

THE

BRAIN DEATH CONTROVERSY IN JEWISH LAW

BY RABBI YITZCHAK BREITOWITZ

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 systemic 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 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 recom-

mendation 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. 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.⁴

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 respira-

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Editor's Note

As Rabbi 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.

FOOTNOTES

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 just-published 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).
4. See *People v. Eulo*, 63 N.Y. 2d 341 (1984).
5. *Brain stem death occurs when, due to trauma,*

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tors, 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 extraordinarily expensive (in terms of equipment and labor) to maintain patients on respirators and other life support and using these resources for "brain dead" 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.*⁵ 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.

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 heart-beat. 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.⁶ 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.⁷ (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:⁸ (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;⁹ 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 — and a specific cause for brain dysfunction must be identified before the patient

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 internment.

6. A good description of the scientific aspects of brain death can be found in 24 Tradition 1, 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).
7. See sources cited in Bleich, "Of Cerebral Cardiac Death", 24 Tradition 44, 61 n.5

(Spring 1989), reprinted in Time Of Death In Jewish Law, pp. 129-160.

8. Much of this information was derived from the articles cited in note 6 and a communication of Rabbi Moshe Tendler to the members of the RCA dated Summer 1991.
9. 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.

10. 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.
11. Compare letter of Rabbi Tendler printed in

will be declared dead.¹⁰

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 bloodstream, 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.¹¹

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.¹² Again, this may or may not be significant.

Is Brain-Death An Acceptable Halachic Criterion Of Death?

This 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 a 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*.¹³ 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*, dealing 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,"¹⁴ i.e., the brain.

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

terized as merely spasmodic 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*.¹⁵ 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.¹⁶

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 for transplantation was murder of the donor.¹⁷ (R. Tendler's re-

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.

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

13. 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.*

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

15. See, for example, *Rabbi Tendler's letter in*

October 1991 Jewish Observer.

16. *The Chief Rabbinate's ruling accepting "brain death" explicitly relies on R. Moshe for authority. See Techemim 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.*

17. See *Iggrot Moshe, Yoreh Deah II, no. 174*

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."¹⁸ (R. Tendler's response: Although R. Moshe accepted the concept of "brain death," his support of an exemption was simply to accommodate the views 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 bahem 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.¹⁹ 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 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).²⁰

2. The Israeli Chief Rabbinat 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 Rabbinat 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 Rabbinat, dismissed any requirement of nuclide scanning since destruction of the brain's respiratory center may be conclusively verified without such test.²¹ 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 Rabbinat Council, qualified the Rabbinat's ruling by imposing, as an additional requirement, that the "patient be like a stone without movement,"²² (but apparently maintaining that heartbeat does not qualify as such movement). It is probable, though not certain, 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 noninsistence 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 liquification (*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 met*.

4. Rabbi Aaron Soloveichik, 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.²³ 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.²⁴

6. Most contemporary *poskim* in Eretz Yisrael (other than the Chief Rabbinat) have unequivocally repudiated the concept of death based on neurological or respiratory criteria.²⁵ Of special significance are recent letters²⁶ signed by R. Shlomo Zalman Auerbach and R. Yosef Elyashiv, widely acknowledged as the leading *poskim* in Eretz Yisrael, (if not

(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.

18. Written statement of 8 Shevat 5737.

19. 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.

20. 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*.

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

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

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

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

25. 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 Karelitz, 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.

26. Letter of 18 Menachem Av 5751. A second

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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 be 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 v'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.

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,²⁷ 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.²⁸

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 deter-

mination of brain death and to make “reasonable accommodation” for the patient’s religious beliefs.²⁹ In all other jurisdictions, doctors would be empowered unilaterally to disconnect a patient from life-support mechanisms once that patient meets the legal definition of death.³⁰ 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.³¹

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 *Hakadosh Baruch Hu* grant them the insight to truly make our Torah a *Torat Chayim*. □

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letter reaffirming this stance was issued during the Aseret Yemei Teshuvah 5752.

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

28. 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.

29. 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).

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

31. 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.

Contributions, Ed. Ehud Apanier (Keter: Jerusalem '87).

In closing, let it be said that no aspersions have been cast on the integrity of the *gaon* and *tzaddik* R. Gershon Hanokh of Radzin on his 100th *yahrzeit*. No personal attack was intended either by Rabbi Herzog *z"l* (apologies to the Ba'al ha-Tekhlet's nephew, R. Yeruham Leiner *z"l*, in *Hadarom*, Elul 5750, pp. 12-16) or Dr. Ziderman *she-yihyeh* in revealing the true chemical composition of the Radziner *techelet*, namely Prussian blue. Both have reiterated time and time again that the rebbe was evidently deceived by a chemist. To R. Gershon Hanokh's eternal credit is the *zechut* of having reopened the *sha'ar hatzitzit*.

Rabbi Bezalel Naor
Spring Valley, NY

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BRAIN-STEM DEATH

To The Editor:

Your attempt to present a definitive, unbiased summation of the controversy surrounding the halachic validity of Brain-stem Death (B.S.D.) is most commendable. However, there are several errors in Rav Breitowitz's presentation that must be corrected...

I.

He should have removed any doubt concerning Rav Moshe's opinion. He cites "strong support" for my position but fails to mention that:

a) For almost a decade, during his lifetime, I articulated Reb Moshe's opinion that B.S.D. is halachically valid and no one challenged me during all that time.

b) The letter sent to the New York State Legislature over Reb Moshe's signature which was drafted by Rabbi Moshe She'erer of the Agudath Israel, unequivocally affirms the halachic validity of B.S.D.

II.

The Lazarus Reflex is cited as proof that a B.S.D. patient is not really dead. Yet the Lazarus Reflex occurs in guillotined prisoners who are surely dead and is so cited in the *teshuvah* of the Chachom Zvi... To quote the Chachom Zvi, "*tenuah lechud, v'chaim lechud*." It can only be a spinal reflex, if the patient is decapitated!

III.

a) It is not "Rav Tendler's response" that the *Teshuva 146*, refers to cerebral death, not B.S.D. Rav Moshe said it clearly. The patient is one who *sheyachol linshom*, can breathe without a ventilator."

b) I did not deduce Reb Moshe's opinion from analysis of his writings. I reported it as *maaseh rav* — what he said, wrote, and ruled in the numerous cases referred to him for halachic *psak*.

c) The requirement of "respiratory failure" in the responsum of the Chief Rabbinate

and standards for "physiological decapitation" are identical and not based "on somewhat different theories."

IV.

Rav Breitowitz is in error when he rejects Rav Angel's statement that if B.S.D. is not halachically valid, a Jew cannot receive a vital organ transplant. The fact that there are others who are ready and willing to remove these organs in no way mitigates the act of murder. (*Rambam Hilchot Rotzeach 2:1 and 4:6*). If ten "hit men" are hired to kill someone, the one who murders him is the murderer and is put to death despite the readiness of the nine to do likewise. Indeed it is in opposition to the thrice repeated ruling of Rav Shlomo Zalman Auerbach *shlita* that if it is forbidden to remove the heart it is forbidden to accept the donation.

V.

The halachic rulings of Rav Auerbach are most enigmatic. After issuing the blanket *issur* against heart transplants in Av 5751 which was published in *The Jewish Observer*, he wrote two letters concerning heart transplants in *Tevet* and *Shevat* 5752. In these letters he implicitly accepted the concept of B.S.D. but expressed concern over the need to inject a radioisotope affirming B.S.D. by blood flow study. Fearing that this is tantamount to (*hazakas goseis*) removing the patient who is in extremis. No objection was voiced to declaring a heart-beating patient dead, if B.S.D. is affirmed.

In a most recent letter (Adar II 5752) he restates his position and insists that the heart not be removed until it has completely ceased its contractions. Yet he acknowledges an experiment done at his behest, in which a pregnant sheep was decapitated (an incontrovertible state of halachic death) and then a live lamb was delivered by caesarean section. During many hours the decapitated sheep's heart maintained normal beat, without loss of blood pressure. Rav Auerbach cited this experiment to retract his statement that ability to give birth to a live fetus is proof that the animal is not dead. He clearly admitted that the presence of the ventilator enables a dead animal to give birth to a live lamb. Surely this same logic and proof holds for the beating heart when on a respirator: A beating heart is not a sign of life, if there is total cessation of all brain function, as in a B.S.D. patient. Indeed in a decapitated prisoner, the heart continues to beat for some time, yet the uncontested halachic ruling is that he is dead.

In addition, Rav Auerbach has ruled that:

1. A ventilator can be removed from a patient in extremis (*goseis*) to permit him to die, since it is considered *hasaras moneah*, not euthanasia.

2. He ruled in an actual case at Hadassah Hospital (*Shevat* 5752) that a pregnant B.S.D. patient may be subjected to a caesarean section, although her heart was surely beating, in order to save her fetus. A B.S.D. patient can with his heart, two lungs and liver

save the life of four people! We must await further clarification of the position of this great *posek*...

I am indebted to *Jewish Action* for their attempt to prepare a level field so that all can see the majesty of Torah law as it impacts on our society.

Rabbi Moshe David Tendler
Monsey, NY •••••

Rabbi Breitowitz Responds:

Since I am in no sense an advocate of the anti-B.S.D. position, I will not attempt to refute each individual proof that Rabbi Tendler proffers nor do I desire to be caught in cross-fire that, to a large degree, is directed towards other targets. Nowhere in my article, for example, did I ever cite the Lazarus reflex as proof "that a B.S.D. patient is not really dead." I simply noted the reflex as a factor that "may or may not be significant." The pages of this magazine are also not the most appropriate forum for intricate textual analysis of technical halachic points. Nevertheless, some clarifying comments may be helpful.

I. The Position of R. Moshe Feinstein

A. *The Teshuvot*: The point of my article was that the written record of R. Moshe's *teshuvot*, standing alone, does not furnish unequivocal evidence that he in fact supported a B.S.D. standard. This is not to deny the possibility that he may have done so, but merely to state that one cannot definitively infer such a conclusion from his writings. I had previously cited *Iggrot Moshe*, Y.D. III, no. 132 which validates the use of nuclide scanning in connection with a determination of death as "strong support" for Rabbi Tendler's position. A close reading of the *teshuvah*, however, reveals that this conclusion is somewhat equivocal. The first mention of nuclide scanning appears in the third paragraph of the *teshuvah* dealing with victims of automobile accidents or falls. Here, R. Moshe concludes that even persons who apparently are incapable of spontaneous respiration (ventilator-dependent) and have no other signs of life should not be declared dead until nuclide scanning verifies lack of circulation to the brain. Nowhere does *teshuvah 132* utilize nuclide scanning (which, at best, demonstrates B.S.D.) as a sufficient criterion of death; it comes into play only if there are no other signs of life. Whether heartbeat and circulation of blood (which B.S.D. patients on respirators absolutely have) constitute such "signs of life" is precisely the controversy at hand. This interpretation of Y.D. III, no. 132 is not my own. Rabbi Tendler himself has acknowledged that the *teshuvah* may be susceptible to multiple interpretation. As quoted in the addendum to the recently published fourth volume of Dr. Abraham's *Nishmat Avrohom*, both R. Yosef Elyashiv and R. Shlomo Zalman

Auerbach interpret R. Moshe's validation of nuclide scanning as an additional *chumra* (stringency) to be employed only after the patient has met all the other signs of death: lack of spontaneous respiration, pulse (heartbeat), and nonspasmodic movement/reflexes. It must be made clear that these two *gedolim* who strongly oppose the notion of B.S.D. do not purport to disagree with R. Moshe; rather, in their view R. Moshe himself never necessarily upheld B.S.D. They regard their negative *psak* as entirely consistent with Y.D. III, no. 132. R. Elyashiv states this as being "explicit" in the *teshuvah*; R. Auerbach states this as a possibility; R. Aaron Soloveitchek also construes R. Moshe's opinion in this manner. Note too that R. Moshe in that very *teshuvah* cites Chatam Sofer Y.D., 338 who explicitly enumerates lack of pulse as well as respiration as a necessary prerequisite for a determination of death. Again, as noted in my article, this restrictive interpretation finds additional support in a *teshuvah* written two years after Y.D. III, 132 where R. Moshe reiterates that removal of a heart constitutes murder of a donor. See H.M. II, no. 72. Since under American law hearts are not removed until the patient has been diagnosed as brain dead, this too suggests that B.S.D. is *not* equivalent to halachic death. (I would note, however, that H.M. II, 72 makes no mention of nuclide scanning and it is perhaps arguable that R. Moshe was concerned that doctors would act precipitously in removing an organ without a definite B.S.D. diagnosis but that once such a diagnosis could be made, removal of the heart would indeed be permitted. At best, however, this is ambiguous).¹

B. Maaseh rav: Rabbi Tendler asserts that he did not "deduce R. Moshe's opinion from an analysis of his writings but reported it as *maaseh rav* - what he said, wrote, and ruled in the numerous cases referred to him for *halachic psak*." I am not in a position to question R. Tendler's claim; certainly as one who was very much in close contact with R. Moshe, particularly in matters of medical *halachah*, his views are entitled to great weight and respect. What I would like to know, however, is whether R. Moshe actually permitted the removal of an organ from a B.S.D. patient or merely allowed Orthodox Jews to receive heart or liver transplants. If the *maaseh rav* is limited to the latter, it tells us nothing regarding the *halachic* status of a B.S.D. patient since even if such patient is *halachically-alive*, the recipient would arguably be allowed to benefit from the organ once it was removed. See III, below. At most, such *maaseh rav* would simply indicate that R. Moshe no longer regarded transplants as murder of the recipient. I refer the reader again to the new edition of *Nishmat Avrohom*, comments Y.D. 339.

C. The Miller Letter: Rabbi Tendler also notes the fact that for almost a decade, he articulated R. Moshe's opinion "that B.S.D.

is *halachically* valid and no one challenged [him] during all that time." Again, I cannot fully address the substance of this contention since the principle of *shetikah ke'hodaah* (silence is tantamount to admission) may not be determinative in matters of *psak halachah*. Rabbi Tendler is correct, however, that the full text of R. Moshe's 1976 letter to Assemblyman Miller, in opposition to proposed time of death legislation, is highly illuminating. The letter was drafted by Rabbi Moshe Sherer of Agudath Israel and went out with R. Moshe's signature. The letter first explicitly states:

"The sole criterion of death is the total cessation of spontaneous respiration."

This sentence alone does seem on its face to unequivocally affirm that B.S.D. (or even something less than B.S.D.) is *halachic* death. It is a significant piece of evidence to support Rabbi Tendler's construction that should have been included in my original article and I apologize for that omission. Nevertheless, even here, the next sentence appears to immediately modify the implication of the preceding one:

"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 has occurred."

In other words, absence of respiration is a necessary confirmation of death only when coupled with absence of other vital signs. Arguably, heartbeat and circulation may be precisely the type of vital sign that prevents absence of breathing from being determinative.

II. The Views of R. Shlomo Zalman Auerbach:

A. The Letters: At the time of the writing of my article, the only pronouncements from R. Shlomo Zalman that I had seen were the brief communications of 18 Menachem Av, 5751, and *Aseret Yemai Teshuvah*, 5752, where he and R. Elyashiv both stated, without any explanation, 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. Since then, R. Auerbach has issued various *teshuvot* in Tevet, Adar, and Nisan of this year. While these later *teshuvot* eliminate some of the uncertainty surrounding the earlier pronouncements, they also indicate that no significant retraction from the earlier *psak* has occurred. Indeed, in a letter dated Iyar 5752, both R. Auerbach and R. Elyashiv explicitly reaffirmed their earlier stance, again in summary fashion.

In a letter dated 6 Nisan 5752, however, R. Auerbach does offer some significant elaboration of his position. He states that even after all tests have been performed - including tests involving circulation of the blood to the brain - and the doctors have definitively determined that the entire brain

including the brain stem is dead, as long as the patient is attached to a respirator and the heart is beating, the patient is classified as a *sofeik goseis* (a doubtful case of a *halachically-alive* person whose death is imminent). As such, it is even prohibited to move the *goseis* and certainly prohibited to (possibly) murder him by removal of the heart.²

R. Shlomo Zalman does permit under these circumstances (a definitive diagnosis of brain stem death) shutting off the respirator.³ If no respiration or heartbeat is detectable for a period of thirty seconds, the patient may then be *halachically* declared dead and his organs harvested. Significantly, while it had long been thought that such a waiting period would make transplants impossible (because of rapid deterioration of the heart muscle), a number of transplant surgeons have recently indicated that even after a 30-second delay, transplantations are still feasible though they lose their optimal effectiveness. In essence, R. Auerbach's *psak* paves the way for the legitimization of heart and liver transplants even according to those views that do *not* accept B.S.D. as definitive *halachic* death.

B. The Sheep Experiment: A word should also be said about the sheep experiment. The Talmud in *Archin* posits that a fetus cannot survive its mother's death. Since B.S.D. patients can carry babies to term, it was thought that this alone was conclusive proof that B.S.D. patients were *halachically-alive*. To test this hypothesis, an experiment was performed at R. Auerbach's request, whereby a pregnant sheep was decapitated and hooked up to a respirator. Heartbeat and blood pressure were maintained and a live lamb was successfully delivered by caesarean section. Since it is undisputed that under these circumstances, the mother sheep was dead, (decapitation results in death according to all authorities), the Talmud's ruling that the life of the fetus establishes vitality of the mother does not apply when the mother's vital functions can be mechanically maintained. At best, however, this merely negates what would otherwise have been an incontrovertible proof that the B.S.D. patient must be alive. *Not being able to prove that B.S.D. equals life is not the same as proving B.S.D. is death*. Thus, even after the experiment, we are still left with the possibility of *sofeik goseis* as R. Auerbach concludes.

C. The Caesarean Birth: It has also been reported that R. Auerbach permitted the performance of a caesarean on a B.S.D. patient although, if the patient is a *goseis*, such a procedure would undoubtedly constitute forbidden movement that is tantamount to murder. Although this *psak* was widely circulated in R. Auerbach's name, in his most recent letter of 6 Nisan he states that he never issued such a *psak* nor was he even asked.

III. If B.S.D. is not acceptable as halachic death and the removal of a vital

organs is either certain or doubtful murder, could an Orthodox Jew receive a heart or liver transplant?

Here, I departed from my reportorial style and stated that, in view of the fact that there were many more demands for organs than supply and if the Orthodox Jew would refuse a transplant, the organ in all likelihood would be removed anyway, acquiescence to an organ transplant could in no sense be considered a causative factor in a homicide. As noted in my article, this was not my *chiddush* but was also the position taken by Rabbi Aaron Soloveitchik as well as Rabbi Bleich and it seemed *l'aniyat daati* to possess considerable merit.

Rabbi Tendler questions this analysis by citing the example of ten hit men, where the one who actually does the killing is culpable despite the readiness of the nine to do likewise. The analogy, however, is inapt. Obviously, if one actively commits a *maaseh retzichah* (act of murder), one cannot assert as a defense that it would have been done by someone else anyway. The recipient of an organ, however, is not a *rotzeach*. It is the doctor who is the *rotzeach*. One who places his name on a list to receive a transplant is at worst only a *goreim retzichah* — an indirect cause. And while it is true that even a *geram retzichah* is forbidden, the existence of alternative recipients means that any given recipient cannot even be characterized as a *goreim*.

Rabbi Tendler is correct, however, that R. Shlomo Zalman has indeed rejected this

line of reasoning and has ruled that in Israel, where a majority of those in need are Jewish, not only is it prohibited to remove a heart but it is prohibited to enlist as a potential recipient as well. In the letter of 28 Adar II, 5752, R. Auerbach distinguishes between recipients in Israel, where most of the transplant surgeons, donors, and potential recipients are Jewish and outside of Israel, where most are non-Jewish.⁴ Where both the donor and the surgeon are, or can be presumed to be, non-Jewish, even R. Auerbach permits the Orthodox Jew to receive the transplant although the removal of the organ by the surgeon was a prohibited act of homicide.⁵ In result, if not analysis, the conclusion stated in my article remains unchanged, at least for recipients in the United States.

IV. B.S.D. and the Israeli Chief Rabbinate:

“Respiratory failure” and “physiological decapitation” are indeed somewhat different theories. First, as originally formulated, the Rabbinate’s ruling did not mention any requirement of “absence of movement.” As such, a patient in an iron lung could conceivably have been declared dead although fully conscious, communicative, and capable of mental functioning of the highest order. This is far short of anything even remotely approaching brain death. Second, even after the clarification that its ruling applied only if in addition to lack of respiration, there must be total absence of movement, the Rabbinate did not require nuclide scanning; apnea testing alone could conclusively demonstrate

irreversible destruction of the respiratory centers of the brain and would be sufficient to establish death. By contrast, a full-blown determination of “brain death” would require considerably more. In any case, I was certainly not positing that these standards are diametrically opposed but are simply “based on somewhat different theories,” as in fact they are.

Rabbi Tendler and I are in agreement that there are a number of points in all these *psakim* that still need further clarification: the distinction between Israel and *chutz l'aretz*, between donors who are Jewish and those who are not Jewish, the relevance of the doctor’s religious affiliation, whether R. Shlomo Zalman’s dispensation to shut off the respirator is limited to B.S.D. patients or applicable to other types of terminal or even PVS (persistent vegetative state) situations,⁶ how the ruling applies to other forms of treatment and sustenance (e.g., hydration and nutrition), what are the implications of a state of *sofeik gesisah* for other areas of Jewish law (inheritance etc.), the *heter* for performing a life-threatening caesarean on a B.S.D. patient if, after all, such patient is at least a *sofeik chai*; and whether indeed there is such a *heter* at all. We have not yet heard the last word on this difficult subject. Hopefully, our *poskim* will offer us the necessary guidance to approach these delicate matters of life and death in accordance with the dictates of the Torah and the will of *Hakadosh Boruch Hu*. □

FOOTNOTES:

1. Rabbi Tendler also cites Y.D. II, 146. That teshuvah indeed states that a patient sheyachol linshom — that is capable of breathing independently — cannot be declared dead merely on the basis of a lack of cerebral functioning. The language, however, does not establish the converse — that inability to respire spontaneously necessarily is equivalent to death. In any event, the language of yachol linshom does not appear in teshuvah 132.
2. It should be noted that while this position rejects B.S.D. as a definitive halachic definition of death, the psak equally rejects Rabbi Bleich’s position that such patients are unquestionably alive. R. Auerbach thus joins those groups of authorities that treat the matter as one of *sofeik* (doubt) where a stance of passivity must be adopted.
3. This aspect of R. Auerbach’s psak is somewhat problematical. If there is any chance at all that a B.S.D. patient may be halachically-alive, what justification could there be for shutting off the respirator and killing the patient? There are two possibilities: (1) R. Auerbach regards removal of a respirator as a passive withholding of life-sustaining treatment (*hasarat hamoneah*) which Rema in

- Y.D. 339 permits in the case of a *goseis* (in this sense he differs with R. Moshe who regarded shutting off a respirator as an act of prohibited intervention); (2) a patient whose heartbeat and circulation is maintained only because of mechanical respiration is in fact already dead. We need to shut off the respirator, however, to verify that fact. Shutting of the respirator does not therefore result in the patient’s death but simply confirms that the patient was in fact dead all along. If the second reading is correct — and I believe it is — R. Shlomo Zalman would appear to concede in principle that true B.S.D. is in fact death, but unwilling to rely on any of the existing tests — including apnea and nuclide scanning — to confirm this fact.
4. R. Elyashiv apparently does accept the non-goreim argument but again limits it to non-Jewish donors.
 5. It is not entirely clear what the basis for the distinction is. If one were to accept the non-goreim argument, it should follow that receiving the organ should be permitted even in Israel, whether or not the donor is Jewish. In prohibiting placing one’s name on a list, R. Auerbach apparently maintains either that: (1) if the heart is removed because of A,

- A is indeed characterized as a *goreim retzichah* even if B would have made the same request; (2) alternatively, if A is not a *goreim retzichah*, he *trānsgresses* the prohibition of *lifnei ever* (causing another to commit a sin) by causing the surgeon to commit murder. All of these considerations apply equally to Jews or non-Jews. The distinction is apparently premised on the fact that where all the recipients are Jews subject to the laws of the Torah, no one individual Jew can legitimately take the position that he is committing no sin since others will sin if he doesn’t. See Mishna L’melech Ch. 4, Hilchot Malveh U’Loveh; according to this explanation, however, the only relevant factor would be the identities of the other recipients, not the identities of the donors. R. Auerbach seems to require that both the donors and a majority of the recipients be non-Jewish. This point needs further clarification.
6. The letter of 6 Nisan indicates that the dispensation does not apply to other cases of *goseis* but does not explain why. This supports my conclusion in note 3 that the psak is not predicated on *hasarat moneah*.