a central decisive authority, and religious diversity of Orthodox Judaism and its many different interpretive communities epitomize halakhic loyalty, but simultaneously confirm a systematic irreconcilability. Thus, in a matter concerning life and death, halakhic argumentation, resulting in thesis and antithesis, renders (complete) reconciliation infeasible. Different social and religious realities clash in a context where religion, science, and politics try to rule or negotiate over the sovereignty of knowledge.

Taking this into account, the following discussion of brain death in relation to Halakhah includes meta- and extra-halakhic considerations. The highly controversial subject is complicated by medical discourses that intersect cultural, religious, and socio-political idiosyncrasies, consequently creating a background of tension. Thus, the analysis of central Jewish religious institutions and rabbinic opinion in the United States of America and Israel contributes to an intercultural comparison of conceptual and practical approaches to brain death and organ donation. The topic of brain death in "Judaism" is grounded in the basic understanding that the wide spectrum of Jewish interpretive communities has led to equally valuable approaches and opinions in their respective legal, cultural, and religious frameworks on this issue.

[3] J. B. Soloveitchik, "Majesty and Humility," p. 25.

4.1 The Brain Death Concept and Its Critique

4.1.1 The Harvard Criteria of Death

In 1968 an ad hoc committee at Harvard Medical School published a report describing "irreversible coma as a new criterion of death."[4] The experts of the committee provide two reasons for their efforts. First, improvements in resuscitative medicine and supportive measures lead to prolonged suffering and agony for comatose patients with irreversible brain damage. As much as improved resuscitative and supportive medicine make it possible to save heavily injured patients, coma caused by irreversible damage to the brain leaves the patient in a state between life and death. This circumstance, the committee argues, brings about multiple burdens for the brain-dead patient, for his social environment as well as for the hospital that may not have urgently needed beds available within the intensive care unit. Improved medical support systems often only generate a partial success, with the heartbeat and other bodily functions steadied while the patient's brain is irreversibly damaged. In such a case, after the completion of two sets of tests and the attestation that all functions of the brain, including the brain stem, are irreversibly lost, one speaks of brain death, neurological death, or the irreversible loss of all brain functions.

Second, the Harvard committee maintain that the "obsolete criteria for the definition of death can lead to controversy in obtaining organs for transplantation."[5] A brain-dead patient loses the ability for spontaneous respiration. Without controlled mandatory ventilation, oxygen deficiency inevitably leads to cardiac arrest. Ventilation and medication allow a continuous and sufficient perfusion of the organs which is a precondition for successful organ transplantation. However, if the circulatory system collapses, organs become increasingly damaged, due to the lack of blood circulation and oxygen supply, up to the point that they can no longer be transplanted.

Subsequently, the landmark legislation of the Uniform Determination of Death Act (UDDA), enacted in the United States of America in 1980, gives statutory recognition to the concept of brain death. Today, 80 countries conceptually accept "brain death" as death of a human being and acknowledge it as a diagnostic point of departure for harvesting organs. Though these countries maintain the same criteria for establishing the loss of cranial reflexes, major differences exist in terms of performing an apnea test, the number of physicians required to confirm a diagnosis, as well as the type and requirement of confirmatory tests (for example Transcranial Doppler (TCD)).

[4] Ad Hoc Committee of the Harvard Medical School, "A Definition of Irreversible Coma," p. 337.
[5] Ibid.

Although efforts to establish a criteria for brain death have been largely successful, some countries (e.g. Japan) and religious communities express doubts about the appropriateness of this brain-based account of death. One such religious community is a part of Jewish Orthodoxy. Opponents from medicine, philosophy, bioethics, theology, and other interpretive communities voiced their concerns to the new concept after the publication of the Harvard criteria.[6] In his essay, "Against the Stream" (1974), German philosopher Hans Jonas challenges the motivation behind the committee's declaration that new criteria to determine death are necessary for comatose patients suffering from irreversible brain damage.[7] His critique scrutinizes the link between brain death as a new criterion for the death of a human being and the medical practice of organ transplantation. Indeed, a main thread within the general brain death debate includes the question of whether new criteria were introduced to justify and legally anchor the harvesting of organs from brain dead patients.

4.1.2 Hans Jonas' Critique: Brain-Body Dualism as the New Mind-Body Dualism

Jonas argues that identifying brain death with the death of a human being as a whole and unnecessarily antedating the time of death to the disadvantage of a maximal definition of death[8] equates to nothing more than violently harming the dying patient. His criticism of brain death illustrates the philosophical and human concern in this ongoing debate—a debate that questions primarily the new terminology from an ethical perspective: What purpose, for technology or patient, does the invention of "brain death" serve? Why, the philosopher asks, do we need a "new" definition of death altogether?

Jonas differentiates between acknowledging brain death as a point of no return on the continuum of a dying patient and introducing a new definition that seems to reveal an ulterior motivation: to facilitate organ transplantation. His recommendation is not simply to erect further impediments to the naturally occurring death of the human organism after the diagnosis of irreversible loss of all brain functions, i.e. brain death. In his opinion the whole concept of brain death constitutes an exaggeration of the cerebral aspect, disadvantaging the extra-cerebral remainder of

[6] Such as Albert Jonson, Peter Singer, Martin Pernick, and Robert M. Veatch.

[7] See Jonas, *Technik*, pp. 219–239. He first publicly voiced his critique at a conference on the ethical aspects of human experimentation, which took place only a month after the Harvard criteria was published.

[8] With the maximal definition of death (*Maximaldefinition des Todes*) Jonas suggests a definition of death that includes not only one criterion, but the maximum of criteria available (in Western culture) to declare a person's death. He does not agree to "unneccessarily" replace a maximum definition by (what he holds to be) a minimum definition, i.e. brain death.

the body. An exclusive focus on the brain seems to negate the body's (minus the brain) essential share of the person's identity:

> Now, no one will deny that the cerebral aspect is decisive for the quality of life of the organism called 'human being.' The position adopted by me does advocate the recommendation that under the circumstance of irreversible, total loss of brain function, the subsequently occurring natural death of the rest of the organism shouldn't be impeded. But it is no less an exaggeration of the cerebral aspect—as it was an exaggeration of the conscious soul—to deny to the extra-cerebral body its intrinsic share on the identity of the person.[9] [Translation by author.]

Of course, Hans Jonas knows that his opinion is by no means compatible with the act of harvesting vital organs. However, he does agree to post-mortem retrieval of organs, i.e. the ex-plantation of non-vital organs after the irreversible cessation of circulation.

Besides the fact that Jonas challenges this so-called new definition of death, he allegedly criticizes medical science for its dualistic perceptions in the matter. The "new definition" seems like an odd return of the Cartesian mind-body dualism whose naturalistic reincarnation Jonas calls brain-body dualism.[10] Similar to the trans-natural dualism of earlier times, he argues that this modern version tries to make us believe that the true human person sits in the brain, or is at least represented by the brain. Consequently, the rest of the body is perceived only as a serviceable tool to the brain. Jonas' views do not necessarily differ in terms of general body concepts from clinicians' convictions that favor brain death. In contrast to Cartesian dualism, with its completely separate entities of the body and mind, Jonas and clinicians alike discuss the significance of the brain and determination of death in an embodied context. Both parties perceive the brain as an integral part of the human body and not something detached from it, constituting a different essential substance.

However, the philosopher's argumentation falls short of opposing brain death on grounds of a critique of dualistic concepts. In the era of high-tech medicine, the idea of brain-body dualism is interesting in theory, but fails to be of any substantial importance, because the brain, as an organ, contrary to that of a presumed soul, is part of the human body as much as the heart, skin, or eyes. Hence, it may be better to talk about the assumption that the brain has primacy over the rest of the body. From the perspective of modern medical science, the human brain undoubtedly is of high significance and controls some of the most essential bodily functions like breathing, gag reflexes, body temperature and more. The brain's higher functions and its ability for cognition further exemplify its significance. Western societies perceive the brain as the location of human reason, the mind, rational capabilities, and intelligence, or the self. Thus, brain death is perceived as a

[9] Jonas, *Technik*, p. 234.
[10] See ibid., pp. 234–235.

comprehensible "new" definition of death, supported by medical practice within contemporary health-care settings.

Even though this embodied primacy of the brain speaks to a physicalistic understanding of the human being rather than the dualism that Jonas claims, some medical scholars and clinicians nevertheless factually agree with the philosopher's conclusion. From a health perspective, Neeta Mehta argues that "even when unity of mind and body presents a more realistic picture of the human functioning, physicians rather stick to the familiar dualistic thinking to match that of their mentors and colleagues."[11]

4.1.3 The "New" Brain Death Debate

Disapproving views of the neurological determination of death as a precondition for organ donation exist for as long as the criteria themselves. Philosophers, such as Hans Jonas, and early bioethicists criticize the Harvard criteria for supposedly assisting in transplantation medicine. However, historical analysis of the "Harvard report" reveals other primary intentions that seem to have guided the actual interests, writings, and clinical work of the committee's members. Historian Gary Belkin specifically identifies the committee members' primary research fields as the development of EEG, a measurement of brain waves in comatose patients (neurology), in addition to withdrawal of life support systems in medically futile situations.[12]

Another early point of criticism concerns the report's omission of a philosophical perspective on death and dying. One of the most prominent bioethicists, Robert Veatch, believes that the task of defining death is not a trivial exercise in coining the meaning of a term. "Rather," Veatch states, "it is an attempt to reach an understanding of the philosophical nature of man and that which is essentially significant to man which is lost at the time of death."[13]

Today, several decades after its formal introduction to the medical world and legal implementation, the concept of brain death continues to elicit critique. German philosopher and medical ethicist Ralf Stoecker from the University of Bielefeld argues in his seminal monograph "Der Hirntod" that doctors and ethicists involved in the brain death debate advocate a certain basic assumption or premise: that with death happening, a dying person loses almost his or her entire moral protection and stops being a moral person. Stoecker strongly advocates for dealing with

[11] Mehta, *Mind-Body Dualism*.

[12] See Belkin, "Historical Understanding."

[13] Veatch, "Brain Death," p. 10. Cf. Lenherr and Krones, "Zürcher DCD-Programm" and the way these authors implemented, even if short and concise, the philosophical discussion of death in their article about donation after circulatory death determination at the Universitätsspital Zürich.

death, or rather dying, as a process and to dissociate the discourse about brain death from the discourse and ethics of transplantation medicine.[14]

The recent turn in the debate emphasizes that uncertainty remains as to whether brain death is conceptually coherent and amends evidence to rebut the medical establishment's assertion that a brain-dead patient is "as dead as one can be." The President's Council on Bioethics 2008 White Paper on "Controversies in the Determination of Death" acknowledge such reservations: "With this report, the President's Council on Bioethics takes up this controversy and seeks to illuminate the issues at the center of the renewed debate about the inherently perplexing problems of determining human death in an age of life-sustaining technologies."[15] The White Paper additionally affirms the view that some brain-dead patients could maintain long-term integrated functioning. On a methodological level, recent scientific research scrutinizes the neurological standard, especially the significance of integrative functions of the brain to the rest of the body in brain dead patients.[16] In addition to questionable neurological standards, the existence of various protocols to determine brain death further adds to confusion. The "renewed debate" is fueled by "medical facts" within the medical community and media reports of patients who seem to literally resurrect from the dead. This was the case with 21-year-old Zack Dunlap from Oklahoma in 2008, who was diagnosed brain dead after an ATV accident. Shortly before the physicians proceeded—according to protocol—to harvest his organs, the initial diagnosis had to be reversed due to the patient's sudden positive reaction to tests carried out to determine brain stem activity. The young man fully recovered from his injuries.[17]

4.2 The Orthodox Brain Death Controversy: Sources and Halakhic Rulings

The basic knowledge to answer any issue, including the question whether brain death constitutes halakhic death or not, can be found in the Talmud, its commentaries, and responsa. The vast responsa literature is based on the model of "questions and answers," (*she'elot ut'shuvot*) with answers given by halakhic authorities. Leading religious authorities like Moshe Feinstein (1895–1986 Belarus/New York) and Shlomo Zalman Auerbach (1910–1995, Israel) were constrained to find answers to such a complex question and remaining consistent with Jewish law. But the fact

[14] See Stoecker, *Der Hirntod*.
[15] The President's Council on Bioethics, *Controversies in the Determination of Death*, p. xix.
[16] See Shewmon, "Chronic 'Brain Death'," pp. 1538–1545.
[17] See Morales, *'Dead' Man Recovering*; Celizic, *Pronounced Dead, Man Takes 'Miraculous' Turn*.

that there is no obvious analogy to be found in rabbinic literature made things complicated from the very beginning, when the question of how to define death first arose to international attention with the first successful human heart transplant in Cape Town/South Africa in 1967.

Over the decades, arguments in favor of and opposing brain death—conceptually as well as practically—created considerable controversy within the Orthodox community. Within the American context there are basically two camps. The first consists of those who acknowledge irreversible loss of all brain function as halakhic death, i.e. consistent with Jewish law, and support organ donation (at least theoretically). Therefore, harvesting organs from brain dead patients is perceived in the same way as living donor or (classical) deceased donor transplants, based on the *mitzvah* of *pikuah nefesh*.[18]

The second camp consists of those who insist that halakhic legitimacy should be assigned only to cardiopulmonary death. From a structural point of view, this is a minority perspective within the whole Jewish spectrum. It remains worthy of some attention since this perspective seems to have become more influential within American Jewish Orthodoxy, especially since the Rabbinical Council of America (RCA) published a report on the matter in 2010, which goes further than merely designating the committee's normative stance (see below).

A clear and concise summary of the decades-long rabbinic discussion over relevant halakhic sources, consisting of nested and diachronic, interdependent text, is beyond the scope of this chapter. There are several well written and thoughtful scholarly works on the matter—from introductions to in-depth analyses of the relevant sources used in the discourse.[19] Nonetheless, based upon a select set of rabbinic sources, what follows is a sketch of the main differences in approach within the rabbinic discussion on "halakhic death," or death consistent with Jewish law.

4.2.1 Physiological Decapitation

Rabbi Dov Linzer, the *rosh yeshivah* (dean) of Yeshivat Chovevei Torah in New York begins his essay, "Brain Death or Cardiocirculatory Death," with an important statement:

[18]Considering those Jewish voices who claim that organ donation is the greatest (modern) *mitzvah*: A living organ transplantation seems to be consistent with the idea of living human beings doing *mitzvot* (pl. religious duties, good deeds). However, one might ask how this idea of organ donation as a *mitzvah* can be consistent with the medical practice of deceased donor transplantation, since a dead person cannot (and is not obliged to) fulfill *mitzvot* anymore. This argument against organ donation will be addressed in the next chapter.

[19]See the essays in Farber, *Halakhic Realities*; for overviews regarding halakhic authorities see Abraham, *Medical Halachah*, Steinberg, *Encyclopedia of Jewish Medical Ethics*, and the report of the Vaad Halacha of the Rabbinical Council of America, *Halachic Issues* as well as articles such as F. Rosner and Bleich, *Jewish Bioethics*, Kunin, "Brain Death," Reichman, "Don't Pull the Plug," and Moses, *Really Dead?*

> It goes without saying that brainstem death is not addressed in the Talmud. By attempting to define brainstem death as halakhic death per se, posqim have left themselves open to attack that there is no direct evidence for this definition in the Talmud. Many try to prove the definition based on the mishna (Oholot 1:6) in which a decapitated animal, although its limbs may still be twitching, is considered dead.[20]

He refers to one of the main sources, Mishna Ohalot 1:6, often used to justify brain(stem) death: "הותזו ראשיהם אף על פי שמפרכסים טמאין כגון זנב של לטאה שהיא מפרכסת—If their heads were cut off, even if they are convulsing, they defile—like the tail of a lizard which convulses [after being cut off]." Tractate Ohalot discusses the ritual impurity of corpses. In the quoted passage, death is linguistically indicated by the state of ritual impurity of a cadaver of an animal. An animal may be considered dead if its head has been cut off, even if certain other body movements continue afterward (convulsion, spasms); therefore, such movements are not antithetical to the determination of death. This passage is also referred to in Gemara Hulin 21a, where a similar statement is introduced: "נשברה מפרקת ורוב בשר עמה מטמא באהל—If the neck bone of a person was broken and a majority of the surrounding flesh with it was cut, that person imparts impurity in a tent."

Many Orthodox rabbis accept the passages in Ohalot and Hulin as valid passages in favor of brain death according to the "whole-brain standard." The statements in the Talmud regarding severance of a person's head from his body and the meaninglessness of random body movements have been equated with neurological death due to irreversible damage to the brain including the brain stem, which can be verified with a medical test, such as a Transcranial Doppler Ultrasonography (TCD). The chief proponent of brain(stem) death, the aforementioned Rabbi Dr. Moshe Tendler, puts forth the concept of physiologic decapitation as a definition of death in Judaism, even if cardiac function does not cease. In a co-authored article with Fred Rosner they write:

> The twitching of a lizard's amputated tail or the death throes of a decapitated man were never considered residual life but simply manifestations of cellular life that continued after death of the entire organism had occurred. In the situation of decapitation, death can be defined or determined by the decapitated state itself as recognized in the Talmud and the Code of Laws. Complete destruction of the brain, which includes loss of all integrative, regulatory, and other functions of the brain, can be considered physiological decapitation and thus a determinant per se of death of the person.[21]

Decapitation also plays a weighty role for the halakhic approach of Israeli *poseq* Rabbi Shlomo Z. Auerbach. After the Chief Rabbinate of Israel ruled in favor of respiratory-brain death in 1986 (see below), Rabbi Dr. med. Abraham Steinberg contacted Rabbi Auerbach for his opinion on

[20] Linzer, "Brain Death or Cardiocirculatory Death," p. 175.

[21] F. Rosner and Tendler, *Practical Medical Halachah*, pp. 64–65, although first published in Veith et al., "Brain Death."

the matter. After thorough study of the relevant sources, Auerbach concluded that based on a passage in Talmud Arakhin 7a, brain death is not death of the whole human being. Arakhin discusses the case of a pregnant woman and whether in case of her death the fetus dies before or after her. Auerbach concludes that a fetus in the stage before its mother goes into labor is dependent upon its mother and cannot outlive her. The *poseq* realized that this Talmudic conclusion contradicts medical reality, since there are cases of women who are diagnosed with brain death and yet the fetus continues to gestate and is subsequently delivered alive. Consequently, Auerbach stated that it is impossible for the Talmud to consider brain death to be death. However, the remarkable result of this scholarly exchange between Auerbach, the halakhic authority, and rabbinically trained physicians such as Avraham Steinberg and Yigal Shafran led to a scientific experiment:

> Rabbi Auerbach suggested that one could, in fact, reconcile the talmudic position with the present-day reality if one assumed that the talmudic belief that the fetus generally predeceases its mother applied only in the past, before the advent of modern medicine. [...] Hence, Rabbi Auerbach proposed that perhaps the talmudic dictum applies only to a person who has died and has not been connected to any life-sustaining equipment, since this equipment may allow the body to simulate the aspects of life needed to sustain the fetus.[22]

Shafran and Steinberg set up a scientific experiment with a pregnant sheep to prove whether a fetus could outlive its mother's death according to the indisputable halakhic criterium of death, i.e. decapitation, while the mother's body is connected to artificial life support, including ventilation.[23] Two experiments were performed and both times the fetus remained viable although its mother was clearly dead. The sheep's brain and later also its head had been removed completely while the rest of the body was maintained by mechanical means. After the second experiment Rabbi Auerbach declared that the Talmudic statement that a fetus does not outlive its mother pertains only to ordinary circumstances of death. The experiment proves that Talmudic statements regarding death may not necessarily be true in the context of today's high-tech medicine and care. It further proves that the heartbeat is meaningless.

Rabbi Shafran recalls well the reaction of Rabbi Auerbach in their discussion of the experiment:

> לכן הרב אוירבך אמר מאחר שמה שאתה הוכחת בניסוי זה עם דקפיטציה, אני אסכים למוות מוחי שידמה דקפיטציה. כמו שאתה כרתת פיזית את הראש, אני מוכן להגיד 'אוקי גם אם כל התאים ימותו, זה כמו דקפיטציה ונקבל זאת', לכן הוא נצמד כל כך למוות של כל המוח, בגלל הכבשה—That is why HaRav Auerbach said: 'Because of what you proved in this experiment with decapitation, I would agree to brain death that

[22] Steinberg, "Sheep Experiments," p. 250.

[23] For a detailed report on both experiments that took place between January 9 and 22, 1992 at a veterinary hospital in Israel, see ibid.

> resembles decapitation; as if you physically cut of the head, then I'm willing to say okay, also if all the cells die, this is like decapitation and we accept it.' That's why he clung so much to [the concept of] death of the whole brain, because of the sheep [experiment].[24]

However, Rabbi Auerbach maintains the opinion that a brain-dead patient is a *goses*. He especially emphasizes this opinion years later when he learns that parts of the brain such as the hypothalamus and pituitary gland may remain functional after the neurological determination of death.[25]

4.2.2 Permanent Cessation of Spontaneous Respiration

Another set of discussions involves a passage in Yoma 85a,[26] probably the prime Talmudic passage for the analysis of how death should be determined or defined in Jewish law. In comparison to the aforementioned sources that better serve the case for a whole-brain death standard, brain death proponents use the text in Yoma to justify brain stem death.

The case, as presented in the Mishna, addresses a situation regarding a person on whom rubble has fallen on Shabbat or a holiday, and it is not clear whether he is trapped, alive or dead. In the case that the person is alive, the Mishna states, clearing away the rubble on Shabbat or Yom Kippur certainly is obligatory, even if it will buy the person only a few moments of life. The Mishna further rules that the person on the site has to continue digging only as long as there is a chance of finding a live victim. The Gemara then discusses how to determine whether a victim is alive once he or she is found:

> תנו רבנן: עד היכן הוא בודק עד חוטמו ויש אומרים עד לבו בדק. [...] אמר רב פפא: מחלוקת ממטה למעלה אבל ממעלה למטה כיון דבדק ליה עד חוטמו שוב אינו צריך דכתיב 'כל אשר נשמת רוח חיים באפיו.'—Our Rabbis taught: How far does one examine? Up to his nose. Some say: Up to his heart[27] [...] Rav Papa said: The dispute is [uncovering the victim] from bottom to top [i.e. feet first], but if [the victim is uncovered] from top to bottom, once one has checked up to his nostrils [for signs of breath], one need not check any further, as it is written: 'All in whose nostrils was the spirit of the breath of life' (Genesis 7:22).[28]

[24] Interview with Rabbi Yigal Shafran, 15.8.2016, Jerusalem.

[25] Abraham, *Medical Halachah vol2*, p. 312. On the development of Shlomo Z. Auerbach's opinion and ruling on brain death see ibid., pp. 307–313.

[26] For an in-depth analysis of Yoma 85a see Reifman, "Rashi's Position." The article is a response to the analysis of some key sources in the RCA report. His conclusions allow for the acceptance of a halakhic standard of brain stem death.

[27] Some texts read ad *tiburo* (until his navel).

[28] The translation of the passage is according to Bin Nun (2015) and Reifman (2012).

In the first pericope ("our rabbis taught") one party states that one should check up to the nose for breathing while the second party states "up to the heart" in order to examine if a heartbeat can be detected. The final statement of this passage ("Rav Papa said") at least partially resolves the disagreement by explaining that there is only dissension between the rabbis in a situation when the rescuer finds the victim by his feet or legs and is digging upwards towards the head. If he approaches the victim from top to bottom, it is enough to check for breathing. But the other way around it is questionable whether he is obliged to continue digging up to the nose in order to check for breathing, or has to stop when he reaches the chest when there is no discernible heartbeat (perhaps indicated by the rise and fall of the chest).

Halakhically, it is tremendously important to determine the exact time of death, since one must desecrate Shabbat to extend or save a person's life, but it is forbidden to do so in the case of a dead body. So, if the missing heartbeat is a sufficient sign for death, then further excavation constitutes a violation of Shabbat. However, if the examination of the nose is a prerequisite, then the act of further digging is not a transgression, because it constitutes *pikuah nefesh*, or the saving of someone's life.

The most influential halakhic codices[29] written by Maimonides (1135–1204) and Joseph Karo (1488–1575) comment on the passage in Yoma and confirm the Talmudic conclusion by Rav Papa that checking up to the nostrils for breathing is the necessary action in such a case. Maimonides' comment in his Mishne Torah (Shabbat, chap. 2:18-19) states:

> מי שנפלה עליו מפולת ספק הוא שם ספק אינו שם מפקחין עליו, מצאוהו חי אף על פי שנתרוצץ ואי אפשר שיבריא מפקחין עליו ומוציאין אותו לחיי אותה שעה. בדקו עד חטמו ולא מצאו בו נשמה מניחין אותו שם שכבר מת. —In case the collapse has fallen on him and there is doubt whether he is there or not, one breaks through [opens the debris] to him; If they find him alive, even if he is crushed, and there is no chance he will recover, they break through to him and pull him out for those few moments of life. If they checked up to his nose and did not find any breath, they leave him, as he is already dead.

Similarly, Joseph Karo in the Shulhan Arukh (Orah Hayim 329:4) asserts that:

> אפי׳ מצאוהו מרוצץ שאינו יכול לחיות אלא לפי שעה מפקחים ובודקים עד חוטמו אם לא הרגישו בחוטמו חיות אז ודאי מת לא שנא פגעו בראשו תחלה לא שנא פגעו ברגליו תחילה. —Even if they found him crushed, and there is no chance he can live more than a few moments, they break through [the debris] and check up to his nose. If they do not sense life at his nose, then he is certainly dead. It doesn't matter whether they reached his head first or whether they reached his feet first.

It is interesting to note that neither Maimonides nor the Shulhan Arukh mention the *mahloqet*, the difference, regarding the situation if the victim is first found by his feet. Karo even states

[29] Those codices are structured differently from the Talmud, and produced with the intention of facilitating a faster retrieval of halakhic information in everyday legal decision-making.

straightforward that the victim's position is irrelevant and both commentaries perceive respiration as the sole indicator of life. Since the brain stem controls autonomous breathing, its irreversible destruction means permanent cessation of spontaneous respiration. Thus, this straightforward understanding of the relevant passages in rabbinic literature can even serve as a proper definition of death.

Dov Linzer, the Modern Orthodox *rosh yeshivah* of Yeshivat Chovevei Torah in New York, adopts a somewhat different perspective. He clearly states in his aforementioned essay that to consider a brain stem dead patient alive also means "to reject cessation of autonomous breathing as the sole criterion of death." Perceiving the issue from this angle, Linzer advances the debate:

> This person is alive only if a new criterion is added: Death requires cessation not only of respiration, but also of circulation. The framing of this debate, then, needs to be reversed. The question is not 'What sources or arguments justify the brain death definition?' but rather, 'What sources or arguments justify adding a new criterion, cessation of circulation, to the standard halakhic definition of death?'[30]

Linzer alludes to the widely-held position of rabbis, especially from within the *haredi* sector, that death is traditionally determined not by cessation of respiration alone, but by at least one more factor. This perspective is firmly established, in reference to at least two sources.

First, there is Rashi's comment to the passage in Yoma. He explains the reasoning behind the "below/upwards"- situation with the following:

> דמר אמר: בלבו יש להבחין, אם יש בו חיות, שנשמתו דופקת שם, ומר אמר: עד חותמו דזימנין דאין חיות ניכר בלבו, וניכר בחוטמו.—For one says: In his heart one can discern if there is life (vital signs), since his *neshamah* beats there. And others say: We examine up to his nose, for sometimes life is not discernible at the heart, but is discernible at the nose.

Rashi does not add his conclusion to the difference in opinion between the Talmudic sages; he only adds another explanation to the case, if "the dispute is [uncovering the victim] from bottom to top." One group thinks that digging up to the heart is sufficient, while the other group claims that further digging-up to the nose is necessary.[31] According to Daniel Reifman, a contemporary Israeli scholar, Rashi's comment suggests that both parties recognize heart activity as a potential indicator of life, and differ only as to whether examination of the nose is more reliable because an examination of the heart alone would not suffice. This formulation drastically impacts Orthodox opinion regarding the brain death controversy, since it "has been understood to mean

[30] Linzer, "Brain Death or Cardiocirculatory Death," pp. 176–177.

[31] See Reifman, "Rashi's Position" for his text-critical examination of Rashi's comment. The fact that in other versions of the Talmud the term "navel" (טבור) is used, and not "heart" (לב), alters the understanding of the passage drastically, since checking the region around the navel may indicate an examination of respiration (lifting and falling of the chest when breathing) and not the heartbeat.

that Rashi recognizes cardiac activity as a definitive indicator of life, and the only reason for requiring examination of the nose is that respiration is more easily detected than the heartbeat."[32] Rashi's explanation that a person's *neshamah*, or life force, may be discernible in the heart is taken by some to mean that the heartbeat, or its cessation, is relevant for the determination of death, even in a situation where respiration is artificially continued in a brain-dead patient. Proponents of brain death assess the passage as confirmation that respiration is the main indicator for determining death. They argue, that since respiration is located in the brain stem, the modern criteria for brain death is congruent with Halakhah. Opponents to this line of reasoning insist on the inclusion of other factors, with heart activity being of crucial significance. For the follower of this assessment, irreversible loss of all brain functions including the brain-stem does not equate to death of the person.

Another source that is adduced to support the relevance of "heartbeat" within the brain death controversy is the responsum (Yoreh De'ah 338) of Moses Schreiber, the Hatam Sofer (1762–1839), one of the most revered and authoritative figures within traditional Judaism. He writes that the death of a person can be declared when complete cessation of movement, pulse, and respiration are verified:

> שאחר שמוטל כאבן דומם ואין בו שום דפיקה ואם אח"כ בטל הנשימה אין לנו אלא דברי תורתינו הקדושה שהוא מת—But, after it [the body] is lying still like a stone, without any [heart/pulse] beating, and if, afterward, the breathing has suspended, we rely only on the words of our Holy Torah [to rely on] that he has died.[33]

Daniel Reifman maintains that this passage must be analyzed together with a statement near the beginning of the responsum:

> ואפ"ה כשפסקה נשימתו שוב אין מחללין שבת וע"כ כלל הוא לכל המתים שזהו שיעור המקובל בידינו מאז היתה עדת ה' לגוי קדוש וכל הרוחות שבעולם אם ימלאו חפניהם רוח לא יזיזונו ממקום תורתינו הקדושה—And even so, when [such a person] stops breathing, we no longer violate Shabbat [on his behalf]. Therefore, this principle applies to all deceased individuals, for this is the standard that has been accepted since the founding of our nation, and all the winds in the world cannot move us from the position of our holy Torah.[34]

So, if cessation of respiration is the only decisive and relevant indication of death, why does he add "cessation of movement" and "pulse" later on? It is important to keep in mind that the Hatam Sofer's formulation takes place within the unique discursive context on new regulations of burial

[32]Reifman, "Rashi's Position," p. 14.

[33]Yoreh Deah 338: 6.

[34]Ibid. Translation according to Reifman, "Hatam Sofer's Position," p. 44. See this article for a critical analysis of the responsum and its influence on the brain death debate.

customs, enacted by the Duke of Mecklenburg-Schwerin in 1772. During the era of Enlightenment, there was widespread insecurity and cultural fear over apparent death ("Scheintod") caused by misdiagnosis of death.[35] In reaction to this, the Duke prohibited the custom of burial on the day of death. To prevent cases of being buried alive, he decreed a three-day waiting period, which thereby affected the ancient Jewish tradition of prompt burial of the deceased. The Jewish community of Schwerin approached Rabbi Jakob Emden (1697–1776) in Altona with the request to explain to the Duke the necessity for prompt burial as a halakhic duty and interference with autonomy rights regarding religious practice. Emden assigned his student Moses Mendelssohn, the German philosopher and precursor of Jewish Enlightenment (Haskalah), with the task. Mendelssohn was able to reach a compromise with the Duke: he suggested that instead of a longer waiting period to ascertain the death status of the deceased, no burial would take place without a death certificate signed by a physician. The Duke consented and on August 31, 1772 enacted the first law ever "requiring a medical certificate as precondition to burial."[36]

Nevertheless, traditionalists, like the Hatam Sofer, did not welcome Mendelssohn's "compromise," taking a fervent stance against any change in Jewish burial practice. Sofer's answer, directed at Rabbi Zvi Hirsch Chajes who was sympathetic to certain novel changes regarding burial customs, maintains that in some cases, due to natural illness, a person might remain motionless and breathless for a day or two.[37] In contrast to Chajes, the Hatam Sofer clearly rejects such differentiations and claims that "when [such a person] stops breathing, we no longer violate Shabbat [on his behalf]. Therefore, this principle applies to all deceased individuals."

Against the backdrop of such a socio-historical context, the responsum by the Hatam Sofer does not introduce another criterion for death. He instead defends the "cessation of breathing" criterion as the only "Jewish" acknowledged sign for the determination of death in a medical context where the cessation of breathing and heartbeat (circulation) occurred simultaneously and is not reversible due to the fact that cardio-pulmonary resuscitation was not widely practiced back then. Daniel Reifman contends that cessation of breathing, movement, and pulse "occupied the same ideological space within the Hatam Sofer's milieu: in the polemic against delayed burials, both effectively meant, 'Death need not be determined by the onset of decomposition.' "[38] Furthermore, as Michael Barilan concludes, the Hatam Sofer advocates both tests mentioned in the Talmudic deliberation—the breathing test and the heartbeat test, the combination of which is enough to be secure from error (apparent death): "But the kind of error this avoided is halakhic,

[35] See Gehring, *Theorien des Todes*, p. 84.

[36] Barilan, *Jewish Bioethics*, p. 203. See also Wolff, *Medizin und Ärzte*, pp. 166–196; Heinrich, "Akkulturation und Reform."

[37] See Barilan, *Jewish Bioethics*, p. 205.

[38] Reifman, "Hatam Sofer's Position," p. 45.

not necessarily a factual error. In this sense, Sofer contained the deliberation within the realm of halakhic epistemology, not medical science."[39]

Some of the most influential rabbinic authorities of the last century have integrated the Hatam Sofer's tripartite definition of death—cessation of movement, pulse, and respiration—"literally" into their rulings on bioethical issues within the context of high-tech medical technology. For example, this is the case with the responsa of Rabbi Eliezer Yehuda Waldenberg (1915–2006), the Tzitz Eliezer. The Israeli *poseq* who was well aware of the Hatam Sofer's two statements, concludes that one ought not to exclusively rely on the "cessation of respiration," but to include "pulse" and "movement" as well. This integration of a brain-dead patient's medical reality thereby precludes a definition of death based on the neurological brain death standard.[40]

Nonetheless, Rabbi Linzer, the Modern Orthodox Rosh Yeshiva, as a brain death proponent, states that "the burden of proof is on those who would introduce this criterion," i.e. cessation of circulation. This deeply contrasts with the 2010 opinion of the Vaad Halacha of the RCA:

> As the neurological standard came to partly supplant the long established traditional cardiopulmonary standard, the burden of proof is on the new, neurological standard. Indeed, this paper is not being one sided [...] it merely recognizes that, as a חידוש [*hiddush*], the neurological standard must stand up to close scrutiny.[41]

Though Linzer's contention is undoubtedly straightforward and compelling, the fact that rabbinic literature "introduced," "mentioned," and "considered" at some point additional factors like heart, pulse, or movement seems to be reason enough to reject irreversible cessation of spontaneous respiration in correlation with brain stem death as halakhic death. Ever since interpretation by legal commentators of the Talmudic *mahloqet* (difference in opinion) in Yoma 85, the heart factor has become an "issue."

The bottom line is that there are rabbinic authorities who rule "according to heartbeat" and those who rule "according to brain (stem) death."

4.2.3 Cessation of Circulation

While brain death proponents almost exclusively rely on the passage in Yoma in order to halakhically legitimize the factor of respiration, opponents emphasize heartbeat or circulation, even

[39] Barilan, *Jewish Bioethics*, p. 208.

[40] Other authorities, such as the *poseq* Rabbi Shlomo Zalman Auerbach do not allow the use of confirmatory tests that could, even slightly, involve moving the brain-dead patient whom he classifies as *safek goses*, a possibly dying person, for fear of hastening death.

[41] Vaad Halacha of the Rabbinical Council of America, *Halachic Issues*, p. 7.

though, pulmonary and cardiac arrest occur almost simultaneously if no reanimation takes place. Before turning to additional, non-halakhic factors in the discussion, it is worthwhile examining the perspective of Hershel Schachter, *rosh yeshivah* of the Rabbi Isaac Elchanan Theological Seminary at Yeshiva University in New York. He is considered to be one of Modern Orthodoxy's *posqim*.

Schachter approaches the question of when is a person dead by asking the reciprocal: what makes a person alive?[42] He concludes that within the Jewish halakhic system it is the circulation of blood that constitutes the essence of life, as deduced from to the Torah and Talmud. A remaining question whether death of the brain due to the cessation of blood flow to the brain is equivalent to death of the entire body. Schachter quotes passages from Talmud Arakhin (and Temurah), which discuss vows concerning the donation of an individual's value, similar to a sacrifice to the Temple. This discussion includes various body parts, the entire body, half a body or bodies of other people. Without referring to the intricacies of the tractate and the eventual relevance for the topic at hand, Schachter states:

> The Talmud posits specific organs which are vital to life. Each one is an 'eiver shehaneshama teluya bah,' an organ upon which the soul depends. This is a halachic concept. Rambam in quoting the Talmud names three such vital organs: the heart, brain, and liver. [...] One could argue that if only *one* of these three vital organs is halachically declared dead, then the entire body is pronounced dead. On the other hand, one could also claim that a person is not dead until *all* the vital organs are dead.[43]

Thus a dilemma exists as to whether death of the entire human being may be declared if the brain including the brain stem as a vital organ (body part) is irreversibly damaged, i.e. dead, or if, according to the texts, other factors (e.g. heart) must have ceased to function irreversibly. Closer investigation of the sources, starting with Mishnah Arakhin 5:2–3, seemingly cancels Schachter's second proposition, namely that a person is not dead until *all* of the vital organs are dead, is an option at all:

> §2: [...]ערך ידי וערך רגלי עלי לא אמר כלום ערך ראשי וערך כבדי עלי נותן ערך כולו זה הכלל דבר שהנשמה תלויה בו נותן ערך כולו—The value of my hand or the value of my leg is upon me–he has said nothing. The value of my head or the value of my liver is upon me–he pays his entire value. This is the rule: Anything the *neshamah* is dependent upon, he pays the whole value.
> §3: חצי ערכי עלי נותן חצי ערכו ערך חציי עלי נותן ערך כולו —Half of my value is upon me—he pays half his value. The value of half of me is upon me–he pays his entire value.[...]זה הכלל דבר שהנשמה תלויה בו נותן ערך כולו—This is the rule: Anything the *neshamah* is dependent upon, he pays the whole value.

[42]See Schachter, "Determining Death," p. 34.
[43]Ibid., pp. 37–38.

The Mishnah distinguishes between the value of the entire person and the value of one's body parts. Body parts *shehaneshama teluya bah*, without which a person could not survive, equate to a person's overall value. The same goes for the *erekh* (value) of half of someone's body, since loosing half of a body is equivalent to a person's entire value, and not just a collection of limbs.

A straightforward reading of this passage points towards an affirmative stance of Schachter's first proposition (i.e. the cessation of only one vital organ is necessary to declare death), especially since the Mishnah defines as a general rule that דבר שהנשמה תלויה בו נותן ערך כולו —anything the *neshamah* is dependent upon, pays the whole value. In his critique of Schachter's argument, Zev Farber points out that, medically speaking, this could also mean any organ or body part *shehaneshama teluya bah*, such as the intestine, without which one would not survive either, and not just the few body parts that Schachter mentions.[44]

During the course of his evaluation Schachter puts forth two ways of halakhic reasoning. First, he refers to a responsum by Rabbi Moshe Feinstein regarding a gangrenous limb. Feinstein was asked whether one is allowed to don *tefilin* on a gangrenous arm. He did not allow it, because he considered such an arm a dead limb due to cessation of blood circulation. Schachter argues that if this position (or more generally a limb that is not perfused) is accepted along with the premise that loss of only one vital organ renders a person dead, then cessation of blood flow to the brain means death of the brain. Following this line of reasoning, brain death is halakhically acceptable based on the criterion of cessation of blood flow, regardless of heartbeat.[45]

However, to counter this possible interpretation, Schachter points out that no one would claim that someone with a removed liver is dead because one can live without a liver for a short amount of time (i.e. one or two days). Since such a person is certainly not dead, then the death of only one organ is not enough to declare the death of the entire person. Instead, according to the Halakhah, all vital organs must irrevocably cease functioning to declare death of the entire person. Thus, Schachter does not consider death of the brain "enough" to rule in favor of a halakhic acceptance of brain death and the medical practice of organ transplantation. Yet he is not persuaded by the rabbinic extreme-position that a brain dead patient is "alive beyond any shadow of a doubt." This doubt leads Schachter to conclude:

[44]See Farber, *Halakhic Realities*. Schachter's definition of vital organs or body parts *shehaneshama teluya bah* is confusing. Mishnah Arakhin indicates the head and liver to be examples of these vital body parts *shehaneshama teluya bah*. First, Schachter translates head as brain, which is in itself problematic because the whole rabbinic brain death discussion is sensitive to terminology and context. Second, he basically combines the Mishnaic "list" with the one given by Maimonides, who refers to the heart and liver (but not the head) in one place, and then to the heart, liver, and head in another. Thus, contrary to Schachter, Farber claims that the combination of liver, heart, and head is not based in the Talmud, but is of Schachter's own invention (or merger).

[45]See Schachter, "Determining Death," p. 40.

> However, since each of these two premises is by no means certain as we have documented, it would appear that a person in such unfortunate circumstaces [sic] should be considered *safek chai safek met*–questionably alive, questionably dead. In such a situation of *safek*, of doubt, the proper course to follow seems to be Chumra, to follow the stricter possibility, both regarding removal of organs as well as on the issue of *halitzah*.[46]

4.3 (Un)translatable Contexts and Incommensurate Paradigms

Besides the fact that Yoma and other sources are the main precedents within the debate over "halakhic death" within a contemporary medical setting, their use raises the issue of translation. Specifically, there is a problem of translatability of knowledge between incommensurable frameworks, i.e. Halakhah, science, ethics (synchronic), as well as the incommensurability of scientific paradigms (diachronic).

4.3.1 Situational Contexts and Meta-Halakhic Impacts

The situation depicted in Talmud Yoma 85a, or any other situation described in ancient rabbinic literature, is one of rescuing a victim in a pre-modern context without the availability of life-support devices. Clearly, the situation of a brain-dead patient in an ICU, supported by all kinds of mechanical equipment, is not really comparable to a person buried in rubble. This fact leads to a crucial question: to what extent are situational contexts comparable and how does this affect a question's content? How much of the original situational context, i.e. the victim buried under a pile of rubble on a religious holiday, can be omitted while keeping enough validity to count as a valid analogy for the new case at hand? The case in Yoma presents a comparable question, i.e. determination of death in a situation, but deals with a very different situation of "triage" that is not relevant to a brain-dead patient. Both Rabbi Shlomo Zalman Auerbach and Rabbi Moshe Feinstein, the most notable halakhic authorities in this controversy, draw this obvious conclusion. In private communication with Rabbi Dr. Abraham S. Abraham, an Israeli physician and Jewish scholar, Rabbi Auerbach states:

> It is interesting to note that the Mishnah Berurah quotes *rishonim* who write: If found alive, even if his brain is crushed and he only has a short time to live, efforts must be made to rescue him.
> Rav Auerbach zt"l told me that this *halachah* was based on the extant medical knowledge at the time. Since there was no treatment for a patient who had stopped breathing, even if his heart was

[46] Schachter, "Determining Death," p. 40.

> still beating, there was no point in setting aside Sabbath laws for him as there was no way that his life could be saved or even prolonged. Therefore, the question of whether his heart was still beating or not was immaterial. Today, however, since treatment is available, full resuscitation efforts must be made as long as there is even a remote chance that the patient might be saved.[47]

With respect to the special situation of a brain-dead patient, Auerbach feels that the halakhic categorization should be one of *safek goses*, *safek met*,[48] doubtful actively dying and doubtful dead. Therefore, a brain-dead patient's death is halakhically indeterminate. Auerbach thus makes a revision of his initial opinion that brain death is halakhic death if there is physiological decapitation (see sheep experiments).

Rabbi Feinstein's approach is a bit different from that of Auerbach. According to Daniel Reifman, whose research covers Rabbi Feinstein's position and handling of the issues of brain death and organ donation, the *poseq* tries to transfer the classical halakhic position of cardiopulmonary death into contemporary medical reality.[49] Essentially he translates the classical position of "death is determined by cessation of respiration" into modern medical reality and its scientific paradigm. In a letter to the Chairman of the Assembly Committee on Health in 1976 Feinstein states:

> Any bill defining death must contain the following clarification as I wrote in my responsum: 'The sole criterion of death is the total cessation of spontaneous respiration.' In a patient presenting the clinical picture of death, i.e., no signs of life such as movement or response to stimuli, the total cessation of independent respiration, is an absolute proof that death had occurred. This interruption of spontaneous breathing must be for a sufficient length of time for resuscitation to be impossible (approximately 15 min.)."[50]

Rabbi Feinstein acknowledges in this letter that "total cessation of spontaneous/independent respiration" is consistent with the death of the whole organism from a halakhic perspective if the "clinical picture of death" is such that restoration of spontaneous breathing is impossible. Although Feinstein does not mention brain death as a criterion, one may interpret his statement accordingly. Unfortunately, some inconsistencies in his written responsa regarding his position on brain stem death and organ donation created a controversy in its own right.[51] Consequently, both camps in the discourse follow Feinstein's "position," which is "in favor" for those who accept brain death and "against it" for those who reject brain death as a concept. Though there are responsa by Feinstein that testify to his acknowledgment of brain death in the case of total destruction of

[47] Abraham, *Medical Halachah vol1*, p. 219.

[48] This halakhic category differs from the classical definition regarding a *goses*, or a clearly actively dying person whose death is imminent.

[49] Reifman, "Feinstein on Brainstem Death."

[50] Tendler, *Responsa of Rav Moshe Feinstein*, p. 90.

[51] See the study of the Vaad Halacha of the Rabbinical Council of America, *Halachic Issues*.

the brain or lysis (נרקב לגמרי), a recent report of the Vaad Halakhah of the Rabbinical Council of America [52] reaches the opposite conclusion:

> Given that Rav Feinstein specifically rejected 'brain death' based on functions of the brain, and that the 'fully rotten brain,' as described by Rav Tendler to Rav Feinstein, is not found in the patients generally used for organ donation; it would be most misleading to present Rav Moshe's words as supporting organ donation based on 'brain death' as the term is used today.[53]

The study's conclusion regarding Feinstein's responsa is that there is no explicit responsum which permits the harvesting of organs from brain-dead patients who lack spontaneous respiration.[54] Additionally, various oral communications, posthumously shared known by different scholars and family members, add to the discomfiture within the wider Orthodox camp surrounding the *poseq*'s position.

The question over whether Feinstein conceptually agreed with brain death to be halakhically legitimate, is really a question as to whether one comprehends Feinstein's ruling as a successful translation of the determination of death from one paradigm, i.e. death by cessation of respiration, into another, i.e. neurological determination of death. In an interview with the Halakhic Organ Donor Society (HODS), Rabbi Feinstein's son, Rabbi Dovid Feinstein, says that his father said the definition of death is "cessation of spontaneous respiration." Dovid Feinstein refuses to further comment on whether it is halakhically correct or not to interpret this statement the way Moshe Tendler, Rabbi Moshe Feinstein's son-in law, outspokenly does: equating brain stem death with irreversible cessation of respiration. Orthodox rabbis who subscribe to neurological death, such as Rabbi Moshe Tendler and the Chief Rabbinate of Israel, feel that a proper analogy can be drawn.

To get to the core of the controversy, it is crucial to consider meta-halakhic aspects as key: Rabbi Daniel Gordis (see chapter three) claims that the adherence to precedents in the realm of contemporary medical ethics "destroys the meaning of the original case" and prevents consideration of the "new ethical agenda at hand" within the discursive context of the Orthodox brain death controversy. In responsa and statements, such as the one quoted by Rabbi Auerbach, it is evident that *haredi* authorities are well aware of the situational differences between ancient, Talmudic cases and present ones. It is usually the traditionalists themselves who dismiss the analogy, precisely because it is obvious that the precedent that seems to best fit the case, does not translate

[52] The RCA is the main rabbinical association within Modern Orthodoxy in the United States. Established in 1935 and after several mergers with other rabbinical organizations, the RCA today numbers approximately 1000 members worldwide. In addition to the goal of advancing the "cause of Torah and the Orthodox rabbinate," the council is the publisher of the scholarly journal "Tradition: A Journal of Orthodox Jewish Thought."

[53] Vaad Halacha of the Rabbinical Council of America, *Halachic Issues*, p. 42.

[54] Ibid., p. 55. Also, Feinstein, even before the Harvard criteria were published, ruled against the transplantation of hearts, a ruling that he has never revoked.

well enough. This is the reason why most *haredi* authorities do not go by the criteria of respiration and brain function alone. In Gordis' opinion this approach creates a "conservative stance" and thus misses the ethical agenda at hand (saving lives through organ donation)—at least from a modern scientific perspective. However, from a formalistic perspective, "ethical agendas" do not matter in halakhic decision-making. It is a matter of Jewish law, and thus a legal issue due to the self-referentiality of Halakhah. Hence, for *haredi* legal interpreters there is no *a priori* assumable translatability between the halakhic system and the ethical issue or agenda at hand. As discussed above, philosopher Hans Jonas addresses the issue of brain death and organ donation not from a religious perspective but rather an ethical one. While he does not "miss the ethical issue at hand," Jonas nonetheless dismisses the brain death criteria, feeling that it is used to legitimize organ transplantation. Therefore, it is not necessarily the precedent-driven approach or methodology that is a problem, as many non-Orthodox rabbis like Rabbi Gordis claim; instead, it is an issue of interpretive communities and paradigms.

4.3.2 Scientific Paradigms and Medicine

The back and forth "translation" between religio-legal and medical frameworks can cause inconsistencies. Such untranslatability of hermeneutical systems (ethics or law) is based on synchronic difference. However, untranslatability is also significant with respect to different paradigms, thus emphasizing diachronic difference.

In his comment on the passage in Yoma, Rashi uses a different Talmud edition as compared to practically all other important halakhic authorities of the time who comment on the passage. The word in Rashi's edition is heart (*lev*/*ad libbo* = up to his heart). But all other versions use the word navel instead of heart (*ad tibburo* = up to his navel). Daniel Reifman argues that the choice of the term *libbo* not only indicates the area of exposure of the victim, but also its purpose:

> We uncover the victim until the 'heart area' (i.e. the chest) in order to verify heart function. But a survey of instances of the term *libbo* in Tannaitic sources shows that in virtually every other context in which it refers to a part of the body (as opposed to a state of mind), it cannot plausibly be explained as having such a dual connotation: *libbo* is consistently used idiomatically to refer simply to the external chest area, with no connection to the heart organ that lies beneath.[55]

This conclusion questions the role of heartbeat altogether, since examining the chest area indicates the victim's respiration due to the rise and fall of the chest. Reifman concludes that premodern halakhic sources that address medical topics must be assessed in light of Thomas Kuhn's

[55] Reifman, "Rashi's Position," p. 12.

model of scientific paradigms.[56] The challenge in applying pre-modern halakhic texts to contemporary medical issues is that different paradigms are incommensurable, meaning that there cannot be a precise translation of terminology from one paradigm to another. For example, Rashi's reference to heart function cannot possibly resemble modern medicine's conception of heart function.

American *poseq* Hershel Schachter also addresses another meta-halakhic factor that impacts the relationship between medical knowledge and Halakhah. In a footnote to his claim that Maimonides lists three vital organs, i.e. the heart, brain, and liver, as those body parts (organs) without which a person cannot live, Schachter writes:

> It is irrelevant whether medical facts in the twentieth century support this conclusion, which is a legal, not a medical statement. Jewish law follows the principles laid down by the Talmud; all halachic categories have been fixed by the Talmud and are the basis for developing all further Torah decisions. Thus, those organs designated by the rabbis of the Mishnah as the 'vital organs' retain that halachic status. For a further discussion of this fundamental principle of development of Jewish halacha, see the Chazon Ish to Yoreh Deah (5-3).[57]

In his formal declaration, Schachter refers to the self-referentiality of the religio-legal system *ad extremis*: contemporary medical insights are irrelevant for the halakhic process. As a consequence, there is a gap between "medical death" and "halakhic death" to the extent that the latter completely ignores physical reality. Although one cannot live permanently without a liver, one may survive a day or two without one; thus, a person without a liver is dying, but not dead. Zev Farber takes issue with Schachter's rationale and concludes:

> First, although death is a process, and choosing a particular part of this process as 'the moment of death' is a legal/halakhic issue, the choice must at least be reasonable. To call someone without a liver dead seems more than a little unreasonable. Second, even if one were to accept the argument that halakha has absolutely free reign in determining death, it would seem that halakha does not function this way in practice.[58]

Farber's perspective values the halakhic process as a practice that does not ignore other scientific paradigms. The same perspective was the basis for the practical approach of the Israeli rabbis and physicians who performed the sheep experiments under the auspices of Rabbi Auerbach (see above). In contrast, Schachter's perception of medical science and its place in the halakhic process is irritating, especially considering the measures that his Israeli colleagues took in order to fully comprehend the medico-halakhic question at hand. A highly sophisticated collaboration

[56] Kuhn, *Scientific Revolutions*.
[57] Schachter, "Determining Death," p. 38.
[58] Farber, "Hershel Schachter on Vital Organs," p. 241.

between physicians, rabbis, and halakhic authorities came about to solve the halakhic death riddle. However, such experiments are clearly exceptional and usually do not constitute a part of the halakhic process; in fact, it was the only scientific experiment of its kind ever performed, and thus revolutionary. A halakhic approach that is open to empirical examination of a halakhic matter presents an approach very contrary to the formalistic methodology applied in the scope of halakhic self-referentiality. Contrary to Schachter's assertion, modern technology and the empirical world *are* relevant to halakhic decision-making, at least to other Modern Orthodoxy. This is evidenced by the latest position of the Rabbinical Council of America (RCA) on brain death criteria.

In 2008 the RCA's committee on issues regarding Jewish law, the Vaad Halacha, authored a 110-pages long report. This in depth-analysis entitled "Halachic Issues in the Determination of Death and in Organ Transplantation: Including an Evaluation of the Neurological Brain Death Standard," aims "to assist members of the RCA in the process of psak halacha and is itself not intended as a formal ruling."[59] Throughout the report the authors consistently argue against the adequacy of using ancient rabbinic textual sources to answer the question of brain death. Consequently, they reject the relevant texts in question as inadequate analogies. By quoting the White Paper of the President's Council on Bioethics where it states that "[...] reliance on the concept of 'integration' is abandoned and with it the false assumption that the brain is the integrator of vital functions,"[60] the report's authors base their main argument against the legitimization of brain death from a halakhic perspective on recent scientific literature. Any halakhic source that could be interpreted to support brain death criteria as halakhic death (e.g. rabbis Tendler and Linzer, or the Chief Rabbinate) based on the argument of "loss of somatic integration" is delegitimized by the authors on the grounds of natural science; or rather on the basis of scientific results used by medical brain death skeptics. This rationale is particularly noteworthy in light of the report's general stance regarding the interrelationship of science, ethics, and Halakhah:

> The halachic process has abiding respect for medical and scientific knowledge that reflects scientific research, methodology, and well-established conclusions. Indeed, we at the RCA's Vaad Halacha have, in recent years, followed precisely such an approach when ruling that the use of tobacco and smoking is forbidden, basing our ruling on the preponderance of scientific and medical evidence that conclusively established the life and health-threatening dangers of such activities. [...] But such abiding respect for the established findings of science and medicine does not extend to fundamental philosophical and ethical definitions and criteria of life, of death, or to the assignment of priorities in choosing

[59] Vaad Halacha of the Rabbinical Council of America, *Halachic Issues*.
[60] The President's Council on Bioethics, *Controversies in the Determination of Death*, p. 60.

> whose life to prolong. For such questions are not by any means in the exclusive domain of science, medicine or technology.[61]

While the Vaad uses a minority of scientists' opinion and their findings to legitimize their rejection of brain death (i.e. the function of the hypothalamus and the pituitary gland in brain death patients), they do not extend such respect for medical standards and definitions to the realms of life and death in general. Rabbi Charles Sheer, Modern Orthodox chaplain and author of biomedical literature highlights this inconsistency:

> And de facto all of those to the right of Rav Tendler, Rav Feinstein, who do not accept brain death, functionally they really do. Meaning, the cars that they drive, they're built upon an understanding of science that accepts all kinds of things and when you ask them 'Do you believe in this,' [brain death] they say 'Heaven forbid,' it's forbidden according to the Halakhah. When they go to the doctor, when their wives go to the doctor, their children, their grandchildren are born in hospitals, all of the concepts of how the body functions are based upon ideas that view neurological failure as death. The whole system of modern medicine accepts it. So technically, all of the folks who do not accept neurological death are living lives when which neurological death is accepted. And if God forbid one of their families comes to the hospital they will be treated by physicians who make certain assumptions that they really disagree with if they say the Halakhah says the following. Do you understand what I'm saying? (I: Mmh, mmh.) And sometimes when I say this in discussions, in rabbinic forums, you know, my colleagues get a little bit uncomfortable with that.[62]

Despite its "neutral" intention to assist halakhic decision-making, the study clearly evolves and settles with what could be called "a position." The report's conclusions clearly reject a neurological "brain death" standard. This is surprising because the RCA Executive Committee took a positive position on brain death in a brochure entitled, "A Torah Perspective Regarding the Health Care Proxy," authored by Rabbi Moshe Tendler in 1991. There it reads: "In accord with the ruling of Harav Hagaon Moshe Feinstein zt"l and the chief rabbinate of Israel, brain stem death together with the other accepted neurological criteria fully meets the standards of halacha for determining death."[63] This pronouncement corresponds to the wording of the United Determination of Death Act (UDDA, 1981). If the 2010-report is to be trusted, then the RCA's Vaad Halacha[64] never endorsed the brochure. In fact, the Vaad issued a responsum in August 1991, regarding the brochure, therein rejecting both permanent cessation of spontaneous respiration and brain death as criteria for determining death. These inconsistencies indicate "a major rift"[65] between the organization's

[61] Vaad Halacha of the Rabbinical Council of America, *Halachic Issues*, p. 9.

[62] Interview with Rabbi Charles Sheer, 10.6.2010, Westchester, New York. Quotation at time stamp #00:40:45-4#.

[63] The Health Care Proxy, appendix C.1. See also interview with Rabbi Charles Sheer, 10.6.2010, New York. Quotation at time stamp #00:57:57-7#.

[64] See Vaad Halacha of the Rabbinical Council of America, *Halachic Issues*, p. 10.

[65] Sheer, "Tora U-Madda and Brain Death," p. 350.

Executive Committee and its Vaad Halacha to the extent that "much confusion and even ill-will surrounded this issue."[66]

4.3.3 Interpretive Communities

The outcome, of course further complicated by additional sources and commentaries, is the existence of two halakhic realities, not compatible with each other. On the one hand, brain death is halakhically accepted death and the inability for spontaneous respiration is the only factor necessary to declare a person's death if the brain stem is irreversibly damaged. Consequently, organ donation by a brain-dead donor can be encouraged. On the other hand, brain death is refuted and not accepted as halakhic death because the heart is as much an indicator for life as human respiration and both have to cease in order to accept a person's death. To explant an organ from such a patient is considered murder or even "bloodshed" by some of the most influential rabbinic authorities in the debate like Rabbi Elyashiv.[67]

The Orthodox brain death controversy shows how the production and governance of knowledge, both scientific and religious knowledge alike, depend on processes of legitimization within a specific interpretive community. Text interpretation, premises about sovereignties of certain fields of knowledge, and authority-oriented understanding of community are heavily intertwined. Decisions, to be made for example by a *haredi* Jew, happen in a certain interpretive community, which is ruled and regulated by halakhic authorities and rabbinic leaders whose decisions are respected and followed. Thus, as literary theorist Stanley Fish notes"interpretive activities are not free, but what constrains them are the understood practices and assumptions of the institution and not the rules and fixed meanings of a language system."[68] The existence of these two halakhic realities show that trust in the uncertainty of the dying process as well as in the medical determination of death are both legitimate options within the same religious normative framework. The history of these two halakhic realities, as they co-exist today, lead to major struggle within the Orthodox community. Politics also must be taken into account when understanding this struggle that involves religious as well as medical truth claims. In Israel, brain death and organ donation are strongly intertwined with different *piskei halakhah*, from various rabbinic authorities within the *haredi* sector, and the Chief Rabbinate. The latter unanimously affirmed in 1986 that brain-stem death, including irreversible cessation of spontaneous respiration, constitutes death.

[66] Vaad Halacha of the Rabbinical Council of America, *Halachic Issues*, p. 10.
[67] See Abraham, *Medical Halachah vol2*, p. 308.
[68] Fish, *Text in Class*, p. 306.

The practical consequences of these different halakhic realities will be described below in more detail. Interviews with Israeli rabbis employed in hospitals show how, on a practical level, both halakhic realities, after decades of controversy, continue to co-exist today. Rabbi Doron Blaufarb (p) repeatedly says, "There are great rabbonim on both sides," indicating the social aspect of halakhic decision-making[69] by of acknowledging that there are different interpretive communities that seek out the advice of one or the other religious authority—and stick to it. Though it is especially difficult for Ultra-Orthodox Jews to acknowledge social forces or any social scope in halakhic decision-making, according to Waxman, the process of seeking out and receiving halakhic advice is an utterly social one. The brain death controversy in Jewish Orthodoxy is a clear example of this point: It shows, in a nutshell, how the production and governance of secular (including medical) and religious knowledge alike depend upon processes of legitimization within specific interpretive communities.

4.4 Reform Judaism's Take on Brain Death

In contrast to Orthodox Judaism, the Reform Movement has not seen such controversy. In fact, there are no Reform responsa that explicitly deal with brain death as an issue in its own right. There exist responsa on euthanasia, Alzheimer's disease, palliative care and many more; but not a single one is dedicated specifically to the question of whether brain death is to be identified with the death of the person from a liberal Jewish or "progressive" halakhic perspective. The reason for this is rather simple. Since the publication of the Harvard criteria, Reform Jewish rabbis and scholars have accepted the neurological determination of death as a medical fact.

As evident from the interviews with Reform rabbis and chaplains, this acceptance is based on the conviction that regardless of performed tests, the determination of death is solely a medical decision. While Orthodox brain death proponents accept the criteria due to strong halakhic evidence and the existence of an interpretive community in support of it, Reform Jews accept the criteria because medical science is entitled to determine it. Rabbi William Cutter supports this premise by observing that "many liberal thinkers are probably willing to relinquish specific decisions to those who understand contemporary scientific empirical evidence. Their medical decisions are likely to determine the decisions of the modern liberal. While liberals may applaud certain absolutes in the interest of preserving a sense of traditional value and stability, these more

[69] This is an integral part of a not yet well researched concept that sociologist Chaim Waxman named "the sociology of psak." See Waxman, "Sociology of Psak."

nearly absolute norms probably will not be applied in the experience of the sick room unless they make scientific or economic sense."[70]

This conclusion is further supported by Rabbi Salomon B. Freehof's responsum on surgical transplants, written in 1968, the year of the publication of the Harvard criteria. The responsum basically rehashes Rabbi Moshe Feinstein's ruling that post-mortem (after cardiac arrest) retrieval of organs does not constitute *hana'at ha-met* (benefit/satisfaction from the dead). It further states:

> There are serious discussions today among doctors—especially with regard to obtaining organs for transplanting without delay—as to exactly when the potential donor is to be considered actually dead. At first the rule was: when the heart has stopped beating. Now they are considering a further test: when the brain stops functioning. As the discussion in medical circles continues, they will devise more, and even stricter tests. As far as deciding when the potential donor is actually dead, modern scientific opinions are much stricter than Jewish tradition. The controversy arose a century ago as to whether the Jewish law of immediate burial was too hasty an action or not. Various governments in central Europe decreed that there must be a delay of three days before the burial. The great Hungarian authority, Moses Sofer, defended the Jewish custom of immediate burial (on the same day) and said that our traditional judgment, embodied in the knowledge of the Chevra Kadisha, was sufficient proof of death. Let us therefore say at the outset that—at least according to the spirit of Jewish law—the stricter the test as to the time of death which physicians will arrive at, the better it is. We therefore agree with the strict judgments of modern medicine that it must be absolutely clear that the patient is dead.[71]

Twelve years later, Freehof's successor as chairman of the CCAR responsa committee, Rabbi Walter Jacob, includes the Harvard criteria of death in his responsum on euthanasia. It discusses the case of removal of life-support from a comatose end-stage cancer patient. As it is the case with patients in futile situations, the question decides between two maxims: prohibition of hastening death versus avoidance of impediments that may prevent someone from dying. Within Orthodox discourse the question arises as to whether removal of an object that keeps a patient alive is killing or unnecessarily prolonging suffering, which is forbidden according to some *posqim*. Jacob instead tries to define "the turning point, when 'independent life' has ceased." In his opinion, the best way to do so is "by looking carefully at the Jewish and modern medical criteria of death."[72] After paraphrasing the most relevant sources in Yoma, the Shulhan Arukh, and responsa of the Hatam Sofer, Jacob concludes:

> We are satisfied that these criteria [Harvard criteria] include those of the older tradition and comply with our concern that life has ended. Therefore, when circulation and respiration only continue

[70] Cutter, "Rabbi Judah's Handmaid," p. 62.
[71] Freehof, "Surgical Transplants," p. 118.
[72] Jacob, *American Reform Responsa*, p. 272.

> through mechanical means, as established by the above-mentioned tests, then the suffering of the patient and his/her family may be permitted to cease, as no 'natural independent life' functions have been sustained. We would not endorse any positive steps leading towards 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.[73]

Jacob's responsum clearly indicates the Reform Movement's acceptance of brain death. It does so, even though the initial case outlined in the *she'ilah* (question) does not ask for such a statement and it is questionable whether it even answers the case under discussion. Since the *she'ilah* does not state whether the patient is comatose due to a brain tumor, ultimately leading to brain death, the *t'shuvah* (answer) is problematic. If a cancer patient who does not suffer from brain tumors lapses into a deep coma due to other factors than brain cancer, and no neurological determination of death performed, then, according to Jacob, life-support should not be removed. However, it is debatable whether a comatose and actively dying cancer patient, regardless of the presence of brain tumors, would receive a brain death diagnosis. The conclusion of this responsum is thus not applicable to discussing the removal of life-support or "euthanasia" of cancer patients who are on life-support and actively dying.

4.5 Opinions and Experiences of Rabbis Involved in Brain Death Decision-Making

4.5.1 The Status of a Brain Dead Patient

Asking whether brain death constitutes death in Judaism frames the issue as a dichotomy of either yes or no. When the answer is "no," then such an individual is considered alive. However, analysis of the deliberations and statements of rabbis and chaplains interviewed for this study provides varying descriptions for the "status" of someone who is brain-dead. These descriptions roughly translate into three "categories:" The first category equates a brain dead patient with a dead person. The two other categories include opinions that do not acknowledge brain death as halakhic death. The second category is affirmative in its stance that brain-dead individuals are halakhically considered alive. Nevertheless, these patients are understood to be actively dying and therefore do not warrant further medical treatment or heroic measures. The third category comprises the most extreme opinion on the spectrum: that brain-dead individuals are fully alive and

[73] Jacob, *American Reform Responsa*, pp. 273–274.

therefore warrant the administration of full medical treatment. These categories are rooted in the various *posqim*'s rulings on the matter and each perspective implies different medical care as well as halakhic consequences.

All Reform rabbis accept brain death as a medical fact that does not need further legitimization by religious sources. Likewise, Orthodox brain death proponents who accept neurological death as halakhically identifiable with the death of a human being as a whole, clearly describe a brain dead person as "dead." However, the question remains how "alive" do rabbis in the latter two categories consider brain-dead patients to be? Interviewees use various terms to describe the condition of a brain-dead patient. Some use halakhic terms, while others give descriptions in English. Some rabbis in category two believe that the status of a brain-dead individual is actually indeterminate. Rabbi Auerbach considers such a person to be *safek goses safek met*, doubtful actively dying, doubtful dead. Similarly, Rabbi Schachter claims a brain-dead individual to be *safek hai safek met*, doubtful alive, doubtful dead. Rabbi Lapin, a rabbi with a medical degree who leads a Modern Orthodox congregation in one of the Boroughs in New York and whom other pulpit rabbis and chaplains consult with on bioethical issues, shares the latter position:

> I would say my opinion about brain death would be, which is the opinion of some of the *posqim* including some of my *rabbim*, one of my *rabbim* in particular, that brain death is really an indeterminate halakhic status, it's what we call a *safek goses*, it's a question whether the person really is dead, whether the person is still alive or perhaps the person is a *goses*, the person is imminently dying but not yet dead.[74]

Similarly, two Brooklyn based *hasidic* chaplains describe the status of a person with irreversible loss of all brain functions as "half dead, half alive" and "not a 100% dead" respectively: "There's no question about it that brain death is a certain level of death. We're not saying that's not death, but what we're saying is, it is not a 100 percent dead."[75] Rabbi Frank also believes that the Talmudic category of *shkhiv mera* (שכיב מרע) best describes the situation of someone who is brain-dead:

> I wouldn't say a brain dead is a *goses*, because a *goses* is someone who is unstable. Once a patient is stabilized he is not considered a *goses*. He's stabilized. The problem with a *goses* is, that because by a little touch you can cause him to die. In this situation you're not gonna cause him to die by whatever you do on him. You're not causing him to die, so he probably is what we would call *shkhiv mera* [deathly ill person]. He is destined to die, this person, because he's very very sick. That yes, but not *goses*.[76]

The traditional understanding of a *goses* is indeed that of an actively dying person who is likely to die within 72 hours. In bT Semahot and in the Sefer Hasidim a *goses* is compared to a flickering

[74]Interview with Rabbi William A. Lapin (p), 3.6.2010, Queens, N.Y. Quotation at time stamp #00:11:22-8#.
[75]Interview with Rabbi Gabriel Frank (p), 1.6.2010, Brooklyn, N.Y. Quotation at time stamp #00:14:53-6#.
[76]Ibid. at time stamp #00:20:56-0 #.

candle that is about to extinguish at any minute. Since the state of a brain dead person, or any patient on life-support in an ICU, does not resemble the natural dying process of a *goses*, most interviewees suggested that this traditional category is not applicable to the new context.

Even though organ donation is not permitted before cardiac arrest, the rabbis of this category believe that a brain-dead patient's condition is irreversible and no heroic measures should be taken to keep him or her alive. Rabbi Shlomo Zalman Auerbach previously permitted disconnecting a respirator from a brain dead person, representing an act of removing an impediment to dying.[77] This view, however, is not prevalent among the rabbis interviewed for this study. In contrast to those who accept brain death, the rabbis of this group do not advise the withdrawal of respirators, since it constitutes an action understood as hastening death:

> I think one can say this fairly certainly, I think that someone who is brain dead is a *goses* at very at least, someone is actively dying, then one doesn't have to be aggressive in maintaining a person's vital signs. One wouldn't necessarily have to use vasopressors to maintain the blood pressure [...] I'm not kind of issuing a decision about any particular treatment, but the general approach would be that one wouldn't have to be as aggressive in treating if somebody's a *goses*. One perhaps could not withdraw actively, let's say a ventilator, but one wouldn't necessarily have to provide aggressive care. Certainly, somebody who's brain dead, I think, should be a DNR at the very least, do not resuscitate for sure, but that would be an opinion.[78]

Likewise, the only American *poseq* interviewed for this study, Rabbi Yisroel Belsky (1938–2016), the *haredi rosh ha-yeshivah* of Yeshiva Torah Vodaas in Brooklyn, believes that life need not be restored in a brain-dead patient and active steps need not be taken to prolong the agony of a patient in such a state. He emphasizes that there is a balance to keep: not to destroy the life that is still there, but also not to try to restore that life:

> The attitude is, if there's brain death we won't restore the life after it, just, he's not viable, by getting the heart to beat again, by getting the lung to operate again through tubes, intubation, there's no intelligent life, there's no activity of life or communication. You won't do anything to restore the life but you won't destroy that life. So that if you have a person whose heart can be retrieved for a heart transplant and you wanna extract it while that person is alive (.) you will never do that. You'll do that only after a person, you know, is physically gone.[79]

It is evident that Rabbi Belsky's position is rooted in his understanding of Rabbi Moshe Feinstein's opinion. As described above, Feinstein's responsa are subject to dispute and used in support of either rejection or acceptance of brain death:

[77] Steinberg, *Encyclopedia of Jewish Medical Ethics*, p. 701.
[78] Interview with Rabbi William A. Lapin (p), 3.6.2010, Queens, N.Y. Quotation at time stamp #00:13:27-3#.
[79] Interview with Rabbi Yisroel Belsky/1„ 25.6.2010, Brooklyn, N.Y. Quotation at time stamp #00:10:00-1#.

> What Rabbi Feinstein said is crystal clear, but it's very easy to take a response that's a couple of paragraphs long and pick out those few sentences to favor my position. You can't do that because, what he said was that the person is not dead if the brain ceased functioning but there's no purpose of restoring life to a patient like that. Like I said, you don't do anything to restore life, you don't reactivate the kidney, you don't reactivate the heart, you don't reactivate the lungs, that's it, you let it go and follow its natural course, but you can't destroy the life that there is.[80]

Thus, most rabbis would recommend to stop treatment, but not to withdraw the respirator. Rabbi Yosef Ungar, a chaplain at a major hospital in Manhattan accompanies many families during or after declaration of brain death. When a family concludes that their brain-dead family member is still alive, he uses the practical implications of Rabbi Moshe Feinstein's *p'saq* to guide his counseling: "Your rabbi says that brain death is you're still alive, ok, Rabbi Feinstein says we can take away the blood pressure support, we can take away hydration and nutrition etcetera and let the patient die. That's kind of how I counsel."[81] Further difficulties that arise in such a situation pertain to the differences of opinion within the family regarding the status of the patient. As a chaplain he provides specific information to guide the family through the halakhic process and often serves as a go-between family members:

> You have the same man, you've got son-in-laws and sons arguing about what the father said. So, basically at that point of time when someone is surely brain dead, you can take away medications and then let the patient die. The question is, can you take away the ventilator or not. So, those who follow Rabbi Tendler say you can. Those who follow Rabbi Feinstein's son-in-law [Rabbi Tendler][82] say you can, those who follow Rabbi Feinstein's son [Rabbi Dovid Feinstein] say you can't. But usually if you take away the medications, then the heart is gonna stop anyway and then you don't resuscitate, so usually, it's usually resolved itself.[83]

While brain death proponents feel that ventilation of a brain-dead individual is equal to "pumping air to a dead body," there is an even stricter halakhic ruling regarding the medical procedure after the neurological determination of death. The third category includes rabbis who consider such a person to be fully or completely alive. The Israeli *poseq* Rabbi Yosef Shalom Elyashiv, the former *haredi* authority behind Shaare Zedek Medical Center in Jerusalem, holds this position. Due to Elyashiv's long lasting impact on *haredi* society, this view is prevalent among Israeli *haredim*. According to his ruling, everything must be done to keep this person alive until his/her

[80] Ibid. at time stamp #00:12:14-9#.

[81] Interview with Rabbi Yosef Ungar (p), 1.6.2010, Manhattan, N.Y. Quotation at time stamp #00:28:09-8#.

[82] Ungar refers to the position of Rabbi Tendler twice. In the oral statement the embedded clause "those who follow Rabbi Feinstein's son-in-law" is easily comprehensible, but textual logic would suggest that another (opposing) view is presented, which is only the case in the next clause (Dovid Feinstein).

[83] Ibid. at time stamp #00:27:04-3#.

heart stops. Rabbi Doron Blaufarb who is the hospital rabbi at one of the four religious hospitals in Israel, describes the difference between the approaches of the second and the third categories:

> According to certain *rabbonim* he is a *goses*, a *safek goses*, according to Rav Elyashiv he's *hai lekhol davar* (חי לכל דבר), he's alive, he's alive and you do everything for him, including on Shabbes. According to Rav Elyashiv he's not a *safek goses*, he's חי לכל דבר and his words are: 'If you kill him'—*shfihut damim*' (שפיחות דמים), *shfihut damim* is spilling blood. There are *rabbonim* who consider him, Rav Shlomo Zalman Auerbach considered him a *goses*, yes, but Rav Elyashiv holds him חי לכל דבר and he's alive and that's how he has to be treated.[84]

Such treatment includes the administration of medication, nutrition, and hydration. The category of "completely alive" also corresponds with the medical practice of the other religious hospital in Israel that was visited for this project. Tvzi Weinheimer describes the hospital's policy regarding brain death and medical care of a brain-dead individual with reference to the Hatam Sofer:[85]

> 'Cause, the truth is like this: Death in the brain, it doesn't say any place [in the sources]. What it says in our scripts is that only breathing, in the Torah it says that a person is considered alive when he can breathe. *Neshamah* which means a soul is a *neshima*, is a breathing, that's why, that's why the thing which really counts is the breathing. But since, since they have the, you know, the artificial breathing, so that criteria is not so relevant anymore because somebody cannot breathe and he can live afterwards a few years. So, therefore what most of the big rabbis say is that only if there are no signs of life anymore, then we know he is dead, which includes brain death, breathing, the nerve system and if there's any pulse. If there's any pulse one of the great rabbis two hundred years ago (I: Which one?), Hatam Sofer his name was, he says '*kol z'man*,' we never, till there's pulse, the heart is working, the person is considered alive. Whatever happens he is considered alive. So, and that's what we do, we practice that over here, you know, and even if people come here with brain death they get the full treatment, they get food, they get oxygen and everything until the heart stops.[86]

In contrast to Israeli *haredim*, New Yorkers do not seem to relate much to this category. New York *haredi* rabbis also explicitly state that they consider a brain-dead person alive, but they do not mention taking such measures as described if one goes according to the practice of *hai lekhol davar*, completely alive.

Rabbis' perceptions of the status of a brain-dead individual and his/her medical support range from completely dead to completely alive. This gamut highlights the diversity of existing Jewish approaches in practice and strengthens the argument that there is no single normative Jewish

[84]Interview with Rabbi Doron Blaufarb (p), 25.5.2011, Israel. The hospital demanded that neither the interviewee's nor the hospital's names be disclosed. Quotation at time stamp #00:49:42-2#.

[85]Find the alternative interpretation of Sofer's responsum on this issue above in Rabbi Dov Linzer's statement.

[86]Interview with Rabbi Tzvi Weinheimer/2 (p), 20.6.2011, Israel. Quotation at time stamp #00:11:04-7#. There are only four Jewish religious hospitals in Israel: Due to Blaufarb's request for anonymization, Weinheimer's name is anonymized too.

view on the time and determination of death. Presenting Jewish notions of death must take into account a variety of approaches and normative opinions, some of which are based on religious sources and some relying on scientific results. Furthermore, the above classification indicates a major difference between Israel and the United States. There is a greater range of opinions with respect to the status of a brain-dead individual within Orthodoxy in the former versus the latter. In Israel, the widespread adoption of Elyashiv's stance creates an extreme position against brain death, while the Chief Rabbinate traditionally holds a strong position in favor of the neurological criteria of death. This dynamic reality, influenced by medical technology, the media, legal regulations, and public discourse, impacts the opinions and professional role of rabbis in both nations. Their positions and experiences constitute the object of interest in the following sub-sections.

4.5.2 Interpretive Communities and the Rabbinic Opinion on Brain Death

The rabbis interviewed for this study tell many stories, sharing multiple impressions and experiences. Their accounts of brain death include their rabbinic opinion and often their personal position on the matter. As apparent from the rulings of major *posqim*, there is a spectrum of approaches and interpretations to consider as well as many medical, psychological, social, and halakhic subtleties. In addition to rabbis' positive or negative opinions of the brain death standard, it is particularly important to appreciate the weight of their normative voice and opinion. The following results reflect rabbis' statements and experiences with brain death cases in relation to the speaker's authority and his/her place in the professional network.

Interviewees who speak with ease and a decided voice are the easiest to comprehend. They either state that yes, brain death *is* death or no, it is cardiac death that constitutes death. There is no hesitancy in their statement, since they are completely convinced of their position. It is interesting that regardless of position, both groups provide normative statements. It is a matter of truth for them, a decided issue that does not trouble them. Thus, it constitutes the basis for their knowledge and professional practice. Their accounts and way of stating their position is firm and well-embedded in their interpretive communities' normative realm. However, there are differences with respect to grounds of justification and the speaker's role and place in the religious hierarchy as well as their halakhic loyalty.

Regardless of national and religious context, the largest group of the sample interviewed unequivocally states that brain death is death.[87] This category is large due to its combined composi-

[87] This group entails only those who state their position or opinion clearly. We will later deal with those whose account and argumentation is suggestive due to the speaker's uncertainty regarding the concepts and professional

tion of all Reform rabbis and some, primarily Israeli, Orthodox rabbis and chaplains. The group consists of twenty interviewees. The primary difference between these Reform and Orthodox rabbis lies in their grounds of justification for their normative stance. The former consider brain death to be a medical decision alone, since neither Halakhah nor other philosophical arguments play a role in their considerations. In accordance with Reform *posqim*'s approach, these rabbis acknowledge that death determination is conceptually and practically part of the medical profession. While they may consult with senior rabbis or rabbis from the responsa committee on certain complicated and bioethically difficult issues, e.g. patients in a persistent vegetative state, they are not concerned with the concepts and time of death. Pulpit rabbis in both countries unequivocally share that they are certain that the neurological determination of death is death of the human being. Using the words of chaplain Ellis Benda: "So, if one of those, the up here [head/brain] or the in here [heart], if one of those is not functioning or not alive, then that means that the person is dead."[88] Consequently, these rabbis usually are not contacted in a brain death case. They may be involved in the aftermath of the tragic event, the spiritual support of the family, but they do not interfere with the clinical aspects of a medical case. Rabbi Robert Greenspan, a Reform rabbi in New York city expressed his involvement as follows:

> In practice, I accept whatever the doctors in the hospitals say. I walked into a hospital a few months ago, literally three minutes after somebody was declared dead. It was enough for me, and he was brain dead for two days before, ok. It was enough for me to hear from the doctors that this person died.[89]

While such practice seems straightforward, it remains challenging for all parties involved in a case where neurological determination of death occurs. Rabbi Richard Address, who served the URJ's Department of Jewish Family Concerns as its founder and director for over thirty years, concisely describes the gap between theory and practice:

> Over the course of my career, and the Liberal Movement has accepted the so called Harvard definition of death or the popular name is brain death, for decades. (..) But that does, but the acceptance of it, this is where the difference is, the acceptance of it in an academic level and the practical application of it when it's your loved one in that room that's different. It's a lot easier to sit in an academic conference and say 'Oh yes of course that makes sense;' it's a lot different when it's your sister lying in that bed and your natural inclination is to do everything possible; and that's where the role of the rabbi comes in, and that's where the role of the pastoral counselor comes in, of really trying to walk a family. That's why I go back to the family. For a family to do this walk is very difficult and it's very contextual and there's no time frame and there's no (.) there's no template, that's why every situation

inexperience. Similarly, this group does not include those who are undecided on the matter or think that their opinion is irrelevant.

[88]Interview with Ellis Benda/1 (p), 3.6.2010, Manhattan, N.Y. Quotation at time stamp #00:52:17-3#.

[89]Interview with Robert Greenspan (p), 12.5.2010, Manhattan, N.Y. Quotation at time stamp #00:43:45-6#.

> and every case has to be judged on its own level. That's why the, that's why the advanced directives are important, that's why the power of attorney for health care is important. We created a whole book for the Movement just on that.[90]

American Reform rabbis typically give emotional support and assist families with their decision-making. They guide them "as they move toward decision-making."[91] American rabbis from both denominations included in this study often highlight the importance of discussing and signing advanced directives, living wills, and health care proxies. In contrast, their Israeli counterparts do not mention such formal healthcare precautions. Among the Israeli Reform sample, Rabbi Mia Oppenheimer is the only one who discusses a brain death case in which she was actively involved. She describes how she gave her "consent" to remove the patient from life support, indicating a more directive and not solely supportive role:

> I did have one case (.) where I was asked, when the *geza ha-moah* (גזע המח) was hurt (I: Ah, the brain stem). I think it's called, the *geza ha-moah*. And I was the only one next to the family and again the decision was that there was no sense in pumping, in keeping the person alive artificially and that he did not want to be kept artificially, but as long as he could, as long as his body sustained itself they wouldn't touch him. But ahm, he could have been kept on machines for months and they gave permission with my (I: Who was 'they?'). The family. With my consent and my encouragement to not prolong his life in vain. And it was, he was, it was done, yeah. And not an old person, he was 67. He just went in, got his pension and was dreaming of, yeah, sad, very very very close family to the congregation.[92]

Orthodox interviewees who firmly accept the brain death standard mostly work in a clinical setting, but none are *haredi*. Rabbis of the Israeli sample are all experts on medical Halakhah and deeply involved in practical decision-making. Medical Halakhah is Rabbi Shafran's and Steinberg's area of expertise, and Rabbi Cherlow, a *dati leumi* rabbi from Petach Tikva is a member of several ethics committees and involved in numerous projects of bioethical relevance:

> [...] My opinion in general is that the Halakhah doesn't contradict science, and the question if a person has died or didn't die is not a rabbinical question, it's a medical question. And when the scientists say that when the, there's brain death, it's a complete death without any exceptions of going backwards and so it's not reversible, yeah, so therefore I don't see any reason why shouldn't the Halakhah accept it.[93]

Cherlow uniquely aligns Halakhah with science. This deeply contrasts with the many tales and stories that brain death opponents adduce to express unease with medical practitioners or their

[90] Interview with Rabbi Richard Address/2, 23.6.2010, Manhattan, N.Y. Quotation at time stamp #00:19:21-8#.
[91] Interview with Rabbi Bryan Epstein (p), 25.5.2010, Brooklyn, N.Y. Quotation at time stamp #00:30:19-3#.
[92] Interview with Mia Oppenheimer (p), Jerusalem area, 24.5.2011. Quotation at time stamp #00:37:33-3#.
[93] Interview with Rabbi Yuval Cherlow, Petach Tikva, 13.6.2011. Quotation at time stamp #00:20:31-2#.

mistrust of the medical establishment. For example, a Chabad rabbi in New York City opines that "generally medicine leans towards the idea of brain death, that when the brain ceases to function the person's considered dead and Halakhah generally does not accept that. Now, and it's a problem, because besides the monetary think, the hospitals wanna move people out of there, which is very uncomfortable."[94] This contrasts with medical Halakhists in Israel, whose expert knowledge, authority, and position within the professional network affects the way they communicate their opinion and guide patients and families. All unequivocally state that brain death *is* death; Steinberg and Shafran worked closely together with those halakhic authorities who, decades ago, decided on the subject matter. Israeli rabbis are experts on the topic, in theory and practice, and have the professional experience and the necessary credentials to state their opinion.[95] Rabbi Steinberg uses his position on the matter to counsel families in cases of brain death:

> So, if I'm asked by a family: 'Should we go through the brain death diagnosis and should we donate organs?' So I tell them: 'Depends after whom you go. If you go according to the Chief Rabbinate or to Rabbi Feinstein or those *posqim* that agree to brain death, then it's very advisable to do it because you are saving lives.'
> I: And can they decide by themselves who they would follow?
> Avraham Steinberg/2: No, I'm asking them 'Who are you?' Usually when you have a question, who do you go to? Because on any other question there is also differences of opinion. So how do you choose your rabbi, your *poseq*? If they know how to choose, then I tell them according to what you chose his position is for or against, because we know usually what the major *posqim* have said on these issues. If the person says 'I don't have any one specific that I go for and I don't belong to any poseq specific,' and so I'm telling him 'If you want my opinion, I'm telling you, yes, if you want a different opinion, the answer is no,' and then he can choose between my opinion, if he asked me, he can choose my opinion or someone else's which is legitimate. So that is how we solve it on an individual basis. The hospital does agree to do the testing for brain death, so if I do the testing and I diagnose that a person is brain dead, now it's up to the family to decide if they want to donate or not. If they don't want to donate then we just wait for the heart to stop and it goes to burial. If they want to donate then we move the body, because from my understanding it's a dead person, right? So we move the body to another hospital that does organ recruitments and they take out the organs if the family agrees. So, I think it's a good solution.[96]

Steinberg is one of the most revered experts for medical Halakhah in the clinical context. His role description elucidates some aspects of the social process of *p'saq*, or, more general, the sociology of *p'saq*, as was conceptualized by Chaim Waxman.[97] Similar to the job description of healthcare chaplains, the main goal is to find the best solution for the family and patients. In order to

[94] Interview with Mendel Salomon/1 (p), 28.5. 2010, Manhattan, N.Y. Quotation at time stamp #00:29:26-4#.
[95] Rabbis David J. Bleich and Moshe Tendler are comparable figures within the American context.
[96] Interview with Rabbi Dr. Avraham Steinberg/2, Jerusalem, 9.8.2016. Quotation at time stamp #00:05:06-9#.
[97] See Waxman, "Sociology of Psak."

accomplish this, Steinberg first must determine the family's religious identity in order to provide them with the appropriate advice. Due to the decentralized structure of Orthodox Judaism, observance of the decisions made by a specific halakhic authority constitutes an important part of such religious identity.

In contrast, chaplains, even if they are ordained rabbis, usually do not share their opinions or views with patients or families (or interviewers). Instead they help sort out a course of action that is best for the patient's well-being or assist family members with decision-making. This is why many of the chaplains interviewed for this study claim that their opinion is irrelevant. They understandably keep up their professional persona, because they define their mission in the hospital to be one of service to the patients. They maintain that patient-centered care and support for families, and sometimes staff, does not require their personal opinion. In fact, doing so may even be obstructive. While some chaplains share their personal view and qualify the relation between their private and professional self, some prefer not to do so. Of those who share, two Reform chaplains reveal that they support the brain death standard because they believe it is a medical decision. In contrast, *haredi* Doron Blaufarb, who is employed as the official hospital rabbi at the same hospital as Steinberg, opposes the brain death standard:

> My personal position is irrelevant what I hold of brain death. There are some very great people on both sides, (..) very great *rabbonim*, *choshuv rabbonim* [engl. important rabbis] even though I'm a *talmid* [student/follower] of Rav Elyashiv, but there definitely are important *rabbonim* on the other side, it's not only the *rabbanut ha-rashit*, there are other *rabbonim*.[98]

Only Orthodox rabbis believe irreversible cardio-pulmonary arrest is the correct time of death. Roughly half firmly state that brain death is *not* considered death. Most directly formulated by Edgar Ganzfried, a healthcare chaplain at a major hospital in New York City bluntly says: "[...] I will be very straight forward with you (.) the truth of the matter is, brain death is not death in Judaism, it's just not [...]."[99] He insists on the veracity of his position, deeply convinced that it constitutes the majority opinion in Orthodox Judaism. Rabbis who reject the brain death standard from a halakhic perspective often legitimize their position by referring to the majority opinion of the most important rabbis in the world. For example, Rabbi Vilner, a Modern Orthodox rabbi on Manhattan's West Side, explains that he subscribes to the wider camp, the "more mainstream opinion"[100] which holds that "prior to that time [cardiac death] we can't say someone is dead."[101] Similarly Ganzfried says:

[98]Interview with Doron Blaufarb/1 (p), 25.5.2010, Israel. Quotation at time stamp #00:51:08-1#.

[99]Interview with Rabbi Edgar Ganzfried/1 (p), 27.5.2010, Manhattan, N.Y. Quotation at time stamp #00:31:42-9#.

[100]Interview with Rabbi Paul Vilner (p), 27.5.2010, Manhattan, N.Y. Quotation at time stamp #00:20:30-7 #.

[101]Ibid.

> You know, again, there is a difference in opinion, but I will say, and I have the utmost respect for Rabbi Tendler and I won't ever come to his heels even, but he is not the only *gadol*, the only great rabbi in Israel[102] that says that. If you go to, around the world, if you ask Rav Elyashiv in Yerushalajim, if you ask Rav Tuvia Weiss of the Eda Ha-Haredit in Yerushalajim, the head of the *beis din* [rabbinical court] in Yerushalajim, if you ask, I can go down the list, the vast majority do not believe that brain death is brain death and it's, it's an overwhelming majority and it's from the most *hashuve*, the most prominent *posqim* in the world, so, it's not even a close, that opinion [that brain death is death] is not even a close second, it's not even, again you will have people, they would argue with me possibly but I'm just telling you, in actuality, if you go where I live, I live in Brooklyn, I live in the area of, in Flatbush, in Midwood, ok, and and this is all main Jewish, you will not, if you were to interview people there, maybe you'll get one person that will tell you brain death is is, you know, the vast vast majority will not, we do not hold, an Orthodox Jew, most Orthodox Jews, very very observant Jews do not believe brain death is death, end of discussion with that.[103]

Ganzfried's demographical summary is correct, including his assumption that maybe there is one person in Brooklyn who holds brain death as a halakhically legitimate form of death. This professional is an Orthodox chaplain who lives in Midwood as well and works in a major hospital in Brooklyn. In contrast to Ganzfried who justifies his decision by referring to the majority opinion of *posqim* on the matter, Rabbi Adonolem relies on Rabbi Moshe Feinstein's position when it comes to his personal opinion:

> There is some controversy with brain death. (..) I've taken the position of Rabbi Moshe Feinstein, he took the position that if (.) the part of the brain that controls breathing no longer functions, the person is dead. So, that I accept. I'm not gonna, why would I go against, who am I to go against him.[104]

Though Adonolem shares his personal position, he still maintains it is irrelevant to his work. The key task of chaplains and hospital rabbis is to determine the course of action towards which the family is inclined. Therefore, chaplains and professionals in the medical setting, such as Steinberg, always try to refer patients and family to the rabbis and religious network in which they are socially embedded:

> But I'll share that they should really speak this over with their (..) with their rabbis that they have or I can guide if they want. A lot, see, Sarah, a lot of things in life (.) it's not just Halakhah, it's also the emotional part, letting go, acceptance of terrible things, also very difficult for some religious families, they have a very hard time letting go.[105]

[102] With Israel he means the entirety of Jews, not the country.

[103] Interview with Rabbi Edgar Ganzfried/1 (p), 27.5.2010, Manhattan, N.Y. Quotation at time stamp #00:34:03-2#.

[104] Interview with Rabbi Benzion Adonolem/4 (p), 14.5.2010, Brooklyn, N.Y. Quotation at time stamp #00:09:26-3#.

[105] Ibid.

Adonolem's remark that besides the halakhic issues, a rabbi or chaplain has to deal with the emotional situation of the person involved, refers to the invisible line between job assignments of American chaplains who have a rabbinical degree and Orthodox pulpit rabbis. Both occupations encompass pastoral care and halakhic knowledge to a certain degree. Though, the pulpit rabbi or *rosh yeshivah* is not the most educated in pastoral care, the chaplain is not decisive in matters of complicated halakhic cases. However, as with Ganzfried, rabbis justify their positions by referring to the majority opinion of *posqim*. Rabbis also may legitimize their positions by referring to *only one* of the major *posqim* relevant within the halakhic discourse. Those who are involved in halakhic decision-making processes, especially if they are not high within the hierarchy, usually legitimize their opinion by naming *posqim* who are still alive. However, Rabbi Belsky names Moshe Feinstein, who is deceased, because he personally knew him:

> I've been in contact with all these, I was very very close to Reb Moshe Feinstein, to Rav Auerbach, we have a picture here up in the wall, I've known them and discussed things with them, anytime, personally, so you know, and time goes on, they would be well over 100 each of them. And that's the way, that's the way it goes, but it's not as if, you know, and you get to a certain point in life, your old men start to no longer be there to guard you.[106]

Most rabbis who are against the brain death concept from a halakhic perspective justify their positions by referring to multiple rationales. Sometimes rabbis state that they belong to the "camp" that goes according to "heart beat" or that their opinion is justifiable due to the majority opinion in Orthodox Judaism ("because of the rule in Judaism, we always go according to the majority"[107]). Yet they amend their statements by claiming that they did not choose this opinion, often clarifying that they follow their teachers' and ra.bis' position. This is how young as well as old, experienced rabbis express their halakhic loyalty. Rabbi Shalom Rabinowitz, who was never involved in a brain death case, accepts Rabbi Dovid Feinstein's position on the matter.[108] Rabinowitz states "that my opinion was not formed by my own understanding of that passage of the Talmud. It's an issue so vital and important that I defer to simply accept Reb Dovid Feinstein's position."[109] Rabbi Kagan, an experienced Chabad rabbi says, "I follow the opinion of, not that I decided though, senior rabbis of my predecessors that said that we have to go by the function of the heart."[110] Rabbi Katznelson, a Brooklyn based *haredi* rabbi in his sixties, shares that he discussed it with "my own rabbis and the conclusion they came to is beating heart."[111] He remembers

[106]Interview with Rabbi Yisroel Belsky, 25.6.2010, Brooklyn, N.Y. Quotation at time stamp #00:06:26-6#.
[107]Interview with Rabbi Doron Blaufarb (p), 25.5.2011, Israel. Quotation at time stamp #00:51:08-1#.
[108]Dovid Feinstein is Moshe Feinstein's son who is based on the Lower East Side of Manhattan.
[109]Interview with Rabbi Shalom Rabinowitz (p), 9.5.2010, Brooklyn, N.Y. Quotation at time stamp #01:09:37-2#.
[110]Interview with Rabbi Uriel Kagan/1 (p), 1.6.2010, Brooklyn, N.Y. Quotation at time stamp #00:09:25-1#.
[111]Interview with Rabbi Moshe I. Katznelson/3 (p), 26.5.2010, Brooklyn, N.Y. Quotation at time stamp #00:07:08-3#.

that this question came up many times in his rabbinical career and the "procedure that I follow, the conclusion that I followed"[112] is the halakhic opinion that only cardio-pulmonary death is halakhically legitimate. Occasionally, when he needs to discuss a case, Katznelson turns to Rabbi Belsky, his neighbor for over thirty years. He recalls the first time when he was involved in a brain death case:

> There was a young boy, who was a victim of a fire, was burnt very badly and was brought to the hospital and without asking the parents the boy was put on, intubated, so that it could help him breathe, his lungs were burnt. And at some point he became brain dead and the doctors wanted to unhook the breathing machine, so the parents asked me what to do. And so, at that point I discussed it with a number of rabbis in the community and based upon a number of sources concluded that as long as the boy's heart was beating we considered him to be alive and the parents could not give permission to unhook the life-support machinery. And we waited three days until the heart stopped [...] The parents waited knowing their child was technically dead for three days.[113]

It is noteworthy how Katznelson acknowledges that under these circumstances there is a difference between a medical (technical) and halakhic reality of death. According to the halakhic perspective, the child was still considered alive, even though he was "technically" dead. Both time markers, i.e. brain death and cardiac death, define a process that is identical with what Hans Jonas comprehended to be a minimal and a maximal definition of death.

Halakhic loyalty is a religious responsibility, stretching across time as well as distance. The issue of brain death exemplifies how halakhic loyalty serves the Orthodox community's strive for continuity. This phenomenon becomes evident during an interview with Rabbi Yigal Shafran, the director of the Jerusalem Rabbinate's Department of Medicine and Halakhah and his translator, Aaron D. Jachter, a young American Modern Orthodox pediatrician who received his education at Yeshiva University in New York and made Aliyah.[114] Rabbi Shafran acknowledges the brain death concept in theory and practice: he has been involved in the implementation of the religious standards regarding brain death as established in the Brain-Respiratory Death Act (2009; see below). Nevertheless, he emphasizes that both halakhic views have their legitimacy within Orthodox Judaism. Furthermore, Rabbi Shafran does not believe in converting firm adherents of one or the other halakhic position because both are legitimate options. He recalls when Rabbi Elyashiv voiced his respect for the Chief Rabbinate's approach:

> גם הרב אלישיב אמר ימה אני אעשה יש לכם שיטה שלכם, אני לא יכול להגיד שאתם מדברים שטויות, כי יש לזה בסיס, אבל אני סובר אחרת. זה כמו אביי ורבא בגמרא, יש שתי דעות לגיטימיות. לכן אני חושב שלא

[112] Ibid.

[113] Ibid. at time stamps #00:08:11-1# and #00:09:36-8#.

[114] Shafran had just given a ten part lecture series on the issue of brain death in Halakhah at a *shul* in Kiryat Moshe, a *dati torani* and *hardalim* neighborhood in Jerusalem. Dr. Jachter (p) had attended the class.

> צריך לעבוד לשנות את הדעות של אנשים הרב אלישיב. ששערי צדק ימשיך כמו הרב אלישיב, זה מצוין.—Also Rabbi Elyashiv said: 'What do I do, you have your own method, I cannot say that you talk nonsense, because it has a basis, but I think otherwise.' It's like Abbaye and Rava in the Gemara: there are two legitimate opinions. Therefore, I think it is not necessary to work to try and change the views of Rabbi Elyashiv's people. Shaare Zedek will continue according to Rabbi Elyashiv, and that's fantastic.[115]

Shafran then shares that Jachter agrees with the "cardiac death" position, due to his education at Yeshiva University: "אני אתן לך דוגמה מאוד טובה. הנה, עומד לפניך רופא שסובר שצריך ללכת לפי מוות לבבי." Jachter considers himself to be a very close student of Rabbi Hershel Schachter. Thus, it is due to halakhic loyalty that Jachter, a trained pediatrician, is submissive to the religious authority of the YU's *rosh yeshivah*:

> So, I try to do what ever Rav Schachter advocates and recommends, but I have great respect [for the rabbis who hold differently] [...] I think that there are very few people that have the magnitude to have an opinion on that matter. People like Rabbi Schachter have the right to an opinion, I don't have the right of an opinion. I am not a master of the Talmud, I am not a master of that level that I can have a different opinion. I studied many years in Yeshiva University, and that is why I follow Rabbi Schachter.[116]

Shafran describes Jachter's position as that of a physician who goes according to cardiac death. His "choice" is noteworthy because he bases his opinion on the majority opinion of his religious community and not on the majority opinion of his profession, i.e. the scientific community. Furthermore, he maintains loyalty to his American "rebbi," even though he is part of a different community in Israel. In many cases, *roshei yeshivot*'s special interest is not medical Halakhah and they might not take sides or have their own approach to the issue. But since Rabbi Schachter does and discusses it with his students, this paves the path for his followers to also go down. Regardless of later relocation, one always follows the way of his rabbi and teacher. Rabbi Shafran justifies such *k'vod ha-rav* (honor for the rabbi) and its importance for an individual's way of life in a Torah-observant community:

> זה הלכה, שאסור לתלמיד ללכת לבחור רב אחר אחרי שהוא למד ממנו את רוב התורה. הרב שממנו למדתי את רוב התורה הוא מחייב אותי לכל החיים. ולכן, אם אני למדתי מהרב שמוות מוחי הוא מוות, גם אם אני חושב אחרת אני אומר 'כנראה שאני לא מבין כי הרב שלי מבין יותר ממני והוא אמר שזה מוות מוחי', ואותו הדבר גם להיפך. אם הוא למד אצל רב שצבר רוב התורה שלו ואסור לאדם לומר דבר שלא כפי שלמד מדעת רבו שרוב התורה ממנו. זה לא כמו באוניברסיטה שאת שומעת הרצאה מזה והרצאה מזה ומזה. תורה זה לא רק לדעת, תורה זה אורח חיים, זה השקפה, זה חיים. ואני לא בוחר חיים אחרים ממי שבנה לי את החיים. תורה זה לא מדע. תורה זה גם מדע.—It is Halakhah that it is prohibited for a student to go look for another rabbi, after having learned most of the Torah from him. The rabbi from whom I learned most of the

[115] Interview with Rabbi Yigal Shafran and Aaron D. Jachter (p), 15.8.2016, Jerusalem, p. 12.
[116] Ibid., p. 13.

> Torah is binding for me for a lifetime. And so, if I learned from the rabbi that brain death is death, even if I think otherwise, I say 'I probably don't understand, because my rabbi understands more than me and he said it was brain death.' And vice versa. If he studied with a rabbi and accumulated most of his Torah from him, therefore a person is forbidden to say something that is not according to what he leaned from the knowledge of his rabbi from whom he learned most of the Torah. It's not like in the university where you hear a lecture from this [lecturer] and a lecture from that or that [lecturer]. Torah is not just knowing, Torah is a way of life, it's a view, it's a life. And I don't choose another life from the one who built my life. Torah is not science. Torah is also a science. [Translation by author][117]

Those rabbis who are considered to be contact persons, i.e. congregational rabbis, have set up a network of experts for the various fields of halakhic expertise, including medical ethics. This is true for the young and inexperienced rabbis as well as experienced ones who have served their communities for decades already. They either have a direct connection to *posqim* or contact a "middleman," someone such as Edward Reichman, William Lapin or Avraham Steinberg, who will refer them or the family in question directly to a higher authority, if needed. In Israel, rabbis employed by hospitals usually fill this role. And in the United States, chaplains may be a valuable source for halakhic referral, since they usually know the contact details and have access to relevant experts and religious authorities within the various Orthodox communities. However, of those interviewed for this study, a significant amount of younger Orthodox pulpit rabbis and some chaplains do not reveal their position on the matter. This unwillingness to comment on the matter questions not only the interrelationship of professional role and "private" opinion, but also the applicability of the concept of *k'vod ha-rav* and halakhic loyalty in practice—at least to a certain degree.

When asked whether they accept brain death as halakhic death several do not answer with a firm "yes" or "no." They do not provide a clear normative stance. This group consists of those who a) consider their "own" opinion so irrelevant that they do not reveal it; b) rabbis who allude to the camp with which they identify, but are ambiguous in their statements; c) those who think that they are not entitled to "have" an opinion due to their low rank within the religious hierarchy of halakhic decision-making and expertise; and d) those who are undecided on the matter.[118] All rabbis who are undecided, do not feel comfortable revealing their opinion, or think that it is not part of their professional role to have an opinion, are Modern Orthodox.

The rabbis and chaplains who consider their personal opinion to be irrelevant, like Reichman and Ungar, provide the same reasons for their reticence as those who feel the same way but nevertheless share their "private" opinion: since all are employed within the healthcare setting, they

[117] Ibid.

[118] B) and c) are sometimes intertwined.

consider their key role to be facilitation for families and assistance in decision-making. Reichman explains that he is careful not to tell people whether he accepts or rejects brain death, because it is not his role. In addition to this professional self-image he emphasizes the irrelevance of his opinion, since he does not consider himself to be one of the great rabbinic authorities of the twenty-first century. Furthermore, Reichman points out the fact that most congregational rabbis do not feel comfortable deciding on the matter, since "these are very weighty, complicated issues and you can't get more life and death than in the brain death issue."[119] Thus, a patient can turn to their personal congregational rabbi or long-time family rabbi.[120] This rabbi can then refer to the opinion of the rabbi under whom s/he studied: "It's too much for the average rabbi. They don't have their shoulders broad enough to decide whether brain death is legal death, because it's really deciding whether this person is alive or dead, so usually the brain death cases are in consultation with the higher level of rabbinic authorities."[121]

The religious network within American Orthodoxy operates along the lines of hierarchical structures, based on various specific interpretive communities, halakhic loyalty, and networks of halakhic experts that are specialized in different subject matters. Apparently it makes a difference whether the "average rabbi" has a "longer beard"[122] or not. Arie J. Rozin, who works for an organization in Manhattan whose community services attracts many young Jews is a rabbi who consults experts in the field for guidance or directly refers the questioner to the expert himself:

> Sometimes I go to, what I refer to as, you know, longer bearded rabbis. Sometimes for a guidance also 'cause I ahm, I'm very reluctant to make (.) specific ah, to draw specific conclusions for people when it comes to life and death matters. So, on occasion I've consulted with (.) more senior types of rabbis.[123]

Though the average neighborhood rabbi does not decide on the matter of brain death or any other complex end-of-life matter, this does not explain why some of the rabbis state their position and some do not. Data suggests that the average congregational rabbis, who are not new to the job and have a lot of experience in all areas of Halakhah over the course of their rabbinical career, do make such decisions. This is the case with rabbis Katznelson and Kagan, both senior rabbis, who "discuss" a case with another rabbi they respect, but take the full responsibility for their advice. Israeli specialists in medical Halakhah, such as Rabbi Yigal Shafran, also consult with other rabbis. "Beard quality" seems to bear some importance for Shafran as well:

[119]Interview with Dr. Edward Reichman, 10.6.62010, Bronx, N.Y. Quotation at time stamp #00:05:52-5#.
[120]See ibid. at time stamp #00:08:52-6#.
[121]Ibid. at time stamp #00:05:52-5#.
[122]This term is an expression used by Arie J. Rozin (p).
[123]Interview with Rabbi Arie J. Rozin (p), 11.5.2010, Manhattan, N.Y. Quotation at time stamp #00:08:47-2#.

> כמעט בכל הדילמות הקשות, אני מתייעץ עם עוד רבנים. לדוגמה, מעולם לא התרתי הפלה בלי שיתוף של עוד רב מבוגר, לא רב עם זקן שחור אלא רב עם זקן לבן, ולכן אנחנו בקשר הרבנים. מאוד מאוד צריכים אחד את השני.—In almost all the difficult dilemmas, I consult with other rabbis. For example, I never permitted an abortion without the inclusion of another older rabbi, not a rabbi with a black beard, only a rabbi with a white beard. So, we are in contact with the rabbis. We need each other very very much. [Translation by author][124]

Professional inexperience and lack of expertise regarding a certain subject matter is certainly a factor for the unwillingness of young pulpit rabbis to share their view. However, there is another aspect to take into account, since other young Modern Orthodox congregational rabbis such as Paul Vilner unhesitatingly state, "I subscribe to the wider camp, really, cardiac death seems to be the deciding moment."[125] However, conflict of loyalty is an issue for rabbis who are influenced by more than one major *poseq*. Rabbi Margalit from Manhattan says:

> The reason I can't comment is 'cause I have rabbis who say it is valid and rabbis who say it's not, I'm, so who am I, who am I to say that one way or the other? So, I would just ah, like I said, contact colleagues, explain the situation and my network, and then I would, you know, make a decision or make a recommendation based on, you know, what my colleagues guide me.[126]

The same conflict is present for Rabbi Gershon Elbaz, a Modern Orthodox rabbi who immigrated to Israel from England.[127] His account reveals that the struggle to decide which position to side with, is a consequence caused by the intellectual exposure to not just one, but several Torah giants of the generation, all of whom have had great influence over the controversy. Thus, the issue at hand results from having multiple halakhic loyalties in the post-modern age of pluralism.

> I am very close to a lot of people who have very strong opinions. On both sides. [...] I'm annoying in that I don't have an opinion and it's highly problematic, because I'm close to a lot of people who have strong opinions. Ahm and in both directions. And maybe it's wrong that I don't have an opinion, but that's kind of my personality; I prefer to deal with philosophical questions more. Right, and eh, I have a big problem. When I was thirteen or fourteen I was very close to a rabbi, a very great rabbi. How I got so close at that age, I was very lucky, very fortunate. Who was incredibly active, maybe one of *the* [emphasis] most active people in America at the time, Rabbi Schachter. So I was to hang out in his house a lot when I was thirteen or fourteen. On vacation. (I: Schachter, the *rosh yeshive*?) Rabbi Hershel Schachter, in YU, in Yeshiva University. So, it was in the years of his big fight with Rabbi Tendler over these types of issues. And I used to hang out in his house all the time, every day, every day. (I: Oh, interesting.) So as a thirteen, fourteen-year-old I was exposed to the charge in this

[124]Interview with Rabbi Yigal Shafran and Dr. Aaron D. Jachter, 15.8.2016, Jerusalem.

[125]Interview with Rabbi Paul Vilner (p), 27.5.2010, Manhattan, N.Y. Quotation at time stamp #00:21:15-5#.

[126]Interview with Rabbi Rafael Margalit/1 (p), 23.5.2010, Manhattan, N.Y. Quotation at time stamp #00:48:10-1#.

[127]Elbaz's (p) profile is interesting because he takes a special interest in Jewish philosophy and general philosophy, subjects he teaches at a major national Zionist *yeshivah*.

> direction. He told me all kinds of stories. Ah, how I was so fortunate, I was very fortunate, ah on vacation, he has guys who just learned in his house in vacation, I was there in America, so I was very lucky. Ahm, I've been close to rabbis who are very very lenient on this and take the exact opposite position. In the *yeshive* I learned and I don't know what the position, when I was there at Gush Etzion, so that was the *yeshive* l learned most, so you've got, I mean now it's different because they moved over to a new generation, but when I was there it was Rav Lichtenstein and Rav Amital, Rav Amital has now passed away. Rav Lichtenstein is now older and less involved. And I don't know exactly what Rav Lichtenstein's position in this is but I would guess that they would argue on this point. Ah, although I don't know exactly what his position is, 'cause I never asked him.[128]

It is unclear whether and when rabbis who are undecided at the beginning of their rabbinical career take sides. Their positions most likely evolve over time as they gain experience with medical cases. Elbaz admits that he has only been confronted with the question once on a theoretical basis, and never with a real case. However, he says that aside from brain death and organ donation he can have a position on every other medical question. This insight is reminiscent of Charles Sheer's assessment that Orthodox Jews trust in medical science with every medical question other than brain death. The subject of trust or mistrust in medical science and practice shall hence be addressed in the following part.

4.5.3 Mistrust in the Medical Establishment and the Relevance of Practice

Narrative expressions of mistrust in the medical profession and establishment are part of many accounts of rabbis who are involved in the medical histories of their congregants and patients. In addition to the halakhic arguments against brain death, many rabbis stress other factors that influence their skeptical perspective. Media reports, hearsay of medical malpractice, or rabbis and their congregants' first hand bad experiences generate such mistrust.

A recurring theme in the discussion of brain death is of "people who wake up." These are stories about people who "wake up" after neurological determination of death was performed and the ascertainment of irreversible loss of all brain functions. The fear of being buried alive or to die a premature death due to medical practitioner's misdiagnosis is quite common. Rabbi Charles Sheer who is one of the few American interviewees who defends the brain death standard for decades and fights for its retention within the RCA, confirms that the stories of people who come back to life again always get plenty of attention in the media. After publication of Zack Dunlap's story, Sheer recalls receiving emails from colleagues, who knew that he is actively against the shift on the issue within the RCA, reading "So, now what do you have to say about it?" The fact

[128]Interview with Rabbi Gershon Elbaz/1 (p), 3.6.2011, Jerusalem. Quotation at time stamp #00:36:12-4#.

that those scenarios happen due to diagnostic errors in brain death diagnosis does not help the cause and strengthens the public's mistrust of the medical system. Sheer points out that occasional errors are intertwined with the fear that the declared dead are in fact still alive:

> You can't be dead and alive at the same time. It means there was a diagnostic error that was there. And that's exactly what happens, that's why you have to make another apnea test and you keep doing it again. I'm not aware of any situation where a person basically was in a grave, in a coffin and was, you know, banging on it saying 'Let me out, let me out.'[129]

Mourners are vulnerable during the liminal stage after death of a significant other. Sheer is correct in noting that accurately diagnosed cases do not return to life, but the irrational fear or hope that it may happen is enough for people to believe in its possibility. Rabbi Motti Shapiro, a Manhattan based Modern Orthodox pulpit rabbi, reveals some uncanny stories of congregants who made him open the casket to check multiple times whether the deceased was really dead:

> I remember twice, once at the funeral home, having, undoing it, the guy was white, I mean, he was over 90 years old and I had to go and I said, ' What do you want me to do, they checked him in the funeral parlor, the hospital pronounced him dead, the doctor signed the death certificate.' And he [family member] said, 'You have to make sure he's dead, I heard him knocking.' So I said, 'Look at him! That man did not knock.' So I took a feather and I put it right near his nose and I said, 'If this feather moves, then we'll call a doctor.' And he, and of course it didn't move. And then as we were marching down, you know, you have to stop seven times on the way to the cemetery, on the way to the grave, and he says, 'I heard him knocking again.' So he made me undo it again at the cemetery (.) to make sure he was dead.[130]

As a chaplain in a clinical setting, Sheer's perspective on medical realities is constantly shaped by this specific professional context. His experience is based upon hundreds of the same cases over the years. This contrasts with the professional setting in which pulpit rabbis operate. Though pulpit rabbis do not have constant exposure to such cases, their personal experience with congregants' cases or even a single tragedy may leave a long lasting impression. For instance, a family tragedy that involved his mother has strongly influenced Rabbi Shapiro: "I do have an experience, my mother was once called brain-dead and I remember the chart, they wrote unexplained miraculous recovery. The next day she was, she lost some memory and she's been, this is twenty years ago, she hasn't been so well ever since, but she's with us.[131]" Shapiro accepts that his mother was not really brain dead, but believes that the doctors thought so, because "something mimicked brain death."[132] He nevertheless emphasizes that whenever he speaks about brain death in front of an

[129]Interview with Rabbi Charles Sheer, 10.6.2010, Westchester, NY. Quotation at time stamp #00:52:34-8#.
[130]Interview with Rabbi Motti Shapiro/1 (p), 9.5.2010, Manhattan, N.Y. Quotation at time stamp #00:09:11-0#.
[131]Interview with Rabbi Motti Shapiro/1 (p), 25.5.2010, Manhattan, N.Y. Quotation at time stamp #00:01:05-0#.
[132]Ibid. at time stamp #00:06:25-6#.

audience, he adds this personal experience. Although Shapiro deals with "real" brain death cases, where he believes that the individual has died, he still maintains hope: "But let's say someone is in a car accident, you know, and he's seventeen years old and we're hoping, let's hope that he, you know, some thread of life is going to catch on to something."[133]

His mother's liminal experience has a long-lasting impact on Shapiro. Robert Berman, founder and director of the Halachic Organ Donor Society HODS recalls having been invited to Shapiro's congregation to talk about organ donation. The fact that Shapiro argued against Berman based on the story of what happened to his mother alludes to the importance of extra-halakhic factors (e.g. personal experience) in halakhic decision-making and guidance. It is an example of how Shapiro's biography directly influences his professional actions. He hopes that some miracle will happen or prayer will work, just as he believes the real reason his mother did not pass away was due to prayer. Thus, Shapiro argues for the to continuation of life-supporting measures on brain dead individuals. The hope for miracles is a religious aspect that constitutes another Orthodox interviewee's considerations. Rabbi Rabinowitz discusses postponing withdrawal of life support in relation to the coming of the messiah. If "the *mashiah* were to come, then miracles will happen and then this person will have still been alive at the time *mashiah* came."[134]

Media reports and court cases about "modern revenants" impress upon the only interviewed Reform rabbi who is not completely certain whether brain death is really death:

> You know, I'm a little confused, because we had instances where people have been considered (.) brain dead or whatever (.) and it's been years and they wake up, they wake up. I don't know what I would do in those circumstances (.) I think I would tend to accept the fact that somebody is declared brain dead and they lay there and there's no future for them. I think I would (.) pull the plug. Thank God I don't have to have that, haven't have that kind of decision.[135]

When Loeb says "brain death or whatever" and then refers to cases of people who wake up after years, he likely has in mind patients who suffer from other states or syndromes. However, individuals who are correctly assessed as brain dead die from cardiac arrest anywhere between a couple of days to two weeks, even with life-support devices in place. Yet scientific literature in opposition to the brain death standard claims that it is based on false scientific assumptions and medical procedures that are not designed to prove with certainty that irreversible loss of brain function is equivalent to the death of the whole organism. Doyen Nguyen, who gives a concise overview on recent research, identifies four fundamental flaws of the brain death concept. First, there is a lack of scientific data that is necessary to validate clinical tests for the determination of

[133]Ibid. at time stamp #00:06:42-9#.
[134]Interview with Rabbi Shalom Rabinowitz (p), 9.5.2010, Brooklyn, N.Y. Quotation at time stamp #01:10:31-9#.
[135]Interview with Rabbi Michael Loeb/2 (p), 9.6.2010, Brooklyn, N.Y. Quotation at time stamp #00:14:20-6#.

brain death. This critique is directed at the Harvard criteria which are not based on medical tests and patient data.

Second, Nguyen identifies a lack of consensus regarding clinical testing. By quoting Van Norman he claims that it is not a theoretical question, but a practical one, since there is evidence that "physicians involved in declaring brain death were unable to correctly identify or apply the whole brain criteria for determination of brain death."[136] Thus, patients may be inappropriately labeled as dead.[137]

A third flaw with the criteria concerns its logical and scientific incoherencies. Quoting Shewmon, Nguyen adduces the issue of inverse fallacy: he claims that the medical community blindly accepted the absence of evidence (of conscious activity) to constitute evidence of absence (of conscious activity). Lastly, "a proper understanding of the pathophysiology of brain injury helps to explain why the absence of response to the bedside clinical tests, as well as the lack of detectable electrical activity or cerebral flow, do not necessarily indicate brain death."[138] From the perspective of medical professionals who oppose the brain death standard, "survivors" of brain death who wake up in the operation theater are not necessarily victims of misdiagnosis. It is the clinical basis of the brain death standard and enhanced understanding of pathophysiology of brain injury that explain these cases.

One Chabad rabbi who works part-time as a chaplain without clinical pastoral education (CPE) at a Brooklyn hospital expresses this combination of mistrust in physicians' practical skills in neurologically examining potentially brain dead patients as well as the brain death criteria:

> You'll see many times that the doctors say that the person is brain-dead. And with a person's brain dead usually he lives another day, two, three. Yet a person lives sometimes many months, sometimes many weeks. So what does a doctor tell you, when you ask him a question? 'Well, the brain-stem wasn't a hundred percent, know the picture shows that it's dead, but there is still a little bit, a little bit life left and because the person has a little bit of life that's why' [...] But I've seen more than once, that it didn't exactly work the way the doctor said it, which means, the doctor doesn't exactly know what's going on in the brain. They estimate, because there's no ways over there, therefore he should be dead, but the fact of the matter is, sometimes they are even mistaken in the cat scan. Number one. Sometimes, again, they misdiagnose the situation.[139]

There is an ever shifting negotiation among medicine, philosophy, and religion when it comes to determining valid paradigms, methods, protocols, perspectives, and other normative founda-

[136]Nguyen, "Brain Death and True Patient Care," p. 264 quoting Van Norman, "A Matter of Life and Death," p. 281.

[137]See ibid.

[138]Nguyen, "Brain Death and True Patient Care," p. 265.

[139]Interview with Rabbi Gabriel Frank (p), 1.6.2010, Brooklyn, N.Y. Quotation at time stamp #00:14:53-6#–#00:19:11-2#.

tions that guide the human approach to death. God's "last secret of life," an ontological territory that once firmly belonged to the religious and philosophical realms, seemingly has been taken over by science. Yet, some segments of the Jewish community are not willing to surrender this specific territory to medicine. In fact, some modern Jewish hagiographies staunchly adhere to religious sovereignty in matters regarding life and death.

Shalom Rabinowitz (p), an Orthodox Brooklyn bound pulpit rabbi with expertise in the Talmud, provides an example of why Torah wisdom is understood to supersede or include all other knowledge. He tells the story of a person suffering from a tumor embedded in a part of his brain that the doctors feel is inoperable. This person goes to see the Hazon Ish (see above) in Bnei Brak in order to receive a blessing. He explains to the rabbi his situation. The Hazon Ish answers that he does not think that it's inoperable and that he thinks that it is possible to get to the tumor in this and that way to remove it. The revered rabbi describes to the doctors in Tel Aviv how they should approach the surgery; they should go from the side instead of the way they were trained to remove a tumor and in doing so they will not affect the other parts of the brain and thus will be able to remove the embedded tumor. The surgeons perform the operation based on the Hazon Ish's suggestions and the patient recovers, living many years after that delicate operation. After this success, the Hazon Ish was asked how he could possibly give such accurate advice and the rabbi answers that he understood the problem from a passage in the Talmud where the Gemara discusses what is considered *treifah* (not kosher). The passage includes what to do if something is found deep in the brain of an animal. If it can be removed and the condition is not permanent, then the animal is not terminal. Although the brain of a cow is significantly different from that of a human, the rabbi was able to figure out how to remove the patient's tumor after seeing pictures and understanding the structure of the human brain.[140]

4.6 Tensions between Civil Law, Medical Science, and Religious Practice Regarding Brain Death

4.6.1 The Israeli Way: Brain-Respiratory Death Act (2009)

The Brain-Respiratory Death Act accompanies Israel's new Organ Transplantation Law[141] and represents a consensus between the medical establishment, i.e. the ministry of health, and reli-

[140] See interview with Shalom Rabinowitz (p), 9.5.2010, Brooklyn at time stamp #00:58:28-5#.
[141] See chapter five.

gious authorities. The Chief Rabbinate, unlike *haredi* arbiters who traditionally rule against brain death, confirms that irreversible cessation of respiration caused by brain stem death is consistent with Halakhah. This acknowledgment dates back to 1986 when the committee[142] unanimously recognized irreversible loss of spontaneous breathing in combination with brain stem death as the halakhic definition of death. The constitutional passage of the document, translated and annotated by Dr. Yoel Jakobovits, reads:

> 3. Based upon the Talmudic principles of Yoma 85, and [ruled accordingly in Responsa] Hatam Sofer in Yoreh De'ah no:388, the halakha holds that death occurs with cessation of respiration. (See also Responsa Iggrot Moshe, Yoreh De'ah III, no: 132.) Therefore one must confirm that respiration has ceased completely and irreversibly. This can be established by confirmation of destruction of the entire brain, including the brain stem which is the pivotal activator of independent respiration in humans.[143]

The Chief Rabbinate reaches this conclusion in consultation with Rabbi Moshe Tendler, the aforementioned son-in-law of Rabbi Feinstein and well-known advocate of halakhic brain stem death, assuming that Feinstein's ruling "clearly" endorses brain stem death. Although the ruling supposedly applies only to heart transplantations from dead victims of traffic accidents, their other organs also are removed.[144] Despite the Chief Rabbinate's endorsement of the criteria for brain death and organ donation, halakhic opponents of brain death from within the Ultra-Orthodox milieu vehemently oppose this practice and "[dissuade] the public from donating organs for transplantation until further requirements [are] met."[145]

The Brain-Respiratory Death Act of 2009 includes most of the requirements of the religious establishment and develops a unique definition and protocol that is attuned to the Israeli social context. Prior to the law's enactment, physicians in Israeli hospitals followed a brain death protocol endorsed by the ministry of health and according to medical standards. But it was a medical protocol and not enforceable by law. The 2009 law includes demands made by the religious sector to accommodate to the halakhic conclusions of its *posqim* and medico-halakhic experts. Israel is the only country that enhances the standard brain death definition of "irreversible loss of all brain functions including the brain stem" by supplementing it with "irreversible cessation of respiration." Medically speaking, irreversible destruction of the brain stem encompasses irreversible

[142]The committee was composed of the two chief rabbis, Avraham Shapira and Mordechai Eliyahu, as well as Rabbis Shaul Yisraeli and Zalman Nechemia Goldberg. Two physicians (with rabbinical ordination), namely Dr. Avraham Steinberg and Dr. Mordechai Halperin were also present. Additional rabbis from the Chief Rabbinate as well as other physicians were consulted and included for the final ruling.

[143]Y. Jakobovits, "Israeli Chief Rabbinate's Directives," p. 2.

[144]See Avraham Steinberg's statements for the study of the Vaad Halacha of the Rabbinical Council of America, *Halachic Issues*, p. 95.

[145]J. Cohen et al., "Brain Death Determination Israel," p. 2514.

cessation of respiration. However, a purely traditional definition of death, anchored in halakhic literature, never explicitly mentions "brain death." Traditionally death is determined based on "cessation of respiration." Therefore, the "Israeli way" of determining brain death combines two indicators rooted in different paradigms: 1) cessation of respiration as the only way to determine death in a pre-modern setting, void of respirators, and 2) neurological death as the new standard within high-tech medicine.

4.6.2 The "Death Act" and Medical Practice: A Secular Physician's Perspective

To a certain extent, this compromise dismantles medicine's sovereignty in the determination of death, allowing "religion" to re-enter a sphere once "occupied" by science and physicians. Though the new regulations respect the idiosyncratic needs of religious individuals and institutions, it also complicates or makes it impossible for physicians to determine brain death. The compromise between medical protocol and religious needs, as established in the Act, is indicative of the tensions between medical and religious interests. Dr. Michael Halberthal, a physician with over twenty years of experience in determining brain death, voices frustration with the current situation.[146]

Major differences between the previous protocol and the 2009 Brain-Respiratory Death Act persist with respect to five issues:

1. The previous protocol informed the family about the intention to perform brain death testing. In contrast, the Brain-Respiratory Death Act states that there must be consideration for the patient's written wishes and opinion towards the concept of brain death. Though the latter strengthens respect for the patient's autonomy concerning determination of death, irrespective of religious or other motivations, the rationale for the change is due to strong *haredi* opposition to brain death as a definition of death. Cohen et al.'s (2012) three-year survey reveals in cases where the next-of-kin opposes determination of brain death and there is an absence of confirmatory evidence on the patient's views regarding brain death, medical staff refrain from performing such testing. Such restraint occurs even though the law directs that "the attending physician need only take the patient's wishes into consideration, that is, they are not binding."[147] Such ambiguity leads to insecurities and difficulties with interpreting the requirement in practice and constitutes the main reason for non-determination of brain death.[148]

[146]The interview was conducted in Haifa on June 2, 2011. Dr. Michael Halberthal is currently the General Director of the Rambam Health Care Campus in Haifa.

[147]J. Cohen et al., "Brain Death Determination Israel," p. 2516.

[148]Non-determination due to this circumstance occurred in 27 out of 60 cases in 2010, and 26 out of 37 cases in 2011 (see ibid.).

2. Previously, the apnea test was performed whenever possible, as part of full clinical examination. Ancillary testing was required only if it was medically not possible to perform an apnea test.[149] Under the new law, the apnea test is mandatory; without it brain death cannot be declared. This is due to the aforementioned conviction of Jewish traditional sources, which maintain that the absence of spontaneous breathing is the "only" reliable indicator for the occurrence of death. From a medical perspective, the mandatory apnea test may constitute a problem in cases where the injuries or the medical status of the victim are such that this specific test cannot be performed. Since apnea and ancillary tests are mandatory under the new law (see next point), neurological determination of death may become impossible.

3. Previously, an ancillary test was performed if confounding factors required it. Under the new law, such a test is mandatory. The Chief Rabbinate also requires this in order to have an "objective" test on top of the clinical diagnosis (apnea, etc.). Previously, such ancillary testing was performed when medically indicated, such as in cases of drug abuse or hyperosmolar state of the patient. From a medical perspective, mandatory ancillary testing may be perceived as a sign of mistrust against the medical practitioner. However, from a halakhic perspective, such testing can medically confirm virtual or physiological decapitation, a halakhic argument in favor of brain death due to the brain's lack of perfusion. While Halberthal believes that religious reasoning should not impact medical diagnostic investigation, he nevertheless recognizes the advantages in having to perform the mandatory ancillary test:

> I can live with it. It gives a lot of people some eh easiness, you know, you can say 'Oh, it's not a decision of someone that can make error, this is something more objective.' So you have to stop with doing an objective test, most of the time we do a TCD, Transcranial Doppler; so if we have an objective test and there is no flow of blood to the brain we continue with the clinical tests.[150]

4. The previous brain death protocol did not require physicians to undergo training before receiving authorization to perform brain death testing. However, according to Dr. Halberthal, so-called "brain death committees" existed in the hospitals and physicians who became involved in brain death diagnosis received training by seniors. The new law now mandates courses under purview of the ministry of health. They include information on the medical, religious, and ethical issues regarding brain death.

5. The Brain-Respiratory Death Act requires the establishment of an authorization committee of ten members, including three rabbis, an ethicist, a philosopher, a lawyer, and four physicians

[149] For example Transcranial Doppler (TCD), computed tomographic angiography (CTA) or, since 2011, radionuclide angiography using single photon emission CT (SPECT).

[150] Interview with Dr. Michael Halberthal, 12.6.2011, Haifa. Quotation at time stamp #00:10:59-9#

from various specialties. The previous protocol had no requirement for such a committee. In Dr. Halberthal's opinion, this committee is biased due to the fact that all religious members are Jewish, and there is no intention to include other clergy:

> Three of the people in the committee are religious people. They are allowed to check what we are doing. And one of the other issues were, when they talk about religion, they talk about Judaism. There are Muslims, there are Christians, there are other people [in Israeli society]. They were not really put inside the committees and I personally have difficulties with this also, because you know, if religious people are involved, it has to be from all religions and not only from Judaism.[151]

From a physician's perspective, some of the changes introduced by the new law have the most negative consequences for medical practice. Perceiving neurological determination of death as an "option" rather than a medical diagnosis necessary for determining the status of the patient complicates established medical processes. Such perceptions challenge physicians' professional self-understanding and allows for religious agendas to permeate medical practice. Dr. Michael Halberthal describes this difficult situation, especially emphasizing the negative consequences of the new law:

> Until recently it was logical, recently it became illogical. [...] So, what was changed is, first I believe declaring brain death is part of medical practice. It's no different from anything else, this is like I declare a patient who needs to go for operation, I declare his medical status, I declare if he's brain dead. And I don't need permission to declare a patient what his medical status is. But now the law has changed. I don't need permission, but I have to tell the family that I'm going into a process of declaring brain death and obviously we get a lot of negative reaction or some of the families don't allow us to do it. And it's not clear what to do then. I can continue but then, you know, the atmosphere is becoming very tense. So, this is the first thing, and you know, you get by that but it's not so simple, because I believe it's not, not connected to organ donation. I need to tell my staff what is the condition of the patient, like I do every day in anything.[152]

The interaction with patient's families is another issue that physicians struggle with more since enactment of the Brain-Respiratory Death Act. Before, in public and non-religious hospitals such as Rambam in Haifa, there were basically two options after determination of brain death: preparing for organ donation or disconnecting from life-support. However, as described above, Orthodox Jews, who hold that brain death is not halakhic death, usually refuse both options. Much of the Israeli *haredi* sector even demands that such individuals be considered "completely alive," a condition that runs counter to the medical perspective. In contrast to religious hospitals, such as Shaare Zedek Medical Center in Jerusalem, Rambam in Haifa does not operate under the auspices of halakhic authorities and therefore the whole medical environment is neither construed

[151]Ibid. at time stamp #00:16:14-6#.
[152]Ibid. at time stamp #00:06:09-8#.

nor accustomed to extreme religious normative conceptions that impede medical diagnosis and the inevitable course towards cardiac arrest:

> And this is where the law gave us lots of problems. Because in the law they managed to pass that if the family refuses we cannot disconnect from life-support. And then all this area is very vague, now the minister, or the deputy minister of health, we don't have a minister, the deputy minister of health is extremely religious and he doesn't believe in brain death and we had a few instances, there were religious people that were brain dead and he himself got involved in treatment and demanded, or threatened the hospital and demanding that they were continuing treatment like nothing happened. Doing dialysis on a brain dead patient. [...] Full treatment. Full treatment. And the law is very vague.[153]

Halberthal believes the "involvement of religion in something that is extremely professional" creates a situation of vagueness, which is problematic for several reasons. As a physician he stresses "that we have to be very clear: this patient is dead," especially because the concept of brain death is difficult to grasp for family members who are not familiar with it:

> It's not something you get into it. Something very abrupt happens, you know, somebody who was most of the time completely healthy, a car accident or whatever and suddenly the family is in circumstances that are strange, stressful and in this stressful position they have to start understanding what brain death is. We see the monitoring, everything is nice, you touch him, he's warm, but we say he's dead.[154]

Talking about organ donation in an atmosphere where brain death diagnosis is a matter of negotiation, further complicates a difficult situation. At the root of Halberthal's discontent is the conviction that changes rendered from enactment of the Brain-Respiratory Death Act do not live up to expectations for increasing the number of brain dead donors:[155] "It was done with a good idea that once they'll be more involved they will let their followers donate more, but the fact of the matter, and I said it from the beginning, they do not donate any more, they donate exactly the same, they don't donate at all."[156]

4.6.3 The Rabbis' Perspectives and Experiences with Cases Involving Brain Death

Frustration with the new law is remarkably common among those in the Israeli sample who closely followed the path of its implementation or deal with it on a professional basis. Not only

[153]Ibid. at time stamp #00:10:59-9#.
[154]Ibid. at time stamp #00:13:14-4#.
[155]See J. Cohen et al., "Brain Death Determination Israel," p. 2516.
[156]Interview with Dr. Michael Halberthal, 12.6.2011, Haifa. Quotation at time stamp #00:15:01-5#.

does the law frustrate Michael Halberthal, who represents the medical establishment, but it also annoys Orthodox rabbis. Halberthal and Rabbi Yuval Cherlow, who is a *rosh yeshivah*, one of the co-founders of Tzohar, and serves on several ethics committees, feel that the law has decreased organ donations. Cherlow believes that while the law is well intended to strengthen the confidence between rabbis and doctors, the Israeli government badly implements it:

> The Knesset wrote in the law: 'But if the family insists that the death will not be recognized as brain death, but only if the heart will stop working, then you [the doctors] must agree and you must behave according to the family's willing, ok?' Now it seems very, a good thing to do, but actually what happened, everybody that reads this law they don't really understand a lot of of this issue, ok, so ordinary people they accept the idea of brain death, but if you want to be special you will not do it, ok? So everybody wants to be special. And everybody wanted to be upgraded, ok, so therefore the numbers of organ donations decreased, because of this law. So this is Israel.[157]

Medical and religious professionals from the whole Orthodox spectrum criticize the practical aspects of the law for different reasons. Yet both emphasize that the basic idea and resultant compromise among different interest groups is an important achievement. Rabbi Tzvi Weinheimer, a *haredi* hospital rabbi at one of Israel's few religious hospitals, highlights politicians' lack of consideration regarding the law's practical consequences:

> It's things like this, when you pass a law it's very good in the parliament, you know, to pass a law but they really don't know how it works in the hospital. In a hospital, three in the morning, according to the law you have to have three people, a rabbi and this and that to decide whether there is a brain death, a special machine you have to have for brain death. I would, even if the law is right but the practical implementing is wrong. [158]

The law does not require a rabbi to be part of the examination team, although attempts to do so once were undertaken by the religious establishment in the past (see next chapter). In a religious hospital such as the one Weinheimer works at, supported by an almost exclusively *haredi* community, the rabbi who decides on all minor and major issues is somehow included to oversee examinations involving the neurological determination of death:

> I: So, yeah, at three o'clock in the morning.
> Rabbi Tzvi Weinheimer: In the morning and you gonna have three people, so what will the doctors do? They phone the rabbi, 'Ja, ok, do you care for, you know, if we take his heart for somebody else?,' 'No, you can't take it!' And it's a matter of life and death and it's not the way things should be treated. So, therefore we have our reservation from this law, but it's better than it was before when the doctors did whatever they wanted. So, therefore I don't, you know, so, we went for it but we went against it, this law.[159]

[157] Interview with Rabbi Yuval Cherlow, 13.6.2011, Petah Tikva. Quotation at time stamp #00:13:21-3#.
[158] Interview with Rabbi Tzvi Weinheimer/3 (p), 20.6.2011, Israel. Quotation at time stamp #00:03:15-4#.
[159] Ibid. at time stamp #00:04:45-2#.

The *haredi* community, which maintains that a brain-dead individual is completely alive, profits from the new legal regulation, because the hospital is not likely to proceed with brain death diagnosis and therefore keeps the patient connected to life-support. Thus, as Weinheimer states, the law considers many central concerns of the *haredim*, but certainly not all of them. All interviewees repeatedly emphasize that the law is a compromise. A main issue for the religious world is what Halberthal refers to as the "grey zone," which involves questions of how to proceed with a patient, who is in kind of limbo state when neither organ transplantation nor withdrawal of life-sustaining therapy are options. An individual who is considered completely alive by one party, while the other claims the contrary, infers dysfunction. Such a clash of perspectives between the medical establishment and *haredim*, who advocate the "completely alive" stance in the matter, has major consequences for practice. Though interviewees express frustration with such cases, they also describe individual solutions to achieve the respective halakhic standard.

A main workaround, to avoid a clash of worldviews at the bedside, is to transfer of the brain-dead individual, whenever possible, to a hospital that is willing to accommodate to the halakhic standard of *hai l'khol davar*, i.e. give full treatment.[160] Rabbi Weinheimer argues that public hospitals are obliged to treat but they try to opt out of it:

> The public hospitals[161] have to, if there's someone's family who doesn't recognize brain death, they have to treat. They don't always do it by the way. I know, people phone me from all over the country and say, 'Look, we have somebody sick, the doctors told us that if we don't agree to, you know, to give the heart and they won't treat him' and things like that. So they want to bring him over here because over here they know that they don't have nothing to worry about. First of all, we can't always bring him over here, sometimes we don't have room, sometimes the patient is in a situation, if he travels he'll, if he travels he'll be, it could kill him.[162]

Weinheimer recalls a case, where such a relocation took place. A boy from a religious family had a serious drug addiction and after an overdose was delivered to Rabin Medical Center in Petah Tikva,[163] one of the biggest hospitals in Israel, where eventually the physicians declared brain death. "They wanted to disconnect him, so the family brought him over here, for two weeks and then he died. So, you know, the way we look at it, we saved his life for two weeks; that's the way we look at it."[164] This perspective indicates that the prolongation of the existence of a brain-

[160]The subject of resource allocation with respect to the above described situation warrants future research. Respondents did not elaborate on this aspect, and the interviewer did not ask probing questions.

[161]By public hospitals he refers to the hospitals that are not under strict halakhic auspices, as for example Hadassah or Rambam versus Shaare Zedek.

[162]Ibid. at time stamp #00:05:39-7#.

[163]Rabin Medical Center was the former Beilinson Hospital. It was renamed after its fusion with Hasharon Hospital in 1996.

[164]Interview with Rabbi Tzvi Weinheimer/2 (p), 20.6.2011, Israel. Quotation at time stamp #00:13:29-4#.

dead individual is ethically justifiable because the patient does not suffer. Weinheimer explains the difference between the situation of a brain-dead patient and another actively dying person with respect to "prolonging life," a practice that is in place at hospitals under *haredi* religious guidance:

> There are some rabbis, even Orthodox rabbis who say brain death is death. We are not saying that, you know, we can't say that's, you know, that we're right and he's not right, but the way we do it at our hospital according to our Rav which is, even if there's brain death we do everything, you know, to prolong the life, especially 'cause since he has no pain. If a patient has pain, that's a different story. We don't always prolong the life. We'll never kill someone, even if he has pain. But to prolong a life, if he, it's a terminal illness. What is a terminal illness is also not so plain. Some people say 30 days, some say half a year, but if it's a terminal illness and a person is having pain, we won't always prolong his life. We never will shorten his life, but we accept MO, morphium, sometimes, you know, some doctors say, you know, it can, it shortens the life.[165]

The premise that extending the "life" of a brain-dead individual is especially unproblematic due to the fact that he feels no pain, is a novel one and highlights the medical practices of a hospital under *haredi* auspices.

Doron Blaufarb, who works at the same hospital as Prof. Avraham Steinberg and is in charge of the hospital's halakhic affairs, including medical Halakhah, provides a similar account of transferring a brain dead person from one hospital to another:

> There have been a few cases where the family, where it would be assumed[166] there was brain death and the family expressed their wish to do organ transplants and we let them go by ambulance to another hospital where it's done, but we do not do it at [name of hospital], because we go according to Rav Elyashiv—who should live for many years—and other great *rabbonim* [rabbis] who are against it, who consider it murder. Not only against it, who consider it murder. But it's not that Rav Elyashiv is against organ donations, he's not against this. It's just a, there's no way to do it, ah, he goes by the heart and not by the brain and there's no way to do it. [...] The question is not the question of organ donation, the question is when is the end of life. Is it brain death or is it when the heart ceases? And this is, there are different opinions between very very great *rabbonim* [rabbis] and there are on both sides very great *rabbonim* who insist that they are right. And it's not a question who's more strict, less strict. There are great *rabbonim* on both sides.[167]

Blaufarb's account is noteworthy for several reasons. First, it concisely expresses respect for rabbis who hold that brain death is halakhically valid. Both hospital rabbis Weinheimer and Blaufarb

[165]Ibid. He refers to palliative care with morphine for appropriate pain management. If the patient dies inadvertently due to high doses of morphine or a comparable product, this is active involuntary euthanasia based on the general principle of double effect. The primary motivation is to relieve pain, and not to practice mercy killing (direct active euthanasia) and is thus legally and halakhically allowed.

[166]The choice of words is a bit confusing, since the hospital does perform the neurological tests necessary to confirm brain death. To just "assume" brain death without further clarification on the status of the patient and make a transfer to another hospital for organ harvesting seems like a medically unrealistic procedure.

[167]Interview with Rabbi Doron Blaufarb (p), 25.5.2011, Israel. Quotation at time stamp #00:40:57-1#.

acknowledge the co-existence of two halakhic realities, where hospitals practice according to guidance of different religious authorities. Second, Blaufarb describes a religious hospital's procedure in the event that a family would like to donate the organs of their family member who has been diagnosed with brain death. Prof. Avraham Steinberg confirms that such transports are indeed performed and considers this practice a good and working solution.[168] However, as inventive as certain workarounds and co-operations between hospitals may be; they do not curtail the major discrepancies between medical and extreme religious perspectives regarding the definition of death and the treatment of brain dead individuals. Israeli *haredi* rabbis direct their anger towards politics and the secular hospitals, where the standard of care does not match the idiosyncratic needs of their community. Dire situations can get very emotional, especially when the hospital's policies and values conflict with individual wishes. Rabbi Itamar Neman, who oversees the religious and halakhic affairs in a big public hospital in Israel, has the difficult task of finding halakhic solutions that satisfy *haredim* and *datiim*, but do not bother the secular population. In contrast to religious hospitals, public hospitals do neither seek nor operate along the strictest possible halakhic parameter. As mentioned in the last chapter, brain death is usually not considered to be the most problematic medical issue in practice, although it is hotly contested in halakhic discourse. However, having to reconcile a variety of opposing perspectives and definitions in combination with a socio-culturally diverse population, Rabbi Neman concludes that the most difficult issue he deals with on a regular basis "is death of the brain. [...] Whether to finish with the machines or not, to give medicine or not, to hold the heart or not, to give the answers, all the questions of giving parts of the body to *lehashti* (one word incomprehensible) *ivarim*, to give it to another man or woman who needs it (I: An organ?)."[169] The difficulty lies in trying to satisfy clients who are members of all parts of Israeli society, bringing with them all kinds of worldviews, needs, ideas, and values into the microcosm of the hospital. Thus, Neman's mission is to understand "how to lead a hospital, a non-religious hospital, according to the view that everyone can have his own answer."[170]

Providing personalized solutions is certainly ideal for respecting patients' and families' values. However, difficulties arise when personalized solutions are not readily available. Rabbi Yaakov Weiner, the director of the Jerusalem Center for Research–Medicine and Halacha, discusses a case where he intervened on behalf of a religious family of a brain-dead family member. The case involves a clash between the normative worldview of Orthodox Jews and a medical setting that is

[168]See interview with Prof. Avraham Steinberg/2, 9.8.2016, Jerusalem, time stamp #00:05:57-3#.
[169]Interview with Rabbi Itamar Neman/3 (p), 17.8.2016, Jerusalem. Quotation at time stamp #00:03:34-4#.
[170]Interview with Rabbi Itamar Neman/2 (p), 17.8.2016, Jerusalem. Quotation at time stamp #00:00:00-0#.

not prepared or willlling to administer time, funds, and other resources to a situation of medical futility.

> I had a case: Two months ago I get a phone call, a hospital here in Jerusalem. 'My sister has been diagnosed as brain dead, so the doctor gives me three options. One option is, if we wanna donate organs,' which they refused, 'The second option is, we will sign the death certificate and we'll move the respirator,' second option, third option, 'If you refuse, we'll put the patient in another room, we won't disconnect, we'll not gonna give food, not give nourishment, give nothing until the patient, until she dies.' That's here in Israel. [...] We had to fight it. He had to get public backing. I got involved. I went to the head of the hospital and said to him, to speak against it. But [the answer was], 'She's dead, why should I, why should I give nourishment, why should I give,' and I said, 'Look, I'm not here to argue. This is a family, there was a tragedy with their sister, they believe she is alive, please,' and they, hospitals don't wanna get involved in newspaper and things like that, so they agreed, so they gave hydration and nutrition and vasopressors, so the patient lived another two and a half weeks. So that's here in Israel, ok? So, that aggravates me, that's, aggravates me. (I: That they did better in New York and New Jersey than here?) Yes, yes, yes, yes, here we are not protected, here we are not protected, we are not protected. It's very sorrowful and they knew, they knew what they're doing. Politicians knew what they're doing. We are not protected. And every time a person is diagnosed from the religious, ah, it starts a Third World War to get them, the doctors refuse to treat. 'We don't treat cadavers.' So we are not protected. [...] It's a very tragic situation, very tragic situation, we're not protected. What can I do? I wrote, I wrote the religious MK 's 'What did you do?' And they said they weren't aware. So change the law! It's not easy to change the law (I: No, no.). Change the law![171]

Weiner insinuates that *haredi* Israelis or people who do not agree with the removal of life supporting—or death-prolonging—treatment on brain-dead individuals are treated with disrespect and unfairness in non-religious hospitals, at least when compared to conditions in New York and New Jersey. His consternation results from his conviction that the lives of *haredim* are less protected in Israel than in the United States. The next section contextualizes and qualifies of this impression.

4.6.4 "One Body, Two Different Realities:" The Differences Between the United States and Israel

Weiner's account underscores the difficult relationship among the medical establishment, politics, and clashing paradigms. As Rabbi Charles Sheer claims (above), no other medical issue involves as many clashes between worldviews as the brain death question. And understandably so, since it is a matter of life and death. Weiner's and Weinheimer's case examples illustrate the practical consequences that Ultra-Orthodox families deal with in a hospital, and/or staff that is not

[171] Interview with Rabbi Yaakov Weiner/1, 19.6.2011, Jerusalem. Quotation at time stamp #00:45:07-7#.

entirely aligned to the religious particularism and idiosyncratic needs of *haredim*. Conflicts of interest may emerge due to hospitals' policies that prioritize economic considerations, distributive justice, and concepts of triage, all of which may be incongruous with certain particularistic standpoints of religious communities.[172] Weiner's feeling of being "unprotected," especially compared to Ultra-Orthodox Jews in the United States, further nurtures his aggravation. To what extent is his impression based on facts?

Agudath Israel of America, an American organization that represents *haredi* Orthodox Jews, strives to negotiate with state departments of health to acknowledge the needs of Orthodox Jews, especially with respect to religious sensitivities at the end of life. Agudath Israel also issues health care proxies, specifically designed to make family members and medical professionals cognizant of the consequences for a proxy holder. It primarily highlights that resuscitation must be performed and all measures taken to keep the person alive, that removal of organs is prohibited, and special rituals should be observed before the burial of the deceased person. The proxy provides a form to fill in with the names and addresses of rabbis that should be contacted.[173] Such proxies and legal guidelines may vary from state to state, as do the legal parameters for the declaration of death. As a result of negotiations with religious organizations such as Agudath Israel of America, the New York State Department of Health has set up legally binding guidelines that require all New York State hospitals to establish and implement written policies for determining brain death. It requests hospitals to:

- List tests and procedures required for determining brain death;
- Notify the next of kin or another person closest to the patient (the "Surrogate Decision-Maker") that brain death determination is in progress;
- Show reasonable accommodation of an individual's or Surrogate Decision-Maker's religious or moral objection to using of the brain death standard for determining death.

With regards to the third point, hospitals have varying levels of accommodation, especially because it is unclear as to what constitutes "reasonable accommodation." Guidelines advise that "policies may include specific accommodations, such as the continuation of artificial respiration

[172] Though the above described incongruities are between the Haredi community and public hospitals, they are by no means unparalleled. Similar conflicts or difficulties exist with respect to other non-Jewish religious traditions or cultures as well, e.g. refusal of blood transfusions by Jehova's witnesses or the rejection of modern Western notions of confidentiality and disclosure of patient status by the Japanese, e.g. in the case of terminal illness for instance (see Macer, "Japanese Bioethics").

[173] The document is attached to the appendix.

under certain circumstances, as well as guidance on limits to the duration of the accommodation."[174] Furthermore, "policies may also provide guidance on the use of other resources, such as clergy members, ethics committees, palliative care clinicians, bereavement counselors, and conflict mediators to address objections or concerns."[175] In practice, reasonable accommodation is somewhat of a "grey zone" with no state-wide consensus and depends on the interpretation of the respective hospital. Additionally, there is no specification as to the duration of such accommodations, even though they only begin after the determination of brain death. Although New York law requires the notification of surrogates of an impending brain death determination, the latter cannot prevent the withdrawal of life-support treatment.[176] In contrast, the legal situation in New Jersey allows families to object to the neurological determination of death. It is the only law in the United States that enables families and patients to demand determination and declaration of death be performed solely upon cardio-respiratory criteria. This objection to the performance of neurological determination of death, i.e. brain death, can only take place on religious grounds, and not due to conscientious, i.e. non-religious, reasons.[177] Another unique aspect of the New Jersey law is that it "prohibits health insurance providers from denying coverage on the basis of brain death when there is a religious objection, thus removing the potential for financial conflicts of interest for hospitals and financial coercion of families facing decisions concerning the withdrawal of life support."[178]

Thus, Rabbi Weiner's aggravation with lacking protection must be contextualized. First, New Jersey seems to be the most liberal state in the United States with respect to religious accommodation and *haredi* Jews probably feel well protected in this environment. However, the law in New Jersey differs from New York, because it mandates that if a patient or family object to the neurological criteria, then the time of death is declared upon the cardio-respiratory criteria. Such a legal mandate for reasonable accommodation neither exists in New York nor California. Rabbi Yosef Ungar, an Orthodox chaplain in New York who works at a Manhattan hospital, confirms that the Israeli *haredi* way of treating a brain-dead individual differs from the American *haredi* way:

> There is one rabbi, Rabbi Elyashiv in Israel who says you treat a brain-dead person as if completely alive with the medications. So, here in America, you know, even if you say that brain death is not death,

[174]New York State Department of Health and New York State Force on Life and the Law, *Guidelines for Determining Brain Death*, p. 4.

[175]Ibid.

[176]See Gabbay and Fins, "Go in Peace: Brain Death, Reasonable Accomodation and Jewish Mourning Rituals," pp. 1678–1679.

[177]See Johnson, "The Case for Reasonable Accommodation of Conscientious Objections to Declarations of Brain Death," p. 109.

[178]Ibid.

> the physicians do not have to treat. You don't have to give any new medication, they don't have to give any new bags (?), sometimes it's working with families through that, like they really, again, the idea being, the rabbi in Israel thinks that this patient is completely alive, the people that's it's it's dead (I: Completely dead), completely dead. [...] So let's say the family asks for more medication, so they [the hospital] can say no. They don't have to, the hospital has to show reasonable accommodation and not take somebody off the ventilator against their will. The question is how long.[179]

Ungar acknowledges that even though the hospital must show reasonable accommodation, a discrepancy persists between the hospital's perspective, that the patient has died, and the religious one, that the patient is alive. This conflict adds tension and creates what Ungar calls an unpleasant "situation where you get one body, two realities," a situation where "patient's families and rabbis are just focused on the neck down and the hospital's kind of focused on the neck up."[180]

Ungar's experience puts Weiner's impression in context; namely, that religious accommodation in New York and New Jersey automatically "protects" *haredi* perspectives and the standard of care according to Rabbi Elyashiv's approach. Though Maimonides Medical Center in Brooklyn, in the midst of Borough Park, is generally known to respond best to Haredi idiosyncrasies, the rest of New York City is not necessarily "better" in terms of providing treatment to a brain-dead patient, if *haredim* understand the patient to be completely alive. It is understandable for Weiner to feel discrimination when comparing American experiences with Israeli ones. However, the contexts are not comparable due to differences in the halakhic substructure of the respective *haredi* cultures. However, Weiner's impression of the situation may also have to do with a general feeling of institutional and political powerlessness. Agudath Israel of America is an important advocate for American Orthodox Jews. Its special division, Chayim Aruchim (engl. long life), advocates for families in end-of-life issues, where some cases deal with the question of "reasonable accommodation."

A recent court case in Brooklyn epitomizes the institutional power of religious organizations. Sixty-eight year-old Yechezkel Nakar suffered from a stroke and was taken to New York Presbyterian-Columbia University Medical Center. Media articles report that physicians performed neurological determination of death against the express wishes of the family. Furthermore, a confirmatory test was performed and the death certificate issued over Shavuot, a time when the Nakar family would not be available to object or participate in an ethics consultation on the matter. The family only became aware of the death certificate when Mr. Nakar was transferred to Maimonides Medical Center in Brooklyn. The transfer to Maimonides was prompted due to a technical impasse in a nursing home that was initially willing to accommodate him. Maimonides'

[179]Interview with Rabbi Yosef Ungar (p), 1.6.2010, Manhattan, N.Y. Quotation at time stamp #00:28:09-8#.
[180]Ibid. at time stamp #00:25:28-8#.

staff continued to provide Nakar with life-sustaining treatment, even at the risk of not being reimbursed for its services by the medical insurance company. An inquiry into the case revealed several incongruities, including the issuance of a death certificate before removal of life-support. According to the newspaper report in Hamodia, the court order reads: "Because respondents did not take sufficient steps to reasonably accommodate the Nakar family's concerns, including steps set forth in their own written policy and practice, it was not proper for respondents to declare Mr. Nakar brain dead when they did."[181]

American denominationalism and its fine meshed institutionalized structure and superstructure may provide the support religious communities ask for. While institutional intervention may be appreciated, as in the Nakar case, it is by no means asked for in every event. For example, Rabbi Benzion Adonolem, a Jewish chaplain in a hospital in Brooklyn, describes an instance when Agudath Israel's unsolicited intervention was unwelcomed. He recalls a case of a Russian man with severe brain damage, but in a condition where "Halakhah would have said 'keep him going,' because his breathing was ok:"[182]

> So, I got a call from Agudas Israel: 'Can you talk to the son and try to convince him that he should continue maintaining the father?' I said: 'Well, I don't know if I can convince him, I can talk to him.' Ok, I talked to him and he said: 'I know you're religious and now you want me to continue, I know your agenda.' I said: 'You know, it's not my agenda. I'm just wanna share with you, you know, does that mean anything for you, is that important? The Hala...' He says: 'Look, I know the Halakhah, but I'm, I don't want my father to suffer, I made up my mind, I'm gonna have, have him, let it go, I don't need him to suffer.' So I called back Agudas and said: 'That's what that young man said and I let go. I know you want me to push it—I can't. I can't do it. He told me explicitly he, he was aware of the Halakhah, ahm, he doesn't wanna follow the Halakhah. So now, if you guys wanna do it, that's up to you, but I can't. As a chaplain, it's a violation of the patient's rights. I don't have the right to do that to him.'[183]

Against the backdrop of Weiner's experience, such intervention may understood to be just the assistance a *haredi* community wishes for. But normative and unsolicited intervention may also be felt as an unwarranted interference with the family member's autonomy in decision-making. This was certainly the case in Adonolem's report. Furthermore, his story illustrates how Jewish chaplains must at times walk between the raindrops. The clear advantage of the health care system

[181]Hoffman, *Judge Rules that Hospital Must Rescind Death Certificate for Orthodox Patient*. Cf. the assessment of the case from a brain death accepting position in Berman, *Declared Undead*.

[182]Interview with Rabbi Benzion Adonolem/4 (p), 14.5.2010, Brooklyn, N.Y. Quotation at time stamp #00:18:16-6#. Adonolem was not very specific about the medical details. From his description it does not seem that the person was neurologically dead according to the legal requirement. It is unknown whether it was a so-called cerebral death or another condition with an undamaged brain stem.

[183]Ibid.

in New York over Israel (for now) is in the institution of professionals, i.e. Jewish chaplains with rabbinic degrees. Besides the performance of their main duty, i.e. spiritual care, they have become masters of cultural translation at the bedside. Thus, they are indeed—to use their own terms—diplomats, mediators, translators, advocates, and bridge builders.

4.7 Conclusion

In his 1986 essay, The Halakhic Mind, Rabbi Joseph B. Soloveitchik, the foremost religious leader, thinker, and halakhic authority for many non-*haredi* Jews in the United States, concisely describes the relationship between the physical (scientific) and metaphysical (philosophical) world views: "The scientific method, which exalts the microscopic idea and integrates reality out of the simplest elements, has collided with the metaphysical world-view which strives towards boundless ontological totality. As a result of this conflict, new vistas now beckon to the homo religiosus."[184]

This clash of perspectives, the microscopic idea and the perspective of science and the boundless ontological view of philosophy, epitomizes the brain death controversy. Consequently, this conflict not only beckons new vistas to the "homo religiosus," but beckons more dilemmas. The human body is a battlefield for the constitution of hegemonies and the erection of new truth claims. Science is a contested knowledge producer and is premised upon authority—an "authority that is premised on the scientific basis on which its knowledge has been built up and warranted true and effective."[185] Since religion and philosophy also produce contested knowledge, clashes over the authority of knowledge are inevitable.

Jonas' critique attempts to re-establish philosophy's claim to power over medical science, since the latter touches the "sovereign" territory of meta-physics by proclaiming a "new definition" of death. Further, it is possible to read Jonas' statements as an enterprise of correctional re-establishment of the paradigmatic power relations between the realm of the fact or data producer, i.e. physics (science), and the data interpreter, i.e. meta-physics (philosophy). The normative evaluations or interpretations of medical data by Jewish religious actors have produced a variety of positions in the discourse on brain death. Positions range from the Reform Jewish delegation of "best knowledge" and best practice with respect to determining death to the medical profession, to the most extreme *haredi* rejection of the concept of brain death. Difference in opinions between various Orthodox communities with regards to the halakhic validity of brain death are due to three major factors: the meta-methodological understanding of Halakhah, the paradigmatic character

[184] J. B. Soloveitchik, *The Halakhic Mind*, p. 3.
[185] Cunningham and Andrews, "Western Medicine," p. 6.

of science, and the power of interpretive communities. Acknowledging that each framework of knowledge production, whether science, philosophy, or religion, constitutes an interpretive community, may contribute to a certain conciliatory stance within debates that continuously repeat truth claims.

Truth claims and normative rigor are easier to maintain on paper than in a reality of social interactions. The second part of this chapter shows that opposing halakhic rulings can nevertheless co-exist in practice. In Israel, the medico-halakhic experts mostly have tremendous respect for the opposing view on the matter; thus, solution oriented pragmatism seems to work most of the time. Hospitals that are under halakhic auspices take in patients from public hospitals who refuse to treat brain-dead individuals according to the halakhic standard of *hai le khol davar* (completely alive). In contrast, religious hospitals that do not perform organ transplantation from brain dead donors have according arrangements with public hospitals. However, working solutions are not always enough to bridge the existing gaps and to cover up ideational differences, especially if they exist between the medical establishment in public hospitals and the *haredi* community. In contrast to the previous medical protocol, the new Israeli law, i.e. the Brain-Respiratory Death Act (2009), is heavily infused with halakhic norms. Serving as a compromise between the medical and religious establishment, secular medical professionals feel religiously coerced by the law. As Dr. Michael Halberthal states, religion enters a sphere that is "extremely professional,"[186] thereby impacting medical practice at large—a condition that doctors find unreasonable. Though the law accommodates to religious populations,[187] *haredi* families can still feel discriminated against in public hospitals.

The legal situation in the United States, i.e. New York and New Jersey, is different. The option of religious accommodation was established with the support of Agudath Israel of America and seems to make similar concessions to religiously motivated brain death opposition as does the Israeli Brain-Respiratory Death Act. However, it is up to hospitals to define and provide religious accommodation to patients and their families. Analysis of the roles of rabbis and chaplains involved in brain death cases indicates a minority believes questions on brain death and organ donation are the most difficult to handle, while a majority, especially the medico-halakhic experts, think otherwise. The halakhic discourse on brain death has evolved into an extremely complex issue, while in practice, whether from a halakhic or a medical point of view, it is in fact not. Many rabbis hold other medical cases more problematic (vegetative state, dementia, issues of withdrawing and withholding of medical treatment).

[186] The expression was used by Dr. Michael Halberthal. See interview with Halberthal, 12.6.2011, Haifa, time stamp #00:13:14-4#.

[187] See interview with Rabbi Tzvi Weinheimer (p).

Results from the analysis of the interviews also indicate Orthodox rabbis' differing positions with respect to their professional network, or hierarchy. Those rabbis who consult with senior rabbis in brain death cases either adopt their rabbis' (or *rosh yeshivah*'s) opinion at an early stage of their career or do not allow themselves to have an opinion. In contrast, Reform rabbis consider the subject of brain death to be a medical decision and not a religious one. Within Orthodoxy the interrelationship between rabbinic persona, individual opinion, and rabbis' negotiation with discourse on brain death indirectly indicates interviewees' religious identity. *haredi* rabbis unhesitatingly answer the question of whether brain death is equivalent to halakhic death. Their individual opinion and rabbinic persona are both embedded in their interpretive community, with *posqim* at the top of the authority ladder. It is noteworthy that no Ultra-Orthodox or "right wing" Modern Orthodox rabbi reacts surprised or thinks that his opinion or position is somehow irrelevant. This contrasts with the Modern Orthodox sample, where deference to experts and *posqim* is standard practice and "personal" opinions are unwillingly shared if at all.

5 | *Mitzvah* or Murder? Organ Donation in Judaism

From an Orthodox Jewish perspective the issue of organ donation is framed by two extremes: Does it constitute the "killing" of a brain dead individual or is it the ultimate *mitzvah*, a *matnat hayim* (gift of life), because it saves lives? And is the Reform community as accepting of organ donation as it is regarding brain death? This chapter explores the religious discourses, rabbinic experiences in various professional fields and the consequences of tensions that persist between legal, medical, and religious spheres of power and knowledge.

In contrast to the issue on brain death, religious opposition against organ donation pertains to the dead body itself. The act of harvesting organs, even after cardiac arrest, is oftentimes perceived as an interference with what is believed to be the holiness or sacredness of the dead body. *K'vod ha-met*, the dignity that stays with the deceased person's body, is traditionally an important value in Jewish law and ethics. The fact that the major Jewish legal issue for or against organ donation has to do with the acceptance of brain death is only part of the story. Additionally, there is emotional struggle, dependent and independent of religious normative categories: the feeling that the process of harvesting of organs somehow damages the integrity, sacredness, or dignity of the dead body penetrates Jewish imagination throughout the religious spectrum and beyond.

The first section introduces the topic with respect to living donors. Living donor grafts have become an important additional resource to deceased organ donations, especially in Israel where a low donor rate renders organs an extremely scarce resource. If there are no medical considerations to worry about on the donor's side, living organ donation is perceived as a *mitzvah* by practically all halakhic authorities. While *piquah nefesh* is the guiding principle in this case, it has to be qualified with respect to deceased organ donation, which is the subject in section 5.2. The term "deceased" is oftentimes not defined in research literature. It works well enough as a contrast to "living," but is imprecise when not further specified in the context of Orthodox medical discourse. "Deceased" as a very general term does not refer to a specific "death status," i.e. brain or cardiac death of the person. The term "deceased" is thus identified with "cadaveric" organ transplantation in this

study, e.g. with respect to cornea. Other terminology, such as DBD (donation after brain death) or DCD (donation after cardiac death) are introduced, where applied. This section discusses main concepts and *halakhot* with respect to the Orthodox and Reform sources and responsa literature regarding "deceased" organ donation.

Section 5.3 implements the data obtained from interviews with rabbis, chaplains, and experts of medical Halakha in Israel and New York. The most relevant issues discussed include the interrelationship of guiding values or norms and personal opinion or emotional struggle of the rabbis. As a main part of this dissertation this section explores some fault lines that exist between theory, i.e. values and norms known from religious literature, and practice in the respective interpretive communities. Evaluation includes the question of how organ donation is handled by rabbis in their congregations and whether congregations are at all the place to address this issue. Furthermore, ascriptions and misconceptions that haunt this topic are evaluated with respect to their real or imagined location in religious reality.

The last section deals with the case study of the Israeli Organ Transplant Law as well as its ethical rationales and implications for the religious community and general Israeli population. Two results from the analyzed data are especially relevant within the general Israeli discourse on organ transplants: the free-riding mentality, which is persistent within the whole *haredi* sector, and the politically challenging notion that Jews should give organs, if at all, then only to fellow Jews.

5.1 Living Donor Transplantation and *Pikuah Nefesh*

In discussing organ donation within Orthodox Judaism first comes the matter of living donor transplantations from healthy donors, whereby the donor assumes little to no risk of harm. Such a donation is considered to be a *mitzvah* (hebr. good deed, duty). Its religious basis is found in the Torah statement "Don't stand idly by the blood of your neighbor"[1] (Lev 19:16). One of the tradition's most esteemed commentators on the Bible and Talmud, Rabbi Shlomo ben Yitzchak, better known under his acronym Rashi, who lived in 11th

century Troyes, comments: "To view his death when you are able to save him, for instance, you must save one who is drowning in a river, or if an animal or bandits are coming upon him." Rabbinic scholars have extensively discussed the question of how much risk a rescuer is halakhically obliged to take vis à vis the danger to his own life. The general question within this religio-legal

[1] The ArtScroll translation reads: "You shall not stand over the blood of your friend."

framework is whether one is permitted, required, or obligated to put himself/herself into possible danger in order to save the life of someone who is in certain danger.[2]

Within contemporary Western medicine the extraction of blood, bone marrow, kidneys, and parts of a liver are not generally considered a risk to the donor's life anymore and thus generally permitted by religious authorities (with health status considered on an individual basis). Regarding the donation of a live kidney the American rabbinic arbiter, Rabbi Moshe Feinstein (1895–1986), writes in Igrot Moshe (responsum) that one is permitted to put himself/herself into possible danger, since another Jewish life will certainly be saved. But he also writes that a person who is considered to be helpful in this way may not be obligated to do so.[3]

Interestingly, the Torah's commandment of "You shall not stand idly by the blood of your neighbor" as a *mitzvah lo ta'aseh* (a prohibition) has been reformulated in the Talmud as a positive obligation (*mitzvat aseh*):[4] "Every individual, insofar as he is able, is obligated to restore the health of a fellow man no less than he is obligated to restore his property" (Sanhedrin 74a). Thus, blood donations are actively encouraged even by the most Ultra-Orthodox milieus.

The rationale of *piquah nefesh* that includes self-preservation as well as the duty of saving the life of another human being is equally important to all groups and denominations within the Jewish spectrum. Saving someone's life practically overrides all other religious obligations, even if it involves violation of prohibitions set forth in the Torah. This holds true for patients who are seriously ill as well as those who are trying to help the sick. For example, observant Jews follow the laws of Shabbat in order to honor the seventh day of the week, after God completed the creation of the world and ceased from all the work (see Genesis 2:1–3). The commandment to honor this day and to refrain from labor is repeated several times in the Hebrew Bible.[5] The prohibition to perform any kind of work is not restricted to a labor-kind of work. Included are acts and tasks as basic as lighting or extinguishing fire (including using an elevator, switching on/off lights, starting a car, using a telephone, and cooking) or grinding (including chopping vegetables or taking a pain

[2] See Abraham, *Medical Halachah vol3*, p. 311.

[3] See Abraham, *Medical Halachah vol2*, p. 347.

[4] See Prouser, "Hesed or Hiyuv," pp. 446–447.

[5] The Mishna, compiled around 200 CE, names thirty-nine *melakhot* that are forbidden on Shabbat. More precisely, the thirty-nine *melakhot* are categories of *melakhah*, forms of work, or main activities that are associated with the construction of the *mishkan* (tabernacle) and the fabrication of its components. For example, it is forbidden to plant, sort, kindle/extinguish a fire or to grind something. These so-called *avot melakhah* (primary (lit. fathers) categories of work), all expressions of antiquated agriculture and craftsmanship, were supplemented later with subcategories (*toladot* (lit. descendants)) of more activities (a sub-category to planting would be watering).

Figure 5.1: Poster in front of the Lubavitcher Yeshiva in Crown Heights, Brooklyn, 2010. The sentence in Hebrew is the aforementioned statement in Leviticus 19:16 not to stand idly by when your neighbor's (friend's) life is at stake. Photo: Sarah Werren, 2010.

reliever[6]). For observant Jews, breaking the Shabbat laws is not performed without trepidation. However, Jewish codes of law, other halakhic works, and statements of rabbis who give halakhic guidance emphasize that even in cases of possible threat to a person's/patient's life, Shabbat laws are to be set aside. The Shulhan Arukh[7] (Orah Hayim, Siman 328, §2 and §4) states:

> §2: It is a mitzvah to set aside Sabbath laws (as necessary) for a seriously (or dangerously) ill patient. He who does so immediately is praiseworthy whereas he who delays in order to ask is guilty of shedding blood.
>
> §4: One should not be strict in assessing the needs of a seriously ill patient; even if there is no expert guidance available and the patient does not request it specifically, one must nevertheless do whatever would be done on a weekday. However, if the nature of the illness, even a serious one, is known to be such that one may wait and not need to set aside Sabbath laws, one must not desecrate the Shabbat.

[6]Forbidden due to the *av ha-melakhah* of grinding. Taking pills or any other medication (not in the case of life-saving medication like heart diseases or diabetes) is prohibited, because the fabrication of medication involves grinding remedies.

[7]The Shulhan Arukh is a code of (religious) law written by Joseph Karo in 1565.

Thus, taking action without hesitation in case of danger to someone's life takes precedence, even when one is uncertain whether this is indeed the case. The guiding principle that legitimates the violation of Torah laws is based on the verse in Leviticus (18:5): "You shall observe My decrees and My judgments, which man shall carry out and live by them—I am Hashem." It implies that one shall live and not die from the laws.

Further, §4 refers to the fact that there are different levels or halakhic categories of sick patients, each with specific rulings relating to the course of action for the patient regarding various issues like Shabbat, the festivals, fast days, and forbidden foods.[8] Clearly, a patient in need of an organ falls into the category of *holeh she'yesh bo sakanah* (a dangerously/seriously ill patient), and saving this person's life has precedence. Nevertheless, there are three exceptions to the rule that *piquah nefesh* overrides all other Torah laws. These are, sexual relations that are considered forbidden (*gilui arayot*), idolatry (*avodah zarah*), and murder/shedding blood (*sh'fikhut damim*). A person is not allowed to conduct any one of the three prohibitions even if his/her life is in danger.

Within the context of modern transplantation medicine, the third exception, the prohibition to "kill" or "murder," constitutes a problem for those Orthodox Jews who do not find brain death (irreversible loss of all brain functions) consistent with Halakha. From this perspective, harvesting vital organs like the liver, heart, or lungs would constitute intentional killing of the donor, since the patient is not considered dead, but *safek hai*, *safek met*, which means that it is doubtful whether s/he is alive or already dead, or even *hai le khol davar*, completely alive. In case of halakhic uncertainty, authorities usually apply stringent ruling. Thus, by accepting these convictions, *piquah nefesh* is not an applicable principle and does not serve as the all-encompassing principle to save lives. Certainly, those Orthodox institutions, authorities, and individuals who are convinced that brain death is in fact halakhic death—as does its most prominent proponent, Rabbi Moshe Tendler, son-in-law of Rabbi Moshe Feinstein of New York—can justify the practice of organ donation with *piquah nefesh*. However, as long as *piquah nefesh* is considered to be in conflict with the exception of "murder," which is the case when irreversible loss of all brain functions is not acknowledged as a valid criterion for death, the harvesting of organs constitutes a halakhically forbidden act. Consequently, two halakhic realities exist due to irreconcilable ontological, religio-legal, and hermeneutical differences.

[8] See Weiner, *Guide to Observance*, pp. 16–23. There are five categories: Minor ailment (*maihush*), where one is in a state of slight discomfort; a minor ailment (*miktzat holi*) that includes a minor illness or localized aches (irritating cough, headache); an incapacitating illness (*holeh she'ayin bo sakanah*) like a flu, migraine headache, or chronic arthritis pain; the fourth category refers to a patient where there is danger of losing or causing permanent damage to a limb (*sakanat eiver*); the category of *choleh she'yesh bo sakanah* includes patients that are possibly seriously or dangerously ill, or may become so (also pregnant women towards the end of gestation).

5.2 Deceased Organ Donation

In contrast to discourse about living donor transplantation, organ transplants from deceased (or cadaveric) donors, require the consideration of four rationales.[9] All involve the importance of proper respect towards the deceased's body after the occurrence of death:

1. The prohibition of *nivul ha-met*, the desecration of a corpse.
2. The prohibition to make benefit or take profit from a corpse (*hana'at ha-met*).
3. The obligation to bury the deceased as fast as possible (*halanat ha-met*).
4. The obligation to respect the bodily integrity of the deceased upon burial and all its parts.

Early rabbinic discussions about organ transplantation conclude that the *mitzvah* of *piquah nefesh* overrides these guiding instructions. Thus, the practice of organ transplantation is compatible with halakhic rules and traditions regarding a dead body in Judaism. In order to save the life of a patient who needs an organ, overstepping the above listed *mitzvot* is justified. This approach holds true at least for those transplants that can be harvested after cardiac death. In this case, all authorities agree that the grafting or harvesting of cornea, skin, or bone after cardiac death is halakhically legitimate, since *piquah nefesh* overrides the *mitzvot* that are essential for honoring the dead.

A typical deceased organ donation that does not involve the diagnosis of brain death is the harvesting of cornea. In the broad area of deceased organ donation, the question of halakhic legitimation of cornea transplantation has provoked some rabbinical discussions in the past. The main question is whether transplantation of cornea is allowed on the grounds of *piquah nefesh*, the principle that supersedes the prohibition of *nivul ha-met*, or the mutilation of a dead body; is a blind or visually impaired person's life in danger when s/he cannot see or does this condition somehow constitute a lethal disease? Would s/he be halakhically considered a *holeh she'yesh bo sakanah* or not? Because, if this were not the case, then consequently there is no necessity to transgress *nivul ha-met*. Rabbi Isser Y. Unterman (1886–1976), Ashkenazi Chief Rabbi in Israel from 1964–1972, ruled in his influential and classical responsum of 1955 that a blind person finds him/herself in a life threatening situation; a person could likely die from falling down stairs (or the like) due to vision impairment. Therefore, according to Unterman, the harvesting of cornea is halakhically justified.[10]

Transplantation of only one cornea leads to greater halakhic debate, since the principle of *piquah nefesh* does not seem to be applicable. Again, Rabbi Unterman does not find this medical practice equivalent to the prohibition of benefiting from a corpse, since, in his opinion, an organ

[9] See Nordmann, *Zwischen Leben und Tod*, p. 65.
[10] See F. Rosner, "Organ Transplantation in Jewish Law," pp. 392–395.

that was transplanted into a living body comes back to life. Therefore, he argues, the laws pertaining to a corpse (or part of one) no longer apply to it and the benefit obtained from it ought to be considered a benefit from the living.[11] Also Rabbi Ovadia Yosef, once Israeli Chief Rabbi for the Sephardi community, rules in favor of transplantation of only one cornea. As the Israeli physician and rabbi A. Abraham notes, Ovadia Yosef does so in reference to Sho'el u'Meshiv[12] (1808–1875) and Maharil[13] (1365–1427) who both consider the prohibition of desecrating a corpse only if it is done for no purpose.[14] Rabbi Yosef states that even blindness in one eye is considered a defect that generates much suffering and shame.[15]

Dismissing Rabbi Unterman's argumentation, Rabbi Joseph Shalom Elyashiv (1910–2012), a *Haredi* authority who lived in Jerusalem and was known for his stringent rulings, gave the following opinion:

> For when a part of a corpse is transplanted into a living person, even though it is accepted and not rejected by the recipient's body, nevertheless it does not become alive but merely remains attached to a living person. Therefore, if there was a *mitzvah* to bury it before, this does not disappear following transplantation. And since, according to the Minhat Hinuh,[16] the *mitzvah* of burial applies even to a *k'zait*[17] of a corpse, the Torah commandment has been set aside in a situation not involving *piquah nefesh*.[18]

Furthermore, Rabbi Moshe Feinstein and Rabbi Shlomo Zalman Auerbach, both halakhic authorities, do not rule in favor of transplantations that do not clearly take place with respect to *piquah nefesh*.

Thus, there is considerable rabbinic dissent regarding cornea transplantation of one eye or body parts that do not involve *piquah nefesh* on the recipient's side. However, with respect to possible life threatening situations, all authorities agree that saving a person's life takes precedence over prohibitions and considerations related to the aforementioned rituals related to a deceased's body.[19]

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[11] See Abraham, *Medical Halachah vol2*, p. 342.

[12] Rabbi Joseph Saul Nathanson from Lemberg. His responsa's title is Sho'el u'Meshiv.

[13] Acronym for Morenu ha-Rav Jakov Levi (our teacher, the Rabbi Jakov Levi), a prominent halakhic authority for Ashkenazim, who lived in Mainz and Worms.

[14] See Abraham, *Medical Halachah vol2*, p. 343.

[15] Ibid.

[16] A collection of essays about the 613 *mitzvot* and commentary to the Sefer ha-Hinuh, written by Rabbi Y. ben Moshe Babad, 19th century.

[17] *K'zait* means "like an olive"—like the amount of an olive. It is an indication of measurement and predominantly pertaining to the laws of *kashrut* (dietary laws) and *b'rakhot* (blessings).

[18] A responsum by Elyashiv, portrayed by Abraham, *Medical Halachah vol2*, pp. 342–343.

[19] Again, this unanimous approval is when there is no involvement of brain death diagnosis.

5.2.1 Reform Responsa on Organ Donation

The official positions of both the Reform Movement and Conservatives (or Masorti) is approval of organ donation. The Union of Reform Judaism advocates for organ and tissue donation since the mid-eighties. In 1996, the Committee on Bioethics, in collaboration with the Committee on Older Adults of the Union of American Hebrew Congregations (UAHC), addressed in depth the issue of organ transplantation. Based on the religiously legitimizing rationale of *piquah nefesh* and the repeatedly affirmative communication that organ donation is perceived as a major *mitzvah* by a variety of CCAR responsa,[20] the UAHC created a program called "*Matan Chaiim*: the Gift of Life."[21] This program aimed at raising awareness and the need for organ donation. It came with a study guide edited by the UAHC, including a brochure and an organ donor card. The study guide was used for educational purposes and is based on a number of Reform responsa.[22]

There are two responsa written in the 1950s by Israel Bettan and Solomon Freehof on cornea and eye transplants after cardiac death. The first to deal with transplants more generally is the aforementioned response on "Surgical Transplants" by Rabbi Salomon Freehof, published in 1968. In the first part of his argumentation, Freehof makes it clear that the principle for any discussion about organ transplantation must be the certainty of the undoubted death of the donor established by medical diagnosis. It is from this point on, as Freehof points out, "that the real problem begins."[23] As much as he is not concerned with what haunts Orthodox discourse, i.e. the halakhic legitimacy of brain death, his halakhic reasoning instead discusses the moral admissibility of explantation of organs from a dead body and its subsequent implantation into a living body. Freehof refers to the principle of *piquah nefesh* without explicitly using the Hebrew term, but quotes instead a passage in Pessahim 25a, which he translates as: "We may use any material for healing, except that which is connected with idolatry, immorality, and bloodshed."[24] Since for Freehof brain death constitutes death, the overruling principle of *piquah nefesh* allows organ harvesting. With this halakhic "permission," Freehof continues, discussion can end, if it were not for the fact that a dead body in Judaism has a very special sacredness, *k'vod ha-metim*. One aspect of *k'vod ha-metim* is *met assur bahana'ah*, i.e. the prohibition to profit from a dead person.[25] For the sake of argument, Freehof postulates: "If the two principles are taken together, the general

[20]These are the responsa published by the Central Conference of American Rabbis, the professional umbrella organization for American Reform rabbis.

[21]See Address, *A Time to Prepare*, p. 34.

[22]Unfortunately the study guides that were created by the UAHC Committee on Bioethics have disappeared from the website, since the organization has been renamed the Union of Reform Judaism.

[23]Freehof, "Surgical Transplants," p. 292.

[24]Ibid. Pessahim 25a:כי אתא רבין אמר רבי יונן בכל מתרפאין חוץ מעבודה זרה וגילוי עריות ושפיכות דמים

[25]*Hana'ah* is usually translated as "pleasure" or "satisfaction" in the context of *kashrut*.

permissiveness would then need to be restated as follows: We may use all materials except those involved in the three cardinal sins mentioned above and except, also, the body of the dead."[26] The problem with the "dead body," according to Freehof, lies in the use of the word *hana'ah*, or benefit. Freehof bases his further argumentation on a responsum by Rabbi Moshe Feinstein who argued that *hana'ah* is not understood in the sense of a general benefit or profit, but specifically as satisfaction and primarily relevant in connection with satiety by food. Thus, substances that are supplied to the body not for the purpose of pleasure (*lo k'derekh hana'ato*) have a different status. For example, the consumption of blood is forbidden, but a blood transfusion is allowed.[27] Logically then, the prohibition of making a profit from a dead person does not include organ transplants. Consequently, Freehof concludes:

> The exceptional nature and rights of the dead body do not stand in the way of the use of parts of the body for the healing of another body. The part used is not taken into the living body as food, hence it is not considered *derech hana-a*. The part becomes integrated into a living body, and therefore the requirement of its burial has lapsed. Therefore, the general principle stated first remains unimpugned, i.e. that "we may heal with any of the prohibited materials mentioned in Scripture." This is especially true, as Maimonides indicates, because the patients about to receive these implants are actually in danger of death, and for such patients any possible help is permitted by Jewish tradition.[28]

Freehof's conclusion that organ donation is an act of *piquah nefesh* has been repeated by succeeding Reform scholars. Walter Jacob confirms it in his responsum on banks of human organs:

> As we view the traditional reluctance in this matter, we feel that the desire to help a fellow human being, especially in these dire circumstances of *piquah nefesh* is of primary significance. From our liberal understanding of the *halakhah*, this is the decisive factor. The act of donating organs does honor to the deceased; many of those about to die would gladly forego any other honor and donate organs for this purpose.[29]

Mark Washofsky, in his responsum on live liver transplantation, repeats parts of Freehof's argumentation, including Feinstein's ruling. The rather lengthy paraphrase of halakhic literature and reference to *haredi* authorities, who decided such issues decades ago, pushes the "Reform twist" to the very end of the responsum. This is especially so, since, as stated in the last chapter on Reform Jewish responsa, such dedicated halakhic reasoning does not bear any importance on the Reform community who do not commit to Halakha, neither in practice nor in theory. Washofsky eventually cautions that the value of "informed consent" in cases of live liver donation is difficult to realize, because potential donors are often family members of the patient. Thus they are

[26] Freehof, "Surgical Transplants," p. 293.

[27] The same applies also to medicines containing non-kosher components, if there is no "kosher" alternative available.

[28] Freehof, "Surgical Transplants," pp. 295–296.

[29] Jacob, *Contemporary American Reform Responsa*, pp. 131–132.

likely "subject to the sorts of emotional pressure that negate the likelihood of an autonomous non-coerced decision."[30] Applying and valuing the concept of relational autonomy, Washofsky further adds for consideration "that ethical decisions are made in the real world, a world in which every one of us lives within a tight web of social connection and in which none of us is immune to the 'pressures' of social and family life. The demand for total autonomy, therefore, is unrealistic."[31] Washofsky appeals to physicians, medical personnel and the family's rabbi to ensure that donors are safe against excessive pressure and to remind them that a decision to not be a donor is a legitimate decision as well.

5.2.2 Religious Reasons for a Low Donation Rate Among Jews

Although the religious elite have generally ruled in favor of organ transplantation as long as there is no involvement of brain death diagnosis (living organ transplantation; non-vital organ transplants from the deceased), misconceptions about the permissibility of organ transplantation remain widespread.[32]

Reasons for a religiously informed dismissal of organ donation are rooted in what is generally known about the aforementioned prohibitions, obligations, and customs of a dead body in Jewish societies. People assume by inference that observance of the relevant *mitzvot* are not consistent with the medical practice of organ donation. The prohibition of *nivul ha-met* (desecration of a corpse) as well as the obligation to bury all parts of the deceased contribute to Jewish religious hesitance or unwillingness to sign organ donor cards. Furthermore, the idea of bodily integrity is theologically underpinned by the concept of (bodily) resurrection of the dead, *t'hiat ha-metim*. Bioethicist Elliot Dorff (Conservative Movement) finds that Jewish audiences almost unfailingly raise the concern of resurrection at the end of days, and not, as would be expected, by Orthodox Jews, but rather by Conservative and Reform Jews alike. He concludes that "this belief is deeply ingrained in the folk religion; indeed, it is often expressed by Jews who are otherwise totally secular in their thought and actions."[33]

Other common perceptions concern factors that are not met by Jews only, but are rather an expression of Western notions of death and the dead body à la the modern *Verdrängungshypothese*.[34] According to Dorff, the difficulty to contemplate one's own death and the accompanying aver-

[30] Washofsky, *Reform Responsa 1999–2007*, p. 156.
[31] Ibid., p. 157.
[32] See Dorff, *Matters of Life and Death*, pp. 230–239.
[33] Ibid., p. 235.
[34] The hypothesis of the suppression of death anxiety.

sion to thinking about death are psychological factors that prevent Jews—and probably not only Jews—to sign organ donor cards. Furthermore, the surgery necessary to remove an organ, as well as the bodily intrusion as a consequence thereof, is felt from an embodied perspective, as if one's dead body is still alive and conscious during the procedure and thereafter. As elaborated upon in the last chapter, Western intellectual traditions that further dualistic perceptions of the mind-body relationship are challenged by theories of embodiment, e.g. the comprehension that psychological and cognitive processes are embodied. Thus, reservations and concerns against organ donation may be understood as completely independent of any religious content; many times they are interlinked with different aspects of embodiment, as for example cellular memory (see below).

Resistance from Jews may also come from the (Jewish) tradition's view that death does not come at a clear, definable moment but rather happens in stages. In the Jewish religious language, a person advances from the category of *t'refah*, a patient afflicted with an incurable disease who nevertheless may still live for a long time, to the stage of being a *goses*, an actively dying patient.[35] Whether expressed "Jewishly" or not, a brain-dead patient may be thought of as a dying patient rather than an already dead body. The main argument against the surgical removal of organs from a brain-dead patient that Hans Jonas put forth shortly after the publication of the Harvard criteria is actually expressing just that: the concern that this practice equates to violently harming the dying patient.[36]

5.2.3 Donation After Cardiac Death/Donation After Circulatory Determination of Death (dcd or dcdd)

Facing a constant low rate of donated organs from brain dead patients, the transplant community in some countries increasingly draws on donations from donors after circulatory death (DCD). This practice is defined as organ recovery from patients who are declared dead on the basis of permanent absence of respiration and circulation. The term DCD is used in lieu of the former NHBD, non-heart-beating donor.

The following descriptions of medical practices and rabbinic discourses employ information primarily from US and Swiss medical contexts. Israel has started a DCD program in 2016, but only allows for uncontrolled DCD, i.e. recovering organs after failed reanimation.

[35] See Dorff, *Matters of Life and Death*, p. 232.
[36] See Jonas, *Technik*, pp. 221–222.

In comparison with primary brain damage, which is the diagnostic precondition for donations from brain dead donors (DBD), DCD originates from individuals who suffer from secondary brain damage, but are declared brain dead only after withdrawal from life support and cardiac arrest. Neurological death is determined after a "no-touch" phase that varies in time depending on which DCD-protocol is observed. This "no-touch" phase (echocardiographic silence) can vary between two minutes, as according to the Pittsburgh protocol in the United States, and twenty minutes, as practiced in Italy.[37] The European standard is five minutes, but may vary depending on hospital. The University Hospital Zurich (USZ), for example, implements a "no-touch" phase of ten minutes before determination of brain death (without an apnea test).[38]

Hospitals in Switzerland that set up DCD-programs like the University Hospital Zurich are bound by regulations of the wiss Academy of Medical Sciences (SAMW), which published relevant guidelines (*Feststellung des Todes im Hinblick auf Organtransplantationen und Vorbereitung zur Organentnahme*) in November 2017. The guidelines implement the Maastricht classification, developed at an international workshop on non-heart-beating donors in Maastricht (Netherlands) in 1995, and subsequently modified in Madrid 2011 and Paris 2013. They set up five categories (Maastricht 1-5) that differentiate between controlled and uncontrolled situations, with the former describing situations where cardiac arrest occurs after withdrawal of life-support (Maastricht 3) and the latter occurring after failed reanimation (Maastricht 2).[39]

The procedure to obtain vital organs (excluding the heart) involves preparatory measures for the potential donor. These measures help to preserve the organs and include examinations for donor suitability. They may be necessary before, as well as after, determination of death.[40] These measures have been the subject of much critique and public debate.[41]

In the United States this procedure has been rejected by all major Jewish denominations including Reform Judaism, the Jewish movement known for its pro-active organ donation programs. The responsum published by the Central Conference of American Rabbis concludes: "Two minutes of pulselessness 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)."[42] The responsum bases its judgment on literature that notes the lack of clear empirical data proving that a patient meets the neurological criteria

[37] See Paquette and Frader, "Controlled Donation," p. 110.

[38] See Lenherr and Krones, "Zürcher DCD-Programm," p. 13.

[39] Swiss law allows for Maastricht 2 and 3 (see ibid.).

[40] See Schweizerische Akademie der Medizinischen Wissenschaften (samw), *Medizinisch-ethische Richtlinien. Feststellung des Todes im Hinblick auf Organtransplantationen und Vorbereitung der Organentnahme*, p. 17.

[41] See details in Lenherr and Krones, "Zürcher DCD-Programm," pp. 10–11.

[42] Washofsky, *Reform Responsa 1999–2007*, p. 170.

of death after cardiac arrest and only a 2-minutes "no-touch" phase. Since Reform leaders have repeatedly approved the concept of brain death, the key for converging with the values of these religious liberals appears to lie in the irreversibility of the process, given that the protocol for determination of brain death has been followed. The responsum further adds that "the fact that pulse and respiration will not be restored through medical intervention does not prove that they cannot be restored." However, this point is void in the case of an uncontrolled DCD (as in Israel since 2014)—a situation where reanimation has failed and cardiopulmonary death is irreversible. Furthermore, assuming that the responsum implicitly only accounts for situations under controlled DCD, it is worthwhile to consider whether Reform Judaism would assent to DCD under Swiss law as depicted above with a "no-touch" phase of 10 minutes, including a neurological determination of death.

Regarding the highly controversial preparatory measures before a controlled DCD, the same responsum takes an affirmative stance: "The administration of anticoagulant drugs to a non-heart-beating-donor is permissible so long as it is done so as not to harm the patient or hasten his or her death. Organ retrieval is permissible when, but not before, the patient is declared to be brain dead."[43]

With respect to DCD and the perspective of Orthodox Judaism, acceptance strongly depends upon the specific halakhic authority. DCD may be possible within Modern Orthodox settings, where the assumption of brain death is acknowledged, withdrawal from life-support systems is an option (though this is often not the case and many arbiters have ruled against it), and protocol for brain death is followed. A halakhic authority who forbids patients, regardless of declared brain death status, to be withdrawn from life-support systems, would clearly oppose such practices. Additionally, like the aforementioned Reform opinion, liberal Orthodox would most likely oppose DCD when doubt exists over determination of brain death (including the irreversible destruction of the brain stem) after controlled termination of treatment, followed by cardiac arrest.[44]

Rabbi Yuval Cherlow, a *dati leumi* rabbi and member of several ethics committees in Israel, referred to the question regarding the possibility of DCD as the most controversial issue under scrutiny in Israel. At the time of the interview in 2011, Cherlow was part of a group that discussed this option and prepared it for legislation:

> I'll give you the hardest question that we have, now we have it. It's a question that is connected to organ donation. Now, as you probably know when the heart stops working you can't really take organs

[43] Washofsky, *Reform Responsa 1999–2007*, pp. 172–173.

[44] See the description by Breitowitz, *Halachah about Organ Donation*, on the matter: As is the case with the Reform statement, Breitowitz refers to the American context with a likely application of the Pittsburgh protocol. In such a case, either the removal of life support or the lack of clarity regarding brain death would be an argument against DCD.

> from the body and you can't donate. But when we are speaking about kidneys, if the heart stopped, let's say five minutes, nothing was done, the person is dead completely, when his heart [stopped] and he doesn't breathe anymore, that after five minutes you put a kind of an injection into his body; you can restore the ability to take his kidneys for let's say forty-eight hours. Ok? Now, the question today in the State of Israel is, let's say a person died and he's stopped and five minutes, and the family is not here, I would permit it to put the injection only and then to ask, when the family will come, to ask them: 'Are you willing to donate the organs or not?' Or you can't touch the body without the family's permission because of two reasons: First of all you can't do it and second publicly it will look like you were stealing organs, even though you didn't do anything except restoring the potential organ donation. Ok? So that's a very complicated ethical issue and that's now, I'm part of a group that is trying to write the legislations that will, eh, the policy of the hospitals. That's the hottest question today.[45]

A 2020 comparative international study on DCD affirms an existing program for Israel, which only includes uncontrolled DCD, compared to Switzerland for example that operates with controlled and uncontrolled DCD (UDCD) programs. Between 2008 and 2016 a total of 11 grafts have been harvested in Israel by UDCD (only kidneys). In contrast, Switzerland recovered 165 organs in both CDCD and UDCD programs, including kidneys, livers, lungs, and pancreases. The absolute number is not quite comparable though, since Israel started the DCD program only in 2014.[46] The study reveals that although DCD is less effective than DBD and post-transplant outcomes of DCD organs are probably inferior to those from DBD donors, the benefits of a DCD program outweigh the alternatives. Remaining on the waiting list reduces the chance at survival and impacts the quality of life of the patient.[47]

5.3 Rabbis' Perspectives and Practices Regarding Organ Donation

5.3.1 A Modern *Mitzvah*: Conceptions and Practice in Reform Congregations

Since Reform Judaism relates positively to the concept and determination of neurological death, the general tenor regarding the practice of organ donation is positive. Three out of four pulpit

[45] Interview with Rabbi Yuval Cherlow, 12.6.2011, Petah Tikva. Quotation at time stamp #00:08:46-9#.

[46] The rate of grafted organs by this method would nevertheless be extremely low; 44 if extrapolated. The population size of both countries is practically the same, thus adequate for comparison. Portugal which started a UDCD program only in 2016, nevertheless resulted with 12 kidneys.

[47] See Lomero et al., "Donation after Circulatory Death."

rabbis of Reform congregations in the New York area and all of their Israeli colleagues unambiguously explain that organ donation is endorsed by Reform Judaism. They use different Jewish concepts to describe this affirmative stance. As a guiding rationale for such affirmation they most often refer to the principle of *pikuah nefesh*. Alternatively they use the expression "saving lives" and some feel that it is a *mitzvah* to be an organ and/or tissue donor.

One Israeli rabbi, Mia Oppenheimer, is of the opinion that compared to the usually overriding principle of *nivul ha-met* in Jewish law, organ donation is considered a *mitzvah* and therefore an act of *k'dushat ha-haim* (sanctity of life):

> Mia Oppenheimer: People think that according to Jewish law you're not [allowed] to donate, you are not to touch the body. However, see, you always have different values. On the one hand, indeed, you cannot, it's the desecration of the body.
> I: *Nivul ha-met*, right?
> Mia Oppenheimer: *Nivul ha-met*, נכון כל הכבוד. And on the other hand, there is *k'dushat ha-hayim* and the need to save Jewish life. So, when you weigh both, this one wins.[48]

This tension between the traditional sensation that a dead body has to be treated with the utmost dignity, *k'vod ha-met*, which includes not to engage in damaging it, and the obligation to engage in saving lives is approached from a different angle by Rabbi Bugsy Cohen, another Israeli Reform rabbi:

> I don't think there's any holiness (..) in the dead corpse, in my dead corpse. So, whatever can be useful for others I think it is a *mitzvah* to give. I don't feel like it's a belonging to me, you understand? I don't feel a belonging there. I belong to the creation. There is, you know, this identity that is me, has my biography, and each one other has his biography, but this is only temporal. [...] And I'm sure this is the will of God, I'm sure this is the will of God. I'm positive about it. Whenever there is giving, this is the will of God. When there is holding back, this is us.[49]

Cohen's perception that his body does not belong to himself is noteworthy in contrast to the way the concept is used by Orthodox rabbis. Traditionally the body is understood not to belong to an individual person but to God. Consequently, man is like a trustee of his body that has to be handed back to God—undamaged.[50] Cohen reinterprets this idea to mean that by giving "his" body to others he is part of God's creation rather than belonging to God.

The rationalizations undertaken by Reform rabbis is often set either against "the Orthodox" approach, or rather what is thought to be the Orthodox rejection of organ donation, or the halakhic opinion of it. Such discursive strategies to separate one's own interpretive community's

[48]Interview with Mia Oppenheimer (p), 24.5.2011, Jerusalem area. Quotation at time stamp #00:30:36-9#.
[49]Interview with Rabbi Bugsy Cohen (p), 16.6.2011, Jerusalem. Quotation at time stamp #00:32:29-5#.
[50]This religious body concept is known as *v'nishmartem meod l'nafshotekhem*, the obligation to guard one's health, a *mitzvah* to avoid danger. This basically includes all actions that harm a person's physical or mental health, such as abuse of drugs and alcohol.

religious approach from another can be perceived as patronizing as compared to Orthodox rabbis' actual statements regarding their acceptance or rejection of organ donation. Though Reform rabbis' particular discursive approach in depicting their denominational stance against the backdrop of Orthodox norms and religious practice occurs with respect to various subject matters, they especially employ it when discussing organ donation. Three out of four American Reform pulpit rabbis are of the opinion that either Halakhah or Orthodoxy holds that organ donation is forbidden due to the belief of *t'hiat ha-metim* (*mehayeh metim*), the resurrection of the dead at the end of times. Robert Greenspan, pulpit rabbi of a large congregation in Manhattan explains:

> In Judaism the Orthodox believe, they're inclined against, although there are some exceptions and there are some authorities that believe differently, but generally, as a general rule they're inclined against organ donation, because they believe [...] in restoration of the body at the end of days. And so, in order to be fully restored you need all of your organs, that's what they believe. We don't believe that. And we believe the greater good from harvesting organs for other people outweighs that perspective on what might happen on the end of days.[51]

As early as 1885 Reform Judaism has officially rejected this idea of bodily resurrection. The seventh point of the Pittsburgh platform, the foundational document of Classical Reform, also dismisses this concept as an idea "not rooted in Judaism." Hence, Reform prayer books exchanged *mehayeh metim* in the *g'vurah* (God's might) section of the Amida prayer, with *mehayeh ha kol* (give life to all).[52] Rabbi Bryan Epstein of an active Brooklyn Reform congregation is also convinced that Orthodoxy, or rather Halakhah, does not allow organ donation on the grounds of its eschatological concept of the bodily resurrection. His statement on the subject matter thus reveals further theological ascriptions in the direction of Orthodoxy, though simultaneously provides insight into the interrelationship of his identity as a Reform Jew and his dismissal of the concept of bodily resurrection:

> The Halakhah is pretty strict about organ donation, right? The Halakhah doesn't allow you to donate your essential organs, right, those are supposed to stay with you so that your body can be resurrected whole in the world to come. That's really just the doctrine of it. What happens when you, in a desire to be intellectually honest, you don't believe that your body will be physically resurrected. When I believe in God, I believe in some world beyond this world, but I don't think that it's gonna be

[51] Interview with Rabbi Robert Greenspan (p), 12.5.2010,Manhattan, N.Y. Quotation at time stamp #00:44:30-7#. Rabbi Michael Loeb portrays a similar view regarding the Orthodox view on autopsies when he states that "they don't want the body disturbed, because the body is gonna be needed for the *t'hiat ha-meitim*, for the arrival of the dead when the Messiah comes. You don't know it, but you better get ready, you gonna have to come up out of the grave and you gonna roll all the way to Jerusalem (I laugh). Are you prepared?" (Interview with Rabbi Michael Loeb/3 (p), 9.6.2010, Brooklyn, N.Y. Quotation at time stamp #00:35:59-3#).

[52] This was at least the case in *Gates of Prayer: The New Union Prayerbook*, published in 1975. The new Reform Siddur *Mishkan Tefilah*, published in 2007 reintroduced *mehayeh ha-kol* as an option along *metim* in parentheses.

> in a bodily form, it's hard to imagine, you know. It sounds overly logical, but one must ask which body? Do I get myself at sixteen, thirty, forty-seven? Which body is gonna be resurrected? So, you know, you kind of played it out and it seems almost absurd, and therefore here's where I proudly rely on principles of Reform. So, when I'm asked, yeah, I encourage organ donations, 'cause it's an opportunity to save a human life and Judaism very strongly privileges the saving of a human life, right? You save a human life it is as if you saved the entire world, it says in the Mishna,[53] so you weigh those two principles against each other. The liver is an essential organ. In theory you can't donate a liver, but if you have the opportunity to save someone's life knowing your life is gonna go, why do I need to be buried with my liver if someone else can use it and live longer? It doesn't make sense to me at all. From a religious perspective, it doesn't make sense to me and there are also times when I say to myself 'Well, I'm not a halakhic Jew, so I don't follow all of the Jewish law and therefore I'm not gonna listen' or not gonna let the voice of Halakhah dictate this decision and rather I'll use Judaism slightly differently and say it's an opportunity to save a human life. Take the liver, take the lungs.[54]

In contrast to this Reform Jewish affirmation of organ donation construed against the backdrop of Orthodoxy's alleged rejection, two interviewees are of the opposite conviction. In their opinion, all denominations recognize organ donation to be a "modern *mitzvah*," as one of them put it. Whatever the position of Orthodoxy within the argumentation strategy of Reform rabbis, seven out of eight pulpit rabbis in the US and Israel identify personally with the official Reform position as repeatedly published in CCAR responsa and other publications of the UAHC (URJ). They do not problematize the issue or uttered emotional struggles; they firmly expressed, with a strong normative voice, that organ donation is "the right thing to do."

As a matter of social engagement, many congregations pro-actively running programs, campaigns, and events to encourage people to carry donor cards and arrange for donation. Some of them dedicate lectures or sermons in order to raise their community's awareness. Israeli Reform congregations seem especially sensitive about the subject and all their rabbis describe their methods to discuss organ and tissue donation in their congregations. For instance, Mia Oppenheimer states that her congregation was the first to put up a box with ADI cards (see figure 5.2), the Israeli organ donor card, between Rosh ha-Shana and Yom Kippur. This along with a sermon about the importance of life and the *mitzvah* to possess a ticket, as Israelis like to call their ADI's, is what the congregation and its rabbi do every year to address the topic.[55]

Although Rabbi Sarit Steinbaum recommends acquiring an organ donor card, and reveals she possesses an ADI herself, she does not run the same kind of open campaign in her congregation,

[53] See Mishna Sanhedrin 4:5.
[54] Interview with Rabbi Bryan Epstein (p), 25.5.2010, Brooklyn, N.Y. Quotation at time stamp #00:32:17-8#.
[55] See interview with Mia Oppenheimer (p), 24.5.1011, Jerusalem area, time stamp #00:29:42-3#.

Figure 5.2: ADI organ donor card, named after Ehud Ben Dror, who died while waiting for a kidney transplant. Source: `https://www.adi.gov.il/en/`

because many members are elderly people. Her reluctance is based on her feeling that to address this sensitive topic before this age group would be inappropriate.[56]

5.3.2 Permissive Religious Ideal Versus Personal Struggle

Most Reform pulpit rabbis are personally convinced that organ donation is a good deed and reach out to their congregants by means of running campaigns and lectures. In the American context, programs and campaigns are created by the religious superstructure to support congregational work at the basis. Thus, there is a high accordance of personal and structural conviction with this sub-sample of rabbis.

This finding is complemented by another few rabbis and chaplains who theoretically subscribes to this positive Reform position. Their statements show that they have adopted the structure's position on the importance of *matan hayim/matnat hayim*, the gift of life, but nevertheless struggle with the idea on a personal level. Their struggle is primarily rooted in private and intimate concerns that, according to their descriptions, do not have to do with religious concerns at all. In fact, Jews throughout the religious spectrum and those who are secular have their own, usually very private and diffuse reasons as to why they do not sign donor cards.[57] Though interviewees were not asked whether they personally hold donor cards, two Reform chaplains reveal their emotional ambivalence as to why they cannot bring themselves to acquire a donor card. Fay Trachtenberg, a young chaplain, addresses this tension between religious justification of organ donation and her personal restraint:

[56] See interview with Sarit Steinbaum (p), 23.6.1011, Jerusalem, time stamp #00:40:11-0#.

[57] This may hold true for Orthodox individuals too, even though their justification for organ transplantation or its refusal is mainly based on halakhic arguments.

> To make an organ available to a person who needs it (.) after a loved-one has died, I mean it's a gift, it is a cliché, it's a gift of life, it is in the most extraordinary way and you know, and I (.) I ahm, I feel that deeply and I think that is why I'm gonna get an organ donor card ahm, but I (.) ahm (.) personally I (.) I struggle with the idea of another, of one person's organs being inside another person's body. I think that our organs carry memories and dreams and emotions.[58]

Trachtenberg addresses an issue that is of much importance to recipients of allografts: The psychological consequences and the influence on self-identity are especially relevant with respect to organs and tissue transplants that people have a strong personal connection with, such as is the case with heart, facial, skin or hand transplants. Since emotions do not simply occur in our minds, but depend on embodiment, the subjective experience of someone living on inside them may become a psychological challenge.[59] The topic is also covered by media articles that report stories of people who experience the phenomenon of so-called cellular memory transference. Transplant recipients report receiving the memories, feelings, tempers, fears, food, and musical preferences of the donor or gain skills which they never possessed before. In some cases, people start having disturbing dreams of their donors' last moments before death. However, the prevailing assumption that memories are stored primarily in the nervous system challenges the credibility of these reports on cellular memory.[60] Although the transformation of one's own personality may be of minor concern to someone who desperately needs a life-saving organ, Rabbi Trachtenberg's struggle with the idea of organ transplantation due to cellular memory transference is comprehensible.

Rabbi Ann Kornblum, another chaplain at a home for the elderly in Manhattan, repeatedly says that she cannot bring herself to sign the back of her driver's license, an option for American holders of a driver's license to consent to organ donation. Although Kornblum feels that she is being irrational ("I'm allowed to be irrational") about it, she nevertheless gives two reasons for her reluctance.The first reason must be set in a larger ethical context. In 2005 Hurricane Katrina flooded New Orleans and storm-ravaged hospitals ran out of resources. Due to dire circumstances, including impending electricity failure, sleep deprived and totally burnt out staff, and the impossibility to provide all necessary care to all patients, medical staff began to apply reverse triage. It was not possible to provide ventilation to ICU patients who needed it, or to move morbidly obese patients to the helipad with no elevators working. Consequently, the care teams decided to evacuate the sickest last, as applied in the military setting for instance. Memorial Hospital gained notoriety for their staff's decision to use people's DNR's to do such triage and rank them at the "bottom of the list." However, this misuse of the DNR order to triage patients was not the prime ethical issue

[58]Interview with Rabbi Fay Trachtenberg/1 (p), 7.5.2010, Westchester, N.Y. Quotation at time stamp #00:35:00-9#.

[59]See Blumenthal-Barby, "Facial Allograft Transplantation," pp. 451–452.

[60]See Pearsall, G. E. R. Schwartz, and Russek, "Changes in Heart Transplant Recipients," p. 203.

that led to the arrest of Dr. Anna Pou and the nurses connected to the deaths of four patients. Pou was accused of having committed murder of the second degree because she decided to sedate "category 3 patients" with injections of morphine and midazolam. Autopsies revealed lethal doses of morphine.[61]

The mishandling of DNR orders made Rabbi Kornblum wonder whether such documents or orders may be misused again in a similar situation. The argument is comparable to the one that medical staff do not take the same effort at treating a patient if they know that he is a potential organ donor.[62] Secondly, Kornblum rationalizes that her reluctance may also be based on her "Jewish belief that once the person dies, the body has to have integrity and we need to have ultimate respect for the body."[63] It is noteworthy that Kornblum perceives bodily integrity as a necessity to "keep it together," to bury the body complete as an act of honoring the dead; however, it is not interlinked with *t'hiat ha-metim* as the ulterior motive.

Though the underlying principle of the integrity of the body is a reason not to donate organs, Reform rabbis do not highlight the theological concept linked to it, namely bodily resurrection, neither on a personal level nor with respect to what they experience with their congregants. Elliot Dorff's impression (see above) that Jews who raise the concern of bodily resurrection are Conservative, Reform, and secular rather than Orthodox is not confirmed by this study's data.

Kornblum's feeling that she is being irrational is something Rabbi David Reich also faces with his congregants. Leading a very large congregation in Manhattan and running campaigns to raise awareness and discuss the topic with people in his community, Reich realizes that "it's very hard for people. The best people I know are very hesitant, very reluctant to donate organs, it feels creepy to them, you know. They just can't quite get the intellect away from the emotional part of it."[64] The question of brain death is not even relevant. Reich specifies: "They just don't want it to happen to them or their family. It's almost as if the dead body can feel, you know, in some bizarre way and knows and is upset about it or what ever, so, I don't know what goes through people's minds, but I would certainly encourage people to do organ donation.[65]"

It is noteworthy that Reich's impression of his congregants' struggle identifies the main reason as the embodied perspective. The idea that the dead might be "upset" certainly warrants more clarification; it rudimentarily alludes to the fear of the living that the deceased returns to revenge

[61] See Bailey, "The Case of Dr. Anna Pou."

[62] Rabbi Benzion Adonolem (p), the only Orthodox chaplain who shares personal reasons against organ donation, also discusses this argument, although he is in favor of brain death. His case is presented below.

[63] Interview with Rabbi Ann Kornblum/2 (p), 18.5.2010, New York. Quotation at time stamp #00:25:44-4#.

[64] Interview with Rabbi David Reich (p), 3.5.2010, New York City. Quotation at time stamp #00:20:57-8#.

[65] Ibid. at time stamp #00:21:41-8#.

his/her wrongful death. Pre-modern societies and various cultures even today take "precautions" in order to prevent such revenants or unwanted contacts.[66]

Rabbi Michael Loeb and his secretary Marcy Simmons also discuss the unease of having organs harvested from their dead bodies. Eager to learn what a "practical Jew" thinks about this issue, the rabbi invited his secretary to join the interview. Both approve of organ donation as a good and honorable deed and therefore endorse it from a rational point of view. Yet, their discussion reveals aversion to the idea of incision into their deceased bodies:

> Marcy Simmons: And that's funny, because my mother is an organ donor.
> I: See, look at that!
> Marcy Simmons: And me and my father, we are very against it. I am (.) I just am [against it]. It's nothing to do with religion, I just (.) you know, 'cause I feel like when she's dead she's dead, but the thought of them taken from my mother, you know, a body part, and yes, I know it could save somebody's life, you know, I'm just not happy with it. So, but it's really nothing to do with religion, I have to be very honest with you. Michael Loeb: Yeah, I understand.
> Marcy Simmons: She wants everything to be taken, she wants, you know
> Michael Loeb: Let it be used.
> Marcy Simmons: Her feeling is 'let it be used.'
> Michael Loeb: Yeah, to enhance somebody's life (Marcy Simmons/3: Right.) and I think it's really very right and I'm, I'm with you. I don't know that I wanted to cut up my body (Marcy Simmons: Right.), I don't, that bothers me.
> Marcy Simmons: Yeah. You know, but like, the truth is, if, you know God forbids she died and we didn't know why (.) or we had to do an autopsy, believe it or not, I wouldn't have a problem with that.
> Michael Loeb: Mmh, no, no, autopsy is all right. And some Orthodox do it, too.
> Marcy Simmons: Yeah, but they're (Michael Loeb/3: Some, some) not supposed to.[67]

Reform Jews do not employ religious or moral terminology to describe their unease or struggle regarding organ donation. They do not use words such as "desecration" of the body. It is a rather abstract and diffuse unease that is responsible for the "non-religious" resistance to organ donation and has vaguely to do with a certain uncomfortableness regarding dissection of one's own body after death. Despite Simmons' rejection of organ donation and antipathy regarding "cutting up" the body, she endorses the use of autopsy to determine cause of death. From a rational perspective, these feelings seem to be inconsistent, especially if one considers that organ donation is connected to directly saving lives, while autopsy is not. But yet again, it is the transference of body parts into

[66]See Bryant and Peck, *Encyclopedia of Death and the Human Experience*.

[67]Interview with Rabbi Michael Loeb/3 (p) and his secretary Marcy Simmons/3 (p), 9.6. 2010, Brooklyn, N.Y. Quotation at time stamp #00:36:39-4#.

another body that is problematic for Simmons when she struggles with the "thought of them [body parts] taken from my mother."[68]

These examples show a wide range of considerations regarding organ donation. The Reform Jewish experiences, opinions, and personal struggle with organ donation is a phenomenon that has no comparable output within the Orthodox sample. The only Orthodox interviewee who voices such a personal struggle is a chaplain. He is one of the few American Orthodox respondents who very clearly states that he accepts the neurological determination of death following the opinion of Rabbi Moshe Feinstein. His statement is comparable with those of his Reform colleagues who delegate such decisions to the physicians, but cannot bring themselves to practically fulfill what their interpretive community endorses: to sign an organ donor card because it is a *mitzvah*. Rabbi Benzion Adonolem's personal reflection mirrors Ann Kornblum's considerations regarding differential treatment based on donor status:

> I didn't do it. Couldn't. Why, what's the fear? The fear here, all the Orthodox people have this fear, is that, eh, maybe it's (.) a little bit, you know, just, not based in reality, but that's the fear. The fear is, once they know that you're willing to give up, so they sort of don't wanna treat you. That's the fear, that the hospital care becomes diminished. And the Orthodox people have a hard time on that, because sometimes the Halakhah will require to, you can't give up, you have to keep going. So, the fear is that, indirectly, you're helping them with their agenda, although they'll never admit to that. It's, it's a very tricky area here, a lot of it is perception. I can share with you one story. I had a Jewish lady here, who, the family agreed to sign DNR, do not resuscitate, and they had the Rav tell them, allowed to sign it, but at the same time they wanted all other interventions done, hydration, nutrition, treating her infections with and so I spoke to one of the doctors, it was a woman doctor, she said: 'Rabbi, I don't get it. Why are we doing this, we're wasting time, effort, energy, what for, she's finished. It's just a question, is she gonna die today, tomorrow, one week, two weeks, so what's [it good for],' she couldn't grasp, an Indian doctor, whatever she was 'Why would you do this?' As far as she was concerned she really wanted, as she could, she would definitely stop everything. But, I tried to help her understand: 'But that's your wish. The patient has a right, whatever the family decides, they feel, their religious texts, their religious instruction tells them that we have to, even though we're not, we're agreeing she is gonna die, but they want everything maintained. Just they're not gonna do heroic measures, there's a difference.' Heroic measure they're not gonna do, but to treat an infection, and I saw the woman (.) incredulous like 'Why?,' she didn't get it. So, if she had her way, she would stop it. In some states they actually have the right to do that, not New York. Other states, they have a right, if the hospital, in Canada I believe it's also that way. In certain provinces, if the hospital says this treatment has no value, we don't care what the family says (I: Oh, really?), we don't care what you religious, yeah, yeah. So that, that's a lot of controversy, you know, is there a violation, but here, but here in New York they have a lot of laws, but again, you know, there's other ways how to get around the law, you know. You can't openly violate. That's the fear. If it makes sense to you. (I: Yeah, it does.) So, I'm not signing the

[68] Ibid.

> organ transplant, because if I come in from a, into an emergency room and they see 'organ transplant,' so they'll just go right away, that's the fear. I don't say they will, but that's the fear. Without even trying to do their utmost to save me, they'll harvest me.[69]

From a narratological perspective we note that the accounts of both interviewees, Adonolem and Kornblum, explain their reluctance to sign a donor card on the basis of a medical intervention that involves a DNR order. Rabbi Adonolem's fear that is "not based in reality" and Rabbi Kornblum's "irrational" fear are rooted in the same *angst*—that due to carry an organ donor card or a DNR order they will not be treated as they should, whatever the circumstances. Although Adonolem points out that the fear of not being treated properly to an extent that Halakhah would require is not based in reality, he nevertheless amends a case from his everyday professional practice. By doing so, he unconsciously refers his fear to reality; a reality that he, as a full time chaplain in a hospital, is part of. His conviction that staff who are unfamiliar with Jewish life-styles and worldview, and particularly with the strict halakhic "take" on futile clinical situations, may treat him against his wish as an Orthodox Jew, is therefore far from being "unrealistic." As much as stories such as the case of Zack Dunlap of Oklahoma stirs mistrust in medical professionals with respect to the correct determination of death, exceptional circumstances as hurricane Katrina and individual experiences with insensitive staff add to such feelings of loss of control.

Though such qualitative data is not necessarily representative, it is nevertheless noteworthy that those interviewees who utter a personal struggle with organ donation independent of the neurological determination of death are primarily chaplains, i.e. staff employed in the healthcare setting. Einat Ramon, who is a supervisor of a spiritual care training program in Israel, also encounters these issues in her work with spiritual care givers:

> This is not a rational discussion. There is a mystical belief that is shared, I would say, by the majority of Israeli population, that if you damage the body that is something, you're doing something wrong to the disease. They're not even clear about their mystical beliefs, and therefore you don't do that [organ donation]. You may be an atheist but still would follow the Ultra-Orthodox on that issue. Ok, so it's not something that can easily be debated in any situation. I'll give you an example from my work. I had two students, and one of them was, in the same group, they did not know each other's story, but I knew it because I interviewed them. One of them was Orthodox, mainstream Modern Orthodox from a Kibbutz. The Orthodox woman, her husband died kind of surprisingly in a very unexpected way at a young age and she immediately decided to donate his organs because she said: 'In the world to come he does not need his body.' And there was a secular woman from Tel Aviv, she was very atheist, but she believed in reincarnations and she said her dad who had Alzheimer's for maybe 10 years died when she was right sitting next to him, and she never wanted to, she said: 'They

[69] Interview with Rabbi Benzion Adonolem/4 (p), 14.5.2010, Brooklyn, N.Y. Quotation at time stamp #00:20:25-8#.

> came to me and they've asked for organ donations and I said 'I will not touch my dad's body." So, that is something that all the scholars and the big researchers of Jewish ethics do not understand, that there is something beyond that convincing people that there is brain death and this and that, it is a very mystical thing and that Israelis, this is part of their culture. The other thing is the mistrust of the medical establishment, to some degree. 'Is the person really dead? Are we really, can we trust them?' I think there is also that element. So, that is a challenge with the medical training right now and the medical technologies that rely so much on organ donations, ah, you know, and you know it's a real challenge. Are they, is the hospital, are the hospitals really killing people to get organs because this is their medical interest or are they not?[70]

Ramon's account confirms many of the above described individual perspectives on organ donation. The main issues she encounters in her professional life is mistrust against the medical establishment, the embodied perspective when organ donation is addressed, irrespective of the ethical question of brain death, and mystical beliefs in connection with the "right" handling of the corpse.

5.3.3 Opinions and Positions in Orthodox Congregations and Institutions

The decisive factor for or against a positive stance toward organ donation in Orthodox Judaism is interlinked with the question as to whether brain death is halakhic death or not. Consequently, all Orthodox rabbis who are brain death proponents halakhically endorse organ donation as it constitutes *pikuah nefesh*. This permissive halakhic or religious stance that is adopted in theory may not necessarily be identifiable with the individual's personal conviction though. The struggle between what "I should" and what "I would" may constitute two separate realms of personal relatedness, as in the case of Rabbi Adonolem, the Orthodox chaplain. Although permissive structural preconditions regarding organ donation persist in both denominations, the Reform Movement and Orthodoxy, there are huge differences on a practical level: None of the interviewed Orthodox rabbis of the congregations in New York (0/12) officially, i.e. in his position as rabbi, support the brain death concept. They all either reject it because they subscribe to the camp that "goes by the heart" or they do not allow themselves to decide which interpretive community they side with. Consequently, and very much in contrast to the Reform Movement, Orthodox communities included in this study do not run programs, events, or campaigns to raise awareness for organ and tissue donation.

This result should be evaluated within the context of the American Orthodox super-structure. Neither Agudath Israel of America, including the Moetzes Gedolei Hatorah of America which

[70]Interview with Rabbi Einat Ramon/1, PhD, 16.8.2016, Jerusalem. Quotation at time stamp #00:30:08-3#.

is their council of leading Torah sages, nor the Rabbinical Council of America (RCA) accept the brain death standard from an institutional point of view. Since the RCA revised its stance and published a report (see chapter four), proponents lack a strong organizational basis. This is in contrast to the time between 1991 and 2010 when the health care proxy issued by the RCA stated that "in accord with the ruling of Harav Hagaon Moshe Feinstein zt"l and the chief rabbinate of Israel, brain stem death together with the other accepted neurological criteria fully meets the standards of halacha for determining death."[71] It is against the backdrop of this institutional discourse and shift in policy that the strongest support in favor of the neurological concept of death has come from the wider circle that may be called "Open Orthodoxy."[72]

In terms of organizations, the Halachic Organ Donor Society, or HODS, is of utmost importance. This organization was founded by the former journalist Robert Berman and pursues the mission of educating Jews with respect to medical and halakhic issues involving organ donation. HODS offers its own organ donor card which is tailored to the idiosyncratic needs of Orthodox Jews. The advantage of this card is the optional selection of organ donation after irreversible cessation of respiration or irreversible cessation of heartbeat.[73] It respects both halakhic realities and thus contributes to the enhancement of the number of donors. Although the card gives both options, the halakhic mission statement of the society is far from being undecided on the matter. In the FAQ section on their website HODS state that they recognize brain death as halakhic death, but concurrently are aware of the rabbinic debate that exists and thus offer two options of death on its organ donor card.[74] In Israel, lay people get the national card, ADI, issued by the National Transplant Center. HODS and ADI are strategic partners and therefore Berman generally offers ADI in Israel.[75] For rabbis and female religious leaders it is nevertheless possible to sign a HODS donor card in Israel. HODS' mission is to raise awareness to the permissive stance of Orthodox Judaism towards organ donation. An efficient way to spread this message is to convince the religious leaders of congregations and Orthodox communities to take a position on the issue.[76]

In general, Orthodox social life and individual identity is governed by heteronomous structures to a considerable degree. Furthermore, *k'vod ha-rav*, halakhic loyalty, ideally guarantees the continuity of tradition and the perpetuation of a certain interpretive community. It is for that

[71] The Health Care Proxy, appendix C.1. See also interview with Rabbi Charles Sheer, 10.6.2010, Westchester, N.Y. Quotation at time stamp #00:57:57-7#. On the problematic history of this proxy see chapter four.

[72] See Klapper, *The Rabbi Linzer–Agudath Israel Debate*.

[73] See Halachic Organ Donor Society, *Rabbis*.

[74] See Halachic Organ Donor Society, *FAQ*.

[75] See Interview with Robert Berman, 7.8.2016, Jerusalem, time stamp #00:22:24-7#.

[76] According to their website, 85.23% of HODS-Rabbis define brain-stem death as death and 7.59% define only cardiac death as death. The rabbis' organ donor cards are published on the HODS website for everyone to see, except those who did not agree to disclose that information.

reason that Berman segments the "market" and approaches religious leaders according to their religio-cultural affiliation:

> I mean anyone knows, in marketing, like Coca Cola knows, when you wanna convince people to do something you have to segment your market and you, just to say, I have advertising just for teenagers, advertising just for adults, and you have to have different advertising for the different groups. So, same thing with the non-prof org.[77]

HODS thus creates a variety of brochures, each one addressing a separate segment: New York Orthodox physicians, women in leader positions, rabbis of the Sephardi community, Chabad, or rabbis living in various regions of the world, e.g. Canada and Israel.[78] The brochures show pictures of rabbis regardless of their "halakhic donation policy," i.e. heart or brain.[79] Contrary to the principle of halakhic loyalty of rabbis towards their teachers and authorities, Berman observes a suspension of this "rule" when it comes to the behavior of laity:

> Well, I tell you, my perception is, in the rabbinic world, the more *haredi* Ashkenazi are against brain death, but the followers, the lay people they are more willing to say 'I don't care what the rabbi said I wanna get your card.' In the Sephardi world, the Sephardi rabbis are all for organ donation. All these major, these are all the chief rabbis, here all for brain death, all for organ donation, but the lay people are more superstitious, Sephardim are more superstitious, so they don't want to donate organs even though the rabbis said it's ok.[80] That's the sociological crossover of the two groups. It's quite an interesting phenomenon, I think.[81]

In Berman's opinion, the reason for the permissive stance of the Sephardi *posqim* towards brain death and organ donation has "to do with politics. There's always friction there. So, Ashkenazis come out and say 'No,' so they're [Sephardim] like 'Yes.' How crazy is that?"[82] The consequences of Berman's impression for the halakhic organ donor "movement" are problematic. If the leaders' position totally mismatches with what their own community holds true, the exertion of influence on the level of the leaders seems useless and not the means for influence to raise the numbers of donor card holders. It would be worthwhile to conduct a study comparing the respective behavior of lay people with the religious elite regarding organ donation.

In Israel, Orthodox congregations seem to struggle with similar issues, although the situation is not directly comparable on the level of congregational organization due to the prevalence of

[77]Interview with Robert Berman, 7.8.2016, Jerusalem. Quotation at time stamp #00:12:01-1#.

[78]See Halachic Organ Donor Society, *Brochures*.

[79]See Halachic Organ Donor Society, *Rabbis*.

[80]One such belief entails the conviction that consent to organ donation might invoke bad luck (an "evil eye") and lead to premature death. See Quigley, Wright, and Ravitsky, "Organ Donation and Priority Points in Israel," p. 970.

[81]Ibid. at time stamp #00:13:22-0#.

[82]Ibid. at time stamp #00:15:08-1#.

the mainstream open community structure (see chapter two). Nevertheless Rabbi Gershon Elbaz, who himself is undecided about brain death, made an important observation with respect to organizational aspects and organ donation in Israel:

> Organ donations, because the *shul* rabbi issue is not a young people's thing in Israel today. [...] And part of the reason maybe why it doesn't move forward is 'cause people are not organized in that way and will go only through *yeshivot*. In other words, if the rabbis in *yeshivot* think it's the right thing to do, they might push the guys to do it. So for example, I know you have a lot of people who signed and made a whole public thing, but only some of them are rabbis of communities.[83]

Indeed, the HODS donor cards signed by Israeli rabbis and religious leaders that are displayed on the HODS website confirm this socio-religious pattern. Within the Israeli context, the *rashei yeshivot* replace the position of the local or neighborhood rabbi in many instances. Israeli rabbis who signed those cards are mostly *rashei yeshivot*.

It thus confirms that the rabbis who have the greatest potential to influence Israeli Orthodox Jews are the deans of schools for Jewish learning. Yuval Cherlow, himself a *rosh yeshivah* of a Hesder yeshiva in Petah Tikva, assesses his impact as follows:

> They should be convinced that this is the right thing to do, you know, it's very sensitive, so I'm, my contribution is to try to change the image as if halacha is against organ donations, ok? My mission is that people will know that many many Halakhah authorities think that it's not only something that you are permitted to do, maybe it's something that you are obligated to do, you're committed to do, because if you can save life and, as you said, *pikuah nefesh* that's important enough to do that. [...] I will never agree that you are permitted to murder, and if a donor has only two seconds to stay alive I don't think you can do anything, ok, anything eh to do that, ok? But once a person has died and he's dead, this is the main thing that we should.[84]

Consequently, the influence by a *rosh yeshivah* may be long lasting. As exemplified in the discussion on brain death between Rabbi Shafran and his translator, halakhic loyalty may outlive major geographical distances. Educational experiences have a major impact on the young, their worldview, and the decisions they make for their future lives. Thus, national Zionist *rashei yeshivah* seem to be the key figures in Israel who may potentially pass on an admissive stance towards brain death and organ donation from a halakhic perspective to the next generation of Modern Orthodox Jews. Except for the Reform sector which is much more engaged in raising awareness, Orthodox pulpit rabbis are of marginal importance in raising awareness of organ donation in society as a whole.

[83]Interview with Rabbi Gershon Elbaz (p), 3.6.2011, Jerusalem. Quotation at time stamp #00:35:22-1#.
[84]Interview with Rabbi Yuval Cherlow, 13.6.2011, Petah Tikva. Quotation at time stamp #00:21:48-8#.

In the New York area, the rabbis and dean of Yeshivat Chovevei Torah, left wing Modern Orthodox (former Open Orthodox), are apparently the only ones from within the Modern Orthodox sector who are accepting of the brain death concept and organ donation. From an organizational perspective, most Modern Orthodox congregations do not contribute to the educational goal of raising awareness for organ donation due to rabbis' opposing or hesitant stances in the matter. RIETS *rosh yeshivah*, Hershel Schachter does not halakhically acknowledge brain death and the RCA's revised policy signals a change of heart as well. Thus, the community structure that provides congregants with much support in all other areas of life, is of practically zero relevance with respect to the organ donation issue in the New York context.

5.3.4 Body Concepts and Deceased Organ Donation

How do interviewed rabbis perceive deceased organ donation, i.e. cadaveric organ donation? The majority of the Orthodox rabbis of the American sample believe that living organ donation or donation from a deceased family member is considered to be a *mitzvah*. However, on a practical level, responses are heterogeneous when asked whether they recommend, or at least endorse, organ donor cards. Some agree that it would be permissible to sign a donor card for organs like kidneys and corneas to be harvested after cardiac arrest, but do not mention whether such discussion takes places in their congregations. One can reasonably assume that these discussions do not take place, since the rabbis do not mention this, as opposed to their Reform colleagues who do. One rabbi says that congregants have not asked him about organ donor cards.

In some interviews the question triggers the disclosure of a personal opinion, commitment, or a broader reflection of the topic. Only one of those rabbis who do not subscribe to the brain death camp mentions that he has a HODS organ donor card allowing for deceased organ harvesting.[85] Some voice opposition to harvesting organs even after cardiac death, but usually not with a strong normative tenor. Nevertheless, they are part of Orthodox argumentation. For example, Rabbi Rafael Margalit, a young Manhattan based rabbi, who belongs to the category of the officially undecided with respect to the brain death question, has a strong personal stance on organ

[85]See interview with Rabbi Motti Shapiro (p), 25.5.2010, New York. There is a certain ambiguity in Shapiro's statement due to his confusing usage of the term "respiration." Usually brain death opponents declare that they go according to "the heart." This expression means that they reject the neurological determination of death and consider a person dead only after cardio-pulmonary death has occurred. When Shapiro says that he goes according to respiration, one usually understands in this discursive context that he considers the halakhic criteria of irreversible respiration as the main criteria for death. But Shapiro actually means cardio-pulmonary arrest. This becomes also evident from the publication of his organ donor card on the HODS website.

donation. He answers clearly "I wouldn't" to whether he would recommend an organ donor card, if asked:

> I'm just not in that camp, you know. I believe the person should be buried whole and complete. There are people who argue it's a *mitzvah*, ah, I think there are very specific parameters that have to happen in order for it actually to be permitted. So, I'm not an endorser of the Halachic Organ Donor Society, you know.[86]

HODS uses "Make Your Last Mitzvah the Most Important One" as its slogan. It implies that organ donation supersedes all other *mitzvot*, because it saves other peoples' lives. Furthermore, *posqim*, including Moshe Feinstein, explicitly consider organ donation to be a *mitzvah*. However, this understanding serves as a point of contention not only to Rabbi Margalit. A Chassidic chaplain in Brooklyn, Yehuda Leib Danziger suggests to perceive the matter from another perspective. In his opinion, the act of organ donation may not be linked to some kind of *mitzvah* at all, since the dead are exempted from performing *mitzvot*. Thus, Jewish conceptions of *mitzvot* refer only to the living:

> A kidney transplant, a cornea of an eye, that is written already in Jewish law that is acceptable on the situation, but a heart or another organ, we don't accept. Let's put it this way (.) when a person dies, he's gone. At that time he's not obligated to do good deeds. A good deed is done, when you are living and well, so ah, it's not permissible to desecrate the body. A person is born with certain organs, we have to return him with those organs. Again, we don't have title (?) to take and dissect a person.[87]

This very same argument against organ donation has been put forth by Israeli *poseq* Rabbi Eliezer Yehuda Waldenberg (1915–2006) who, according to Michael Barilan, claims that "the dead are exempt from all religious duties, including the duty to save life."[88] This perspective implies the following question: If we assume deceased organ donation to be a *mitzvah*, what are the exact requirements for its fulfillment? Does the willingness of an actor to donate organs, i.e. by possessing an organ donor card, constitute the *mitzvah* of *pikuah nefesh*, since the "good deed is done, when you are living and well?" Or is the *mitzvah* only fulfilled at the time of harvesting? Furthermore, since it is *pikuah nefesh* one could also argue that the recipient indeed has to live for a substantial amount of time in order for the donor to have fulfilled the *mitzvah*. Although this is a halakhic question and cannot be answered here, Danziger's understanding that a deceased person does not have to fulfill *mitzvot* anymore points towards a reasoning that complements the more common perceptions regarding the dead body in Judaism.

[86]Interview with Rabbi Rafael Margalit/1 (p), 23.5.2010, Manhattan, N.Y. Quotation at time stamp #00:48:58-6#.
[87]Interview with Rabbi Yehuda Danziger/3 (p), 8.6.2010, Brooklyn, N.Y. Quotation at time stamp #00:18:59-5#.
[88]Barilan, *Jewish Bioethics*, p. 21.

Another *Haredi* interviewee, Moshe I. Katznelson, who basically agrees with cadaveric organ donation on a halakhic basis, nevertheless struggles with the idea on a personal level.

> I'm not sure how I understand this philosophically in any event. I can understand that (..) God decrees a person lives so many years, I would assume that he means that you live with your own organs providing that life ahm I have, I've never grappled with this philosophically, but I always had questions about it.[89]

His reservations are similar to those put forth by the young Reform chaplain, Fay Trachtenberg, who says that the idea of another person's organs being inside another person's body bothers her.[90]

The idea of Reform rabbis that Orthodoxy rejects any kind of organ donation because of the eschatological concept of *t'hiat metim* is not rooted in Orthodox religious reality at all. Not a single Orthodox interviewee mentions bodily resurrection as an objection to donate. This may well have to do with the fact that rabbis in such professional positions are part of the rabbinic discourse and generally know about the major *posqim*'s rulings on different issues. This may not necessarily be the case with laity, as the account of bioethicist Elliot Dorff reveals. Rabbi Doron Blaufarb encounters these beliefs and halakhic misconceptions in his every-day practice as hospital rabbi in a religious hospital in Israel:

> As far as donating organs to save lives all, almost all, I would say all, but let's say almost all *rabbonim* would permit donating organs to save Jewish lives[91] as long as the organs are taken after death. Ahm, there is the question of taking organs, one is called *nivul ha-met*; *nivul ha-met* means to desecrate the dead person and people worry about *t'hiat ha-metim* which means the afterlife. Both of those questions are irrelevant, *t'hiat ha-metim*, they are for everybody, even those who were killed by the Nazis in Germany and were burned, will have *t'hiat ha-metim*, there's no doubt about that, with the organs without the organs, it doesn't prevent *t'hiat ha-metim*, so that's not a question. *Nivul ha-met*, does not exists if, when it comes to saving a life.[92]

5.4 The Israeli Organ Transplant Law (2008)

Israel's deceased organ donation rate is among the lowest in Western countries. It has achieved a consistently low rate of donations between 2001 and 2011, reaching 9.8 per million population at its highest to 6.4 per million population at its lowest.[93] In addition to the prime religious reasons

[89] Interview with Rabbi Moshe Katznelson/3 (p), 26.5.2010, Brooklyn, N.Y. Quotation at time stamp #00:06:24-6#.

[90] See interview with Rabbi Fay Trachtenberg/1 (p), 7.5.2010, New York. Time stamp #00:35:00-9 #.

[91] The remark "to save Jewish lives," which is problematic for several reasons, is discussed below.

[92] Interview with Rabbi Doron Blaufarb/1 (p), 25.5. 2011, Israel. Quotation at time stamp #00:40:57-1#.

[93] See Quigley, Wright, and Ravitsky, "Organ Donation and Priority Points in Israel," p. 970.

described above, recent research identifies a few additional idiosyncrasies within the Israeli context. Aside from religious Jews' aforementioned reluctance to accept the brain death standard, an accompanying cause of the low donation rate is the so-called "free-rider"-behavior. Free riders are people who are willing to accept an organ but refuse to donate one.[94] According to Lavee and others "this phenomenon arouses significant antagonism toward organ donation in many circles and has been repeatedly cited in public opinion surveys as one of the major reasons for the low consent rate for organ donation."[95] Yet another cause for the reluctance in organ donation before 2008, when the Organ Transplant Law went into effect, has to do with the full reimbursement by Israeli insurance companies and sick funds for costs that arise from transplantation surgery performed anywhere abroad, regardless of the respective legal status. This practice has paved the way for transplantation tourism, which had become a major ethical issue in Israel. Another reason for the low donation rate is underutilization of live donation.

In 2005, Dr. Jacob Lavee, a cardiac surgeon and head of the transplantation unit at Sheba Medical Center in Tel Hashomer, challenged Israel's state of affairs regarding organ donation. The foundational narrative that refers to the ultimate rationale behind taking action tells that Dr. Lavee performed heart transplantations on two *haredi* patients. After they recovered from surgery they had a meeting and Lavee asked them for their assistance to raise awareness of organ donation in their community. Both answered that they are against organ donation and would not consider donating their organs, but have no reservations about receiving transplants. After this meeting Lavee drafted the plan for a new transplantation law that the Israeli Ministry of Health subsequently enacted in 2008.[96]

The law addresses criminalization and punishment of organ trade and trafficking. It also bans performance and reimbursement of organ transplantation outside of Israel if procurement of the organ and its transplantation have been illegally conducted abroad. Furthermore, the law prioritizes organ allocation to:

(a) holders of donor cards for at least 3 years prior to being listed as candidates,
(b) family members who have given their consent for actual organ donation of their deceased next-of-kin, and
(c) individuals who have been non-designated living kidney or liver-lobe donors.

[94] See Lavee, Ashkenazi, Gurman, et al., "Allocation of Donor Organs," p. 1132.

[95] Lavee, Ashkenazi, Stoler, et al., "National Organ Donation Rate," p. 780.

[96] See Interview with Robert Berman, 7.8.2016, Jerusalem, time stamp #00:31:18-7#. A similar, probably even first-hand version of the story is to be found in Ofri, *New Approach to Organ Donation*. See also Lavee, Ashkenazi, Stoler, et al., "National Organ Donation Rate," p. 781 and Lavee, Ashkenazi, Gurman, et al., "Allocation of Donor Organs," p. 1131.

These criteria of prioritization do not concern candidates for heart, lung, or liver transplantation, who are in need of an organ due to their serious condition, if another candidate is not equally suitable for a donated organ. Only in the case that two or more patients are equally suitable for the same organ, prioritization rights take effect. The matter of fairness, thankfulness, and justice in the allocation of organs among Israeli citizens has been a matter of contention.[97] The next subsection takes a closer look at the issue of free-riding, and its underlying philosophical and halakhic arguments.

5.4.1 Justice in Organ Allocation: Particularism or Universalism?

The data gathered in interviews for this study confirms the impression that many Orthodox rabbis, who oppose brain death and therefore perceive organ donation as a halakhically forbidden act, nevertheless think it is acceptable to receive organs from a brain dead individual. People who systematically argue in such a way, whether on a halakhic basis or not, are referred to as free-riders. From an ethical point of view, the free-rider's attitude presents a moral challenge to the distributive justice of scarce medical resources. On the basis of reciprocal altruism, the initiators of the Israeli Organ Transplant Law introduced a priority points system, thereby expressing their opposition against the free-rider mentality:

> The basis of this public reaction is mainly a perceived need to rectify the unfairness of free riders—people who are willing to accept an organ but refuse to donate one—as practiced by a small yet prominent proportion of the Israeli public. These individuals are opposed to the idea of brain death and organ donation, yet they do not abstain from becoming candidates for transplantation when they need an organ for themselves.[98]

The authors maintain that pure altruism is violated by the new law, since altruistic acts are not considered to be "paid back." Yet, Lavee and the other initiators of the new law feel that it is not fair if those who are willing to donate are treated on the same basis of medical priority as those who consistently refuse. Furthermore, they argue that the implementation of a priority points policy, if it results in the procurement of more organs for transplantation, will contribute to the "achievement of maximum health."[99] The initiators are aware of the fact that "mutually exclusive ethical imperatives compete and may lead to ethical tension."[100] Nevertheless, they hold

[97] For a general discussion of the ethical challenges of the priority points system see Berzon, "Israel's 2008 Organ Transplant Law"; for a defending stance in that regard see Zaltzman, "Israel's Organ Transplant Law."

[98] Lavee, Ashkenazi, Gurman, et al., "Allocation of Donor Organs," p. 1131.

[99] Ibid., p. 1132.

[100] Ibid.

that "utility tips the balance in favor of the new policy."[101] Classical utilitarianism is often applied within the medical context. It can be used to argue that right and wrong are measured in relation to the greatest amount of happiness achieved for the greatest number of people.

However, the utilitarian motivation to increase the amount of organs available in Israel is clearly subordinated to the initiators' primary rationale, namely the punishment of free-riding. This is obvious due to the fact that maximum utility could be reached in a much more uncomplicated and effective way, such as by shifting the organ procurement system to one of opt-out, just as the UK did in May 2020.[102] Thus, it seems that the prime rationale for the Israeli priority point system is the moralization of Israeli society. Consequently, the chance to receive a very limited medical resource, i.e. organs, is not exclusively dependent on medical factors alone anymore. The initiators' perspective is coined by a universalistic morality that is naturally based on very different hermeneutic preconditions than those within the *haredi* world. Lavee et al. conclude:

> The observances and rituals of a religion are not incumbent on people of a different faith; however, the morality of a religion, in the opinions of its adherents, should be universal. True believers in the immorality of organ donation after brain death would not be affected by this policy because if organ donation after brain death is wrong, then it should also be wrong for their potential organ donors and hence they should not give or accept an organ.[103]

This universalistic perspective and vision of fairness conclusively overrides any form of communitarian ethical interest or behavior. Consequently, all communities holding views or religious perspectives that seem to cater only to the needs of their own adherents and are "indifferent" towards the well-being of the wider society will face aggravated conditions waiting for organs under the new law. As a medical scientist, Michael Halberthal shares a similar perspective.

> I don't have a problem of all those beliefs by the religious party if this says, 'Look we believe in the sanctity of life, so we do not donate, but we will not accept.' This is not what they say. 'Oh, we will accept everything. We are ready to accept organ donation, if we need them. We will not give, but if we need them.' They will do everything to get organ donation.[104]

The problem with this kind of moralizing is twofold. First, as was elaborated above, religious reasons against organ donation involving the brain death standard have nothing to do with what

[101] Lavee, Ashkenazi, Gurman, et al., "Allocation of Donor Organs," p. 1132.

[102] In an opt-out system it is presumed that the deceased's wish is to donate his organs. All adults in England and Scotland are considered to be organ donors, unless they have recorded their wish not to donate their organs on the NHS Organ Donation Register. The consent of the family is still required for organs or tissues to be retrieved though (soft opt-out). (Davis, *'Opt-Out' System*). The country with the highest organ donation rate is Spain which operates with an opt-out system since 1979.

[103] Lavee, Ashkenazi, Gurman, et al., "Allocation of Donor Organs," pp. 1132–1133.

[104] Interview with Dr. med. Michael Halberthal, 12.6.2011, Haifa. Quotation at time stamp #00:24:07-9#.

the authors think is a particularistic, i.e. not universalistic, religious morality. Orthodox brain death opponents are not "true believers in the immorality of organ donation." It is an outright misconception by these authors to make it seem as if "a small yet prominent proportion of the Israeli public" think that organ donation is immoral. First and foremost, the main issue is the questionable time of death involving a concept and diagnosis that is not based on precedent and an existing halakhic ruling. Imposing such an utilitarian and universalistic perception on an interpretive community that is deeply anchored in normative tradition and case law leads to a distorted understanding of "immorality." Second, it is all too simplistic to factor out the heteronomous nature of Orthodoxy, especially predominant within the *haredi* religious culture, while judging the "morality" of Orthodox Jews who are precluded from autonomous decision-making in practically all matters of medical ethics.[105] Rabbi Edgar Ganzfried, a chaplain at a major Manhattan hospital is well aware of the tension that exists between the halakhic insider and outsider perspectives, having confronted it on a professional basis several times:

> And you know, I'm always asked the question, 'But how come you're allowed to receive, I never heard of a Jew rejecting if they need a heart, they need a transplant' (I: Right.), so I can't really, all I just can say, again, it doesn't seem, it may on the surface not seem fair, but again, we have certain obligations, it's not, if you will, we're not trying to say we're better, it's just with the difference and we have certain responsibilities and I'll just, you know, I could just say it like that 'cause, (not understood some words) I can't express, to receive is ok but again the donating, you know, is not, you know, permissible.[106]

However, it is important to keep in mind that there is not only one halakhic perspective which can be countered by a single non-religious, i.e. utilitarian, position. Just as there are different Orthodox (interpretive) communities and thus styles of integrating scientific knowledge into the halakhic process, there are multiple moralities or moral ideas that constitute values separate from Halakha. The issue of distributive justice crosses the boundaries of a single halakhic case, but involves major social consequences that are relevant for the general public. Yuval Cherlow, a co-founder of Tzohar and *rosh yeshivah*, who is a very outspoken advocate of the brain death criteria and organ donation, does not approve of free-riding. While he may accept the fact that there is a divergence of opinions regarding brain death, he argues for a consequent avowal of the "path" one chooses or follows, depending on whether one accepts or rejects brain death:

> One opinion says: 'We don't recognize brain death, only stopping of the heart and breathing, so therefore you can't actually donate any organs.' The problem with this opinion is, one, that a lot

[105] Interview responses as well as the foundational story recounted by Lavee suggest that the displeased reaction that led to the proposition of the priority points system was not solely influenced by the existence of religious free-riders, but by their unapologetic and complacent attitude.

[106] Interview with Rabbi Edgar Ganzfried (p), 27.5. 2010, Manhattan, N.Y. Quotation at time stamp #00:41:13-2#.

> of people are dying because they don't get organs and second [...] [whether] you are permitted to get organs if you don't donate. And some of them say something that I can't understand as moral idea behind it, that you can't donate but you can receive. [...] So, now it seems like it would be the best thing that everybody, that if you are Ultra-Orthodox and you don't accept brain death, ok, you will not donate and you will not receive. And if you say that you should donate, that you can do it according to Halakha because you do recognize brain death either because this is death or either because brain death means also heart death, so this would be the separation or the way that things will be done. But actually many religious people don't donate organs.[107]

From the point of view of a halakhic free-rider critic, the moral consequence of refusing to donate implies refusing to accept a donation. This would indeed be the case, if one is of the conviction that harvesting organs is equal to killing a living human being—as is the case within the *haredi* milieu. But could the rejection of a life-saving organ be halakhically acceptable within a culture that is known for its self-assertion with respect to heroic measures, applied even in futile situations? It seems that the rejection of an available organ may be halakhically forbidden, since it likely constitutes suicide, i.e. "self-killing." With respect to the question of "availability," Rabbi Shlomo Zalman Auerbach once ruled that a Jew is allowed to accept an organ in a country outside Israel, where Jews constitute the minority of the society, but that this would be a forbidden practice in Israel, because the majority population is Jewish: "Even if there will be other candidates who will be prepared to commit this sin and be in line for the transplant, it is nevertheless forbidden since the majority of donors in Israel will be Jews."[108] Auerbach's rationale for allowing receipt of an organ in any country outside Israel is based in the conviction that "the majority of doctors and patients are non-Jews who depend on medical science and do not fear moving a *gosses*, and, after doing all the tests regarding the brain-stem they consider the patient to be dead, even though he is still being ventilated artificially and his heart is beating."[109] Although medical science and practice is the same in Israel as it is in the diaspora, Israeli society is held to a different standard: "They are bound to act in accordance with the Laws of the Holy Torah."[110] While Auerbach refers to relations within a majority, Rabbi Yitzhak Zilberstein, the son-in-law of Rabbi Elyashiv, and current *poseq* of the Mayanei Yeshua Medical Center in Bnei Brak, is more radical in his perception. He rules that "it would be just to transplant organs from a gentile body since their religion and ethical system does not believe that 'the light of the Lord is the soul of a human being' and that whoever extinguishes the light is a murderer."[111] Observance of Auerbach's ruling, that a Jew

[107]Interview with Rabbi Yuval Cherlow, 13.6.2011, Petah Tikva. Quotation at time stamp #00:13:21-3 #.
[108]Abraham, *Medical Halachah vol2*, pp. 307–308.
[109]Ibid., p. 312.
[110]Ibid., p. 316.
[111]Zilberstein, *Halachic Responsa Zilberstein*, p. 168.

is forbidden to get listed for an organ transplantation in Israel but is permitted to within the diaspora, has issue to the problematic matter of transplant tourism. Up until a few years ago, when the new law restricted this practice, it was common for Israelis to travel to Colombia, China, or the Philippines in order to receive organs.[112]

However, Israeli rabbis are not of one opinion as to whether Auerbach's ruling and practice, namely that Israeli Jews are not allowed to get listed, is actually followed. Yuval Cherlow holds that, although "some rabbis will agree with the idea," there is no such practice in reality.[113] In contrast, Rabbi Yaakov Weiner, founder of the Jerusalem Research Center Medicine and Halacha, confirms an existing practice based on that rationale:

> This is not theory, it's what's being done, yeah (I: Really?), that's what's being done. The issue is like this: They are going to harvest the organ anyway [abroad], if not for you, then there is a list, right? The list is thoroughly very very long. So if they're not going to do it here [with that patient], they can do it with someone else. So, here [there; abroad] you may accept, even though you may not donate because that's killing. But since they are going to do it anyway you may accept. [...] Over here [Israel] it's a little different. Here it's different. Over here you'll be obligated at the last moment to refuse and therefore the donor will live longer until they find a new candidate. [...] So, they go abroad. Because over here you cannot accept. If you, you see, over here, if you're the candidate to receive, at the last moment you refuse, so they're not gonna harvest.[114]

Rabbi Weiner's explanation of the religiously correct practice raises some questions: Why would someone be on the list in order to retract from it the moment that there is a positive message and a match for a transplantation? With Auerbach's ruling in mind, it seems that if one is aware of the fact that receiving an organ is forbidden in any event, one would desist from being put on the list in the first place. Rabbi Weiner dispels this confusion when he adds:

> I: Why should you refuse when you ...?
> Yaakov Weiner: Because I don't want to be killed. They're gonna kill him. By my refusing I'm saving

[112]Several Israeli rabbis and Dr. Halberthal confirm this. Furthermore, a responsum co-authored by Rabbi Elyashiv and Rabbi Zilberstein heavily criticizes transplant tourism, which likely involves criminal action on the side of the provider. This especially holds true with respect to hospitals in China. See Zilberstein, *Halachic Responsa Zilberstein*, pp. 149–156. The highly problematic developments regarding transplant tourism is discussed from an Israeli perspective in a recent interview conducted by Health Europa Quarterly with Jacob Lavee, the aforementioned heart surgeon and initiator of the new Israeli Organ Transplant Law. He describes his experiences with patients who went to China to receive organs. It was in 2005, when he first realized that not only kidneys, but a heart transplant was offered to one of his patients. Since the surgery was planned only two weeks ahead of time, he became aware that this means only one thing: "That somebody knows ahead of time that somebody will die in order to become a so-called 'donor.'" (Health Europa Quarterly, "This is Beyond Understanding," p. 66).

[113]See interview with Rabbi Yuval Cherlow, 13.6. 2011, Petah Tikva. Time stamp #00:19:29-6#.

[114]Interview with Rabbi Yaakov Weiner/1, 19.6.2011, Jerusalem. Quotation at time stamp #00:49:52-9#–#00:50:56-0#.

> his life. So, here in Israel that would have to be the approach. [...] But abroad, since they are going to kill him anyway, I don't have to extend life. They do it anyway.[115]

It is of course very doubtful what Weiner means by "at the last moment." Halakhic goals and moral practice clash yet again. To help perform what must be perceived as *hayeh sha'ah*[116] donating an organ may constitute a halakhic virtue; at the same time, it seems unethical for several reasons. First, if such rejection is done late in the process, the organ may have been grafted already. Basic transplantation procedure in Israel does not differ from other countries of the Western world, where national (or local, depending on the country size) transplant centers and organizations start the matching procedure as soon as there is determination of a donor's brain death and obtainment of consent for organ donation. Preparations on the side of the recipient run alongside those of the donor within a tight time frame. Due to the short ischemia time of vital organs, which is four to six hours for a heart, there is no time to loose. If the practice of declining organs in the last moment, as described by Weiner, exists and *haredi* rabbis recommend it, this would constitute the waste or at least endangerment of life-saving and scarce resources, as well as humiliation for the medical staff, deceased donor, and his family.

Theoretically, another option for a *haredi* Jew to receive an organ is transplantation abroad. Contrary to statements by other interviewees who do not think such an option is feasible, Weiner recalls a case that also affirms his belief in God:

> There is an interesting story: When you had the volcano in Iceland, right, and no no air flight, no flights, so this fellow from Jerusalem needed a liver transplant: here he couldn't get it, so he went to Antwerp. And he's waiting. So, I said to him 'You have no chance because first you are an Israeli, you are not a citizen, right?' And then there's a line. He was there in the hospital and all of a sudden someone was killed in a motorcycle accident and they declared him brain dead and it turned out that the match was a fellow in Germany, but he couldn't get there because of the ash, the clouds of ash. So, by default the fellow in [from] Yerushalajim, Mattersdorf, got it, it was a match for him also (laughing). So, God planned it, God planned all this. A neighbor of my sister in law. The boy lives in the same building as my sister in law. (laughing) That's, God runs the world, God made this (laughing), so he can't come from Germany to Antwerp, so by default it was a match, he got it. So, he's healthy.[117]

[115] Ibid. at time stamps #00:51:14-7# and #00:52:03-6 #.

[116] The concept of *hayeh sha'ah* holds that since the value of life is infinite, so must be the shortest amount of time a person is alive. The life of a person who only lives another minute is thus of the same value as one who is assumed to live many more years. This concept gains special relevance in all matters having to do with triage or end-of-life decisions involving pain and suffering of the patient.

[117] Ibid. at time stamp #00:52:51-5#. I would assume though that it was the transplant that was sent and not the patient who was supposed to travel from Germany to Antwerp, which is indicated by Weiner the way he told the story.

American Orthodox rabbis who speak about the quantitative disproportion caused by free-riders are hardly or not at all concerned about possible consequences. However, Rabbi Paul Vilner, a young West Side based rabbi, is aware of the fact that free-riding may eventually backfire on Jewish communities that are known to not contribute to the organ pool: "I mean in this country [United States], I don't think anyone discriminates, no one says 'Oh, you come from a community that doesn't donate organs, so you can't receive organs.' But I do know maybe that goes on in other places and that has to get factored in."[118] Jews constitute approximately two percent of the American population, including *haredi* Jews, while Israel's *haredim* constitute eight percent of the Jewish population, which is seventy-five percent of the general population. It is thus understandable that American Orthodox free-riders are not as concerned about the possibility that one day consequent refusal will backfire, as expressed by Rabbi Vilner. They constitute a very small sector of American society, and are unlikely the only group that is reluctant to contribute to the pool. This is in contrast to Israel where this specific religious sector proportionally constitutes a much bigger part of the general society.

5.4.2 Organs for Jews Only

An interesting subset of results pertains to the myth or the actual notion that donation of organs should be donated to other Jews. One Reform rabbi in New York is under the impression that Orthodox Jews restrict organ donation, especially in Israel, only to Jews. Though Reich is mistaken in assuming that this is an actual practice in Israel, some in the *haredi* sector express wishes that it were the case. Two interviewees claim that if organs are harvested at all, they should be administered preferably or exclusively to Jews. Moshe Katznelson, a *haredi* pulpit rabbi in Brooklyn, is not in favor of organ donation:

> I cannot tell people to go for an organ donor card, unless they wanna limit it to an eye perhaps or a similar, but for major organs I would have to tell people that I'm not in favor of the organ donation program, unless there is a specific person and *preferably Jewish*, whose life could be preserved by you giving something. But then the question is when do you harvest it.[119]

One of the hospital rabbis of a religious hospital in Israel, Doron Blaufarb, on the other hand clearly states that "as far as donating organs to save lives all, almost all, I would say all, but let's say almost all *rabbonim* would permit donating organs to save Jewish lives as long as the organs are

[118] Interview with Rabbi Paul Vilner (p), 27.5.2010, Manhattan, N.Y. Quotation at time stamp #00:25:02-6#.

[119] Interview with Moshe Katznelson/3 (p), 26.5.2010, Brooklyn, N.Y. Quotation at time stamp #00:05:03-1#. The italics are mine.

taken after death."[120] He further stresses this point in adding that "if you hold that it's brain death, real brain death I would say, then not only I would say the organs can be retaken, it's probably a *mitzvah* to give. Again I'm adding that it should be given to Jewish persons, which is a problem with the Israeli law in the moment because you don't know who's gonna get it. But assuming, you know, it's gonna go to Jews, then it would not only be permitted, it would probably be a *mitzve*."[121] This advice does not correspond with the official opinions of religious leaders. However, there are persons who will consent to the procedure only when the recipient is of a particular religious or ethnic background. Dr. med. Michael Halberthal from the Rambam Medical Center in Haifa remembers several cases of families who were ready to donate a relative's organs on that specific condition:

> I can tell you that we had some cases, first that a family that wanted to donate but "We want to donate to a specific background." We are not allowing this. We tell them from the beginning "You have no say." We are talking about priority medical clear cut priorities without any influence of anything. And if you don't want to donate, do not donate, but we will not agree of any preferences (I: Would be corrupt.). Obviously.[122]

Medical priorities dictate the distribution of scarce resources, such as human organs; any other distribution would imply discrimination. With this in mind, it is well worth mentioning a project that reflects this tension between particular religious and general societal interests. After enactment of the Organ Transplant Law and the Brain-Respiratory Death Act the Chief Rabbinate sought to establish a committee to oversee the determination of brain death, including an advisory body providing guidance to families. Though this proposal never came to fruition, two organizations, Arevim[123] and Bilvavi were founded. The latter sought to offer its own organ donor card, similar to the religious organ donor card distributed by HODS, but available and valid only in Israel. There were two rationales behind Bilvavi. First, a religious card would ensure that the "determination of death is legal, that is, in accordance with the prescribed sequence of actions and the belief system of the patient."[124] Second, Bilvavi intended to counter a specific behavior arising from the law's introduction of a priority point system. Those who do not adhere to the concept of brain death could still sign an ADI to receive preferential status, but would ultimately decline to donate themselves or advise family to interfere. Such evasive behavior could be prevented, or at least impeded, if there was a card organized by rabbinic authorities.[125] However, the Bilvavi card

[120]Interview with Doron Blaufarb/1 (p), 25.5.2011, Israel. Quotation at time stamp #00:40:57-1#.

[121]Ibid.

[122]Interview with Dr. med. Michael Halberthal, 12.6.2011, Haifa. Quotation at time stamp #00:25:51-8#.

[123]Arevim was supposed to be a religious supervisory body to oversee the correctness of the process of brain death determination of a potential organ donor.

[124]Boas and Lavi, "Organ Donation," p. 270.

[125]See ibid., p. 271.

was abandoned as soon as the intensive negotiations with the National Transplant Center, which issues the ADI card, and other parties of interest successfully created a new version of ADI that implemented Bilvavi's core concerns. Rabbi Avraham Steinberg, who was involved in the process of establishing Bilvavi, explains that one of the main interests of Bilvavi was in the elimination of the "clergyman" clause. The prior version of ADI contained the option for family members to consult with any religious clergy prior to their affirmation to organ donation (of the card holder). Steinberg, who himself holds an ADI card, finds the clause to be counter-productive:

> [...] there is a condition in ADI [the old version] that the family is allowed to ask a religious leader. And we thought that this is wrong. On the one hand, why should the family ask someone? I'm signing the donor card. I want to give the order what to do. [...] And a religious leader, what is a religious leader? We don't know what it is. So, then the family can make decisions that I didn't want to. So, we made it more specific that "I" request that a consultation will be done with a qualified rabbi by the Chief Rabbinate for this purpose. And we now qualify close to a hundred rabbis all over the country.[126]

Despite successfully cooperating to create a card that maximally addresses diverse worldviews and sensitivities, Bilvavi issued a card (see fig. 5.3), reflecting an attitude that does not go over well with other agents in the field. The sentence visible on the card is a quote from the Babylonian Talmud, Mishna Sanhedrin 4:5: וכל המקיים נפש אחת מישראל מעלים עליו הכתוב כאילו קיים עולם מלא—And whoever saves a soul in Israel is accounted by Scripture as if to have saved a whole world. This sentence is a version to a quote stated differently in other manuscripts: there, the

Figure 5.3: Bilvavi organ donor card.

term מישראל (*mi'israel*) is lacking and thus changes the sentence to mean "whoever saves a soul

[126] Interview with Rabbi Dr. med. Avraham Steinberg, 9.8.2016, Jerusalem. Quotation at time stamps #00:13:15-4# and #00:14:09-1#.

is accounted by Scripture as if to have saved a whole world."[127] Robert Berman, founder of the Halachic Organ Donor Society, takes issue with this policy because, " you give people the impression that the organs are only going to go to Jews which is not true. You can't do that in Israel. So, it is heavily criticized for doing that."[128] Although the new ADI implemented some of Bilvavi's requests, one thing, however, has not changed: The new ADI card uses the universal slogan וכל המקיים נפש אחת ... כאילו קיים עולם מלא (see figure 5.2) instead of the particularistic one, thus signaling that Israeli organ allocation is still an enterprise of the whole society and does not tolerate discriminatory practices. Considering the promoters of Bilvavi it is highly unlikely that they purposefully sent the message "Jewish organs for Jews only." The statement remains problematic, however, since some Orthodox clergy unhesitatingly state that organ donation—if at all—should preferably save Jewish lives.

This aspect of organ donation is especially relevant in a country like Israel, where most donor families and recipients prefer to be in touch with one another. Michael Halberthal confirms such behavior and the families' wish to be involved:

> And I think it's very nice because it gives them, you know, with all this horrible situation, it gives them, you know, the fact, you know, from whatever happened, there is continuity and they could maybe adjust easier to the death of the beloved one. And most of the families want continuously to be involved with the people who got the organs.[129]

At times, organ donation between Jews and Arabs has been understood as a reconciliatory move in the decades long Israeli-Palestine conflict. Such was the case with Yoni Jesner, a Scottish *yeshivah* student who died after a Palestinian suicide attack in Tel Aviv in 2002. His parents decided, after having discussed the issue with Rabbi Aharon Lichtenstein (1933–2015), the former *rosh yeshivah* of Yeshivat Har Etzion, to donate Jesner's organs.[130] One of Jesner's kidneys was subsequently implanted into an Arab girl who suffered from kidney failure growing up in Eastern Jerusalem.

In contrast, knowing donor identity may cause harm and damage, especially in an environment that is highly charged with cultural and political conflict. The case of Ahmed Khatib offers such an example.

> I can tell you the story about, we were involved here I think this was 2002 [2005] or something like this in one of the, in the first or second intifada. There was in the northern part of Judea and Samaria, there was riots there, there was some kind of Arabs there and between the Arabs, the Palestinians there and

[127]This version is to be found in the Kaufmann and Parma manuscripts, while the version with מישראל in it is from the Rav Herzog and the Karlsruhe Rochlin manuscripts.

[128]Interview with Robert Berman, 7.8.2016, Jerusalem. Quotation at time stamp #00:38:20-7#.

[129]Interview with Dr. med. Michael Halberthal, 12.6.2011, Haifa. Quotation at time stamp #00:29:39-4#.

[130]Regarding the opinion and role of Rabbi Lichtenstein in this case see Vaad Halacha of the Rabbinical Council of America, *Halachic Issues*, pp. 44–46; cf. the statement of the Jesner family in Jesner, *Inaccurate Report*.

> the army, and somebody starts shooting and the army responded and basically one that was hit was a child. The child was hit in the head with a bullet and he arrived to this hospital [Rambam, Haifa]. After 24 hours he was brain dead. And he was declared brain dead, and the father, a Palestinian, we approached him and he accepted, he was willing to donate. (I: Yeah, I heard of that.) And he donated his child's organs. And it was amazing, it was amazing. He had all the reasons to be very angry and he donated his child's organs. Most of them went, some of them went to Arab, it's not an issue, but one of the kidneys went to a religious girl [Jewish], a child, a five years old girl or I don't know, not five maybe more, but a child. And they had lots of media around that and after a while someone here, I don't remember all the details anymore, by the way, the one that managed to convince him to give the organs was our deputy head of the nurses in the pediatric ICU that was Arab, Christian Arab. And he was involved and he spoke to the father and he was willing to donate. And in this, I saw, a few years later, they had some documentary on that story and they spoke to the father of this child [the recipient] and he said, he said that he had extreme difficulties with the fact that this is a kidney from an Arab. I could kill him. You know, this father, you know, saved your child, you can kiss his feet, not eh, I was, it was, and it was lots of responses on the media about this. Everybody was extremely angry on the response of the father.[131]

The various aspects of an interrelationship of utilitarian values and particularistic worldviews, society and individuality, are difficult to consider; especially with respect to a subject as emotional as organ donation. We shall therefore conclude the evaluation of this chapter's topic by applying Maurice Mauss' seminal work "The Gift" (*essay sur le don*) to the issue: Mauss conducted extensive field work in such remote places as Polynesia and Melanesia, where he came up with what finally was his idea on the gift, a theory transferable to modern society as well. Its basic idea is that each gift is part of a system of reciprocity, a system following the rule that every gift has to be returned. Anthropologist Mary Douglas describes the idea as a "total system in that every item of status or of spiritual or material possession is implicated for everyone in the whole community."[132] This cycling gift system is made up by gifts that are either of equal value or must exceed the value of the first gift received, consequently "producing an escalating contest for honor."[133] Although anthropologist Mary Douglas doubts that such broadened application of the initial research question may be successfully applied to the modern context, some key factors may be taken into account regarding organ donation though.

In his conclusion, Mauss notes that the reciprocity of the gift is a moral obligation. He tries to show that what is supposed to be a voluntary act, is actually an obligatory one: Societies are based on the moral idea of the reciprocity in exchanging gifts. Every gift is part of a system of reciprocity in which the honor of giver and recipient are engaged. Applying this idea to the issue of

[131]Interview with Michael Halberthal, 12.6.2011, Haifa. Quotation at time stamp #00:25:51-8#.
[132]Douglas, "Foreword: No Free Gifts," p. viii.
[133]Ibid., p. ix.

organ donation, it becomes clear that the Israeli priority points system corresponds with the idea of "the gift," the way Mauss conceives it. Organ donation is not an altruistic "*matnat hayim*," but rather a life saving gift that society expects to be reciprocated—at least theoretically, via acquirement and signing of an organ donor card. Resentment arises when individuals or communities systematically proclaim that "receiving is ok, but donating is not." This notion of the "gift of life," is semantically anchored in many Western languages as well as Hebrew. "*Matan Chaim*" is the name of the American Reform's organ donor drive campaign. Similarly, the Israeli organization led by *haredi* Jews is called "*Matnat Chaim*." Mauss' conception leads one to understand how unreciprocated "gifts of life" can upset the social order on a national as well as international level: Israel has been cut loose from the Eurotransplant network due to practically non-existent returns of organs to the pool.[134] Since "honor" is an essential factor in the gift exchange, two Israeli Reform rabbis, who are pro organ donation, state that the low donation rate in Israel in combination with transplant tourism is the complete opposite of honor: shame.[135]

Maurice Mauss's theory cannot be fully played out at this point, but is nevertheless an integrative concept that seems to be applicable to challenging questions regarding organ donation at the intersection of particularism, utilitarianism, and the ethical principle of justice.

5.5 Conclusion

Analysis of the rabbis' opinions and professional experiences in their respective work setting reveals that eight out of nine Reform rabbis in congregations promote organ donation. They do so on the basis of Reform Judaism's conviction that this medical practice constitutes a life saving act which does not interfere with any other religious deed that would otherwise prevent it. Pulpit rabbis' answers are unambiguously positive in their stance toward organ and tissue donation from a Jewish perspective. Some congregants' advanced age, however, prevent congregations from run-

[134] Although this happened in the past, in 2011 Eurotransplant signed an agreement with the National Transplant Center-Israel. So called surplus organs for which no suitable recipient can be found are offered to a suitable recipient in another country. Such an agreement also exists with sixteen other organ exchange organizations as well (see Eurotransplant, *International Organ Exchange*). A successful outcome of this cooperation is the case of a donor liver that was shipped from Israel to a child in Germany, since there was no match to be found among Israeli patients (see Beyar, "Challenges in Organ Transplantation," p. 8).

[135] Two Israeli rabbis express their feelings using this very term. Rabbi Mia Oppenheimer: "But I know that the number of people who hold an ADI ticket is a growing number. And so I hope we will have more organs instead of people dying or going abroad which is a shame." (Interview with Rabbi Mia Oppenheimer (p), 24.5.2011, Jerusalem area. Quotation at time stamp #00:33:00-0#.) Rabbi Eitan Peretz (p) even feels that the low donation rate is disgraceful: "As you probably know, [it] is disgraceful the low number of people who are willing to donate organs and that's to the great shame of the country and a lot of this is because of the Orthodox prohibition, so, but that's very hard to change." (Interview with Rabbi Eitan Peretz (p), 26.5.2011, Jerusalem. Quotation at time stamp #00:17:50-2#.)

ning campaigns for donor drives. Regardless of the structural endorsement, a significant portion of the Reform interviewees relate to the issue from an emotional perspective. On the one hand, they subscribe to the idea of organ donation as a modern *mitzvah*. But on the other hand, they struggle to accept it on a more individual basis. It is worthwhile further investigating discussion of organ donation in relation to cognitive or mental processes from an embodied perspective at the intersection of personal and religious normative worldviews. As Einat Ramon suggests, reasons for declining to be a donor ought to be viewed separately from the discourse or the personal acceptance of brain death. In this way, religious acceptance of the neurological determination of death does not necessarily coincide with a general or individual endorsement of organ donation. This is especially true within a non-Orthodox context.

With few exceptions, those pulpit rabbis who wholeheartedly subscribe to the halakhic brain death standard also promote organ donation. It appears that Israeli Orthodox rabbis are more involved in this social enterprise than their American colleagues. One cause for this may be that the former are collectively more decided on the issue of brain death than the latter. Furthermore, a major and powerful part of the religious establishment in Israel is in favor of brain death and thus supports organ donation. The Rabbanut contributed to the implementation of a new law to "accommodate" brain death diagnosis to halakhic needs. In contrast, many Orthodox pulpit rabbis in New York are not openly decisive over brain death. Consequently, when undecided on the brain death question, they tend to be against organ donation.

Based on their understanding of the right behavior towards the dead body, the religious elite have reservations over organ donation. Such consistency cuts similarly across the most *haredi* rabbis and the most liberal Reform chaplains. Both sectors feel that "my organs belong to my body" and should be buried along with the rest. Thus, the Orthodox professional elite can ignore halakhic endorsement of organ donation, even if it is only cadaveric organ donation. Einat Ramon's observation that rational arguments are not relevant in this discussion aligns well with the fact that some professionals intentionally overlook halakhic ruling.

Rabbis affiliated with the Rabbanut concur on the question of brain death and organ donation. Together with the Ministry of Health and other concerned parties, the Organ Transplant Law was enacted in 2008 to strengthen the Israeli organ donation program. Although the whole *haredi* sector rejects the concept of brain death, both in the States and in Israel, the "modern" sector shows considerable national differences. Due to their minority status, American Jews are in the "comfortable" situation where they can allow themselves to be free riders when it comes to organs. They may rely on the general availability of organs provided in their large society. This situation contrasts with Israeli Jews who are the majority in their small nation, which is not part

of a wider international network. Furthermore, Israelis face a different social reality. Free riders are no longer socially tolerable dead weight and thus are disregarded under the new law. Under these conditions, Israeli society could benefit from greater religious support. In addition to the Reform and Conservative Movements, social engagement of the *dati leumi* sector and Rabbanut are especially important for maintaining a sustainable provision of donor organs in Israel. The conclusion that organ and tissue donation constitute a matter of *pikuah nefesh* is consistent with halakhic argumentation. Thus, the main reason behind a strong support by national Zionists would be the fact that ideas of embodiment and notions of reincarnation are widespread among all of the non-religious sectors of society and hard to come by.

Conclusion and Outlook

This empirically based dissertation has been concerned with two major issues: first, a closer examination of the interrelationship of rabbinic discourse and practice regarding bioethical issues, and secondly, a religious and national contextualization of such practice. Bourdieu's concepts of the logic of practice and *habitus* offer the theoretical framework for evaluating rabbis and chaplains' role at the intersection of objective structure, i.e. religious tradition and rabbinic discourse, and professional experience with congregants and patients. The "objective" structure, as elaborated in the second chapter, results from a religious tradition's "history of the present." Thus, descriptions of Orthodox Judaism and the Reform Movement in the United States and Israel serve as the cultural and historical basis for evaluating rabbinic discourses as well as rabbis and chaplains' professional experiences. Such contextualization examines the differing communal structures in both countries. Religious communitization in the United States takes the form of congregationalism, while an open model of Jewish religious communities exists in Israel. This difference affects rabbis' involvement in bioethical and halakhic decision-making processes. Additionally, the presence of a religious, i.e. Orthodox, establishment in Israel and denominationalism in the United States further explains structural and communal differences between the two countries.

The American sample of this study includes Jewish healthcare chaplains, which are absent from the Israeli sample. These professionals are greatly involved in medical ethical decision-making processes. The American chaplaincy model has been developed on the basis of Anton T. Boisen's Christian Protestantism. Boisen primarily intended to establish pastoral care in psychiatric institutions and provide clergy with clinical pastoral training. Clinical pastoral education, CPE, has become a valuable alternative to the rabbinate for ordained rabbis of all denominations. This contrasts with the situation in Israel, where the spiritual care movement does not primarily train rabbis to pastorally accompany patients and their families, but instead uses trainees of various professional backgrounds. This approach attracts promising candidates who may lack the theological, religious, or philosophical backgrounds of their American "colleagues." Considering the Israeli movement of *melavim ruhanim* has only begun to establish itself, Israeli spiritual care workers

are not included in this study's sample. Thus, future research should examine the Israeli spiritual care movement and its care workers' roles.

However, despite receiving rabbinical education, chaplains and pulpit rabbis serve different roles in the care of patients. Great Britain's former Chief Rabbi Immanuel Jakobovits, in his essay on "Rabbis and Deans," not only bemoans the erosion of the local rabbinate as the foundation of the Jewish community, he argues that the rabbinate demands highly specialized professional skills in order to be an effective agency of "spiritual leadership and halakhic jurisdiction."[1] Thus, the normative and spiritual realms of the rabbinate serve as end points for the main axis of a model that roughly captures various dimensions of the rabbi-congregant/patient relationship. Consequently, one conclusion of this dissertation is that trust in spiritual/moral and normative authority of the rabbinate, which are expressions of the notion of *habitus*, is crucial for bioethical decision-making in Orthodox and Reform Judaism. Relationships of trust may develop temporarily between chaplains and patients in a hospital setting. The former's persona must be without normative authority when they engage with the latter, thereby serving as a spiritual resource. Pastoral care givers that have a strong Jewish normative identity, but little or no training tend to be an ill fit for the position, particularly when they fail in negotiating their individual ("moi") with their role ("persona").[2] This sort of chaplain-patient encounter fully embraces a patient-centered approach that focuses on the patient's spiritual and physical well-being and his/her capacity for autonomous decision-making. However, Jewish communities established a world of normative resources that also contribute to the care of patients. I therefore suggest that religious traditions generate relationships of trust by reproducing their normative system. Thus, other than the patient-centered and pastoral care oriented approaches that presuppose an individual's autonomy, some Orthodox milieus perceive patient-centrism a bit differently. Trust generating normative resources persist in the hierarchical structure for halakhic decision-making or inner-communal social services such as *bikkur holim* or similar networks.

Another kind of "centrism," namely brain-centrism is co-negotiated in the chapter on the neurological determination of death. In contrast to most topics that involve beginning-of-life issues, end-of-life matters provoke more dissent among Orthodox rabbis. An exception concerns cases that involve questions on abortion. However, the chapter on brain death evaluates the rabbis' involvement in a bioethics case that has generated a controversy on its own right, at least within Orthodox Judaism. This thanatological subject was given much scholarly attention due to many

[1] I. Jakobovits, *The Timely*, p. 326.

[2] There are several concepts for the various aspects of the "self" of a person. Variations are described by Mauss, "La Notion de Personne," MacIntyre, *After Virtue*, and Daston and Sibum, "Introduction: Scientific Personae and Their Histories."

different approaches of medico-halakhic experts and halakhic authorities who ruled on the matter. The danger of loosing focus within the forest of halakhic source discussions is especially prevalent with respect to the brain death debate. Judging from the massive output of literature on the topic, one might assume that it constitutes a major issue for rabbis in practice as well. However, for the average rabbi this is not the case. Analysis of the relevance and frequency of bioethical questions reveals that brain death is neither an issue that is often brought to rabbis' attention nor is it an especially problematic situation for halakhic decision-making due to the rather short period of time between an individuals diagnosis and subsequent cardiac arrest. The more interesting aspect regarding brain death and Judaism is the interrelationship of interviewees' opinion on brain death with their position in the professional hierarchy and their religious identity. Rabbis who consult with senior rabbis in brain death cases either adopt their rabbis' (or *rosh yeshivah*'s) opinion at an early stage of their career or do not allow themselves to have an opinion. In contrast, Reform rabbis consider the subject of brain death to be a medical decision and not a religious one. Within Orthodoxy interrelationship of rabbinic persona, individual opinion, and rabbis' negotiation with discourse on brain death indirectly indicates interviewees' religious identity. *Haredi* rabbis unhesitatingly answer the question of whether brain death is equivalent to halakhic death. This contrasts with the Modern Orthodox sample, where deference to experts and *posqim* is standard practice and "personal" opinions are unwillingly shared if at all.

In addition to discussion of rabbinic support for congregants and patients in brain death cases, this dissertation has shifted the focal question away from how Jewish clergy reflect at the intersection with "consumers" and towards what position a rabbi holds within a normative network. Who contacts whom? The illustration of these professional inter-dependencies is important due to the topic's problematic halakhic character. As Dr. med. Edward Reichman highlights: Brain death cases are never handled by average local rabbis, but referred to experts with "broad halakhic shoulders." Thus, the subject of halakhic loyalty and questions of professional networking came to the fore.

While the brain death issue is intense with respect to Orthodox sectors of Judaism, the organ donation chapter illustrated the interrelationship of Reform Jewish ideals, personal preferences, and struggles. Additionally, the relationship between structure and "moi" as opposed to structure and "persona" is a major difference that is relevant for practice.

Chapters four and five extensively discuss the Israeli law on brain death and organ donation. In contrast to interviewees' accounts in New York, who rarely discuss brain death or organ donation in connection with New York State law, Israeli rabbis share their pro and contra stances and how they implement it in a hospital setting. One reason for the topic's prevalence among Israeli rabbis

is the country's new legal situation in Israel. Interviews took place only two and respectively three years after the legal implementation of the Israeli Organ Transplant Law and Brain-Respiratory Death Act. Discussion of the Israeli laws on both issues adds a socio-political, or bio-political, dimension to this dissertation's primary focus on rabbinic discourse and professional role. A rough discursive comparison between the two national settings confirms the initial religio-sociological's evaluation of Israeli and American Jewish identity: While the American Orthodox brain death discourse narratively runs along the inner-Orthodox controversy and its two camps, Israeli accounts run along the demarcation line of the religious-secular divide. Reform positions confirm the mainstream medical opinion in the case of brain death, but reveal personal conflict in the case of organ donation.

This dissertation can spark many questions for future research. For example, it would be worthwhile to study the bioethical decision-making processes among Israeli *masortim*. As indicated in the second chapter of this dissertation, *masorti* Jews orient themselves towards the religious authorities and ideals of Orthodox Judaism, but decide individually which aspects of religious practice they implement. Measured against Jews who call themselves Orthodox, *dati*, or *haredi*, *masortim*'s religious orientation is defined by a certain practical arbitrariness that fails to meet the ideals of Orthodoxy. This aspect of *masorti* identity suggests parallels with Reform Jewish religious practice. However, unlike Reform Judaism that considers personal autonomy a religious value, *masorti* Jews lack the religious, theological, and organizational superstructure that legitimizes such behavior. Yaakov Yadgar notes in his article "Maintaining Ambivalence" that "traditionism" provides a good example of what Pierre Bourdieu calls the logic of practice. A practice-focused research design could investigate patterns of *masorti* bioethical and medical decision-making. Such examination that incorporates a Jewish and religious studies perspective may focus on how and in which cases religious knowledge or the opinion of religious authorities is important for *masorti* decision-making. This question is particularly relevant in light of the fact that Israelis, with their open social structure, use various religious, medical, and spiritual resources, e.g. medical referral or Tzohar, and do not necessarily consult with rabbis.

Future research could also relate to the pandemic spread of the SARS-CoV-2 corona virus. For example, one could ask how Jewish communal life can exist in a time when social interaction is becomes disembodied due to the dangers of physical proximity during pandemic times. Furthermore, how and to what extent is Jewish religious practice transformed by this pandemic? Another question worthy of investigation is whether Covid19 and ensuing social restrictions influenced attitudes and opinions of those who reject vaccination for religious reasons. Additionally, how do opinions form when an individual's opinion is submissive to rabbinic authorities, as is the case

in many *haredi* and *hasidic* milieus? And finally, how are particularistic and universalistic, or humanistic, interests negotiated in a global medical crisis such as this? Chapter five of this dissertation addresses this negotiation in relation to the Israeli law on organ donation. It can serve as a framework for investigating such negotiations with respect to vaccination.

Israeli media recently criticized the *haredi* community for its mockery of social distance rules and restrictions, its failure to close schools, and *haredim*'s behavior as if there was no pandemic. However, a recent Haaretz article with the title "Israel's Haredi Leaders Urge Followers to Vaccinate Against COVID, but Misinformation Hinders Efforts," states that there has been somewhat of a turnaround. There is consensus and advocacy among *haredi* leaders supporting vaccination against Covid19, which is available in Israel since December 2020. Israel Prize winner and prominent medical speaker Rabbi Firer has communicated the opinion of three highly respected *haredi posqim*, directing everyone to get vaccinated. As outlined in the third chapter, Rabbi Firer occupies a central role within the Israeli public sphere. It would be interesting to analyze this kind of knowledge brokering with respect to the actual pandemic crisis.

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Appendices

A Table of Interviews

The table is arranged in alphabetical order. Real names are used for all experts on medical Halakha or Jewish bioethics who published on the subject, or who are *poskim*. All others are pseudonymized and marked with (p). M or h in small letters stand for modern Orthodox and *Haredi* Orthodox; other specifics are written out.

2010: Interviews in New York were conducted between May 3 and June 25, 2010 during a research stay from April to June 2010.

1. Address, Richard, Reform rabbi, Union for Reform Judaism, Manhattan, 06/23/2010.
2. Adonolem, Benzion (p), Orthodox rabbi, healthcare chaplain, Brooklyn, 05/14/2010.
3. Belsky, Yisroel, hOrthodox rabbi/Rosh Yeshiva of Yeshivah Torah Vodaas, Brooklyn, 06/25/2010.
4. Benda, Ellis M. (p), Reform rabbi, healthcare chaplain, Manhattan, 06/03/2010.
5. Burstein, Shimon (p), mOrthodox rabbi, congregation, Manhattan, 05/12/2010.
6. Danziger, Yehuda Leib (p), hOrthodox rabbi, Liska Chasidut, healthcare chaplain, Brooklyn, 06/08/2010.
7. Denker, Adam (p), mOrthodox rabbi, healthcare chaplain, Brooklyn, 06/09/2010.
8. Epstein, Bryan (p), Reform rabbi, congregation, Brooklyn, 05/25/2010.
9. Frank, Gabriel (p), hOrthodox rabbi, healthcare chaplain/congregation, Brooklyn, 06/01/2010.
10. Ganzfried, Edgar (p), Orthodox rabbi, healthcare chaplain, Manhattan, 05/27/2010.
11. Greenspan, Robert (p), Reform rabbi, congregation, Manhattan, 05/12/2010.
12. Gross, Joel B. (p), Reform rabbi, healthcare chaplain, PhD, Manhattan, 05/17/2010.
13. Hershberg, Joshua (p), mOrthodox rabbi, healthcare chaplain, Long Island, 06/02/2010.
14. Kagan, Uriel (p), hOrthodox rabbi, congregation, Brooklyn, 06/01/2010.

15. Katznelson, Moshe I. (p), hOrthodox rabbi, congregation/school, Brooklyn, 05/26/2010.
16. Kornblum, Ann (p), Reform rabbi, healthcare chaplain, Bronx, 05/18/2010.
17. Lapin, William A. (p), mOrthodox rabbi, congregation, Queens, 06/03/2010.
18. Loeb, Michael (p) and Simmons, Marcy (p), Reform rabbi and secretary, congregation, Brooklyn, 06/09/2010.
19. Margalit, Rafael (p), mOrthodox rabbi, congregation, Manhattan, 05/23/2010.
20. Rabinowitz, Shalom (p), mOrthodox rabbi, congregation, Brooklyn, 05/09/2010.
21. Reich, David (p), Reform rabbi, congregation, Manhattan, 05/03/2010.
22. Reichman, Edward I., mOrthodox rabbi, Dr. med., Montefiore Medical Center, Bronx, 06/10/2010.
23. Rozin, Arie J. (p), mOrthodox rabbi, organization, Manhattan, 05/11/2010.
24. Salomon, Mendel (p), hOrthodox rabbi, congregation, Manhattan, 05/28/2010.
25. Shapiro, Motti (p), mOrthodox rabbi, congregation, Manhattan, 05/25/2010.
26. Sheer, Charles, mOrthodox rabbi, healthcare chaplain, Westchester Medical Center, 06/10/2010.
27. Trachtenberg, Fay (p), Reform rabbi, healthcare chaplain, New York, 05/07/2010.
28. Ungar, Yosef (p), mOrthodox rabbi, healthcare chaplain, Manhattan, 06/01/2010.
29. Vilner, Paul (p), mOrthodox rabbi, congregation, Manhattan, 05/27/2010.

2011: Interviews in Israel were conducted between May 2 and June 29, 2011 during a research stay from April to July 2011.

30. Blaufarb, Doron (p), hOrthodox rabbi, hospital, Jerusalem, 05/25/2011.
31. Cherlow, Yuval, mOrthodox rabbi/Rosh Yeshiva of Hesder Petach Tikva (and Tzohar), Petach Tikva, 06/13/2011.
32. Cohen, Bugsy (p), Reform rabbi, congregation, Rishon le-Zion, 06/16/2011.
33. Elbaz, Gershon (p), mOrthodox rabbi, congregation, Jerusalem, 06/03/2011.
34. Halberthal, Michael, Dr. med., Rambam Health Care Campus, Haifa, 06/12/2011.
35. Horowitz, Mayer Alter, Admor Rebbe, Hasidut Mosdos Boston, Har Nof, Jerusalem, 06/29/2011.
36. Oppenheimer, Mia (p), Reform rabbi, congregation, Jerusalem area, 05/24/2011.
37. Peretz, Eitan (p), Reform rabbi, congregation, Jerusalem, 05/26/2011.
38. Weiner, Yaakov, hOrthodox rabbi, Jerusalem Center for Research, Medicine and Halacha, Jerusalem, 06/19/2011.
39. Weinheimer, Tzvi (p), hOrthodox rabbi, hospital, Tel Aviv area, 06/20/2011.
40. Weiss, Ruhama, Reform rabbi, PhD, Hebrew Union College, Jerusalem, 05/29/2011.
41. Steinbaum, Sarit (p), Reform rabbi, congregation, Jerusalem, 06/23/2011.
42. Sznaider, Mordechai (p) and Brill, Elimelech (p), hOrthodox rabbi and his translator/congregant, Jerusalem, 05/02/2011.

2016: Interviews in Israel were conducted between August 7–17 during a short research stay from August 3–24, 2016.

43. Berman, Robert, Founder Halachic Organ Donor Society (HODS), Jerusalem, 08/07/2016.
44. Ettun, Rachel, family therapist, Founder Haverut, Jerusalem, 08/17/2016.
45. Neman, Itamar (p), mOrthodox rabbi, hospital, Jerusalem, 08/17/2016.
46. Ramon, Einat, Conservative rabbi, Marpeh Program, Schechter Institute, Jerusalem, 08/16/2016.
47. Shafran, Yigal, Orthodox rabbi, Director of the Jerusalem Rabbinate's Department of Medicine and Halakhah and Aaron D. Jachter (p), translator/pediatrist, Jerusalem, 08/15/2016.
48. Steinberg, Avraham, Orthodox Rabbi, Dr. med., Shaarei Zedek Medical Center, 08/09/2016.
49. Wein, Berel, Orthodox rabbi, Bet Knesset Hanasi, Jerusalem, 08/08/2016.

B Interview Guides

Interviews with experts contained specific questions, dependent on the experts' area of expertise. The interview guides displayed below cover the core samples.

B.1 Rabbis of Orthodox Congregations/Organizations

1. Could you describe in a few words your religious background and education?
    - How would you describe your community/congregation? Are there any special characteristics?
2. In cases of medical treatment regarding questions about the beginning and end of life; assume a patient or family members wish to talk to you. What is usually expected of you? Why do they seek to talk to you?
3. Within the scope of bioethical/biomedical issues: What kind of sorrows, fears and problems are you mostly confronted with by patients or family members?
4. There are several so-called "Jewish Hospitals" or "Jewish Medical Centers." Do you know whether your congregation members prefer Jewish hospitals or not (and do you personally prefer them)?
    - If yes: For what reasons do they prefer these?
    - Are there—from an ethical point of view—any distinctions to "regular" hospitals?
5. Case 1: An 85 year-old woman is—according to what the doctors say—dying, but is still conscious. She refuses to accept nutrition and hydration which will definitely lead to her death soon. If you as a rabbi were asked by the family members to give your opinion or decision about further actions, like artificial feeding and hydration against her will, how would you react?
    - Have you ever been consulted in such or a similar case?
    - Would it halakhically be allowed to coerce her or would her will be respected?
6. How do you assess a patient's autonomy? And how important is this concept within Orthodox Judaism?
7. How do you assess the impact of *aggadic* textmaterial in bioethics? E.g. Teradjon for euthanasia.
8. In Orthodox Judaism, are the terms "quality of life" and "dignity of human beings"—especially in a bioethical context—used?

9. Do you have any considerations against cloning human beings (reproductive cloning), when—sometime in the future—the technology will be reliable enough?
10. In the United States brain death is a valid definiton of death. Do you accept brain death? Could you please explain the reasons why you accept or reject it?
    - Have you ever been consulted in the case of a brain death patient? For example when decisions about live-sustaining treatments (ventilator etc.) had to be made?
11. In line with the question about brain-death: How would you describe your position regarding organ transplantation?
    - How would you react if a member of your congregation asked you whether s/he could acquire an organ donor card?
    - Assumed someone comes to you, asking whether he/she should take upon him/herself the risk of undergoing a living donor transplantation, such as a kidney or a part of a liver. How do you evaluate the risks and what advice would you give?
12. Case 2: In the last few decades genetic screening has been highly recommended among the Jewish Ashkenazi population in order to prevent some serious, often lethal diseases like Tay Sachs or Canavan. Do you actively propose testing for people who are about to marry or have plans for starting a family? Do you recommend it earlier in life?
    - Do you have any ethical considerations? (E.g. traditional *shiddukh*.)
    - If testing is positive, what consequences follow?
    - If they anyway decide to marry and have children. In case a child is affected by one of these serious diseases. Is abortion allowed?
13. Suppose you would like to ask, discuss or obtain a second opinion concerning a certain bioethical problem (like brain death, euthanasia, treatment of a terminally ill patient or assisted reproduction). Who do you call or contact? Location network?
    - Have you ever asked for a second opinion? What case?
14. Is there any specific *posek*, i.e. his decisions, you prefer when it comes to bioethical questions? Auerbach, Feinstein, Eliyashiv, Waldenberg, Ovadja Josef?
15. How do you handle the problem, that the rabbis of the Talmud and also of later times, in their shaping of Halakha often relied on medical knowledge of their time that isn't accurate anymore? How—if at all—and who would change the halakha based on this outdated knowledge? (E.g. Rashi, Galen and the role of the heart)
16. Opinion forming: How significant are secular or other Jewish but non-Orthodox discourses in bioethics for forming your opinion?

17. Is there anything you would like to add or annotate; perhaps a thought you couldn't bring up so far?

B.2 Rabbis of Reform Congregations/Organizations

1. Could you describe in a few words your religious background and education?
    - How would you describe your community/congregation? Are there any special characteristics?
2. In cases of medical treatment regarding questions about the beginning and end of life; assume a patient or family members wish to talk to you. What is usually expected of you? Why do they seek to talk to you?
3. Within the scope of bioethical/biomedical issues: What kind of sorrows, fears and problems are you mostly confronted with by patients or family members?
4. There are several so-called "Jewish Hospitals" or "Jewish Medical Centers." Do you know whether your congregation members prefer Jewish hospitals or not (and do you personally prefer them)?
    - If yes: For what reasons do they prefer these?
    - Are there—from an ethical point of view—any distinctions to "regular" hospitals?
5. Case 1: An 85-year old woman is—according to what the doctors say—dying, but is still conscious. She refuses to accept nutrition and hydration which will definitely lead to her death soon. If you as a rabbi were asked by the family members to give your opinion or decision about further actions, like artificial feeding and hydration against her will, how would you react?
    - Have you ever been consulted in such or a similar case?
6. How do you assess a patient's autonomy? And how important is this concept within Reform Judaism?
7. How would you describe the Reform Jewish approach in shaping positions or even decisions concerning bioethical issues? (Relation between *Aggada* and *Halakha*, religious authority and autonomy?)
8. In Reform Judaism are the terms "quality of life" and "dignity of human beings"—especially in a bioethical context—used?
9. Case 2: Stem cell research: In the course of stem cell research with embryonic stem cells the blastocyst will be discarded. Do you oppose this technique or do you think that its anticipated benefits, like artificial tissue or organ production, are valid?

10. Do you have any considerations against cloning human beings (reproductive cloning), when—sometime in the future—the technology will be reliable enough?
11. In the United States brain death is a valid definiton of death. Do you as a Reform rabbi accept brain death? Could you please explain the reasons why yes/no?
    - Have you ever been consulted in the case of a brain death patient? For example when decisions about live-sustaining treatments (respirator etc.) had to be made?
12. In line with the question about brain-death: How would you describe your position concerning organ transplantation?
    - Do you recommend—if asked by a member of your congregation—that they aquire an organ donor card?
13. Case 3: In the last few decades genetic screening has been highly recommended among the Jewish Ashkenazi population in order to prevent some serious, often lethal diseases like Tay Sachs or Canavan. Do you actively propose testing for people who are about to marry or have plans for starting a family? Do you recommend it earlier in life?
    - Do you have any ethical considerations?
    - If testing is positive, what consequences follow?
    - If they anyway decide to marry and have children. In case a child is affected by one of these serious diseases. Is abortion allowed?
14. Suppose you would like to ask for, discuss, or obtain a second opinion concerning a certain bioethical problem (like brain death, euthanasia, treatment of a terminally ill patient, or assisted reproduction). Who do you call or contact? Location network?
    - Have you ever asked for a second opinion? What case?
    - What was the basis of this conversation? Halakhic, text-based, principle based?
15. Opinion formation: How significant are secular, Orthodox, or Conservative discourses in bioethics for forming your opinion?
16. Is there anything you would like to add or annotate; perhaps a thought you couldn't bring up so far?

B.3 Chaplains/Rabbis in Hospitals

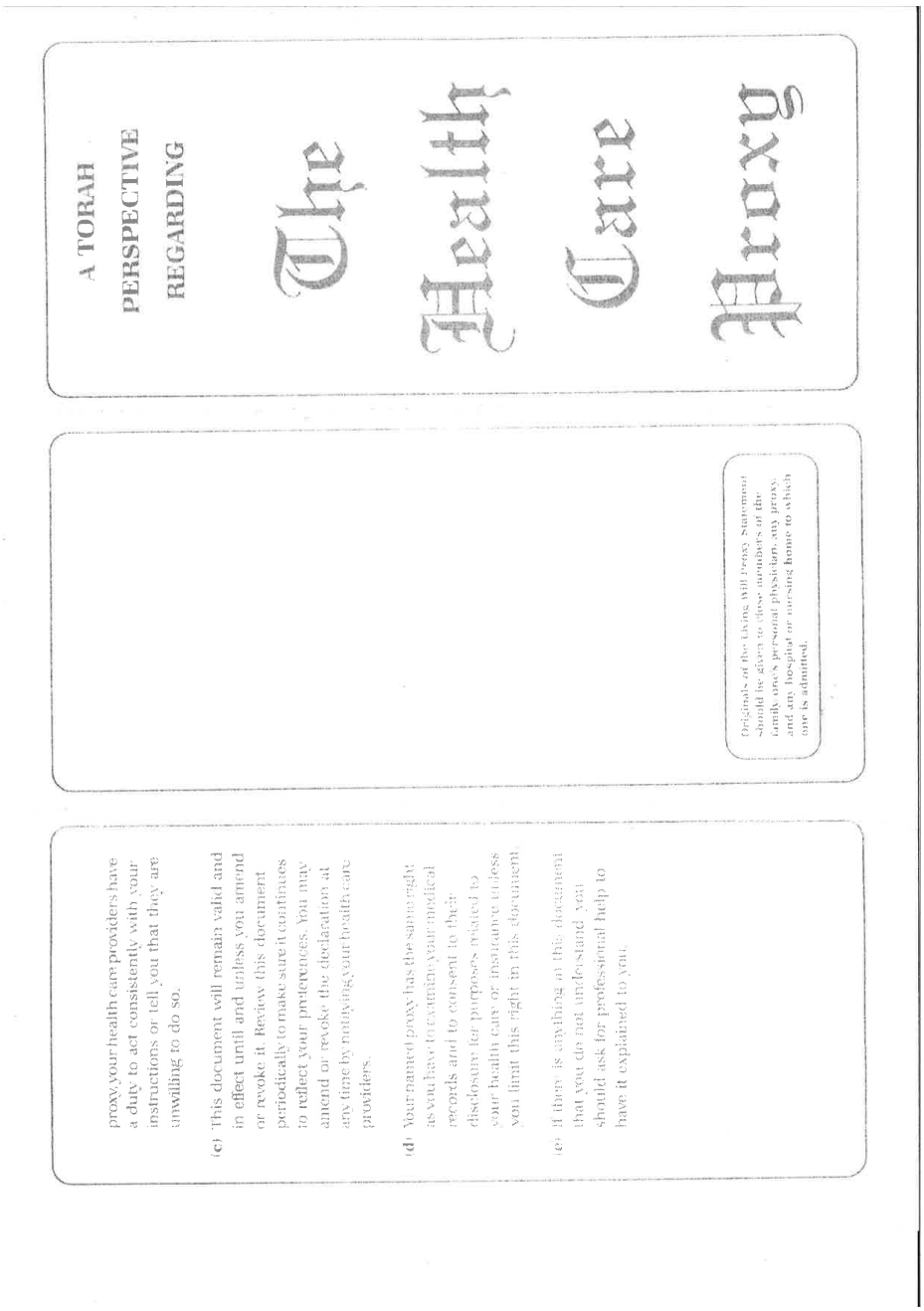
1. Could you describe in a few words your religious background and education?
    - Are you the only rabbi/Jewish healthcare chaplain employed in this hospital or are there others as well? (Denominations?)
    - How did you come to work in this hospital?

   - What is the range of functions you're responsible for?
2. Are there—from an ethical point of view—any distinctions to "non-Jewish" hospitals? (Besides kosher food, *minyanim* etc.)
3. Within the scope of bioethical issues: What kind of problems are you mostly confronted with by patients or family members?
   - What do patients and family members expect when they seek to talk to you?
   - Does the hospital staff sometimes also come to you for advice? What are frequent issues or questions?
4. I suppose that usually patients are affiliated with a specific congregation or community and are especially close to a rabbi they know.
   - Does cooperation take place?
   - Are there sometimes situations of conflict or a clash of opinions for example?
5. Case 1: An 85-year old woman is—according to what the doctors say–dying, but is still conscious. She refuses to accept nutrition and hydration which will definitely lead to her death soon. If you as a rabbi were asked by the family members to give your opinion or decision about further actions, like artificial feeding and hydration against her will, how would you react?
   - Have you ever been consulted in such or a similar case?
6. In your opinion, how do you assess a patient's autonomy?
   - Orthodox Rabbis: How do you assess the impact of *aggadic* textmaterial in bioethics? E.g. Teradjon for euthanasia.
   - Reform Rabbis: How would you describe the Reform Jewish approach in shaping positions or even decisions concerning bioethical issues?
7. In (Orthodox/Reform) Judaism, are the terms "quality of life" and "dignity of human beings"—especially in a bioethical context—used?
8. Do you have any considerations against cloning human beings (reproductive cloning), when—sometime in the future— the technology will be reliable enough?
9. In the United States brain death is a valid definiton of death. Do you accept brain death? Could you please explain the reasons why you accept or reject it?
   - Have you ever been consulted in the case of a brain death patient? For example, when decisions about live-sustaining treatments (ventilator etc.) had to be made?
10. In line with the question about brain-death: How would you describe your position concerning organ transplantation?

11. Suppose you would like to ask for, discuss, or obtain a second opinion concerning a certain bioethical problem (like brain death, euthanasia, treatment of a terminally ill patient or assisted reproduction). Who do you call or contact? Location network?
    - Have you ever asked for a second opinion? What case?
    - What was the basis of this conversation? Halakhic, text-based, principle based?
    - Orthodox Rabbis: Is there any specific *posek*, i.e. his decisions, you prefer when it comes to bioethical questions? Auerbach, Feinstein, Eliyashiv, Waldenberg, Ovadja Josef?
12. How do you handle the problem, that the rabbis of the Talmud and also of later times, in their shaping of halakha often relied on medical knowledge of their time that isn't accurate anymore? How—if at all—and who would change the halakha based on this outdated knowledge?
13. Case 2: In the last few decades genetic screening has been highly recommended among the Jewish Ashkenazi population in order to prevent some serious, often lethal diseases like Tay Sachs or Canavan. Do you actively propose testing for people who are about to marry or have plans for starting a family?
    - Do you have any ethical considerations?
    - If testing is positive, what consequences follow?
    - If they anyway decide to marry and have children. In case a child is affected by one of these serious diseases. Is abortion allowed?
14. Opinion formation: How significant are secular or other Jewish (Conservative, Orthodox, Reform) discourses in bioethics for forming your opinion?
15. Is there anything you would like to add or annotate; perhaps a thought you couldn't bring up so far?

C Brochures and Documents

C.1 Health Care Proxy Issued by the Rabbinical Council of America, 1991



A TORAH PERSPECTIVE REGARDING

The Health Care Proxy

(originals of the Living Will Proxy Statement should be given to close members of the family, one's personal physician, any proxy, and any hospital or nursing home to which one is admitted.

proxy, your health care providers have a duty to act consistently with your instructions or tell you that they are unwilling to do so.

(c) This document will remain valid and in effect until and unless you amend or revoke it. Review this document periodically to make sure it continues to reflect your preferences. You may amend or revoke the declaration at any time by notifying your health care providers.

(d) Your named proxy has the same right as you have to examine your medical records and to consent to their disclosure for purposes related to your health care or insurance unless you limit this right in this document.

(e) If there is anything in this document that you do not understand, you should ask for professional help to have it explained to you.

Sanctity of Life . . .

Life is a sacred trust over which we have stewardship. We have a halachic obligation to preserve this life and to do nothing to endanger it. Active euthanasia is never a permissible option. Since withdrawing either liquids or food inevitably leads to the patient's death, it is a form of active euthanasia.

Organ Donation . . .

The saving of a life takes precedence 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 the halacha, which mandates the highest standards of respect for human dignity. Vital organs such as 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. 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. 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.

Health Care Declaration

Notice:

This is an important legal document. Before signing this document, you should know these important facts:

(a) This document gives your health care providers or your designated proxy the power and guidance to make health care decisions according to your wishes when you are in a terminal condition and cannot do so. This document may include what kind of treatment you want or do not want and under what circumstances you want these decisions to be made. You may state where you want or do not want to receive any treatment.

(b) If you name a proxy in this document and that person agrees to serve as your proxy that person has a duty to act consistently with your wishes. If the proxy does not know your wishes, the proxy has the duty to act in your best interests. If you do not name a

C.2 The Halachic Living Will Issued by Agudath Israel of America, New York

The Halachic Living Will

PROXY AND DIRECTIVE WITH RESPECT TO HEALTH CARE DECISIONS
AND POST-MORTEM DECISIONS
FOR USE IN NEW YORK STATE

*The "Halachic Living Will" is designed to help ensure that all medical and post-death decisions made by others on your behalf will be made in accordance with Jewish law and custom (*halacha*). This document, the "Proxy and Directive with Respect to Health Care Decisions and Post-Mortem Decisions," is the basic form that provides such protection.*

INSTRUCTIONS

(a) ***Please print your name on the first line of the form.***
(b) ***In Section 1, print the name, address, and day and evening telephone numbers of the person you wish to designate as your*** **agent** *to make medical decisions on your behalf if, G-d forbid, you ever become incapable of making them on your own.*
You may also insert the name, address, and telephone numbers of an **alternate agent** *to make such decisions if your main agent is unable, unwilling, or unavailable to make such decisions.*
*It is recommended that before appointing anyone to serve as your agent or alternate agent you should ascertain that person's willingness to serve in such capacity. In addition, if you have made arrangements with a burial society (*Chevra Kadisha*) for the handling and disposition of your body after death, you may wish to advise your agents of such arrangements.*
Note: New York law allows virtually any competent adult *(an adult is a person 18 years of age or older, or anyone who has married)* to serve as a health care agent. *Thus, you may appoint as your agent (or alternate agent) your spouse, adult child, parent or other adult relative.*
You may also appoint a non-relative to serve as your agent (or alternate agent), unless that individual has already been appointed by 10 other persons to serve as a health care agent; or unless that individual is a non-physician employee of a health care facility in which you are a patient or resident.
(c) In section 3, please print the name, address, and telephone numbers of the Orthodox Rabbi whose guidance you want your agent to follow, should any questions arise as to the requirements of halacha.
You should then print the name, address, and telephone numbers of the Orthodox Jewish institution or organization you want your agent to contact for a referral to **another** ***Orthodox Rabbi*** if *the rabbi you have identified is unable, unwilling or unavailable to provide the appropriate consultation and guidance.*

You are, of course, free to insert the name of any Orthodox Rabbi or institution/organization you would like, but before doing so it is advisable to discuss the matter with the rabbi or institution/organization to ascertain their competency and willingness to serve in such capacity.

(d) ***In Section 7, sign and print your name, address, phone numbers, and the date.*** *If you are not physically able to do these things, New York law allows another person to sign and date the form on your behalf, as long as he or she does so* at your direction, in your presence, *and* in the presence of two adult witnesses.
(e) ***In the DECLARATION OF WITNESSES Section, two witnesses should sign their names and insert their addresses beneath your signature.*** *These two witnesses must be competent adults.* Neither of them should be the person you have appointed as your health care agent (or alternate agent). *They may, however, be your relatives.*

***IF YOU RESIDE IN A MENTAL HEALTH FACILITY**, at least one witness must be an individual who is not affiliated with the facility. In addition, if the mental health facility is also a hospital, at least one witness must be a qualified psychiatrist.*

*(f) It is recommended that you keep the original of this form among your valuable papers; and that you **distribute copies to the health care agent (and alternate agent)** you have designated in section 1, **to the rabbi and institution/organization** you have designated in section 3, as well as to **your doctors, your lawyer**, and anyone else who is likely to be contacted in times of emergency.*

*(g) **If at any time you wish to revoke this Proxy and Directive, you may do so by executing a new one; or by notifying your agent or health care provider, orally or in writing, of your intent to revoke it.***

If you do not revoke the Proxy and Directive, New York law provides that it remains in effect indefinitely. Obviously, if any of the persons whose names you have inserted in the Proxy and Directive dies or becomes otherwise incapable of serving in the role you have assigned, it would be wise to execute a new Proxy and Directive.

*(h) It is recommended that you also complete the second component of the Halachic Living Will, the **"Emergency Instructions Card,"** and carry it with you in your wallet or billfold.*

(i) If, upon consultation with your rabbi, you would like to add to this standardized Proxy and Directive any additional expression of your wishes with respect to medical and/or post-mortem decisions, you may do so by attaching a "rider" to the standardized form. If you choose to do so, or if you have any other questions concerning this form, please consult an attorney.

Developed and published by: Agudath Israel of America • 42 Broadway, 14th Floor • New York, NY 10004 • 212-797-9000

The Halachic Living Will

PROXY AND DIRECTIVE WITH RESPECT TO HEALTH CARE DECISIONS AND POST-MORTEM DECISIONS

FOR USE IN NEW YORK STATE

I, _____, hereby declare as follows:

1. Appointment of Agent: In recognition of the fact that there may come a time when I will become unable to make my own health care decisions because of illness, injury or other circumstances, I hereby appoint

Agent

Name of Agent: _____

Address: _____

Telephone: Day: _____ Evening: _____

as my health care agent to make any and all health care decisions for me, consistent with my wishes as set forth in this directive.

If the person named above is unable, unwilling or unavailable to act as my agent, I hereby appoint

Alternate Agent

Name of Alternate Agent: _____

Address:_____

Telephone: Day: _____ Evening: _____

to serve in such capacity.

This appointment shall take effect in the event I become unable, because of illness, injury or other circumstances, to make my own health care decisions.

2. Jewish Law to Govern Health Care Decisions: I am Jewish. It is my desire, and I hereby direct, that all health care decisions made for me be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. Without limiting in any way the generality of the foregoing, it is my wish that Jewish law and custom should dictate the course of my health care with respect to such matters as the performance of cardio-pulmonary resuscitation if I suffer cardiac or respiratory arrest; the performance of life-sustaining surgical procedures and the initiation or maintenance of any particular course of life-sustaining medical treatment or other form of life-support maintenance, including the provision of nutrition and hydration; and the criteria by which death shall be determined, including the method by which such criteria shall be medically ascertained or confirmed.

3. Ascertaining the Requirements of Jewish Law: In determining the requirements of Jewish law and custom in connection with this declaration, I direct my agent to consult with and follow the guidance of the following Orthodox Rabbi:

Rabbi

Name of Rabbi: _____

Address: _____

Telephone: Day: _____ Evening: _____

If such Orthodox Rabbi is unable, unwilling or unavailable to provide such consultation and guidance, then I direct my agent to consult with and follow the guidance of an Orthodox Rabbi referred by the following Orthodox Jewish institution or organization:

Organization

Name of Institution/Organization: _____

Address: _____

Telephone: Day: _____ Evening: _____

If such institution or organization is unable, unwilling or unavailable to make such a reference, or if the Orthodox Rabbi referred by such institution or organization is unable, unwilling or unavailable to provide such guidance, then I direct my agent to consult with and follow the guidance of an Orthodox Rabbi whose guidance on issues of Jewish law and custom my agent in good faith believes I would respect and follow.

4. Direction to Health Care Providers: Any health care provider shall rely upon and carry out the decisions of my agent, and may assume that such decisions reflect my wishes and were arrived at in accordance with the procedures set forth in this directive, unless such health care provider shall have good cause to believe that my agent has not acted in good faith in accordance with my wishes as expressed in this directive.

If the persons designated in section 1 above as my agent and alternate agent are unable, unwilling or unavailable to serve in such capacity, it is my desire, and I hereby direct, that any health care provider or other person who will be making health care decisions on my behalf follow the procedures outlined in section 3 above in determining the requirements of Jewish law and custom.

Pending contact with the agent and/or Orthodox Rabbi described above, it is my desire, and I hereby direct, that all health care providers undertake all essential emergency and/or life sustaining measures on my behalf.

5. Post-Mortem Decisions: It is also my desire, and I hereby direct, that after my death, all decisions concerning the handling and disposition of my body be made pursuant to Jewish law and custom as determined in accordance with strict Orthodox interpretation and tradition. For example, Jewish law generally requires expeditious burial and imposes special requirements with regard to the preparation of the body for burial. It is my wish that Jewish law and custom be followed with respect to these matters.

Further, subject to certain limited exceptions, Jewish law generally prohibits the performance of any autopsy or dissection. It is my wish that Jewish law and custom be followed with respect to such procedures, and with respect to all other post-mortem matters including the removal and usage of any of my body organs or tissue for transplantation or any other purposes. I direct that any health care provider in attendance at my death notify the agent and/or Orthodox Rabbi described above immediately upon my death, in addition to any other person whose consent by law must be solicited and obtained, prior to the use of any part of my body as an anatomical gift, so that appropriate decisions and arrangements can be made in accordance with my wishes.

Pending such notification, and unless there is specific authorization by the Orthodox Rabbi consulted in accordance with the procedures outlined in section 3 above, it is my desire, and I hereby direct, that no post-mortem procedure be performed on my body.

6. Incontrovertible Evidence of My Wishes: If, for any reason, this document is deemed not legally effective as a health care proxy, or if the persons designated in section 1 above as my agent and alternate agent are unable, unwilling or unavailable to serve in such capacity, I declare to my family, my doctor and anyone else whom it may concern that the wishes I have expressed herein with regard to compliance with Jewish law and custom should be treated as incontrovertible evidence of my intent and desire with respect to all health care measures and post-mortem procedures; and that it is my wish that the procedure outlined in section 3 above should be followed in determining the requirements of Jewish law and custom.

7. Duration and Revocation: It is my understanding and intention that unless I revoke this proxy and directive, it will remain in effect indefinitely. My signature on this document shall be deemed to constitute a revocation of any prior health care proxy, directive or other similar document I may have executed prior to today's date.

My Signature

Signature: _____
(If you are not physically capable of signing, please ask another person to sign your name on your behalf.)
Print Name: _____

Date: _____

Address: _____

Telephone: Day: _____ Evening: _____

DECLARATION OF WITNESSES

I, on this _____ day of _____, 200__, declare that the person who signed (or asked another to sign) this document is personally known to me and appears to be of sound mind and acting willingly and free from duress. He/She signed (or asked another to sign for him/her) this document in my presence (and that person signed in my presence). I am not the person appointed as agent by this document.

Witnesses

Witness 1: _____

Residing at: _____

Witness 2: _____

Residing at: _____

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C.3 *Matan Chaiim: The Gift of Life*

an invitation from

Reform Judaism

to become part of the program on

Organ donation

Union of American Hebrew Congregations Committees on Older Adults and Bio-Ethics

co-sponsored by

Women of Reform Judaism

Matan Chaim: the Gift of Life

Organ&Tissue

DONATION

"The UAHC is proud to join the growing movement to raise awareness and involvement in this area of religious life."
Rabbi Eric H. Yoffie: President, UAHC

"Women of Reform Judaism applaud the Gift of Life program as it responds to the urgent need for organ donation."
Ellen Rosenberg: Exec. Director, Women of Reform Judaism

"The need for organs and tissue for transplantation is great...Organ and tissue donation is a fundamental human responsibility and should be considered."
Howard Nathan: Pres. Coalition on Organ and Tissue Donation

"To see with my new cornea is like a miracle... If only people knew the difference their organ donation makes."
B. Spiegelman: Recipient

Matan Chaim: the Gift of Life

Before you sign, please discuss this with your family. Share this decision with them as they are an important part of the process. Discuss the decision with your rabbi. Make sure that your health care providers are informed. Carry the signed and witnessed donor card with you.

Matan Chaim: the Gift of Life

A Program of the UAHC Committees on Older Adults and Bio-Ethics

co-sponsored by

Women of Reform Judaism

For further information:

UAHC Committee on Bio-ethics
115 Walnut Street Suite 401
Philadelphia, PA 19102
1-215-563 8183 800-368 1090
1-215-563 1549 FAX

UAHC COMMITTEE ON BIO-ETHICS - PROGRAM GUIDE IX
Spring, 1997

ORGAN DONATION AND TRANSPLANTATION

On behalf of the Union of American Hebrew Congregations and the entire family of Reform Judaism, we invite you to join in becoming an organ donor and thus to participate in the mitzvah of *matan chaim:* the gift of life.

Life, our tradition's highest value, is at the heart of our invitation. By becoming an organ donor you can join thousands who have placed themselves in a position to bring healing, hope and life to others. The UAHC invites you to choose to make this gift so that others may benefit. We invite you to share this discussion and decision with your family, friends and rabbi; as well as your medical, legal and additional health care providers.

Medical technology has given us the means to dignify, sanctify and sustain lives in ways that were impossible just a few years ago. We invite you to bring to that technology a response of holiness, purpose and life.

Jewish tradition teaches that we are partners with God in continuing and sustaining the daily miracles of creation. Organ and tissue donation are an extension of this partnership. Through donation, you have the unique and holy opportunity to give the gift of life and wellness from one of God's creations-you-to another. With your gift, you respond ***hineni*** to God's call.

Matan Chaim: the Gift of Life

Organ&Tissue
DONATION
Share your life. Share your decision.®

Frequently Asked Questions

Q: What does Reform Judaism say?

A: Reform Judaism has long been an advocate of Organ Donation. A 1968 Reform Responsa commented that the use of such body parts in order to heal or save life is in keeping with the mood of Jewish tradition and a positive act of holiness.

Q: Do other movements within Judaism agree?

A: Yes. The value of ***"p'kuach nefesh"*** (the saving of a life) underscores this belief within our entire community, regardless of denominational affiliation.

Q: Doesn't Judaism require us to be buried with our bodies intact?

A: Judaism does draw a distinction in the area of organ donation and transplantation in order to save a life.

Q: What parts of my body can be transplanted?

A: Heart, kidneys, lungs, liver and pancreas as well as bone marrow, tissue, skin and corneas.

Q: What about age?

A: Donors can range in age from newborn to 75 years.

Q: Can there be a conflict between saving my life and recovering my organs?

A: No. Donation can be considered only after every measure has been taken to save the patient's life and death has been declared.

Q: How do I become an organ donor?

A: The completion of the attached donor card will allow you to become an organ donor. The Uniform Anatomical Gift Act of 1969 (USA) gives you the right to sign such a card. Patients who receive organs are chosen based upon many factors and are matched via need through a computerized system. Organ Donation in Canada is covered under the Canadian Human Tissue Gift Act (revised 1990).

Donor Card

I _____
have spoken to my family about organ and tissue donation. The following people have witnessed my commitment to be a donor:

_____
Witness

_____
Witness

I wish to donate the following:
☐ any needed organs and tissues
☐ only the following organs and tissues:

_____

_____
Donor signature Age Date

_____
Next of Kin Contact

C.4 Halachic Guidelines to Assist Patients and their Families in Making End-of-Life Medical Decisions, 2009

The Rabbinical Council of America
Halachic Guidelines to Assist Patients and their Families in Making "End-of-Life" Medical Decisions
As of August 10 2009

This document is intended to provide general halachic guidance to patients and families involved in making difficult medical decisions that frequently arise at the end of life. It is not intended as a source for halachic decisions, nor is it a substitute for the essential dialogue among patients, families, rabbis and doctors. **All end-of-life issues and questions should be presented to a Halachic authority, preferably, when possible, before they become urgent or emergency decisions.**

1. What are Advance Directives?

Advance directives are guidelines about one's preferences for care in advance of a possible catastrophic event or change in one's mental capacity. The objective of these directives is to provide a person the opportunity to direct their care and share their preferences for treatment even if they are no longer able to participate in the decision-making process. Examples of such circumstances include stroke, coma or dementia.

There are two legal vehicles, or advance directives, that are used to facilitate decision-making when patients are not capable of making them. Both of these documents are used ***only*** in cases where the patients are deemed to be incapable to make their own decisions.

Living Will
This document details what to do in specific medical scenarios. Patients decide, in advance, which specific treatments they would request or refuse in each scenario.

Health Care Proxy
This document allows patients to choose an individual who will make decisions on their behalf in case they are unable to do so. While there are no case scenarios in this document, the patient can append specific requests to the document. In the ideal circumstance, the proxy should be intimately familiar with the patient's preferences for end-of- life treatment.

2. What is a halachic Advance Directive? How does it differ from similar documents?

While there are similarities in the nature of the forms, there are fundamental and profound differences between halachic and secular Advance Directives, especially the living will.

The ethical and philosophical underpinnings of secular Advance Directives are based on contemporary secular ethics. The halachic living will assumes adherence to the principles of the Torah as interpreted in the Orthodox tradition. Consequently, it is essential to consult with an Orthodox halachic authority to assure that Advance Directives are compliant with Orthodox tradition.

3. What is a Do Not Resuscitate (DNR) order? Is DNR ever permitted?

When patients with life threatening conditions are admitted to the hospital, they or their families will often be asked if they would like to sign a Do Not Resuscitate (DNR) order. This order means that that if the patient's heart stops beating, or if they stop breathing, the medical staff will not initiate CPR or any life-saving maneuvers. Jewish law emphatically emphasizes the preservation of life, though there may be circumstances when a DNR order would be halachicly appropriate.

As a word of caution, a DNR order can often be interpreted by the medical staff in a broader sense than intended. It may be perceived as an order to refrain from any aggressive therapy for the patient -- DNT, Do Not Treat. It is essential that the family clarifies their specific intentions and all limitations to the DNR order.

4. What is a Do Not Intubate (DNI) order? Is DNI ever permitted?

One of the treatments often utilized at the end of life is artificial (mechanical) respiration. The procedure for introducing a tube into the lungs, which aids in breathing, is called intubation. The tube is connected to a machine (called a ventilator, respirator, or life-support system). The family will be asked about intubation, either separately, or as a part of the DNR order. The medical indications for intubation are many and are **not** the same in every patient. As with the DNR order, there may be circumstances when it is halachicly appropriate to withhold intubation.

If artificial respiration (intubation) is withheld, in accordance with the ruling of a Halachic authority, oxygen supplementation via face mask or nasal prongs can still be provided. Oxygen is usually considered basic care and should be provided to all patients for whom it is medically indicated.

5. Once a patient has been placed on life support, can it ever be removed?

In Jewish law it is forbidden to perform an act that will directly result in the death of the patient. Therefore, removal of a respirator, when it will directly result in the patient's immediate death, is unequivocally prohibited. However, respirators are used for many reasons, and are safely removed in many situations. For patients at the end of life, it may be medically appropriate, in certain circumstances, to remove a respirator, as the respirator may not be required for the

patient's care. **This area requires the input of medical and halachic expertise, and one should proceed with great caution.**

6. How is nutrition delivered to terminal patients unable to take food by mouth? Must such "artificial" nutrition always be provided?

Certain patients with terminal conditions may be unable to eat normally and may require artificial methods to deliver nutrition and hydration. These artificial means can include the following:

Nasogastric Tube (NG tube) – This is a plastic tube that is inserted into the nose (or mouth) and passed into the stomach. This procedure has few complications. It is usually a temporary (days/weeks) measure for delivering nutrition and hydration. Water and specially formulated nutritional liquids can be administered through this tube.

Total Parenteral Nutrition (TPN) - This requires the placement of a catheter (thin tube) into one of the major blood vessels of the body. Only specially designed liquids can be instilled into this catheter. This can be used for prolonged periods, but is not a permanent method of nutrition. There are some potential complications associated with the insertion and maintenance of TPN.

Percutaneous Endoscopic Gastrostomy (PEG) – This is a tube placed directly into the stomach. The term "feeding tube" is used commonly to refer to this device. This requires a minor procedure (endoscopy) with sedation. There are some potential complications associated with the insertion and maintenance of a PEG. This *can* be a permanent method of nutritional delivery. Pureed foods and pulverized pills can be administered through the PEG.

While secular wills include the option to refuse nutrition and hydration, generally Halacha assumes that nutrition should be delivered to all patients. Halachic authorities consider nutrition to be essential, and generally recommend its provision to all patients, whether conscious or comatose. However, there may be circumstances when artificial nutrition and hydration may be discontinued, in accordance with Halacha.

7. Pain control and the use of morphine

Narcotic pain medications, such as morphine, are often prescribed for terminal patients to alleviate suffering near life's end. These medications which provide pain relief are also associated with rare complications that may potentially hasten a patient's death. The alleviation of pain and suffering is a mitzvah and should not be withheld out of concern for potential adverse effects. It is clearly halachicly permitted for patients to receive narcotic medication, even when it may possibly hasten their death, when the following conditions are met:

- The intent is purely to alleviate suffering; *not* to terminate life.
- The dose of medicine is gradually increased as necessary to alleviate the pain.

8. If someone suffers from a terminal condition, such as cancer, and develops a secondary infection (e.g., pneumonia or urinary tract infection), must the infection be treated?

While Halachic authorities often require the treatment of secondary infections, there may be situations where treatment for secondary infections or complications may be halachicly withheld.

9. Is brain death considered halachic death?

The definition of death, one of the most complex issues in modern medical Halacha, is beyond the scope of this document. There are different halachic opinions as to whether "brain death" constitutes halachic death, and correspondingly, how treatment should proceed in these cases. Even the performance of diagnostic tests for the diagnosis or confirmation of brain death should be discussed with a halachic authority. .

10. Is it permitted to be an organ donor (after death)?

From a medical and legal perspective, organs can be donated from patients who are alive and well (e.g. kidneys, partial liver donation); have sustained cardiac death (e.g. eyes, skin, bone and possibly kidneys); or are brain dead (e.g. heart, liver, lung and kidney). The halachic approach to organ donation is varied and complex, and beyond the scope of this document. Questions about organ donation both before and after death should be posed to a halachic authority.

11. Is an autopsy permitted?

While autopsies are generally prohibited according to Jewish law, there are rare cases when they may be permitted. Modified autopsies or postmortem imaging should be considered where possible even in these cases.

Conclusion

All end-of-life issues and questions should be presented to a Halachic authority, preferably, when possible, before they become urgent or emergency decisions. The above guidelines are intended to provide general information regarding the approach of a Torah observant Jew towards making difficult end -of -life medical decisions. They are not decisive, nor comprehensive. All end-of-life cases should be discussed with a halachic authority. We strongly encourage direct and candid dialogue among the individual, their proxy and their halachic authority prior to completion of the document. In addition, we urge revisiting health care proxy documents on a periodic basis to assure that they are current.

D Interview Transcripts (separate file)

All interview transcripts are included in a file that is sent separately over a dropbox link. For confidential use by the advisory committee of this dissertation only.