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The Brain Death Controversy in Jewish Law

HISTORICALLY, DEATH WAS NOT PARTICULARLY DIFFICULT TO define from either a legal or halachic standpoint. Generally, all vital systems of the body — respiratory, neurological and circulatory — would fail at the same time and none of these functions could be prolonged without the maintenance of the others. Today, with major technological advances in life support, particularly the development of respirators and heart-lung machines, it is entirely possible to keep some bodily systems “functioning” long after others have ceased. Since we no longer face the inevitable simultaneity of systematic failures, it has become necessary to define with greater precision and specificity which physiological systems are indicators of life and which (if any) are not, especially in light of the scarcity of medical resources and the pressing need for organs for transplantation purposes. In recent years, the concept of “neurological death,” commonly called “brain death,” “whole brain death” or “brain-stem death” (and, sometimes, inaccurately termed “cerebral death”), has gained increasing acceptance within the medical profession and among the vast majority of state legislatures and courts in the United States. Whether this standard comports with *halachah* is a matter of

Editor's Note: As Rabbi Marc Angel notes, the more accurate term for this phenomenon is “brain-stem death.” Rabbi Breitowitz chose to employ “brain death,” the term commonly used in the popular press, to enable the readers of his article to relate its contents to reports that appear in the media.

great controversy among rabbinic authorities.¹ The purpose of this article is not to take sides nor in any way resolve the halachic debate. Its purpose is more modest. This article will attempt to explain to the general reader: (1) what is “brain death” and how it is clinically determined; (2) some (not all) of the major sources on whether it is an acceptable criterion of death from the standpoint of *halachah*; (3) the viewpoints of contemporary authorities and (4) the halachic and legal ramifications of one view or the other.

§ What Is “Brain Death” And How Is It Diagnosed?

The concept of total “brain death” as an alternative to the older definition of irreversible circulatory-respiratory failure was first introduced in a 1968 report authored by a special committee of the Harvard Medical School² and was later adopted, with some modifications, by the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical Research, as a recommendation for state legislatures and courts.³ The “brain death” standard was also employed in the model legislation, known as the Uniform Determination of Death Act, which has been enacted by a large number of jurisdictions and the standard has been endorsed by the influential American Bar Association.

1. The literature on brain death — medical, legal, halachic — is huge and only selective citations can be given here. The best nonhalachic survey of the legal and medical issues can be found in a report of the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Defining Death* (1981). Halachic treatment (as well as good discussion of related legal and medical approaches) can be found in a book of Rabbi J. David Bleich, *Time Of Death In Jewish Law* (Z. Berman, 1991) which is a compendium of Bleich’s previously published Hebrew and English articles expounding his well-known opposition to “brain death” criteria. An excellent symposium (which also presents R. Tendler’s opposing view) appears in volume 17 of the *Journal Of Halacha And Contemporary Society* (Spring 1989). Finally, the October 1991 *Jewish Observer* contains an interesting exchange of correspondence between Rabbi Tendler and Chaim Zweibel, General Counsel of Agudath Israel of America.

2. *A Definition of Irreversible Coma* — Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, 205JAMA 337-350 (1968).

3. President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Defining Death: Medical, Legal, and Ethical Issues in the Determination of Death* (Government Printing Office, 1981).

While New York is one of the few jurisdictions that does not have a “brain death” statute, it has adopted the identical rule through the binding decisions of its highest court.¹

The rapid, and near universal, acceptance of neurological criteria of death is probably attributable to three factors. First, moving the time of death to an earlier point facilitates organ transplants, and indeed makes such transplants possible. Organs, especially the heart and liver, are suitable for transplantation only if they are removed at a time when blood is still circulating. Once cardiac arrest stops circulation, rapid tissue degeneration makes the organ unsuitable for such use. Given the increasing success of these operations and the relative uselessness (from a secular standpoint!) of sustaining “brain dead” patients on respirators, there is a natural temptation to redefine death so that organs become available to serve higher ends. It is no coincidence that the movement towards acceptance of “brain death” coincided with the development of cyclosporine and other anti-rejection drugs.

Additional considerations involve triage and allocation of scarce medical resources. It is extraordinary expensive (in terms of equipment and labor) to maintain patients on respirators and other life support and using these resources for “brain death” patients prevents their deployment for those who stand a better chance of recovery. Yet a third impetus towards redefinition is an understandable desire to spare families the agony and anguish of watching a loved one experience a protracted death.

For whatever the reason, the current definition of “death” is now a composite one: death is deemed to occur when there is either irreversible cessation of circulatory and respiratory functions (the “old” definition) or *irreversible cessation of all functions of the entire brain including the brain-stem*.² The principal utility of this second standard permits declaring as dead a comatose, ventilator-dependent patient, incapable of spontaneous respiration but whose heart is still beating due to the provision of oxygen via an artificial breathing apparatus.

1. See *People v. Eulo*, 63 N.Y. 2d 341 (1984).

2. Brain stem death occurs when, due to trauma, the brain swells and the pressure in the skull rises to exceed blood pressure. The brain is deprived of blood and oxygen and the brain tissue begins to liquefy [lyse]. While total dysfunction occurs minutes after deprivation of oxygen, total liquefaction does not take place until some time after cardiac death, indeed sometimes several days after interment.

At the outset, two points must be made absolutely clear. First, contrary to the misperceptions of many lay people, "brain death" is not synonymous with merely being comatose or unresponsive to stimuli. Indeed, even a flat EEG (electroencephalogram) does not indicate brain-stem destruction. The human brain consists of three basic anatomic regions: (1) the cerebrum; (2) the cerebellum; and (3) the brain-stem consisting of the midbrain, the pons, and the medulla, which extends downwards to become the spinal cord. The cerebrum controls memory, consciousness, and higher mental functioning. The cerebellum controls various muscle functions while the brain-stem controls respiration and various reflexes (e.g., swallow and gag). A patient may be in a deep coma and nonresponsive to most external stimuli but still very much alive. At most, such patients may have a dysfunctional cerebrum but, by virtue of the brain stem remaining intact, are capable of spontaneous respiration and heartbeat. Indeed, the most famous of these cases, Karen Ann Quinlan, was able to live off a respirator for almost a decade. While such persons may be popularly referred to as brain dead, they are more accurately described as being in a persistent vegetative state [PVS] and are very much alive under both secular and Jewish law. Removal of organs from such a donor would indisputably be homicide. This is even more true for the phenomenon known as being "locked-in" where the patient is fully conscious but unable to respond.

A second point to keep in mind is the relationship among respiration, circulation, and the brain. The heart, like any organ, or indeed cell, needs oxygen to survive and without oxygen will simply stop beating. Respiration, in turn, is controlled by the vagus nerve whose nucleus is located in the medulla of the brain-stem. The primary stimulant for the operation of the nerve is the presence of excess carbon dioxide in the blood. When stimulated, the nerve causes the diaphragm and chest muscles to expand, allowing the lungs to fill with air. Spontaneous respiratory activity can therefore not continue once there is brain stem destruction or dysfunction. The heart, on the other hand, is not controlled by the brain but is autonomous. It is obvious, of course, that unless the patient is hooked up to a breathing apparatus, destruction of the brain-stem will inevitably lead to cardiac cessation not because of any direct control the brain stem exercises over the heart but simply because the heart muscle is deprived of oxygen. Where, however, the patient's intake of oxygen is being artificially maintained, the heart may

continue to beat and blood circulate for a considerable time after total brain-stem destruction.¹ The time lag between brain death and circulatory death is on the average only two to ten days, though there is at least one case on record where a woman's heart continued to beat for 63 days after a diagnosis of brain death.² (Indeed, she delivered a live baby through a Caesarean section.) It is this crucial gap between cessation of spontaneous respiration and cessation of heart beat that defines the parameters of the phenomenon called "brain-stem death."

The steps taken in a clinical diagnosis of "brain death" vary from medical center to medical center and those differences may have significant halachic repercussions but will typically involve the following:³ (1) a determination that the patient is in a deep coma and is profoundly unresponsive to external stimuli; (2) absence of elicitable brain-stem reflexes such as swallowing, gag, cough, sigh, hiccup, corneal, and vestibulo-ocular (ear); (3) absence of spontaneous respiration as determined by an apnea test;⁴ and (4) performance of tests for evoked potentials testing the brain-stem's responsiveness to a variety of external stimuli. These tests are to be repeated between 6-24 hours later to insure irreversibility — with life support supplied for the interim —

1. A good description of the scientific aspects of brain death can be found in 24 *Tradition* I, 8-14 (Summer 1989) (Dr. Jakobovitz's annotations to the Chief Rabbinate's ruling) and in Kielson, "Determining the Time of Death-Medical Aspects," 17 *Journal of Halacha and Contemporary Society* 7-13 (Spring 1989).

2. See sources cited in Bleich, "Of Cerebral Cardiac Death", 24 *Tradition* 44, 61n.5 (Spring 1989), reprinted in *Time Of Death In Jewish Law*, pp. 129-160.

3. Much of this information was derived from the articles cited in note 1 above and a communication of Rabbi Moshe Tendler to the members of the RCA dated Summer 1991.

4. Apnea testing takes many forms. One standard test may involve providing the patient with 100% oxygen for 20-30 minutes through the respirator and then shutting off the machine, thereby allowing the carbon dioxide in the blood to rise but at the same time allowing for passive gaseous diffusion of oxygen through the tubes of the machine or through a tube inserted directly into the trachea. This allows the CO² in the blood to rise, enabling a test of the respiratory response without depriving the patient of necessary oxygen in the interim. While a normally functioning brain-stem would induce respiration at a fairly low pressure of CO², a diagnosis of death will not be confirmed until the CO² pressure is considerably above the normal triggering point but nevertheless fails to elicit a respiratory response.

and a specific cause for brain dysfunction must be identified before the patient will be declared dead.¹

An additional test that is sometimes employed (when other clinical tests are deemed inconclusive) is radionuclide cerebral angiography [nuclide or radioisotope scanning]. A harmless radioactive dye is injected into the patient's blood-stem, typically through the intravenous tubing already in place. In brain-dead patients, scanning will reveal an abrupt cutoff of circulation below the base of the brain with no visible fluid draining away. While many observers have described this test as nearly 100% accurate, others have claimed the brain-stem circulation, especially in the medulla, is not well visualized and absolute absence of blood flow to this region cannot be diagnosed with certainty.²

Note that a patient who is brain dead may theoretically continue to have muscle spasms or twitchings or even sit up. Whether this so-called Lazarus Reflex is an indicator of life will be discussed in due course; what is undisputed is that such movements are coordinated not from the brain but solely from the spinal cord. It should also be noted that there are several instances of clinically brain dead patients carrying live babies to term.³ Again, this may or may not be significant.

1. Note that a flat EEG (electroencephalogram) is not a necessary condition for a brain death diagnosis. A flat EEG does not in any event insure brain-stem death but at best, indicates only absence of (perceptible) upper brain activity. Conversely, even in patients with a brain death diagnosis, sporadic, minimal EEG activity has occasionally been found. The Harvard criteria regard a flat EEG as helpful and confirmatory but not essential to a brain death diagnosis.

2. Compare letter of Rabbi Tendler printed in the October 1991 *Jewish Observer* with the degree of skepticism expressed by Dr. Keilson, *supra* note 6, at 12. Indeed, some earlier studies had indicated that angiography only measures deficit, not cessation of blood flow even to the cerebrum and that up to 24% of normal blood flow could still be present. Modern refinements in these techniques probably allow for a definitive determination of zero blood flow to the cerebrum but "persistent perfusion and survival of the brain stem" remain a distinct possibility. See studies cited in Bleich, *supra* note 7, at notes 13-21. I have no information as to the accuracy of any of those studies; I simply point them out for the edification of the reader.

3. See the sources in the medical literature cited by Bleich, *supra* note 7, at 62 n. 5 (at 133, n. 5 in the book).

Is Brain Death an Acceptable Halachic Criterion of Death?

The question breaks down into two distinct issues. First, is irreversible dysfunction of the entire brain a valid criterion of death? Second, even if the answer is yes, are the medical tests currently utilized in establishing such a condition halachically valid indicators of its presence? One could easily subscribe to “whole brain” death as a concept and yet reject the particular diagnostic tools employed.

There are number of halachic sources that are relevant to the question of “brain death,” the most important being the *Mishnah* in *Oholot* 1:6, the Talmud in *Yoma* 85a, passages in *Teshuvot Chatam Sofer* and *Teshuvot Chacham Tzvi*, and various pronouncements of R. Moshe Feinstein in his *Iggrot Moshe*.¹ This is not the forum for a detailed examination of these sources other than to note that a number of them are equivocal and subject to a variety of interpretations.

Briefly stated, the *Mishnah* in *Oholot* establishes the dual propositions that, first, physical decapitation of an animal is a conclusive indicator of death and second, some degree of subsequent movement is not incompatible with a finding of death provided that such movement qualifies as spastic in nature (*pirchus be'alma*) like the twitching of the “severed tail of a lizard.” The Talmud in *Yoma* 85a, detailing with a person trapped under a building, rules that a determination of respiratory failure establishes death without the need to continue to uncover the debris to check heartbeat. Proponents of “brain death” argue that a dysfunctional brain-stem is equivalent to a decapitated one (physiological decapitation), that destruction of the brain-stem inevitably means inability to spontaneously respire (meeting the criterion in *Yoma*) and that subsequent “movement,” whether the Lazarus Reflex or the heartbeat, falls into the category of *pirchus* since such movement is not coordinated from a “central root and point of origin,”² i.e., the brain.

The counter-arguments are: first, physiological dysfunction is not the equivalent of anatomical decapitation. The only phenomenon short of

1. See *Teshuvot Chatam Sofer*, *Yoreh Deah* no. 338; *Teshuvot Chacham Tzvi*, no. 77; and *Iggrot Moshe*, *Yoreh Deah* II, nos. 164,174; *Yoreh Deah* III, no. 132; *Choshen Mishpat* II, nos. 72-73.

2. See *Peirush HaMishnayot* of Rambam to *Oholot* 1:6.

actual decapitation that might similarly qualify is a total liquefaction (lysis) of the brain, something that probably does not occur until well after cardiac arrest. Second, according to Rashi in *Yoma*, cessation of respiration is a conclusive indicator of death only when the person is “comparable to a dead man who does not move his limbs.” While certain forms of postmortem movement may be characterized as merely spastic and would not qualify as “movement,” the rhythmic coordinated beating of a heart and the maintenance of a circulatory system can hardly be characterized as *pirchus* since such heartbeat is life-sustaining and identical to that in a normally functioning individual. Reference is also made to the *teshuvot* of *Chatam Sofer* and *Chacham Tzvi* who both write that it is only the cessation of respiration *and* pulse (heartbeat) that allows for a determination of death and the *Gemara* in *Yoma* merely creates a presumption that upon cessation of respiration and an appropriate waiting time, one is permitted to assume that heartbeat has stopped as well. Since this assumption is obviously not true in the case of “brain dead” patients hooked up to respirators whose heartbeats are monitored, such patients may not be declared as dead.

The position of R. Moshe Feinstein, whose *psak* could well have been definitive at least in the United States, is unfortunately a matter of some controversy. His son-in-law, Rabbi Dr. Moshe Tendler, a Rosh Yeshiva in RIETS and Professor of Biology, Yeshiva College, has vigorously argued that Rabbi Feinstein supported a total “brain death” standard based on the concept of decapitation in *Mishnah Oholot*.¹ His position finds strong support in *Iggrot Moshe, Yoreh Deah III* no. 132 which seems to validate nuclide scanning as a valid determinant of death. This is also the understanding of the Israeli Chief Rabbinate, R. David Feinstein (who admits, however, to having no inside information on the topic), and R. Shabtai Rappaport, the editor of R. Moshe’s responsa.²

Others, however, have interpreted his *teshuvot* very differently, pointing out that R. Moshe reiterated twice (indeed, in one instance two years after the “nuclide scanning” reference) that removal of an organ

1. See, for example, Rabbi Tendler’s letter in October 1991 *Jewish Observer*.

2. The Chief Rabbinate’s ruling accepting “brain death” explicitly relies on R. Moshe for authority. See *Techumim* Vol. 7, 187-192 (5746) and Jakobovitz, “Brain Death and Heart Transplant: The Israeli Chief Rabbinate’s Directives,” 24 *Tradition* 1-14 (Summer 1989); R. David’s understanding is quoted by R. Tendler in his own October letter to *JO*; and R. Shabtai Rappaport’s letter appears in 12 *Assia* no. 3-4 (Kislev 5750), pp. 10-12.

for transplantation was murder of the donor.¹ (R. Tendler's response: Both of those *teshuvot* refer to comatose patients in a persistent vegetative state who are capable of spontaneous respiration and are very much alive and not to those who are respirator-dependent.) They also cite R. Moshe's express opposition to proposed "brain death" legislation in New York unless it contained a "religious exemption."² (R. Tendler's response: Although R. Moshe accepted the concept of "brain death," his support of an exemption was simply to accommodate the view of other religious Jews who disagree.) Finally, they note that in the very *teshuvah* upholding the use of angiographic scanning, R. Moshe approvingly cites *Teshuvot Chatam Sofer*, Y.D. no. 338, who insists on absence of *dofeik*, pulse, and indeed states that one is dead only if there is an inability to breathe and no other sign of life is recognizable with them (*Vegam lo nikarim behem inynei chiyut achairim*). Their conclusion: R. Moshe merely validated nuclide scanning as a criterion to verify one determinant of death, i.e., absence of respiration, but did not maintain that it alone was sufficient.³ This author certainly lacks both the competence and the authority to resolve this dispute but presents it to the reader so that he may see why this area has been so fraught with unresolved controversy.

§ Contemporary Views

The following is a cataloguing of the major schools of thought among contemporary *poskim* and *rabanim* on the brain death issue and some of the recent events connected with this question.

1. As noted, Rabbi Dr. Moshe Tendler has been the most vigorous advocate for the halachic acceptability of brain death criteria. In his capacity as chairman of the RCA's Biomedical Ethics Committee, Rabbi Tendler spearheaded the preparation of a health-care proxy form that, among other innovations, would

1. See *Iggrot Moshe, Yoreh Deah* II, no. 174 (5728) and *Choshen Mishpat* II, no. 72 (5738). The *teshuvah* in *Yoreh Deah* III, no. 132 cited in support of brain death criteria was authored in 5736.

2. Written statement of 8 Shevat 5737.

3. It should be noted, however, that the *teshuvah* concerning nuclide scanning was addressed to R. Tendler for his own guidance, surely entitling his understanding of the responsa to great weight.

authorize the removal of vital organs from a respirator dependent, brain dead patient for transplantation purposes. Although the form was approved by the RCA's central administration, its provisions on brain death were opposed by a majority of the RCA's own *Vaad Halacha* (Rabbis Rivkin, Schachter, Wagner and Willig).¹

2. The Israeli Chief Rabbinate Council, in an order dated Cheshvan 5747, has also approved the utilization of "brain death" criteria in authorizing Hadassah Hospital to perform heart transplants but on a somewhat different theory than Rabbi Tendler. Positing that cessation of independent respiration was the only criterion of death (based on *Yoma* 85 but somewhat inexplicably also citing *Chatam Sofer*, Y.D. no. 338), the Rabbinate ruled that brain death was confirmatory of irreversible cessation of respiration. Theoretically, this would allow for a standard far less exacting than clinical brain death, perhaps nothing more than failure of an apnea test. Indeed, Dr. Steinberg, the principal medical consultant to the Rabbinate, dismissed any requirement of nuclide scanning since destruction of the brain's respiratory center may be conclusively verified without such test.² Since defining "death" exclusively in terms of inability to spontaneously respire would lead to the absurdity that even a fully conscious, functioning polio patient in an iron lung is dead, a subsequent communication from R. Shaul Yisraeli, a member of the Chief Rabbinate Council, qualified the Rabbinate's ruling by imposing, as an additional requirement, that the "patient be like a stone without movement"³ (but apparently maintaining that heartbeat does not qualify as such movement). It is probable, though not certain,

1. The current status of the original RCA proxy is unclear. In light of the negative *psak* of Rabbis Auerbach and Elyashiv, Rabbi Marc Angel, the President of the RCA, circulated a cover letter to the membership cautioning that the proxy form should not be used until the individual *rav* has thoroughly studied the issue and consulted experts in the field. Rabbi Tendler has similarly stated that at least portions of the proxy form were merely a first draft to be circulated to *rabanim*.

2. Dr. Steinberg's paper, originally prepared to assist the Chief Rabbinate in their deliberations, appears in *Or Hamizrach* (Tishrei 5748).

3. Quoted in Bleich, *Time Of Death* at 167-168.

that R. Tendler's test of "physiological decapitation" and the Rabbinat's newly formulated test of "respiratory failure coupled with profound nonresponsiveness" amount to the same thing though the Rabbinat has not retracted from its non-insistence on nuclide scanning.

3. Rabbi J. David Bleich, Rosh Kollel at Yeshiva University and author of many papers and a recently published book on the subject, has stated that anything short of total liquefaction (lysis) of the brain cannot constitute the equivalent of decapitation. He further maintains, relying on Rashi in *Yoma*, the *Chatam Sofer*, and the *Chacham Tzvi*, that even total lysis would be insufficient in the presence of cardiac activity but dismissed the matter as being only of theoretical importance since cessation of heartbeat inevitably occurs prior to total lysis. He also asserts that his position is not based on stringency in case of doubt but rather on the certainty that the brain dead patient is still alive, a certainty that could be relied upon even to be lenient, e.g., a Cohen may enter a "brain dead" patient's room without violating the prohibition of *tumat meit*.
4. Rabbi Aaron Soloveitchik, Rosh Yeshiva of Brisk and RIETS, has gone slightly further than Rabbi Bleich. Even if the heart has stopped and the patient is no longer breathing, the patient is alive if there is some detectable electrical activity in the brain.¹ It has been noted, however, that there is no recorded instance of this phenomenon occurring.
5. Rabbi Hershel Schachter, Rosh Yeshiva and Rosh Kollel of RIETS, has taken a more cautious view. Conceding that the concept of "brain death" may find support in the decisions of R. Moshe, he concludes that such a patient should be in the category of *safeik chai, safeik met* (doubtful life). While removal of organs would be prohibited as possible murder, one would also have to be stringent in treating the patient as *met*, e.g., a Cohen would not be allowed to enter the patient's room.²

1. His views may be found in 17 *Journal Of Halacha* at 41-50 (Spring 1989).

2. Rabbi Schachter's intermediate position may be found in the same journal at pp. 32-40.

6. Most contemporary *poskim* in Eretz Yisrael (other than the Chief Rabbinate) have unequivocally repudiated the concept of death based on neurological or respiratory criteria.¹ Of special significance are letters² signed by R. Shlomo Zalman Auerbach and R. Yosef Elyashiv, widely acknowledged as the leading *poskim* in Eretz Yisrael (if not the world), stating that removal of organs from a donor whose heart is beating and whose entire brain including the brain-stem is not functioning at all is prohibited and involves the taking of life. Unfortunately, these very brief communications do not indicate if the *psak* is based on *vadei* (certainty) or *safeik* (doubt) nor do they address what the decision would be in case of total lysis.

§ Halachic and Legal Ramifications

Obviously, in a matter so fraught with controversy, every family confronted with the tragic situation of a brain dead patient must follow the ruling of its *posek*. To the extent the patient is halachically alive, removal of an organ even for *pikuach nefesh* would be tantamount to murder. The principle of *ain dochin nefesh mipnei nefesh* — that one life may not set aside to ensure another life — applies with full force even where the life to be terminated is of short duration and seems to lack meaning or purpose and even where the potential recipient has excellent chances for full recovery and long life. If, on the other hand, the donor is dead, the harvesting of organs to save another life becomes a *mitzvah* of the highest order. In light of the overwhelming opposition to the “brain death” concept, caution and a stance of *shev u'al taaseh* (passivity) appears to be the most prudent course. How the “brain death” problem will play out in other areas such as inheritance, capacity of a wife to contract a new marriage, or the need for *chalitzah* if a man dies leaving a brain dead child will have to await further clarification.

1. These include R. Elazer Schach, Rosh Yeshiva of Ponevez; R. Yitzchok Weiss, recently deceased *Rav* of the *Eida Chareidis*; R' Yitzchak Kulitz, Chief Rabbi of Jerusalem; R. Eliezer Waldenberg, author of *Tzitz Eliezer*; R. Nisim Karlitz, Chief Rabbi of Ramat Aharon; R. Shmuel Wosner, Rabbi of Zichron Meir; and R. Nosen Gestetner. References to those decisions can be found in Bleich, *Time Of Death* at 144-145.

2. Letter of 18 Menachem Av 5751. A second letter reaffirming this stance was issued during the *Aseret Yemei Teshuvah* 5752.

There are, however, two other points that need to be considered. The argument is occasionally made that if *halachah* rejects the concept of “brain” or “respiratory” death, Orthodox Jews would be unable to receive harvested organs on the grounds that the recipient would be an accessory to a murder. As others have noted,¹ this conclusion does not follow. To the extent the organ in question would have been removed for transplantation whether or not this specific recipient consents, i.e., there is a waiting list of several people, the Orthodox recipient is not considered to be a causative factor (*gorem*) in the termination of a life. There is no general principle in *halachah* that prohibits the use of objects obtained through sinful means. It is true that if, because of tissue typing and the like, the organ is suitable for only one recipient and if that recipient declines the transplant, the organ will not be harvested, an Orthodox recipient may indeed be compelled to decline. But this is rarely, if ever, the case.²

A second point: as noted, “brain death” is the legal definition of death in the vast majority of the United States. New York is the only state that requires medical personnel to make a reasonable effort to notify family members before a determination of brain death and to make “reasonable accommodation” for the patient’s religious beliefs.³ In all other jurisdictions, doctors would be empowered unilaterally to disconnect a patient from life-support mechanism once that patient meets the legal definition of death.⁴ Hospital personnel may or may not defer to the wishes of the family but there is no duty on their part to do so or even to ascertain what those wishes are.⁵

1. See comments of R. Soloveitchik, cited in note 22.

2. According to a recently published article in the *Journal Of The American Medical Association* (Jan. 1992), the demand for hearts, kidneys, and lungs far exceeds the available supply.

3. See 10 N.Y.C.R.R., sect. 400-16 (1987). The regulation mandating religious accommodation is also reprinted in an excellent article by Zweibel, “Accommodating Religious Objections to Brain Death: Legal Considerations,” 17 *Journal of Halacha* 49 (Spring 1989).

4. Of course, even in New York, only “reasonable accommodation” is required and one can well imagine triage considerations forcing patients off respirators prematurely.

5. Moreover, even where doctors defer to the family’s wishes, insurance companies may refuse to pay the costs of sustaining what is legally regarded as a cadaver. This is likely not to be a problem in New York since the regulatory duty of “reasonable accommodation” prevents a determination of brain death.

Perhaps one point of consensus that may emerge in an area otherwise fraught with acrimonious controversy would be the desirability of enacting “religious accommodations” exceptions nationwide. After all, even the proponents of a “brain death” standard understand that others, in all honesty and conscience, may hold a different *halachic* view, one which they should not be compelled to violate. Hopefully, our community will be responsive to such an effort.

☞ Conclusion

“You preserve the soul within me and You will in the future take it from me” (Daily Prayers). Only God, Who is the source of all life, can take life away. We are enjoined to cherish and nurture life as long as it is present, no matter how fleeting or ephemeral. Yet it is precisely because each moment of life is so precious that God has imposed on man the awesome responsibility of defining the moment of death, the point after which the needs of the dead may, and indeed must, be subordinated to those of the currently living. No one has ever seen a *neshamah* leave a body and it is the unenviable task of our *gedolim* and *poskim* to tell us when this occurs. May *Hakodesh Baruch Hu* grant them the insight to truly make our Torah a *Torat Chayim*.