

HESED OR HIYUV? THE OBLIGATION TO PRESERVE LIFE AND THE QUESTION OF POST-MORTEM ORGAN DONATION

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The Committee on Jewish Law and Standards of the Rabbinical Assembly provides guidance in matters of halakhah for the Conservative movement. The individual rabbi, however, is the authority for the interpretation and application of all matters of halakhah.

שאלה

What is the halakhic status of post-mortem organ and tissue donation?

תשובה

I. Preservation of Human Life as Obligatory

The inestimable value of human life is a cardinal principle of Jewish Law. As Rabbi David Bleich writes:

Human life is not a good to be preserved as a condition of other values but an absolute, basic, and precious good in its own right. The obligation to preserve life is commensurately all-encompassing.¹

This obligation includes not only self-preservation, but the duty to save the life of one's fellow human being, should he or she be in mortal danger. The Torah's commandment, **לֹא תַעֲמֹד עַל דַּם רֵעֶךָ** – “You shall not stand idly by the blood of your neighbor”² -- provides the halakhic basis for this obligation.

¹ Rabbi J. David Bleich, *Contemporary Halakhic Problems* (New York: Ktav, 1977), p. 93.

² Lev. 19:16.

In addition, the Talmud³ reformulates this prohibition (מצוה לא תעשה) into a positive, prescriptive obligation (מצוות עשה), by relating the duty to intervene in life-threatening situations to the commandment⁴ regarding restoration of lost property – השבת אבידה. “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.”⁵

II. Who is Obligated?

In codifying this mitzvah, Maimonides emphasizes how broadly its obligation devolves: כל רעך – “Anyone who is able to save a life, but fails to do so, violates ‘You shall not stand idly by the blood of your neighbor.’”⁶ In describing the analogous duty to save the life of one being pursued by an assailant (רודף), Maimonides leaves no room for exemption: כל ישראל מצווין להציל – “All Israel are commanded to take life-saving action.”⁷

Indeed, not even the inability personally to save the life in peril relieves one of this obligation:

לא תעמוד על דם רעך לא תעמוד על עצמך משמע אלא חזור על כל צדדין
שלא יאבד דם רעך.

“You shall not stand idly by the blood of your neighbor,” means “You shall not rely on yourself, alone.” Rather, you must turn to all available resources so that your neighbor’s blood will not be lost.⁸

III. Precedence of the Obligation

It is abundantly clear that the mandate to preserve life – פקוח נפש – takes precedence over other religious obligations and considerations. (The prohibitions against murder, sexual immorality, and idolatry are, under normal circumstances,⁹ the only exceptions – יהרג ואל יעבור, “let him die and not transgress”).¹⁰ Former British Chief Rabbi Immanuel Jakobovits articulates this principle in no uncertain terms:

It is obligatory to disregard laws conflicting with the immediate claims of life, and. . . it is sinful to observe laws which are in suspense on account of danger to life or health. . . [I]t is not only permitted but imperative to disregard laws in conflict with life or health.¹¹

Thus, the seriously ill are required to eat on Yom Kippur. Similarly, it is forbidden to circumcise a sick or weakened infant if this would further compromise his health. The circumcision must be delayed, for אין לך דבר שעומד בפני פקוח נפש – “preservation of life

³ B. Sanhedrin 73a.

⁴ Deut. 22:1.

⁵ Bleich, p. 95.

⁶ Maimonides, *Hilkhot Rotzeah u'Shmirat Nefesh* 1:14.

⁷ *Ibid.*, 1:6.

⁸ B. Sanhedrin 73a, Rashi ad loc.

⁹ During a period of religious persecution, however, the law is more stringent, extending the requirement of martyrdom even to minor religious practices. See *Yoreh De'ah* 137:1.

¹⁰ B. Sanhedrin 74a; Yoma 82a.

¹¹ Rabbi Immanuel Jakobovits, *Jewish Medical Ethics* (New York: Bloch, 1975), p. 50.

overrides all other considerations.¹² This principle has many applications in regard to the laws of Shabbat. The requirement to preserve life at the expense of Sabbath observance is unambiguous indeed:

מי שיש לו חולי שיש לו סכנה מצוה לחלל עליו את השבת והזריו הרי זה משובח והשואל הרי זה שופך דמים.

It is commanded that we violate the Sabbath for anyone dangerously ill. One who is zealous (and eagerly violates the Sabbath in such a case) is praiseworthy; one who (delays in order to) ask (questions about the law) is guilty of shedding blood.¹³

A noteworthy expression of this zeal is the recommendation (directed at Israeli society) in *ספר שמירת שבת כהלכתה* that when it becomes necessary to drive an ambulance on the Sabbath, it is preferable that Sabbath-observant Jews do the driving.¹⁴

IV. Primary Objections to Post-Mortem Procedures

To be sure, post-mortem donation of human tissue is not without halakhic difficulties. The halakhic objections to this practice include the prohibitions against *ניוול המת* (disgracing the dead body, as by disfigurement), *הנאה מן המת* (deriving benefit from a dead body), and *הלנת המת* (delaying burial).¹⁵

All three of these concerns, collectively termed *כבוד המת* (the dignity of the dead), are addressed in a responsum by former Israeli Chief Rabbi Isser Yehuda Unterman. As to the first two issues, Rabbi Unterman rules succinctly:

השאלה היא אם מותר מצד הדין לעשות נתוח בכשר אדם מת ולהעביר ממנו בשר... שיתקשר אח"כ באופן אורגני כחלק מן החי... ופשוט בעיני הדבר שיש בהם משום פקוח נפש לא קמבעי לן שאסורי-תורה חמורים נדחים מפני פקוח נפש, ולכן הנתוחים שעושים להצלת נפש ודאי מותרים.

Regarding the question of whether the law permits surgical removal of tissue from a dead body. . .subsequently to be transplanted as an organic part of the living. . .I find the matter to be simple. Since these procedures constitute preservation of life there is no difficulty. After all, weighty Torah prohibitions are set aside for the preservation of life. Hence, such surgical procedures conducted to save a life are absolutely permitted.¹⁶

Rabbi Efrayim Oshry rules with similar clarity: *היבא דשייך ענין של פקוח נפש לא* – “Where saving a life is involved, we are not concerned with the desecration of the dead.”¹⁷ So too, Rabbi Theodore Friedman: *פקוח נפש גדול מכבוד המת* –

¹² B. Yoma 82a. Similarly, *סכנת נפשות דוחה את הכל*, Yoreh De'ah 263:1.

¹³ Orach Hayyim, 328:2.

¹⁴ Rabbi J.I. Neuwirth, *Shmirat Shabbat K'hilchatah* (Hebrew), p. 541.

¹⁵ See Rabbi Isaac Klein, “Autopsy,” in *Responsa and Halachic Studies* (New York: Ktav, 1975), p. 40.

¹⁶ Rabbi I.Y. Unterman, *Shevet Mi-Yehuda*, (Mosad Harav Kook 1983 ed.), p. 54. See also p. 368 for an identical ruling based on *Noda B'Yehuda* and *Maharam Shik* rulings on autopsies.

¹⁷ Rabbi Efrayim Oshry, *She'eilot u'Teshuvot mi-Ma'amakim*, 2:10. English translation from *Responsa From the Holocaust*, p. 72, “Performing a Caesarean Section on a Dead Woman.” Rabbi Oshry authorized a Caesarean section on a woman whose murder he witnessed, even though it was uncertain the baby was still alive.

“Greater is saving a life than the dignity of the dead (*kevod ha-met*).”¹⁸

As to the question of burial, Rabbi Unterman discusses only the particular organs or tissue being transplanted. In this regard, he considers transplanted tissue to be restored to life and thus not requiring burial with the donor’s remains. The question of whether the donor’s transplanted tissue will eventually be buried together with the recipient is not compelling, just as the requirement that blood be buried poses no obstacle to blood donation.¹⁹

Rabbi Unterman does not discuss the issue of delaying burial to facilitate post-mortem procedures. Since, however, such delay is neither typical nor necessary, we should not consider it an impediment.²⁰ In those few, rare cases where burial is delayed, we should rely on Rabbi Unterman’s general approach: preservation of life takes precedence, and the prohibition of *הלנת המת* (delaying burial) is likewise suspended. *אין לך דבר שעומד בפני פקוה* – “Preservation of life overrides all other considerations.”

While organ and tissue transplantation is a relatively new halakhic quandary, the related question of autopsy has a longer general and halakhic history.²¹ “Many medical practitioners,” writes Russell Scott, “regard autopsy as essential to maintaining high standards of medical knowledge, hospital care, and community health.”²² The trend toward permitting autopsy under the rubric of *פקוה נפש*, however, has generally been conditioned by the stipulation that a specific beneficiary of information gained through the procedure be identified (*הולה נמצא לפניו*).²³ That is, theoretical medical knowledge alone does not constitute *פקוה נפש*. A demonstrable need for information required to avert immediate danger to a specific human life is necessary to render autopsy permissible. In the absence of such a need, autopsy remains prohibited. Indeed, Rabbi Unterman suggests organ donation as a desirable recourse when civil authorities mandate autopsies which would otherwise be halakhically objectionable:

היכי שחתכוהו בלאו הכי עפ”י דרישת החוק לצורך חקירה משפטית
וכדומה אפשר שאין זה ניוול אם נשתמשו בחלק מחותך לרפואה.

¹⁸ PRA 17 (1953): 44.

¹⁹ On the requirement that blood be buried, see “A Guide for the Chevra Kadisha” in Rabbi Maurice Lamm, *The Jewish Way in Death and Mourning* (New York: Jonathan David, 1969), p. 244.

²⁰ “The Circle of Life: Organ and Tissue Donation,” American Council on Transplantation.

²¹ In *The Body as Property* (New York: Viking Press, 1981), Russell Scott calls autopsies “the oldest medical activities that use bodies” (p. 29). Skilled dissection of human bodies can be traced to antiquity, as discriminating removal of organs was necessary for embalming, which was commonplace in ancient Egypt (see Gen. 50:2-3,26). Western civil regulation of autopsies can be traced at least to 1504, when the Town Council of Edinburgh granted a charter for post-mortem procedures to the British Guild of Surgeons and Barbers (Scott, p. 5).

²² Scott, p. 15.

²³ This principle was recognized as early as the Talmudic Period. B. Hullin 11b discusses the permissibility of an autopsy to determine whether a murder victim was a *טריפה* – already suffering from a fatal wound or condition, in which case no death penalty was imposed. The prohibition of *ניוול המת* was suspended, as the findings of the autopsy might save the life of the convicted murderer! The earliest clear application of this principle in the responsa literature is in Rabbi Yechezkiel Landau’s *Noda B’Yehuda* (Mahadura Tinyana, Yoreh De’ah no. 310), in which he stipulates that an autopsy is permissible only if a patient in the same hospital is suffering from the same condition and there would thus be an immediate, life-saving benefit from the procedure. Rishon L’Tzion Benzion Meir Chai Uziel ruled more leniently, extending the principle of *פקוה נפש* to general advances in medical knowledge. The Knesset passed the Law of Anatomy and Pathology in 1953, based on an agreement with the Chief Rabbinate, although there were later attempts to restore the more stringent guidelines of the *Noda B’Yehuda*. Rabbi Isaac Klein concludes his responsum on the question of autopsy thus: “If medical science claims that these may save lives. . . it is not only permitted, but it is actually a mitzvah.”

In cases where an autopsy (one otherwise not in conformity with Jewish law) is performed in accordance with the demands of civil law, as part of a criminal investigation or the like, it may no longer be considered a desecration (ניווּל) if excised tissue is used for healing.²⁴

So long as highly sophisticated, computerized, international organ registration networks readily identify prospective organ recipients, the requirement of חוּלָה נִמְצָא לַפְּנִינֵנוּ is, in the case of organ donation, ipso facto satisfied. So immediate and specific is the need for organs that a prospective recipient typically “wears a pocket pager, waiting for a call saying that a new heart is available.”²⁵ (As Rabbi Unterman indicates, however, fulfillment of this condition remains considerably more difficult to establish in regard to autopsy, the benefits of which are generally far less direct and immediate. Autopsy thus remains prohibited unless it is deemed necessary for saving the life of a חוּלָה נִמְצָא לַפְּנִינֵנוּ.)

V. Dimensions of the Need

The halakhic mandate to preserve life by consenting to post-mortem tissue donation takes on compelling urgency by virtue of the massive need for tissue transplants. As of April, 1995, 39,735 people were on the waiting list of the United Network for Organ Sharing.²⁶ “Every thirty minutes, someone is added to this national waiting list. More than 500 patients on the national waiting list are children.”²⁷ Due directly to the shortage of willing donors, “thousands continue to die each year because of a shortage of donated organs and tissues.”²⁸ According to one estimate, seven people die each day for lack of available organs.²⁹

The life-saving impact of organ donation reaches far beyond the sizable number of potential recipients. “Faced with a dire lack of organs from cadavers, transplant surgeons are looking with increasing interest at living donors,”³⁰ in particular, close relatives of recipients. A recent, unsuccessful transplant attempt dramatizes this dangerous, emerging trend:

In a desperate attempt to save the life of a 9-year-old Minnesota girl whose lungs had failed, doctors first transplanted part of her father’s lung and, when that was not enough, tried to transplant part of her mother’s lung. . . . While still on the operating table, the girl, Alyssa Plum, died.³¹

Prospective living donors, as well as recipients, are thus needlessly placed at mortal risk by the shortage of cadaver organs. “Parents want to donate even when doctors are unwilling to do the operation because they think it would be futile or that there is too much risk for the donor.”³² This unacceptable risk led Dr. Thomas Starzl, the renowned

²⁴ Unterman, p. 60.

²⁵ Calvin Stiller, M.D., *Lifegifts: The Real Story of Organ Transplants* (Toronto: Stoddart Publishing, 1990), p. 57.

²⁶ UNOS Newsletter, Apr. 1995. UNOS manages the National Organ Procurement and Transplant Network (OPTN). For updated figures on the data related in this paragraph, see below, p. 191.

²⁷ “30 Facts About Organ Donation and Transplantation,” The National Kidney Foundation, p. 2.

²⁸ “History of Transplantation and Organ Donation,” Hartford Transplant Center, p. 4.

²⁹ Susan Reed, “Toward Remedying the Organ Shortage,” *Technology Review* (Jan. 1994): 38.

³⁰ Gina Kolata, “Lungs from Parents Fail to Save Girl, 9, and Doctors Assess Ethics,” *New York Times*, 20 May 1991, p. A-11.

³¹ *Ibid.*

³² *Ibid.*, quoting pediatrician/ethicist Dr. John Lantos.

surgeon who pioneered liver transplants,³³ to announce that he would no longer perform transplants from living donors. In 1987 he explained his decision:

The death of a single well-motivated and completely healthy living donor almost stops the clock world-wide. The most compelling argument against living donation is that it is not completely safe for the donor.³⁴

Nevertheless, medical reliance on living donors continues to mount. In August of 1995, *The New England Journal of Medicine* reported “increasing numbers of persons donating kidneys to their spouses.”³⁵ Citing evidence that “the survival rates of these kidneys are higher than those of cadaveric kidneys,” the article concludes that “spouses are an important source of living-donor kidney grafts.” Such a trend in the field of transplantation places tremendous pressure on relatives of prospective organ recipients to imperil themselves by serving as donors. In 1994 alone, 2,980 kidney transplants were performed using living donors.³⁶

The *N.E.J.M.* article provides separate statistical data for kidney donation by husbands to wives based on whether the wife had ever been pregnant. The success rate for transplantation into women who had previously been pregnant is 76%, as opposed to 87% for women who had never been pregnant.³⁷ It must be assumed that among the former are a significant number of mothers with young children. Spousal donation in such cases means that both parents (donor and recipient) – and, therefore, their children’s well-being – are placed at mortal risk. Yet an accompanying editorial asserts that there is “no ethical objection to using emotionally related (that is, spousal) donors(!).”³⁸

Even a minute risk to the living is a significant halakhic datum. Rabbi Jakobovits thus rules that “while the gift of blood constitutes a religious obligation, it cannot be enforced, since it may entail some risk for the donor.”³⁹ Similarly, he views higher-risk living donation of organs “as acts of supreme charity but not as an obligation.”⁴⁰ Risk to life, statistically insignificant or profound, constitutes a mitigating factor which renders living donation commendable but optional. This risk is, by definition, completely absent in post-mortem donation. With the absence of risk as a mitigating factor, post-mortem organ donation is, logically, rendered obligatory.

Indeed, the risk to prospective living donors makes the need for cadaver organs – and the halakhic mandate for donation – all the more urgent. It should be noted that, in addition to altruistic relatives acting as living donors, the shortage of cadaver organs has also

³³ Scott, p. 20.

³⁴ Christine Gorman, “Matchmaker, Find Me a Match,” *Time*, 7 June 1991: 61.

³⁵ Paul Terasaki et al., “High Survival Rates of Kidney Transplants from Spousal and Living Unrelated Donors,” *New England Journal of Medicine* 333 (10 Aug. 1995): 333-336.

³⁶ UNOS Newsletter, Apr. 1995.

³⁷ Terasaki et al.

³⁸ Jean-Paul Soullou, M.D., “Kidney Transplantation from Spousal Donors,” *New England Journal of Medicine* 333 (10 Aug. 1995): 379-380.

³⁹ Jakobovits, p. 285.

⁴⁰ *Ibid.*, p. 291. Rabbi Jakobovits here draws a distinction between מצוה and חובה. His allusion to “charity” is instructive: charity is a religious “obligation” which “cannot be enforced” at every juncture. One may, to a great extent, determine those occasions on which one will and will not give charity. In the same manner, according to Rabbi Jakobovits’ argument, one may elect whether or not to preserve another’s life at one’s own risk. Every such act of פקודת נפש מצוה (fulfillment of a “religious obligation”); not every such opportunity for פקודת נפש, however, is a חובה (mandatory).

led to “a recognized market in human body parts.”⁴¹ That is, individuals are hired to donate organs which are redundant (a kidney), “non-essential” (corneas), or regenerative (sections of liver).⁴² While almost universally illegal, trade in human organs, like the “long-shot” attempts of relatives to save the lives of loved ones through living donation, demonstrates the desperate situation caused by the lack of available cadaver organs, and the personal desperation of prospective recipients.

VI. Who Can Donate?

It should be stressed that mandating consent for post-mortem organ donation does not mean that all, or even most compliant individuals will actually serve as donors. However, any individual donor may well be uniquely qualified to save the life of a prospective recipient. About two million deaths are recorded annually in the United States. “Primary donors are between ages 15 and 65. They are in good health but have died suddenly, possibly through accidents and are declared brain dead. . . . An estimated 20,000 to 25,000 brain deaths occur in the United States each year.”⁴³ This select group of potential donors is further narrowed, as any particular organ transplant requires compatible tissue obtained from a “good genetic match” to minimize chances of natural organ rejection. Six pairs of genes are examined to determine matching human lymphocyte antigens (HLA proteins). The closer the match, the higher the prospects for a successful transplant.⁴⁴ Only an identical twin guarantees a perfect match. The smaller the pool of donors, the less likely it is to find a suitable cadaver organ for transplantation.

VII. Secondary Objections to Obligation

An objection raised by some authorities posits that while פקוה נפש may indeed be a privilege for the dead, it cannot properly be ruled an obligation.⁴⁵ The dead are not bound by Jewish law (חפשי מכל המצוות)!⁴⁶ This suggestion is mere semantics. The consent required for organ donation is given prior to one’s death, or by surviving, responsible relatives. The deceased is the means by which פקוה נפש is achieved. The act of consent while alive (or the consent of survivors) constitutes the fulfillment of the mitzvah itself.

It is curious indeed, with the consistent historical penchant for unambivalent zeal in matters of פקוה נפש, that the mandatory status of post-mortem organ donation has not previously been widely asserted. Various reasons for this apparent pattern of omission can be discerned. The first is that the technology of transplantation is still quite young. In the early 1940s “Sir Peter Medawar (Oxford, England) described the rejection phenomenon, for which he won the Nobel Prize. This discovery laid the foundation for the modern era of transplantation.”⁴⁷ This era came into fruition⁴⁸ only in the late 1940s, precisely the time Rabbi Unterman was composing his responsum on this topic. The first successful kidney

⁴¹ Scott, p. 3.

⁴² See Scott, Chapter 1.

⁴³ “30 Facts About Organ Donation and Transplantation,” The National Kidney Foundation.

⁴⁴ See Paul Terasaki, “Getting the Most Mileage from Donated Hearts,” *Annals of Thoracic Surgery* 49 (Feb. 1990): 177-178; Verdi J. DiSesa, M.D. et al., “HLA Histocompatibility Affects Cardiac Transplant Rejection and May Provide One Basis for Donor Allocation,” *ibid.*, pp. 220-224.

⁴⁵ See, for example, Rabbi Yekutiel Greenwald, *Kol Bo al Avelut* (Jerusalem: Feldheim, 1997), p. 46.

⁴⁶ See, for example, B. Shabbat 151b, Nidda 61b.

⁴⁷ “History,” p. 3. See above, n. 28.

⁴⁸ Historical synopsis based on Scott, p. 19ff.

transplant did not take place until 1954, two years after publication of Rabbi Unterman's *שבט מלך*. Liver and lung transplants were first performed in 1963, and then only with limited success. The first recipient of a liver died within three weeks. The first successful heart transplant was performed in South Africa by Dr. Christiaan Barnard in 1967, and provoked years of debate and controversy. Successful lung transplants are an extremely recent achievement.

Thus, those responsa and rabbinic pronouncements issued early in the still short history of transplantation could not assert with confidence that the procedures were in fact life-saving.⁴⁹ The first attempts at each new procedure met with only limited success. Immuno-suppressive therapy – the technology whereby natural rejection of “foreign” organs is medically and chemically combated – is still being perfected. However, this developing technology already accounts for “a near doubling in the numbers of heart, kidney and liver transplants performed. These advances also have increased the survival rates of kidney transplant recipients over age sixty by as much as ten percent.”⁵⁰

Only with time and experience do transplant operations become sufficiently dependable to constitute clear *פיקוח נפש*.⁵¹ Kidney transplants currently enjoy an eighty to ninety percent success rate; heart transplants a success rate of eighty to ninety percent, liver transplants sixty-five to seventy percent. Combined heart-lung transplants have a success rate of approximately seventy percent.⁵² Success implies restoration of the recipient's quality of life and normal life expectancy. “Post-mortem donor kidney transplantation function of more than 20 years is well-documented.”⁵³

Similarly, before the advent of sophisticated, coordinated and computerized national and international organ registries, mandating donation would have been premature. Recipients were more difficult to locate and identify. The requirement of *חולה נמצא לפנינו* (a specific recipient) could not always be fulfilled early on in transplant history. This, as discussed above, is no longer commonly the case. The United Network for Organ Sharing (UNOS), a government sanctioned organ registry, has replaced the less efficient methods for identifying recipients of earlier decades.

VIII. Determination of Death

Finally, there was a greater reluctance in the early years of the transplant era to mandate (indeed, to allow) donation due to fears regarding determination of the donor's death. Using brain-death as a medical, much less halakhic, determinant of death dates only to the twenty-second World Medical Assembly held in 1968.⁵⁴ Brain-death is defined as “permanent functional death of the centers in the brain that control the breathing, pupillary, and other vital reflexes.”⁵⁵ Rabbinic proponents of such a definition of death, that is, the total

⁴⁹ See Rabbi Moshe Tendler, in *Jewish Medical Ethics*, 5th ed. (New York: Federation of Jewish Philanthropies, 1975), p. 50.

⁵⁰ “30 Facts,” p. 3.

⁵¹ In fact, confidence of long-term success should not be a prerequisite to mandating organ donation; see *Orah Hayim* 329:4. See also *Shmirat Shabbat K'hilchatah*, p. 430, par. 2. However, organ transplants were, early in their history, considered a calculated risk which might actually result in shortening the life of the recipient. At such a juncture, the permissibility of such procedures would still be at issue; mandating donation would certainly have been premature.

⁵² “Questions About Organ Donation” and “Fact Sheet, Organ/Tissue Donation and Transplantation,” Hartford Transplant Center.

⁵³ “30 Facts,” p. 3.

⁵⁴ Scott, pp. 158-159.

⁵⁵ *The Bantam Medical Dictionary* (New York: Bantam Books, 1990), p. 112, s.v. “Death.”

cessation of brain and brain-stem activity, as indicated (among other diagnostic methods) by an isoelectric or “flat” electroencephalogram (EEG), include Rabbis Seymour Siegel ל”ר,⁵⁶ Elliot N. Dorff,⁵⁷ Avram Israel Reisner,⁵⁸ and David Golinkin⁵⁹ (all of the Rabbinical Assembly), Rabbi Moshe Tendler,⁶⁰ a preeminent Orthodox authority on Jewish medical ethics, as well as the Chief Rabbinate of Israel. As Tendler writes:

All rabbinic authorities agree that the classic definition of death in Judaism is the absence of spontaneous respiration in a patient with no other signs of life. . . . Brain death is a criterion for confirming death in a patient who already has irreversible absence of spontaneous respiration.⁶¹

It should be noted that the determination of brain-death is often made while the deceased appears to be breathing and to have a pulse, due to the use of a mechanical respirator. Where brain-death is determined, these misleading data in no way constitute life. Quite to the contrary, “it might be forbidden to continue artificial means of ‘life’ in these conditions, since it would, in fact, be *הלנת המת*, a delay in burying a dead person.”⁶²

Writing in 1975, Rabbi Jakobovits pointedly discusses the implications of this issue:

The question of defining the moment of death with precision has . . . been rendered both more difficult and more critically acute by . . . the demand for viable cadaver organs for transplant purposes. The lapse of only a few minutes may spell the difference between success and failure in such operations; on the other hand, the premature removal of organs from the dying may hasten death and constitute murder.⁶³

Greater familiarity with the practice of transplantation, as well as a broader medical and rabbinic literature on determination of death and brain-death, have largely eliminated this concern. Prevalent pre-modern fears of “false death” are no longer compelling. The final moments of the donor’s life are safeguarded by requirements that two physicians certify death, and that these physicians not be involved in the transplant procedure.⁶⁴

IX. *כבוד המת*: The Dignity of the Dead

Perhaps the most decisive factor in rabbinic reluctance to mandate post-mortem organ donation, however, has simply been “the widespread aversion to any interference with the

⁵⁶ “Updating the Criteria of Death,” *Conservative Judaism* 30 (winter 1976).

⁵⁷ Elliot N. Dorff, “A Jewish Approach to End-Stage Medical Care,” *PCJLS 86-90*, pp. 65-126. Rabbi Dorff writes of brain-death: “If the patient meets the criteria for neurological death, we can, on good authority, consider the person dead within the terms of Jewish law.”

⁵⁸ Avram Israel Reisner, “A Halakhic Ethic of Care for the Terminally Ill,” *PCJLS 86-90*, pp. 13-64.

⁵⁹ *Responsa of the Va’ad Halakhah of the Rabbinical Assembly of Israel*, vol. 5, pp. 119-124 (Hebrew).

⁶⁰ See, for example, “Communications,” *Tradition* 28 (spring 1994): 94-96. In this letter, written together with ethicist Dr. Fred Rosner, Rabbi Tendler also asserts acceptance of the brain-death criterion by his late father-in-law, Rabbi Moshe Feinstein, until his death the “dean” of American Orthodox halakhic decisors (poskim).

⁶¹ *Ibid.*, p. 96. For the primary source on cessation of spontaneous respiration as determinant of death, see Yoma 85a.

⁶² Siegel, p. 28, citing Rabbi David Novak.

⁶³ Jakobovits, p. 277.

⁶⁴ See, for example, Connecticut Anatomical Gift Act, Section 7(b).

dead among most Jews.”⁶⁵ In general, this “aversion” reflects entirely appropriate devotion to a venerable religious principle, and should be commended. As Rabbi Lamm writes:

Man is created in the image of God, and thus possesses dignity and value. . . . An indignity inflicted on man is a profanation of the name of God. The body that housed the soul is sanctified by Judaism. . . . Sanctity adheres to the body even after the soul has left. The care and consideration and respect that are bestowed upon the living must be accorded the dead as they are attended, prepared and escorted to their final abode on earth.⁶⁶

כבוד המת – the dignity of the dead – is a weighty and cherished religious imperative. This is indicated by the designation given those charged with these religious tasks: חברה קדישא, the “Holy Society.” As Rabbi Dorff writes:

If the body is honored to the extent that it is in Judaism, even in death. . . one can easily understand how many Jews would hesitate to mutilate it – or allow one’s own body to be mutilated – even when it is for the noble purpose of helping to save someone else’s life.⁶⁷

It is precisely a sensitivity to such well-intentioned sentiments which characterizes Rabbi Unterman’s call “to influence relatives and to persuade them to consent” (להשפיע) (על הקרובים ולשדלם שיסכימו) to organ and tissue donation.⁶⁸ Framing this teaching in terms of persuasion rather than coercion does not imply that this life-saving action is elective. Are not rabbis frequently engaged in educational endeavors and persuasive techniques aimed at generating compliance with clear halakhic obligations? Persuading a Jew, for example, to comply with the laws of Shabbat does not suggest that this observance is optional. Indeed, Rabbi Unterman’s call for persuasive outreach reflects his recognition of the obligatory nature of פקודת נפש. So, too, Rabbi David Golinkin:

לא זו בלבד שמותר ליהודי לצוות את איבריו להשתלה לאחר מותו אלא מצוה עליו לעשות כן כדי להציל נפש אחת או נפשות רבות.

It is not merely permissible for a Jew to bequeath his organs for transplantation following his death, it is a mitzvah for him to do so, in order to save one life, or several lives.⁶⁹

Rabbi Tendler similarly states that “if one is in the position to donate an organ to save another’s life, it’s obligatory to do so.”⁷⁰ The most sacred institutions and practices of Judaism may – indeed, must – be suspended for the purpose of saving lives. Does it not stand to reason that understandable but strictly subjective aversions and aesthetic objections to post-mortem organ donation likewise must be set aside?

⁶⁵ Jakobovitz, p. 279.

⁶⁶ Rabbi Maurice Lamm, “A Guide for the Chevra Kadisha,” in his *The Jewish Way in Death and Mourning*.

⁶⁷ Rabbi Elliot Dorff, “Choosing Life: Aspects of Judaism Affecting Organ Transplantation,” in Stuart J. Younger, Renée C. Fox, and Laurence J. O’Connell, eds., *Organ Transplantation: Meanings and Realities* (Madison: University of Wisconsin Press, 1996), pp. 168-193.

⁶⁸ Unterman, p. 368.

⁶⁹ See note 59. Rabbi Golinkin’s responsum carries the unanimous assent of the Va’ad Halakhah. The English precis in the same volume renders this passage as follows: “It is a mitzvah to donate organs after death.”

⁷⁰ Quoted in “Religious Views on Organ Donation and Transplantation,” in *American Council on Transplantation Promotional Kit* (Alexandria, Va.: 1989), p. 21. Rabbi Tendler adds: “It is given that the donor must be brain dead.”

As to the similar conflict between personal rights and the halakhic obligation to preserve life, the general observation of renowned Israeli jurist Haim Cohn is instructive:

Jewish law, as a system of law, knows no explicit rights. . . . It is no accident that Jewish law concentrates on duties and has no room for rights. It is the performance of duties by which God is served.⁷¹

Rabbi Unterman similarly considers individual liberties, to the extent they have any halakhic status, to be included among those values set aside for **פיקוח נפש**.⁷² We affirm that **פיקוח נפש** – Preservation of life overrides all other considerations. We ought not, as our final act, glorify personal preference at the expense of other human beings' lives.

X. Emotional and Psychological Considerations

Rabbi Unterman's early call for educational outreach in regard to fulfilling the mitzvah of **פיקוח נפש** through organ donation was predicated not only on halakhic principle, but on the spiritual significance of such an act. His metaphysical speculation also reflects a concern with the emotional impact of organ donation on the bereaved. Rabbi Unterman thus offers reassurance to donors' families:

זכות גדולה לו וקורת רוח לנשמתו שנעשית מצוה גדולה כזו בגופו, ואין לזלזל בחשבון כזה.

It is a great merit to the deceased, and gratifying to his soul, that so great a mitzvah is fulfilled with his body. One must not underestimate this consideration.⁷³

It is essential that one undertaking the persuasive outreach advocated by Rabbi Unterman follow his example in sensitively placing organ donation into a constructive context. Referring to life-saving transplant procedures as the "harvesting" of organs, for example, evokes a sense of violence and disregard for the deceased, as indicated by a grieving father:

I'm a farmer and I know what harvest means. When we harvest corn, we tear the corn from the stalk – it just gets trampled under the tires and then thrown away. Nobody is going to harvest my boy.⁷⁴

"Recover" or "retrieve" are more appropriate terms to describe the donation process. It is similarly imperative that a ventilator not be referred to as "life support," as this implies that the patient is not yet dead. (The ventilator is used following brain death to maintain circulation of oxygenated blood to viable organs.) Referring to the deceased by name (rather than as "the donor") "shows respect and sensitivity for the family's grief over the loss of their loved one."⁷⁵

⁷¹ Justice Haim Cohn, "The Right to Die in Jewish Law," lecture delivered at the Jewish Theological Seminary, 10 Apr. 1984. For a more extensive treatment of this subject, see Cohn's *Human Rights in Jewish Law* (New York: Ktav, 1984), pp. 17-19.

⁷² Unterman, p. 61. Rabbi Bleich, citing Rabbi Tucazinsky, states: "It is an established verity that, from the point of view of Judaism, man has no proprietary rights to his body," (See Bleich, p. 126). See also Rabbi Moshe Feinstein, *Iggrot Moshe*, Yoreh De'ah, pt. 3, no. 140; and Abraham S. Abraham, M.D., "Euthanasia," in Fred Rosner, M.D., ed., *Medicine and Jewish Law*, p. 124.

⁷³ Unterman, p. 60.

⁷⁴ Stiller, p. 56.

⁷⁵ Franki Chabalewski, RN, and M.K. Gaedeke Norris, RN, "The Gift of Life: Talking to Families About Organ and Tissue Donation," *American Journal of Nursing* (June 1994): 28-30.

Dr. Calvin Stiller, Chief of the Multi-Organ Transplant Service at University Hospital in London, Ontario, provides an inviting perspective on the transplant procedure:

When the decision to transplant is made, the donor and the recipient are taken to the operating room. The donor's body is treated with profound respect, because we are watching one of the most extraordinary acts that a human being can accomplish. The surgical theatre is hushed and reverence for life prevails as the donor organ is removed and taken carefully to the sick, partially destroyed body of the recipient. The sick organ is removed to make way for the new healthy organ. We watch in silence as the retrieval of life from the donor occurs and the restoration of life in the recipient begins. We watch as the skin begins to clear, the body chemistry begins to improve and the brain gradually quickens as the new organ functions and restores life.⁷⁶

Those contemplating organ donation should also be made aware that “studies have found that donation of the organs and/or tissue of a loved one who has died helps to shorten the time needed by members of a bereaved family to recover from their loss.”⁷⁷ Serving as an organ donor thus not only saves lives, but also provides comfort and healing to one's own loved ones, “a blessedness made more remarkable and unexpected precisely because of its association with an experience of such abysmal despair and suffering. . . . It doesn't remove the pain or loss, but it allows something good to be salvaged from an otherwise horrible occurrence.”⁷⁸ The emotionally therapeutic impact of organ donation is illustrated by the experience of a family who mourned the death of an 18-year old, killed in a motorcycle accident:

We were so proud of Walter. Even in death his quiet, unassuming generosity was still alive. On the day of the funeral, a friend of ours on the police force called to let us know that the heart recipient was doing very well, and was setting records for recovery. This gave our whole family a lot of faith for getting through that day.⁷⁹

In addition to the “redemptive comfort”⁷⁸⁰ inherent in the act of giving, donor families identify further emotional benefits of organ donation. These include the sense that donors “will never be forgotten” by those whose lives they save. Relatives of donors also report a sense of “extended family” and “community” with other donors and recipients: “The giving and receiving of life is the peculiar essence of family, and the gift of life that is tissue and organ donation has extended my family in a very real sense.”⁸¹

The adverse affect on the bereaved who are denied the opportunity to facilitate life-saving organ donations can also be profound. Donation may be precluded if the cause of

⁷⁶ Stiller, pp. 57-58.

⁷⁷ “30 Facts,” p. 5.

⁷⁸ Peter G. Sandstrom, MD, “What Helps When it Hurts: It is More Blessed to Give Than to Receive,” in *For Those Who Give and Grieve* (spring 1995): 3-8. This publication is a quarterly newsletter for donor families published by the National Kidney Foundation. Dr. Sandstrom's wife of twenty-six years served as an organ donor, having been declared brain-dead following a cerebral hemorrhage.

⁷⁹ Bonnie Langeveld, quoted in Stiller, *Lifegifts*, p. 94.

⁸⁰ Sandstrom, “What Helps When it Hurts.”

⁸¹ *Ibid.*

death is unknown. Potential donors may also be disqualified for various medical reasons: malignancies, transmissible disease, hemophilia, auto-immune diseases, rheumatoid arthritis, etc.⁸² Often, however, missed opportunities are due to the timidity of hospital personnel in approaching families for consent. One Canadian woman, whose husband suffered a fatal brain aneurysm, anticipated the opportunity to facilitate organ donation with a measure of solace. Her husband had, on principle, registered as an organ donor. By the time she was informed of his death, however – some ninety minutes thereafter – his organs were no longer viable:

A wave of grief swept over her. Grief exceeding that of loss. It was now laced with anger. Her husband had been denied an opportunity to carry out his last wish. Judy left the hospital filled with rage. She, too, had been denied. The grieving process was now doubly bitter for her.⁸³

Jewish mourners, called upon to grant consent for the use of a loved one's organs in a transplant procedure are, by definition, **אוננים**. This stage of mourning, **אנינות**, comprises the period between death and burial. As Rabbi Joseph Soloveitchik explains:

Aninut represents the spontaneous human reaction to death. . . . Man responds to his defeat at the hands of death with total resignation and with all-consuming, masochistic, self-devastating black despair.⁸⁴

It is little wonder that many individuals at this stage of grief are not naturally inclined to seek out opportunities for organ donation. Understandably, an **אונן** is emotionally ill-equipped to act selflessly and magnanimously for the preservation of human life. It is precisely the **אונן** who is least prepared to “carry the human-moral load”⁸⁵ by opting for organ donation. For this reason, many bereaved families tragically miss a unique opportunity for an act of religious significance and personal therapeutic value. Such was the case of a mother mourning her twelve-year-old son:

Anguish and grief at a time like that is such that all rational acts and thoughts are cast to the side. . . . Time eventually restores you to reality and thoughts of what you could have done before and after the tragic loss. . . . I wish that some or all of Jason's organs and eyes could have been used to help people less fortunate than himself. . . . If only I could look at another human and know that my son lives on in them and that they have had another chance at life because of Jason.⁸⁶

Consenting to organ donation provides an effective source of comfort and emotional healing. Mandating organ donation thus doubly exemplifies human sensitivity. It brings physical healing to the deathly ill. It also brings emotional healing to the bereaved, while relieving them of an emotional burden they are temporarily unable to bear.

⁸² “Guidelines for Tissue Donation,” Northeast Organ Procurement Organization and Tissue Bank.

⁸³ *Ibid.*, p. 91.

⁸⁴ Rabbi J.B. Soloveitchik, quoted by Rabbi Jack Reimer, *Jewish Reflections on Death* (New York: Schocken, 1975), p. 76.

⁸⁵ *Ibid.*

⁸⁶ Stiller, p. 14.

XI. Specific Procedures

A. *Vital Organs and Corneas*

Procedures which replace vital organs are the most obviously life-saving in nature. These include transplantation of the heart, lung, liver, pancreas, kidney, as well as the rarer joint heart/lung transplant.⁸⁷ A single cadaveric donor can facilitate transplants in multiple recipients, saving several lives simultaneously.

As early as 1953, Rabbi Theodore Friedman, “with the approval of a majority of the [R.A. Law] committee,” ruled corneal transplants permissible, stating that “it should readily be granted that blindness should be deemed a case of פקרוח נפש.”⁸⁸

The use of eyes removed from the dead, including their bequest for eye-banks, for corneal transplants has also generally been permitted. In the view of the majority the restoration or preservation of eye-sight is to be regarded as a life-saving act.⁸⁹

While one might infer from the existence of “eye banks” that the requirement of חולה נמצא לפנינו is not satisfied, this is not the case. Transplantation is performed within three to seven days after donation.⁹⁰ Furthermore, over ninety percent of all such procedures successfully restore the recipient’s vision.⁹¹ With 43,743 corneal transplants in 1994, this represents both the most common and most successful transplant procedure being practiced,⁹² “despite a continual shortage of donors.”⁹³ To the extent that restoration of eye-sight can be construed as preservation of life, corneas may thus be accorded the halakhic status of vital organs for the purpose of post-mortem donation.

As with other anatomical gifts, one should specify that consent is given for transplantation only. As Rabbi Jakobovits stresses, “the disused part of the eye after the cornea has been removed should not be disposed of except by burial.”⁹⁴

B. *Skin*

The use of tissue from cadaveric donors for skin grafting, however, presents a different set of considerations. According to Dr. Richard Kagan⁹⁵ of the Shriner’s Burn Institute of Cincinnati, and chairman of the American Association of Tissue Banks’ Skin Council, the most urgent need for skin-grafting is in the treatment of severe burn victims. While some surgeons prefer to use skin within three days of death, this is not always possible. Skin is frozen in a cryostat, and retained by skin banks until a need arises. Due to the nature of their injuries, unlike other transplant recipients, there can

⁸⁷ According to UNOS, sixty-nine such procedures were performed in 1994, as compared to 11,108 kidney transplants.

⁸⁸ *PRA* 17 (1953): 42.

⁸⁹ Jakobovits, p. 285.

⁹⁰ “Questions and Answers About Eye Donation and Corneal Transplantation,” Eye Bank Association of America.

⁹¹ *Ibid.*

⁹² *Ibid.*

⁹³ “Transplant Gives Gift of Sight,” *ConnSight* (Newsletter of The Connecticut Eye Bank & Visual Research Foundation), (Jan. 1995): 1.

⁹⁴ Jakobovits, p. 286.

⁹⁵ This characterization of skin grafting and skin banks, as well as all otherwise unattributed quotations in this section, are based on a telephone interview with Dr. Kagan, 18 Dec. 1995.

be no waiting list for burn victims. The need is sudden and immediate.

The preferred method in treating burn victims is “auto-graft,” the transfer of healthy tissue from elsewhere on the victim’s own body. In cases of extensive burning, a “homo-graft,” the transfer of skin from a human donor can be used only as a temporary measure. Skin is typically retrieved from relatively flat surfaces such as the back, thighs, and hips: not from the neck or face. “The grafted skin greatly enhances the surgeon’s ability to handle a burn wound and to prevent infection,” but must be considered “life-enhancing, not life-saving.” Skin used in a homo-graft eventually falls off the wound “like a scab.” Where auto-graft is impossible, homo-graft is “the tool of first choice.” Synthetic “skin” can serve the same purpose, but represents “a very distant second choice.”

Cadaveric skin thus represents a preferred mode of treatment, not an indispensable or vital medical resource. Skin homo-grafts cannot properly be classified as transplantation, due to the temporary nature of such procedures. Thanks to the availability of other treatment options, any shortage of donor skin cannot accurately be described as life-threatening. Indeed, death of severe burn victims is increasingly linked not to burns, but to pneumonia resulting from smoke inhalation. Donated skin, while frozen, has a limited “shelf-life.” Although the donor can specify that skin not be used for research, tissue which exceeds this period can simply not be used for grafting.

In light of these considerations, no obligation to make an anatomical gift of skin can be inferred from the prohibition of *לא תעמוד על דם רעך*. Such donations, however, should, if used for healing, be considered entirely permissible⁹⁶ acts of profound charity and kindness: *חסד*.

XII. Conclusion

Given the increasing sophistication and success of transplant technology, and the increased confidence regarding determination of death,⁹⁷ the post-mortem donation of vital organs and tissue incontrovertibly constitutes *פקודה נפש*, which overrides all other considerations. The demand for organs far outweighs the supply, creating thousands of desperate, specific, life-threatening situations.

We must therefore conclude that consent must be granted when requested by doctors or hospitals for use in lifesaving transplantation procedures.⁹⁸ This obligation can also be fulfilled by personally registering as a donor by, for example, properly completing a donor card to be carried on one’s person,⁹⁹ and by informing family members of one’s intention in this matter. It is most advisable to provide family members with written documentation of one’s donor status, possibly as part of a more general “living will.”¹⁰⁰

⁹⁶ See, for example, Rabbi David Colinkin, *Responsa of the Va’ad Halakhah of the Rabbinical Assembly of Israel*, vol. 5, p. 122 (Hebrew); Rabbi Grunvald asserts that the prohibition of *הנאה מן המת* does not apply to skin grafts (*Kol Bo Al Aveilut*, p. 45f (Hebrew)).

⁹⁷ While the medical and ethical issues relating to determination of death are increasingly complex, the former rabbinic concern regarding “false death” is no longer compelling.

⁹⁸ According to the National Kidney Foundation, “most states have passed ‘required request’ laws, which make it mandatory for the hospital to offer the family the option of donating their deceased loved one’s organs and tissues” (“Understanding the Organ Procurement Process”).

⁹⁹ Connecticut’s 1988 Anatomic Gift Act ruled that “an anatomical gift not revoked by the donor before death is irrevocable and shall not require consent or concurrence of any person after the death of the donor,” (Section 2(h)).

¹⁰⁰ See the Rabbinical Assembly’s “Jewish Medical Directives for Health Care,” edited by Rabbi Aaron Mackler and based on responsa of Rabbis Elliot N. Dorff and Avram Israel Reisner. Through this document one can indicate the “desire that when I die any or all of my vital organs and other body parts be donated for the purpose of transplantation. The rest of my remains should then be buried in a Jewish cemetery in accor-

The preservation of human life is obligatory, not optional. Since all conflicting halakhic duties are suspended, and specific, readily identifiable human lives are at stake, withholding consent for post-mortem organ and tissue donation when needed for lifesaving transplant procedures is prohibited by Jewish law. It violates the Torah's prohibition of **לא תעמוד על דם רעך**, as well as the prescriptive obligation to preserve human life.¹⁰¹ This applies to the individual in anticipation of his or her own death, as well as to health care proxies or “next of kin”¹⁰² whenever they are legally empowered to make such decisions¹⁰³ on behalf of the deceased. The identity, and certainly the religious status, of the recipient are irrelevant. Life-saving action is obligatory, “even if the donor never knows who the beneficiary will be.”¹⁰⁴

“The act of saving the life of another by donating an organ after death, seems to me the best and most practical demonstration of faith.”¹⁰⁵ A bereaved family member who grants consent for organ donation acts as an agent and partner of the deceased in observance of the mitzvah of **נפוח נפש**. By so doing he or she renders only profound and genuine honor to the deceased, while simultaneously bringing comfort to those who mourn. “There is no greater **כבוד המת** than to bring healing to the living.”¹⁰⁶

והשואל שופך דמים – One who delays is guilty of shedding blood.¹⁰⁷ When needed for life-saving transplantation, withholding consent for post-mortem tissue donation must be considered forbidden.

כי נר מצוה ותורה אור ודרך חיים תוכחות מוסר

dance with Jewish law and custom.” The document is distributed by United Synagogue Book Service, 155 Fifth Ave., New York, NY 10010, and appears in *PCJLS 86-90*, pp. 137-153.

¹⁰¹ See notes 3 and 4.

¹⁰² A typical system of precedence, as in Connecticut's Anatomical Gift Act: spouse, adult son or daughter, parent, adult sibling, grandparent, guardian (Section 3(a)).

¹⁰³ Civil law limits the right of a family member to consent to donation, as when “the person proposing to make an anatomical gift knows of a refusal or contrary indications by the decedent.” So, too, medical facilities are restricted from accepting organ and/or tissue donations “if the donee knows of the decedent's refusal or contrary indications.” (Connecticut Anatomical Gift Act, Sections 3[a] and 6[c], 1988; based on Uniform Anatomical Gift Act [UAGA], U.S. 1987; see Stiller, Appendix E. According to UNOS and the Department of Health and Human Services, Division of Organ Transplantation, similar provisions have been in force in all 50 states since 1968. For a state by state analysis of variations and revisions to the UAGA, see D. Sipes and L.J. McGaw, “UNOS & Uniform Anatomical Gift Act Revisions,” *Nephrology News and Issues*, June 1989.) So, too, the Human Tissue Gift Act of 1986 (Ontario, Canada; Similar legislation has been adopted in all Canadian provinces and territories): “No person shall act upon a consent given under this section if he has reason to believe that it was subsequently withdrawn. . . [or] if he has reason to believe that the person who died or whose death is imminent would have objected thereto” (Stiller, Appendix D). Such refusal, however, is itself in violation of Jewish law. Under ordinary circumstances, an instruction to violate Jewish law, even by a parent, must be disregarded (see Lev. 19:3, Rashi ad loc., citing B. Baba Metzia 32a; Yoreh De'ah 240:15). Since such disregard would violate the law of the land, one is, rather, duty-bound to urge revocation of such refusal prior to death, explaining both the extent of the need and the religious imperative. It should be noted, however, that mere “failure to make an anatomical gift. . . is not an objection to the making of an anatomical gift” (Section 3[e]). Similarly, “A gift to give (or a refusal to give) certain particular parts is not to be taken as a refusal to give other parts. Thus the next of kin may feel free to give additional anatomical gifts,” (see Sipes/McGaw, p. 21; citing Revised UAGA, sections 2[j] and 2[k]).

¹⁰⁴ Rabbi Moshe Tendler. See n. 70.

¹⁰⁵ Stiller, pp. 166-167.

¹⁰⁶ Rabbi Isaac Klein, *A Guide to Jewish Religious Practice* (New York: Jewish Theological Seminary, 1979), p. 275.

¹⁰⁷ It is likewise incumbent upon individual rabbis and rabbinic organizations to educate the Jewish community as to the seriousness of this religious obligation. (See, for example, “Resolution on Organ and Tissue Donation,” *PRA* 52 (1990): 279.

והנשאל הרי זה מגונה שהיה עליך לדרוש ברבים – “A rabbi whose spiritual charges delay life-saving action out of ignorance of the law is disgraced, for he has been remiss in not addressing the matter publicly” (Orah Hayyim 328:2, Magen Avraham ad loc.).