INSTRUCTIONS FROM AUTHOR TO LIBRARY FOR THESES AND PRIZE ESSAYS

AUTHOR Philip Lawrence Bregman

TITLE "A Handbook for Rabbis Counselling Terminal Patients"

TYPE OF THESIS: Ph.D. [ ] D.H.L. [ ] Rabbinic [XX]

Master's [ ] Prize Essay [ ]

1. May circulate [ ]) Not necessary
) for Ph.D.
2. Is restricted [X] for 5 years.) thesis

Note: The Library shall respect restrictions placed on theses or prize essays for a period of no more than ten years.

I understand that the Library may make a photocopy of my thesis for security purposes.

3. The Library may sell photocopies of my thesis. ___ yes X no

April 1, 1975
Date

Signature of Author

Library Record

Microfilmed 7/9/75
Date

Signature of Library Staff Member

A Handbook for Rabbis Counselling Terminal Patients

by

Philip Lawrence Bregman

Thesis submitted in partial
fulfillment of the
requirements for Ordination

Hebrew Union College - Jewish
Institute of Religion

1975

Referee, Dr. Norman Mirsky

DIGEST

This thesis is written in the form of a handbook and is to be used by rabbis who engage in counselling terminal patients. The focus is on the role of the rabbi when he is in such a situation. Its purpose is that of helping the rabbi to better understand what he can expect to meet in the way of expectations from others and how he might best be able to cope with what he encounters.

I begin with an exploration of the rabbi himself. What is it that he feels his role is, and his perception of his function. It is the premise of the author, that the rabbi must first understand what he feels and thinks about the subject before he can effectively deal with the entire matter. Contained in the first section are the opinions of many different rabbis. These opinions serve only as a type of guide from which the individual rabbi is free to make up his own mind concerning the topic.

The next area of investigation is that of the medical profession. For the most part, the rabbi will encounter the terminal patient in the hospital. It is therefore important that the rabbi understand the setting he is walking into.

The patient's family occupies the third chapter. The family plays an important role for any patient, and the rabbi must be aware of this in order to know how to deal with it.

Finally there is the patient himself, and this is the content of the fourth chapter. The rabbi must be aware of what it is that patient wants and how he as a rabbi, (after examining his own thoughts, and studying the hospital and the family), can provide the best kind of

service.

All of these various components are involved in one way or another. The thesis attempts to not only recognize them, but help the rabbi deal with them as effectively as possible.

TABLE OF CONTENTS

INTRODUCTION

"To everything there is a season and

a time to every purpose under heaven.

A Time to be born and a time to die."

Ecclesiastes 3:1

"Rabbi — rabbi, I've just found out — what do I do? My God, it's not fair, it's cruel. I've got so much to do, there are so many things yet to be done. Why? Why? Oh God, why? — help — please God help me!

What do we do as rabbis, as men who represent certain traditions and values, who stand at the head of congregations and act as the leaders of the Jewish communities? What is our role when it comes to the dying patient? We are placed in an awkward dilemma as teachers of Jewish beliefs and values. Our whole philosophy is aimed at the idea of "chaim", life, and its importance. You shall live by the commandments, not die by them, we are instructed. Choose life, we are commanded. Thus it is life and all its dimensions that we as rabbis have elected to teach. How to live, and in what ways we might best try to make our brief existence meaningful, is a major focus for our profession. Moral and ethical judgments are constantly put before us. Day after day we are involved with the various aspects of life, from the cradle to the grave. Even when we make a shiva call, it is with the intention of helping those survivors to once again face the struggles of life in order that they may endure.

Yes, most of our time is spent with the intention of assisting people in the daily events with the purpose of helping them to live a richer and more meaningful life.

And yet, how do we respond to the person who has just found out that he is soon to die, or even the person who has not been officially told? How do we, whose profession is geared to helping people live, now enter a situation where we must try to help someone die?

The subject of death and dying has become a topic that has blossomed within the last few years. It has been the subject for many

articles and books, symposiums and college courses. Where years ago, death was considered an untouchable subject, today we have opened the door somewhat, in order to discover how we might best make that journey and best prepare ourselves. Let me say that I used the word "somewhat" because it is the opinion of this author, that despite all that has been written, and the number of courses that have been offered, there is still a great deal to be done in this area.

It is thus the intention of this thesis, not merely to give another perspective in the area of death, vis-a-vis ways in which other people view it, but rather to provide a guide for rabbis who find themselves involved with counselling a terminal patient.

Though I will use some of the material that has been written, it is my feeling that most of the books and the articles that are before us, have been written from an objective point of view. They tell us of the various stages, (Kubler-Ross[1]) that people go through or how we deny death, (Avery Weisman[2]) or how society views it, (Philippe Aries[3]). The seminars and lectures that I have attended have been informative and interesting. But throughout the course of all of these meetings and consultations, the subject of counselling the terminal patient is never really discussed. Most of what I have seen and experienced has been in terms of what "others" think, with those "others" never having been present.

Death and dying is a crisis. What makes this crisis even more difficult for the rabbi is the fact that he is not coming to see the patient as a doctor or a social worker but is entering the room as a rabbi, a profession which today is not so clearly defined as are these others.

It should also be pointed out that the majority of the time rabbis will see the patient in a hospital or nursing home. When we do visit the hospital, how do we feel? How do the medical personnel feel towards us? Are we infringing or are we part of a team?

We must also be aware of the patient's family and how it sees us and what our response to it will be. What do we do when it instructs us not to say anything? What part does the family play in this crisis?

Then there is the patient himself. What does he want from us and what do we think we can and should give him?

These are all questions which we might face. How prepared are we to answer them?

Before I deal with the attitudes that the medical profession, the family and the patient have towards the rabbi, I have chosen to begin with the rabbi himself. What is it that he feels is his role? What should he be doing in this situation?

Footnotes

1. Kubler-Ross, Elisabeth _On Death and Dying_, MacMillan Company, N.Y., 1969

2. Weisman, Avery _On Dying and Denying_, Behavioral Publishing Inc., N.Y., 1972

3. Aries, Philippe _Western Attitudes Towards Death_, Johns-Hopkin University Press, Baltimore, 1972

CHAPTER ONE - THE RABBI

PART A - TO THINE OWN SELF BE TRUE

Perhaps one of the most difficult questions you could ask a rabbi is, "What is it that you do?" The reason that the question is so difficult is that there are so many different answers. The rabbi is many things. He is a preacher, pastor, scholar, teacher and community organizer among other things. Some people see him in one role, whereas others see him performing a different function. Ultimately, if he is to know what he is doing and who he is, he must as Shakespeare says, "To thine own self be true", and thus decide for himself who he is.

The same holds true I believe, when we are talking about counselling terminal patients. It is very nice to wax eloquent, and talk about the various stages of death. But if rabbis have a role to play, if they are to be part of that entire scene at the hospital, or at someone's home, then one of the most important things that they must do is try to understand what they feel and think about the topic of death and dying. The rabbi must start by asking, "What do I as an individual think about the entire subject, and how do I react? Where do I stand in relation to this whole area?"

There may very well be topics of which the rabbi is afraid, which he really does not want to discuss. Should he not at least know what those subjects are before he goes into the room? Should he not at least examine his own thoughts; his own philosophies as to what he feels and thinks about life and death? If he visits a person without having done this, is he really serving the patient, or is he perhaps just another visitor passing through the room?

What if the rabbi finds that he is unable to cope with the

situation? Then a decision must be made. He might decide to receive some help himself in order to deal with those questions that cause him trouble. In doing so, hopefully he will be able to work out what his feelings are, and subsequently how he can cope with them in an effective manner. On the other hand, he might decide that this is a subject that he cannot as yet face and therefore choose not to deal with it. I feel that this too is a legitimate choice and in some instances might prove to be more helpful and beneficial for all concerned. In either event I strongly feel that at the outset he must be aware of his own feelings about sickness, dying and death, before he can effectively deal with others or decide not to deal with them.

Even if the rabbi decides to deal with the topic, there might arise those occasions where the rabbi is unable to cope with the situation. I myself recall an incident when I was visiting a patient and the wound from her surgery was fully exposed. I had to excuse myself for a few moments in order to get a breath of fresh air, otherwise I felt that I would have fainted. Though it may have been rude to leave, I had to. After a few moments I was able to return and carry on the conversation.

Along the same vein, I remember that I once asked a hospital chaplain if there was ever a time that he was unable to continue to talk to a patient. He looked at me and said, "Yes". I asked him, "What did you do?" He said, "The only thing I could do. I admitted to the patient that I was unable to continue the conversation and that I would be back shortly".*

What the chaplain was saying was, be honest -- be honest to yourself and be honest to that patient. If not, they will see right through

you.

This handbook was not written with the purpose of suggesting that all rabbis have to engage in counselling terminal patients. Rather it was written to provide a guide and some understanding for those who do decide to include these activities in their rabbinate.

PART B - WHAT DOES OUR TRADITION SAY?

It is important to note that our tradition does address itself to this subject. We should be aware that Judaism provides us with at least a framework within which we are able to work. Both Rabbenu Nissim Gerondi[1] in "Nedarim 40a", and the "Shulhan Arukh"[2], Yoreh De'ah, starting with chapter 335:1, "On laws concerning the visitation of the sick", say that it is a religious duty to visit the sick. This idea of "Bichur Cholim", visiting the sick, is very important within our tradition. Interestingly, we are instructed in this same chapter of Yoreh De'ah[3], 335:7, that when a person is dying he is told to consider his outstanding financial affairs. What the law is in fact saying is that a person should be given the opportunity to put his affairs in order before he dies.

In chapter 339:4 of Yoreh De'ah[4], we are told that as soon as a person feels death approaching the visitors should not depart from him so that he is not alone when his soul departs.

Although the concept of "Bichur Cholim" is very important, it raises a question. What are we supposed to do while we are there?" At this point there is some disagreement. The "Shulhan Arukh" instructs us to pray for the soul of the dying person. Yet "Sefer Chasidim", page 100 #315-318[5], points out that we should not pray too hard lest a person

in a coma revive and therefore have to suffer. Ketuboth 104a[6] also describes the merits of abstaining from prayer in order that a person be allowed to die. The case is particularly important because the dying person was Rabbi Judah Hanassi himself, and it was his maidservant who interrupted the prayers intentionally, permitting his death.

In Shabbat 32a[7] we are commanded to say a "viddui", a confession before we die. In the Shulhan Arukh, Yoreh De'ah 338:1[8] concerning the idea of confession it says that in order not to terrify the patient, he is told that many have confessed and lived and that many have not confessed and died. In this way, the person is being told that his condition is critical but that he is not without hope. He is left with the idea that his faith may very well sustain him.

Be that as it may, what are rabbis supposed to do besides using prayer (or in some cases abstaining from its use) and/or the possible administering of a confession. Maurice Lamb in his book, "The Jewish Way in Death and Mourning"[9] provides us with an excellent guide as to what our tradition says and what one is supposed to do from the moment of death on. The problem is, what about the time before death, while the person is dying?

During biblical times, oral and written testaments were given by the dying person to the family and friends who were naturally present at the time of death. Later on the custom of lighting candles around the deathbed came into existence. Some say this custom arose to cause the demons to depart; others felt it was a way of honouring the "Shechina" who comes to meet the departed soul and still others felt it was a symbol of man's soul which at this time is flickering like the candle.

Yet what our tradition describes are things that are done before the actual death which in those days was not a lingering event. But today we are faced with a completely different situation. Today we are living in an environment and society which prolongs death for weeks, months and sometimes even years. Since this is true, what does a rabbi do when he visits a terminally ill patient? Is prayer his only offering?

Tradition provides us with what I call a framework. We are told that visitation is very important. Using it as a point of reference, the rabbi must try to fill in what it is he will do.

PART C - WHAT DOES THE RABBI SEE AS HIS ROLE?

I am sure it will in no way be surprising to learn that there is no one answer to this question. During my research I had the opportunity to sit and talk to a number of different types of rabbis. Some of whom are in the pulpit, others who are in education, a few who are chaplains and still others who are in community affairs. Though each rabbi had a different point of view, the one thing they had in common was the fact that they really were not sure what their role was in this situation. I believe their uncertainty was due to tradition's omission of a script for the rabbi as well as the problem previously alluded to; namely, the medically assisted extension of life. As a teacher, or a "shaleach tzibor" there is no problem, specific guidelines are provided. But in this area of counselling, as we have seen, there is very little to help define the rabbi's role.

It should however, be pointed out that many of the rabbis whom I interviewed also said that it was not their job ultimately to tell a patient that they were terminal. This they said, was the job of the physician. Some however, did say that they would certainly be willing to be present if the physician wanted them to be.

One rabbi said that his primary function was to provide hope for an individual. The idea of hope was to be stressed over and over again.*

Another rabbi asserted that his job was to help a person reflect over his life and bring out the positive elements. In this way, he would let the person enjoy retro-spectively, those beautiful moments in his or her life.*

Still another rabbi felt that his role was to help alleviate any guilt that this person might feel during these terminal stages.*

"My basic function is to provide comfort", was the response of one rabbi. He went on to say, "But I'm not really sure how I do this or in what way. There is no prescribed formula, rather it is I who am meeting this person wherever that person is and allowing that person to talk to me in whatever way they want to."*

I personally feel that one of the best responses I received was from a rabbi who said, "My role or my function is to be available and to make myself available to that person and that family." He continued by saying, "This does not mean that I would say to a patient, If you want me you can reach me at such and such a number. Rather it means my going into that room and by my very presence, saying to that person, I am here for whatever purpose you want. I am here to discuss

whatever you want. That is what my role is and that is what my function is as a rabbi, when faced with a terminal patient".*

PART D - SHOULD THE RABBI KNOW WHAT THE CONDITION OF THE PATIENT IS BEFORE HE ENTERS THE ROOM?

It is to the rabbi's clear advantage to definitely know what illness the patient has and how he is responding, before he enters the room. This way, the rabbi is not walking in blind and therefore not apt to say something which might upset the patient. For example, if a person has a terminal illness and has difficulty talking about it, it could turn out to be an awkward conversation for the rabbi and the patient if there is a lack of awareness on the part of the rabbi.

I believe that the rabbi should not only know what the patient has, if he can, but should also know how much the patient knows about his condition. This information provides a frame of reference within which he can operate.[10]

How does he find out? In many instances the rabbi might get the necessary data from the family, or as the result of someone in his congregation or within the community. There is also the possibility that he will be able to deduce what is wrong with the person, at least in general terms, from the hospital ward that the patient in on, if he is hospitalized.

On the other hand, the rabbi might run up against the situation wherein he does not know anything concrete about the patient's condition. What should he do? He might try to track down the doctor and see if he will be willing to give some insight into the case. Or, the rabbi could

possibly ask the head nurse on the floor the nature of the condition of the person whom he wishes to see.

I personally believe that the rabbi should always try to find out what is wrong with the patient before he enters the room. But he must also be prepared for those situations in which he is not given any specifications as to the condition of the individual.

Though I will deal with this in the next chapter, I would like to at least mention this. The rabbi should be ready for a certain amount of rejection on the part of the hospital staff because they see rabbis as interferring with their routine. A rabbi should not be shocked or dismayed if he finds that there is a great deal of reluctance on behalf of the hospital to give him information which he is seeking. When counselling in general, one should be ready for just about everything.

If no information is forth coming, this should not be a time for panic or dispair. Rather, the rabbi should approach the situation still confident that what he is doing is correct and does serve a purpose. If he finds himself without as much knowledge about a certain case that he would like to have, the only thing he can do is as one psychiatrist said, "Enter the room and begin to engage that patient in a conversation." What does the rabbi say? The psychiatrist added that in a warm and empathetic manner, he should ask the person how he is feeling."

Not every person will immediately begin to talk about his ailment and it might require a little more probing. If the patient wants to avoid the situation, he will let the rabbi know one way or another. The rabbi should take his cue from there. (This will be discussed in further detail in chapter 4, part E). The rabbi must be

cognizant of the fact that when he asks someone how he is feeling he is inviting the patient to respond. He should therefore be prepared for what follows.

PART E - IS THE RABBI PART OF A TEAM?

Though Kubler-Ross in her book, "On Death and Dying"[11] would gladly welcome the clergy as part of her team, I think that rabbis should anticipate a different reality. Granted, it is difficult to generalize but not one doctor whom I interviewed, considered the rabbi to be part of the medical team. Every rabbi I talked to felt that he was in no way included as part of the team. I should mention that in a few instances I did meet some doctors who talked about a team concept. When checked out, this team according to social workers and chaplains turned out to do nothing more than have one or two informal talks about a patient. The sad thing was that the physicians in charge of these so-called teams, ignored what the concensus came up with and merely continued to treat the patient in the same way they had been without incorporating any of the ideas that had been suggested, though they were not suggestions dealing with medical procedures, but rather social care.

Is this attitude changing? Yes, I believe it is, but slowly. However, the rabbi should not discount the idea that he should be aware that when he walks into a hospital, he is not necessarily going to be greeted at the door with open arms. The medical profession is still unsure of the rabbi's function. In many instances I found that the rabbis whom I spoke with were very reluctant to approach the doctors for fear that they would be turned aside. These rabbis were therefore

quite hesitant to ask doctors about the condition of a particular individual because they felt that the doctors would instinctively say "no" when asked to discuss that individual.*

Does this necessarily have to be the case? One chaplain remarked that he felt that doctors used to see the clergy as meddlers. Only in recent years has this chaplain started to notice a difference in the doctors' attitudes. This he attributes to a change in attitude towards religion. By this he meant that religion is now viewed playing a part in the healing process. In order to change the negative impression the many medical staff have towards the clergy, the chaplain said that it is necessary for the clergy not to be intimidated by the hospital and its staff. The clergy, he added, must persevere in establishing relationships with these people. At all times it must be remembered that the interests of the patient must never suffer and that the physical welfare of the person is the direct responsibility of the doctor. Nevertheless, the chaplain remarked that the clergy will do well to remind certain people that man's being does not only consist of physical elements.*

This chaplain has raised a good many points. Many of these issues will be dealt with in the next chapter. Let it suffice to say at this point, that there is a great deal of work to be done by both the medical profession and the rabbinate in learning how to most effectively treat the "whole" patient.

PART F - DOES THE RABBI ALWAYS LISTEN TO WHAT THE FAMILY INSTRUCTS HIM?

One of the most difficult binds that a rabbi can find himself in is the struggle that goes on between the family and the patient. In

many instances it has been my experience that the family does not wish to talk about the illness in front of the patient for fear of upsetting him. The patient on the other hand, does not wish to talk about the topic for fear of upsetting the family. The sad irony of the whole situation, is that in most cases there is a definite need and desire on both parts to discuss the terminal illness.

One rabbi once told me that when the family says to him, "Rabbi do not discuss it when seeing him", he listens to the family and does exactly what it says. A few minutes later, the rabbi then turned to me and said, "Do you know why I listen to the family? I do so because I am afraid to discuss death, and this gives me an out."*

This rabbi at least knew why he was doing what he was doing and was honest enough to admit it. He reached his decision not because he put the family's wishes ahead of the patient's, but because he put his own fears and shortcomings into the picture.

Then again, the rabbi might decide to listen to the family because he honestly believes that it knows what is best and not because of any fear on his part. The rabbi alone must be the judge of that.

The other side of the coin is represented by a number of rabbis who do not necessarily listen to the family. One such rabbi said that he was there primarily for the benefit of the patient. When he goes into the patient's room, what is discussed is between the patient and himself. Therefore, if the family says, "No", and the patient says, "Yes I want to discuss it", (or he feels that the patient wants to talk about it), he must listen to the patient and ignore what the family has instructed him to do.*

I myself would say that how a rabbi answers this question

depends upon his evaluation of the situation. It is not a question of placing the family above the patient or vice versa. The rabbi must ask himself what is in the best interest of the patient. In order to make such an evaluation, he must be as familiar as possible with all concerned.

PART G - IS THE RABBI'S ROLE DIFFERENT FROM THAT OF A PSYCHIATRIST OR A SOCIAL WORKER WHO IS VISITING THE PATIENT?

As I mentioned earlier, a rabbi's identity is not always easy to define. For this reason alone, this question as to how the rabbi's role differs from other professionals, is a very important one. If the rabbi is there merely to visit the patient, or in some instances to discuss what death means to the patient only in terms of the psycho-social aspects, then is he really acting in a different manner than would a psychiatrist or a social worker?

There is perhaps no clear-cut answer to this question. Most rabbis would say that there is a difference but were hard-pressed to define it. One rabbi felt he represents the mysteries of life which are unanswerable. Yet at the same time, he believed that his purpose in being there was also to discuss and talk to the patient in much the same way a social worker might.*

Where the difference lies, is perhaps found in the response from another rabbi. He said that he does not treat psychologically sick people. Therefore, he cannot provide a specific type of treatment which a psychiatrist might prescribe, but rather is there to comfort the patient. This rabbi continued to say that at times his presence might

certainly involve his talking about certain fears and apprehensions that the patient might have. However, his responsibility did not include delving into the subconscious of the patient, even though he is well aware that it does exist.*

I myself would tend to agree that there are certain elements which rabbis share in common with other professions. But I feel that rabbis have a specific function which is peculiar to them alone. The rabbinate represents another dimension of man which the doctors, the psychiatrists and the social workers do not. It denotes the spiritual side of man as well as the emotional and sometimes physical. In many instances, it delineates the uncertainty about life, and in turn represents a world in which everything is not merely black and white or based upon physics and chemistry. What the rabbinate stands for, I believe, is that part of man which is not completely analyzable, which is not completely understood.

Some of the rabbis expressed this sentiment by saying that they feel that they stand for a special kind of hope. In some cases, this was the belief in a world to come and that death is not the final end. Others who did not hold with the idea of a world to come, still felt that their presence established in the minds of the patients the existence of a spiritual reality.*

Though at times, psychiatrists, social workers and rabbis might do similar things, the rabbinate is still unique in the sense that it represents Jews. Though the rabbinate may involve interaction with all kinds of people, the primary concern is for Jews and the preservation of Judaism. Rabbis' beliefs might very well differ, but

their primary clients, if I might use that word, are the same. This alone if nothing else, makes the rabbinate different. To many patients, it allows them to open up and feel more relaxed in the presence of a rabbi.

PART H - ARE RABBIS' PHILOSOPHIES OF LIFE AFTER-DEATH IMPORTANT?

It soon became apparent that a number of the rabbis whom I interviewed did not believe in a "Olam Ha Ba", a world to come as traditionally described. If this is the case, what does the rabbi say to a person who asks him, "Rabbi, what is going to happen to me when I die"? What does the rabbi say if he does not have a traditonal belief in "Olam Ha Ba"? Does he pretend to believe in something that he really does not, and therefore make up an answer he feels will be satisfying to the patient? Or does he come out and directly say, "I do not believe in any of it."?

It is undeniably true that a rabbi's philosophy is an important factor when visiting a terminal patient. Equally important is the way he expresses his philosophy, whether tradional or liberal. A rabbi is involved with the entire subject of beliefs. Perhaps there are times when he feels that people expect him to believe certain things whether or not he really does. If it is the case that the rabbi does not believe in an after-life it is still important that he represents himself truthfully. To do anything less, is according to one rabbi, to be someone you are not, and the patient will see through this.*

One must be sensitive to what the patients are seeking and how they ask it, (which might involve giving a direct answer to their questions).

The best answer that I received was from a rabbi who said that he is a "sympathetic agnostic", when it comes to such questions.* By this he meant that at this time in his life, he does not believe in an "Olam Ha Ba", but that he does not rule out such a possibility.

Perhaps it would be easier if all rabbis had a very firm and staunch belief and were thus able to transmit this to their congregants. But this is not always the case, nor do I think it necessarily has to be. One rabbi told me that when he has walked into a room and has been asked about after-life, he has found that many of the people were not looking for pat answers but were asking the rabbi as to "his" position and were thus looking for the individual answer behind the title "rabbi".*

Though rabbis might not always be able to provide promises of "Olam Ha Ba", they should be able to promise that they will meet their congregants in an honest and yet sympathetic manner. No one can ask for more.

PART I - THE FEARS OF THE RABBI

As I mentioned at the beginning of this chapter, the rabbi should try as best he can to prepare himself before he enters the room or wherever he is meeting the patient. Again I would point out that this does not mean that he must have all the answers. The rabbi therefore might find himself in a situation where he has not been able to come to a conclusive answer about some query. For example, he is not sure about the idea of a "living will"[12] which involves euthanasia. He might not know exactly what to say to a child who is dying. Some of

the rabbis that I spoke with said that if you find yourself in a situation in which you feel that you just cannot function, perhaps the best thing you can do is try to terminate the conversation.

I would agree with this. However, there is possibly another alternative. A chaplain said to me, "If there is something that you are unsure of, or even perhaps a bit frightened of, why not share this with the other person? Why not discuss this with the patients if you feel that they are capable of discussing it with you. In this way, you let them see you as an individual as well as a spiritual leader." This chaplain, who sees a great many terminal patients, felt that it is often beneficial for the patients to meet a person in the hospital who does not have ALL the answers all of the time, and is willing to discuss the subject of dying openly.

By doing this, a rabbi might give an individual the opportunity to discuss with him rather than merely to listen to what he is saying. There might very well be something which this patient is able to give the rabbi. It could possibly be the best thing that could ever happen to this patient during this tragic moment in his life.

I am not saying that a rabbi has to have certain fears or questions which he cannot answer. If he does; however, this is not so terrible. Take a look at it from the patient's point of view. All day long people are coming in and telling him what to do. When the rabbi arrives, here is an opportunity for the patient to talk and perhaps even give some information to the rabbi instead of constantly being the recipient.

A few years ago, I visited a man who had terminal cancer. We built up a very pleasant relationship, though each time I saw him his

physical condition worsened. I remember once I told him how much I had learnt just by talking to him. Just before his death, his family told me how much it meant to him for me to tell him that I had learnt something from him. He felt proud that he was still able to contribute something to someone, even while being so dependent upon the hospital for his every breath. The last time I saw him before he died he was unable to speak at all, but could hear. I again told him that information which he had given me would be extremely helpful and would be used to help others. The smile which he was able to make, will never be forgotten.

PART J - SHOULD THE RABBI PRAY WITH THE PATIENT?

One might think that if the rabbi has any function at all it would certainly be in the realm of prayer. This is not always the case. Not all patients feel comfortable in having a rabbi pray with them. Not all rabbis feel comfortable either.

When a rabbi walks into a room, not everyone is going to greet him in the same way. For some people, it will be a welcome relief. But for others, the rabbi might very well be seen as the "Meloch Ha Movet", the Angel of Death. There were quite a number of rabbis who felt that people saw them in this fashion and were not always sure why this was the case. One rabbi suggested that his mere presence frightened a number of people for they associated the idea of "funeral", with rabbis.* But aside from making conscious or unconscious associations with the mere presence of a rabbi, what seemed to scare the patients the most, according to some rabbis was the mere mention of the word prayer. I believe that this is

due to a transference from what the priest is seen as doing; namely, administering last rites, to what the rabbi may want to do when he asks a patient if he wants to pray.

If it is true, that some patients will be frightened by the mention of the word prayer, then what does one do? Again the rabbi is called upon to use judgement and perception. If the patient wants to pray and tells him, then there is no problem. However, it has been my experience that very few people will come right out and ask the rabbi to pray. I have met people who do want to pray, but do not know how to initiate it and therefore look to the rabbi to make the first mention of it. But the rabbi should not immediately assume that everyone wants to pray.

If the rabbi is not sure that they want to pray, I do not think there will be much damage if he asks the person, thereby giving him the opportunity to respond. One thing that I have learnt while counselling in this area, is that it is not that easy to sum up what it is that a patient believes especially at this time in his life. The greatest agnostic may well turn to a theistic belief, and the rabbi must be prepared for this.

If the rabbi reaches the point where prayer is appropriate, what prayers should he offer? One rabbi told me that he did not think it was that important whether or not the person understood Hebrew, and that somehow he sensed that a prayer said in Hebrew was more acceptable than one said in English. He also assumed that most people know what a "Me sh'bay rach"* is, or have at least heard of it, and therefore would find it comforting.

Another rabbi said that he is always prepared to enter a room with a few psalms, and if nothing else will recite the "Shema"*.

I myself do not think that the actual words of the prayer are as important as its timing. How one knows when to pray when visiting a person,

is contingent upon one's establishing a relationship with the person and thus becoming sensitive to those moments when the patient looks to him for help and hope.

PART K - SHOULD IT MAKE A DIFFERENCE IF THE RABBI KNOWS THE PATIENT BEFORE HE SEES HIM?

It became very evident once I started to interview rabbis, that when I asked them what they felt their role was, in so many instances they said that it depended upon whether or not they knew the individual. I then asked them, "Well, if you did not know them then what do you do?" In all too many instances they said that their stay was very brief.

What the rabbi must ask himself is, does he want to take the time and the energy to get to know someone whom he does not know. This would mean he would have to spend a little more time with people in order to try to know who they really are and what in fact they honestly need. Naturally, the rabbi is not going to respond to everyone in the same way. There will also be those people whom he feels more comfortable with. Nonetheless, his obligation should be to give at least everyone, (whether he knows him or not) a chance to respond, a chance to open up and a chance to discuss.

If the rabbi knows a patient before seeing him, he may not have to spend as much time making an assessment of the total situation. Such an assessment will involve not only finding out how the person is, but who the person is, and all the various aspects that go along with the case such as family and relatives. It should be mentioned that even though he might think that he knows the patient, the nature of the illness might cause some

definite changes in the patient's personality. Too often, the rabbi might think he knows someone, when it really turns out that under these new and strange circumstances, he does not.

Whether a rabbi knows someone, (or thinks he knows him) or not, all patients require his attention and his time — time that he has, and the patients do not.

PART L - SHOULD THE RABBI TELL THE PATIENT HE IS TERMINAL IF THE PATIENT DOES NOT KNOW?

A rabbi might find himself in the position of having to decide whether or not to tell the patient he is terminal. Though many of the rabbis whom I spoke to said that they would not, I am not so sure that I can give a categorical NO.

I do not think that there is any simple answer. Certainly it is more comfortable if a doctor is present, but sometimes the rabbi is not always afforded the luxury of having a physician present. If the rabbi has built up a relationship with the patient (and hopefully he has) he must ask himself what will happen to that relationship if he lies to the patient or is evasive. He must realize that the patient is not insensitive. A patient can not only hear the rabbi's words, but is also cognizant of his meta-communication, or non-verbal communication.

When asked, "Am I dying?", there is not an easy answer. But the rabbi might be called upon to give one, and though he may decide to back off, he must be aware that the patient usually knows what is going on.

Some rabbis will answer the patient by saying, "We are all going to die". Others have thrown the question back to the patient and asked him, "Do you think you are going to die?"

In conclusion, I would therefore say that any decision must be based upon the rabbi's assessment of where he thinks the patient is, psychologically speaking, which includes knowing the patient's strengths and weaknesses. All of this is naturally contingent upon the relationship that the rabbi has established previously.

SUMMARY

In preparing this chapter, what has become most evident is the fact that the role of the rabbi in this area is not clear and has not been precisely defined by the rabbinate. The rabbi will naturally represent different things to different people, and the remaining chapters will enable us to get a glimpse as to what other people consider his function to be.

What I feel has become clear is that this role, in terms of counselling terminal patients, is not necessarily the same with every rabbi, and might possibly change according to the situation. By this I mean, that what a rabbi says, how he says it and basically how he presents himself, will depend to a large extent upon the case before him and his assessment of it.

What the rabbi must bear in mind is that he must be prepared to handle many different types of people. Though there might be certain things that the patients have in common with one another, such as feelings of depression or perhaps guilt, each patient is still an individual and thus requires the rabbi's individual attention.

I think rabbis would do well to remember the words of one of their peers who said, "Whatever I say, and whatever I do, when seeing a

terminal patient, it is done with a personal touch. It must be to bring to this person a sense of humaneness in what has become basically, an impersonal and inhumane situation."*

FOOTNOTES

1. Epstein, Isadore — The Babylonian Talmud, translated and edited by I. Epstein, Soncino Press, London 1935-1952

2. Denburg, Chaim — Code of Hebrew Law -- Shulhan Arukh, written by Joseph Caro, published 1565, Translated by Chaim Denburg, Yoreh De'ah 335 - 403, Jurisprudence Press, Montreal, Quebec 1954

3. Ibid

4. Ibid

5. Freehof, Solomon — Reform Response, Hebrew Union College Press, Cincinnati, Ohio, 1960; Sefer Chasidim is ascribed to Judah Ha-Chasid, German mystic

6. Epstein, Isadore — The Babylonian Talmud

7. Ibid

8. Denburg, Chaim — Code of Hebrew Law -- Shulhan Arukh

9. Lamb, Maurice — The Jewish Way in Death and Mourning, Jonathan David Publishers, N.Y., 1972

10. see Chapter 4, Part E

11. Kubler-Ross, Elisabeth — On Death and Dying, MacMillan Company, N.Y. 1969

12. Living Will -- prepared by the Euthansia Educational Council, Cincinnati Chapter. Such a will is made out and read to the family, the physician, the clergyman and the lawyer, and instructs these people that the person who signs it does not want to be kept alive by artificial or heroic measures if there is no reasonable expectation of meaningful improvement. There is however a legal problem, i.e. whether or not the state accepts it as a legal will.

* represents an interview with a rabbi whose name cannot be released

\# represents an interview with a patient whose name cannot be released

= represents an interview with a doctor whose name cannot be released

CHAPTER TWO - THE MEDICAL PROFESSION

As mentioned earlier, the rabbi often sees the congregant in the hospital, or in some type of medical setting. It is for this reason that it is so important for the rabbi to understand this environment and the people that make it up. By this I mean, not only the patient and his family, but the doctors, the nurses and the entire medical profession that are found there.

The rabbi, when seeing a terminal patient, does not operate alone. There are many times when he must go through the doctor or the nurse in order to see the patient or to get some information about the patient. It is due to these circumstances that I feel that it is imperative that the rabbi understand what it is that these people envision his role to be. If the rabbi does this, he is liable to make better sense about some of the consequences that might flow from their conceptions. In turn, this will better help the rabbi prepare himself when he enters that hospital or nursing home to see a patient.

This chapter is written with the intent of not only describing the various attitudes and dispositions of the medical profession towards the rabbi, but also to provide what recourse the rabbi might use in order to exist within this environment. It should also be noted that at times, the rabbi may very well be faced with the challenge of trying to change certain structures, if change is deemed necessary. With this in mind, let us now take a look at the medical profession and some of the attitudes and ideas which the rabbi must face, and ultimately work with.

PART A - WHAT DO THEY SEE AS THEIR ROLE?

What came through loud and clear when I talked to a number of doctors and nurses, was that their role is to sustain life. The entire medical profession is geared toward this goal. Subsequently, they will try to use every drug or instrument that is at their disposal for the sustaining of life.

Therefore, if one's life is dedicated to the restoration and sustenance of life, the entire concept of a terminal patient might very well cause great consternation. As one doctor put it, "When we take a look at a terminal patient, you must realize that we are looking at a failure of some sort. If we who are here, are supposed to try to help life and to save it, and are then faced with a patient who is dying, then we have in some way failed to do our job". The doctor added that, "Certainly there are those cases in which there was nothing that we could do. Perhaps the parts had just worn out. But no matter what the reason or the cause, it is still difficult for us to accept death at any level".

Some doctors admitted that their reason for entering the medical profession was based upon a drive to conquer death. When death becomes the victor, there is not only a feeling of dispair, but often one of anger and resentment. Yes, to most doctors, a dying patient does represent an omission of some sort on their part, and it is important that rabbis realize this. Though rabbis might not see the patient as the instrument with which doctors challenge death, it is most pertinent that rabbis comprehend that the doctors and the nurses at times see him in this light.

By understanding how the medical profession views its role

and obligations, the rabbi will better relate to the medical profession when he comes in contact with it concerning a patient.

PART B - HOW DOES THE MEDICAL PROFESSION COPE WITH A DYING PATIENT?

It is extremely difficult to generalize with respect to the entire profession in terms of how well it is able to cope with dying patients. Therefore I would preface my remarks here by saying that it has been my experience that when there is a terminal patient on the ward, or when there is such a patient in a certain room, there is a great deal of tension and at times dejection on the part of the staff. Many times the hospital staff are not sure what they are supposed to do. One nurse stated, "I am trained to help a person live, and I am really not sure how I am supposed to help this person die".[1]

In many instances the terminal ward is set apart from the rest of the hospital. It is also noteworthy that the activity on this ward is not as fast or as concentrated. Glaser and Strauss write about the strategy of avoiding patients by the staff in order to cope with the situation.[2] It was David Sudnow's experience as documented in his book, "Passing On", that during the stage when "palliative care" was instituted, physicians lose interest in the patient.[3] A head nurse admitted to me that when a patient rings for a nurse, while in the terminal ward, he will not be answered as quickly as he might be if he was in another ward.[4] This nurse also stated that."We know that someone is calling, but we are not exactly sure what we can do for the patient. We are having difficulty facing this person, so maybe if we ignore him, somehow he will go away and leave us alone."

Does this sound naive and perhaps even childish? Maybe, but it is a defence that all of us might use at one time or another depending upon the situation. In order not to face someone or something, we negotiate in our minds a way of forgetting or ignoring whatever it is that is bothering us, though usually to no avail.

The fact that the patients in terminal wards are not visited that frequently by the medical personnel, has led me to believe that the hospital at times pronounces the patient dead before he actually dies. By this I mean they have given up hope, and in some instances have forgotten that there is a living human being who still fears and has concerns. It would seem that this type of attitude would contradict what I previously said about the medical profession having such a drive to sustain life. Needless to say, it is not a reversal, but when seen within the context of the circumstances does make sense. A doctor and/or nurse might be in charge of X number of patients. They are concerned for the physical health of these people and in most cases are trying their utmost to help these people in whatever way is possible. When it becomes apparent that they are treating a patient who is not responding to their treatment, after repeated attempts on behalf of the staff, there is an air of frustration, and as I said earlier, dejection. By ignoring this patient, the staff are able to ignore their failure, as they would see it.

But there is also another aspect to this type of treatment of the terminal patient. Many times the patient is left alone because the staff are afraid of establishing a relationship with this person. Why? It is not necessarily the case that the staff are cold and indifferent, rather, this is due to their own inability of how to handle a dying

patient. If they become too emotionally attached to the patient, there is a genuine fear that they will not be able to operate efficiently with their other patients, especially if the former dies. In a way, the staff, I have found, are trying to take precautions in order to survive in an environment that is laden with death.

"It is just too difficult for me to establish a relationship with a person, have this person die, and then try to go on with my job with another patient", said a nurse.[$]

Therefore, many staff just stay at a distance and remain aloof. They do what they have to but make sure that they in no way enter the personal lives of their patients. There are those who do attempt to break through this barrier, but very few whom I have met or heard about.

I once asked a group of nurses if they had the choice, would they rather die in a hospital or at home. Overwhelmingly they said that if it were possible they would prefer to die at home — they thought it would be easier and more dignified.[$]

PART C - HOW WELL ARE HOSPITAL PERSONNEL TRAINED IN THIS AREA?

To establish a relationship with someone and then have that person die is hard on each and every one of us. I feel that one of the main reasons why hospital personnel do not deal with the terminal patient and do not deal with the entire subject of death and dying, is not necessarily for the purpose of survival, but rather due to the fact that they have never really been trained to deal with it. Until recently, the medical schools have provided very little content in this area. Erstwhile, an insignificant amount of training was given. This

is changing today but it is not being corrected as rapidly as it should. Not only should there be courses for those people who are still in school, but there is a great need for courses, institutes and seminars for those men and women who are already in the field.

There is a center for "Death Education and Research", at the University of Minnesota, and there is also the "Foundation of Thanatology". However, how many medical staff are directly affected by them? Occasionally we read articles in Time or in Newsweek, or in some newspaper of how this school or that is offering courses and seminars. The occasional school or one semester course is not really enough. To my knowledge, very few of the nurses and doctors have ever been given the opportunity to sit down and to discuss their own feelings about this subject.

In a large North American city whose population is over two million, I learnt that there are only two hospitals which are offering half semester courses in "Death and Dying", to nursing trainees. I learned this from the man who at the present time is instructing these nurses, a psychologist whose area of research at the present time is, "Attitudes towards Death and Dying". What this psychologist also told me was that despite the fact that these courses are being given, he is not really being alloted enough time. He feels that the nurses he is training are still going into the field poorly equipped to deal with the entire subject. If this is the case with nurses who are receiving training, we might well imagine how poorly equipped are the people who have had no training at all.

One group of nurses told me that they just do not have any opportunity to release their emotions. They continued to say that they

they never feel that they can discuss their patients with the doctors and therefore they either become very cold and indifferent, or keep their feelings inside and explode when they get home. They are never given the occasion to deal with their thoughts and emotions while in the hospital. They are left emotionally suppressed much like the patients themselves.[$]

I would like to add, that a course or two alone, is not the entire answer either. What goes into the course and how the material is discussed is also of major import. I remember I once attended a seminar which included, physicians, psychiatrists, interns, nursing and rabbinical students. The feelings and the thoughts of the participants were never really touched upon, but instead we were presented with meaningless statistics about people who were not present. What is needed, from my point of view, are not only courses and seminars about death and dying, but ones which will allow the people to deal directly with their fears and weaknesses. This is reported to be happening in "Grady Memorial Hospital", in Atlanta.[3] There the staff have the opportunity to let loose and deal with the problems in an open and empathetic setting.

If more programmes are not established of this sort, our medical personnel will continue to know what is happening to the patients (physically) but still be in the dark as to how to deal with patients' emotions, because they themselves have neglected their own.

PART D - WHAT DO THEY SEE AS THE ROLE OF THE RABBI WHEN HE IS IN A MEDICAL SETTING?

Just as I received ambiguous answers from the rabbis when I asked

them this question, so the same was true when I approached the medical personnel. The overwhelming answer was, "I don't know what the rabbi is supposed to do. I guess he has some function, but quite honestly I am not really sure what it is."

It should however, be pointed out, that while the vast majority of men and women with whom I spoke, could not specifically define the rabbi's function, there were some doctors who did express the opinion that the rabbi does have a major role to play. One such doctor said that he felt that the rabbi was a "specialized social worker." By this he meant that the rabbi at times might very well perform the role of a social worker. He would do this by engaging the patient as a social worker would, and find out how the patient is and where he is in terms of his own awareness of his illness and his ability to cope with it. But in addition, the rabbi, while on one hand acting as a social worker, also would have the role of a spiritual advisor. As such, the rabbi will subsequently deal with those areas of belief and philosophy which the patient might want to engage in. This doctor continued to remark, that the major job of the rabbi is to know when to switch from social worker to spiritual advisor. He said that this depends upon the expertise of the rabbi and his ability to understand the specific needs of the patient he is seeing at that time.

A psychiatrist whom I interviewed expressed the thought that the rabbi would in some way give a sense of completeness to the lives of the terminal patients with whom he might have contact. "The Jew", he said, "for the most part, has experienced birth, bar mitzvah, marriage ; all within the presence of a rabbi. All these milestones have some religious connotation, and so it is with death as well." In a word, he felt that

the rabbi was there to tie up any loose ends." (I myself feel that this is an important idea for the rabbi to keep in mind. The rabbi is there at every major crisis in life and so should certainly be present during the most traumatic of them all).

Still another doctor stated that in his eyes, the role of the rabbi really overlaps with that of his own profession. "We both are there for the purpose of helping the patient, and though we may use different techniques, they are both very important." Yet when it seemed apparent to me that this physician was truly interested in incorporating rabbinic services as part of his treatment, I asked him whether or not he had ever had a rabbi contact him regarding a patient, or whether he had ever contacted a rabbi. The answer to both the questions was the same; "No!" This leads me to believe that while there are those individuals who say that the rabbi has a role to play, there is still a lot of groundwork to be done to convince them of his efficacy. Let me add, that not all of the training must be done by them, (medical staff) as the following remark by one doctor will indicate. He said, "You know, I am not really sure what the role of the rabbi is, however I do feel that he should be able to differentiate between visiting a patient who has a broken arm, and visiting a patient who is dying. By this I mean, it has been my limited experience that upon those occasions when I have been in the room with a rabbi and a patient, the rabbi has not always been able to distinguish between the severity of the two. The same type of superficial conversation (and at times even jokes), are exchanged whether the patient is seriously ill or not."

There were also those men and women who were not only unclear as to the rabbi's duties, but were hostile to the entire idea of a rabbi coming in and talking to "their patient". I recall one nurse who said that she feels that the rabbi is a type of modern witchdoctor and was afraid that he might do more harm than good.[$]

The majority of medical personnel I saw, were simply unclear. Perhaps their views were best expressed by a nurse who said, "I guess it is okay if the rabbi sees the patient, and says his prayers or whatever. I really do not care what he does, it is not going to affect me and it probably will not affect the patient. I just hope he does not upset the patient."[$]

Though there were some medical personnel who do see the rabbi as having some function, I feel it is fair to conclude that the majority are still unsure. (That is not so bad either). A problem is posed when their uncertainty turns to distrust, (as is already true with some) and this distrust manifests itself with anxiety and fear and ultimately hostility. Then the rabbi has a problem with which he must reckon.

PART E - WHAT DO SOME MEMBERS OF THE MEDICAL PROFESSION FEAR ABOUT RABBIS?

There were a number of occassions when before I was able to visit a patient, I had to clear it with a medical person. More than once I was told before entering that room, "Don't upset the patient." Once, I stopped and asked a doctor what he meant. What was he afraid I might do to the patient? He expressed his apprehension and said, "I have got

the patient in a relatively calm state and do not want the patient to cause any trouble on the floor."

In many instances the doctors knew that I was doing research about counselling the terminally ill. When they told me that they (I was told this more than once by different individuals) did not want any trouble, they were telling me two things. On one hand I believe they were saying that they did not want the patient crying and getting hysterical. Death with dignity, whatever that means, seemed to be the motto of so many physicians. This later made sense when a psychiatrist told me that many of his collegues are able to handle cancer, broken bones, and all sorts of very difficult operations. But the one thing that most of them cannot handle is a crying patient. Here he meant a patient who is crying, not because of some physical pain, but rather due to some emotional anguish.

The second point is really an auxillary of the first. They do not want the patient to cry and scream, not only because it is undignified, and causes other people to get uptight, but it might also force them, (the medical staff) to talk to the patient concerning an area that they themselves are not yet ready to discuss. Some doctors actually said that they feel that a rabbi might force them to deal with their own feelings which could be quite an unpleasant experience.

Are their fears unfounded? Not necessarily. It is quite logical that if the patient has been approached and it is discovered that he really wants to talk about his illness and its consequences, (and finally meets someone with whom he can talk) he might want to carry on this conversation with some of the hospital staff when the initial person leaves.

Is there anything wrong with this? Well there can be if the

medical personnel are in no way prepared to deal with the situation. Though one may think that the hospital staff should be able to handle the situation, we now know that this is not always true, (as it is not always true of the rabbi himself). Sometimes the rabbi might have to tell the patient that what he is discussing is between the two of them, and thereby show his cognizance and sensitivity to the staffs' fears, as well as the patient's.

PART F - ARE THE MEDICAL PERSONNEL HAPPY THAT A RABBI IS THERE IN THE HOSPITAL?

It would seem, from the previous sections, that for the most part they would not be that excited to see a rabbi, or at best indifferent. Though this is a reality in a number of instances, it should be noted that it is not always so. Sometimes the opposite is true. Even though there are some who fear the rabbi because of what he might discuss, there are those who are relieved to see the rabbi (or other professionals) because he will deal with the patients in those areas that they themselves feel they would rather avoid. I have also met some doctors who were very eager to talk to me after I left the patient, and thereby showed their interest and their concern.

But there is another aspect that the rabbi should be aware of when entering a medical setting. Like any profession, there is a certain amount of rivalry connected with medicine, and doctors at times are not always delighted about having someone else come and deal with "their patient". If the rabbi is met with a certain amount of resistance, this may be the reason for it. It might not be due to what he is doing, but could be a result of the doctor not appreciating what he would term,

outside interference.

I would simply add that the rabbi should be aware of these different positions and what the doctors might be saying when they remark, "Yes it is okay to visit the patient", or "No, I would prefer that you did not visit with him at this time."

PART G - DO THEY FEEL THAT THE PATIENT SHOULD BE TOLD AS TO HIS CONDITION?

There have been studies that have been conducted in which patients have been asked whether or not they feel that they should be told, or would like to know about their condition.[4] At the same time, there has been research in which the medical personnel have been asked as to whether they believe that the patient should be told.[5] While the general trend today seems to indicate that people would like to know about their illness, my experience in having talked to over a hundred doctors and nurses, agrees with the literature that I read, which states that in most cases they do not feel that they would like to tell the patient.

In some instances there are doctors who not only feel that it would be best to tell, but actually insist that the patient know their condition before they are to be treated. These opinions are in the vast minority. (Even those who believe that the patient should know, are not always willing to offer this information forthrightly.)

As for the rest, they are of the opinion that if they were to tell the patient, it would drive the person into a state of shock and their condition would deteriorate. If the patient would ask them specifically as to their condition, the response would often be disguised within the

labyrinth of medical jargon. Whereas, years ago we would hear of someone having six weeks or three months to live, today the trend is to be much more vague and evasive.

I personally feel that every patient does not necessarily have to be told, but the decision to say something or not, should be based upon an assessment of the patient. As I mentioned in Chapter 1,[6] sometimes the rabbi will find himself in much of the same position as that of the doctor. If he knows the condition and the patient asks him, he will have to decide what to tell him. Rabbis, doctors, and nurses alike must then make a choice. One which can only be made once they know the patient, the circumstances, his background and his family. In terms of social work, this means being in touch with and clued into the various systems within which this patient operates. Then an assessment is made.

Being clued into systems means that a person is in touch with another person by knowing what he is in touch with. What this means in this context, is that the rabbi or medical person has to understand and thus see the patient, not only in relation to the room or the hospital bed that he is in, but also as part of an entire network of relations. For example, it is necessary to know what type of business the patient is involved in and whether or not if this patient were to die next week, it would leave his estate in such a mess that it would be very unfortunate for his survivors. This is what the "Shulhan Aruhk" means when it says that a person should be told to consider his affairs.[8]

One must also consider the person as an individual and thus evaluate what he considers are his strengths and weaknesses. Perhaps this will involve the opinions of others, if one has the chance to meet

and talk to them. In short, I feel that the rabbi, the doctor, the nurse, or whoever, should tell a patient as much as that person thinks that patient can stand.

As far as the medical staff in particular are concerned, I believe that they often underestimate the strengths of their patients and thus tend not to tell the patient whether or not the person might benefit from the information. A patient once told me, "Now that I know what I have, I feel much more relaxed. Before, everyone was running around and I did not know what was really happening. I suspected, but no one would talk to me. But now that I do know, and the word cancer does apply to me, I feel much more at ease. At least now I know what is happening and I can begin to prepare for my death."#

Granted, this was a remarkable person, but for the longest time he was not told. The medical staff were afraid that he could not stand the shock. However, in being so concerned about hiding the information from the patient, they ignored the signs of anxiety and stress that this patient was manifesting as a result of all the secrecy.

This is what I mean by being clued into the whole person and making one's judgement and decision as a result of this.

PART H - IS THE RABBI ALONE IN HIS STRUGGLE WITH SOME OF THE HOSPITAL PERSONNEL?

Many of the large hospitals today have a social service department which is comprised of social workers and psychologists. A rabbi should know this also that they often face the same struggles and the same battles that he does. When discussing "team concept",

these social workers and psychologists might be as frustrated as the rabbi, for they too have been excluded and often see themselves on the outside of the programme for hospital care.

The rabbi is not alone. There are also others who are trying to counsel terminal patients and are often shunned for their attempts. I mention this not only to point out that the rabbi is not alone in his struggle, but also to point out that if the rabbi finds himself in a situation where he is unable to get a certain amount of information concerning a patient, he might try the social service department of the hospital.

By the same token, there might also arise the situation where the social service department may not want to deal with the rabbi either. The head of one such service told me that she does not like the clergy engaging in social work. "That", she said, "is not their business." If this is the case, then the rabbi might have yet another obstacle to overcome.

PART I - WHAT CAN BE DONE TO IMPROVE RELATIONS WITH HOSPITAL PERSONNEL?

In Part E of this Chapter, you will recall that I felt that the medical profession feared the notion of a rabbi discussing death and dying with a patient who in turn would want to discuss the subject with them. This being the case, it is not only important what the rabbi says to the patient, but also what he conveys to the staff. The rabbi must do his utmost to prove to the medical personnel that he is there to work with them (in terms of the patient), not against them.

A rabbi might have to suffer a few insults and at times accept the fact that he is going to be ignored. There may be certain incidents that annoy him or infuriate him. For example, I recall a conversation with a patient in which she told me that while she was being wheeled into the operating room to have a node removed from part of her body, she overheard the doctor yell to the nurse to tell Mrs. X that she was also having her left breast removed during the same operation. I still shutter when remembering how callous the doctor was in informing this patient of her mascectomy.

Just as the rabbi should accept each patient's personality, so too must he try to accept the doctor's and nurse's. The medical profession is not going to change overnight and one of the worst things that a rabbi can do is cause a great confrontation at the expense of the patient.

A rabbi is in a difficult position. He must accept and yet he must not be intimidated. He should do his utmost to try to understand the hospital and let the staff know that he is trying to learn and that he is open for change. Let the staff know that he is eager to meet with them and talk to them as individuals. In this way, they might get to know him as an individual and thus become aware of his concern for the patient. They may see the rabbi as a witchdoctor and/or meddler, but only after he has proven himself, will there be any chance of his being accepted.

There is no one answer to this question. The best one can say is that there can be no relationship if there is no communication. The rabbi in most instances is going into their ballpark and thus a great deal of the onus is on him to perhaps initiate the relationship

and at times try to sustain it.

PART J - AFTER THE VISIT WITH THE PATIENT, THEN WHAT?

After visiting the patient, there might be something else that the rabbi will want to do which could prove beneficial for the patient and the staff. Sometimes, I myself have been asked, and other times I have taken the initiative to sit down with one of the staff, (or more if available) who is looking after the patient and talk to him-her about the patient whom I have just seen.

As the rabbi talks to the staff, he must certainly bear in mind the aspect of confidentiality. At the same time there might be certain things which the medical staff are not aware of, and if known could help the patient. For example, I remember a patient telling me that everything was okay, except that the hospital served a lot of pork which he found too difficult to eat, even though he did not keep strickly Kosher. He was afraid to tell the staff. I told this to the head nurse and explained why this person would not eat certain meals. The dietitian was able to make up different meals. As a result of this the patient was more relaxed and the staff no longer saw him as a stubborn person when it came to certain meals.

There might be certain times when the patient is depressed, and though the rabbi may not go into specifics, with the staff, his informing them about it would probably be of some benefit.

There is also another way of improving relations, and

that is by letting them see that the rabbi is willing to take the time to sit down and talk to them and thus give them information that could possibly make their job a little easier.

SUMMARY

This chapter was not written for the purpose of downgrading medical personnel, but rather for the purpose of allowing the rabbi to become more aware of the situation in which he might find himself. The rabbi is not always going to be accepted, and then again there will undoubtably be men and women who are very appreciative and co-operative.

In any event, the rabbi has to be cognizant that he is entering an established institution -- a system which includes rules, regulations and a highly structured bureaucracy. It also involves the most unpredictable commodity of all -- people. Subsequently, he must learn to adjust to all these various facets if he hopes to involve himself with counselling the patient while he is in the hospital.

Allow me to make one final point. The one thing that stands out as a result of my involvement with doctors and nurses, is that many times, they will also require counselling along with the patients. They are connected to a profession that is highly charged with stress and strain. It is not unusual for people to succumb to such pressure now and then. As the rabbi continues to make himself known in the hospitals, he might also have occasion to sit and talk to the staff, not about certain patients' feelings, but about the staffs' feelings. By doing this, the rabbi will not only help the staff, but will also help the patients who will reap the benefits of a more empathetic and sensitive staff.

FOOTNOTES

1. Glaser, Barney G. and Strauss, Anselm L. — Awareness of Dying, Aldine Publishing Company, Chicago, Illinois, 1965 p. 42, 226

2. Sudnow, David — Passing On, Prentice-Hall Inc., Englewood Cliffs, N.J., 1967, p. 86-87

3. Newsweek, Living with the Dying, December 2, 1974, p. 89

4. Glaser and Strauss — Awareness of Dying, p. 31 footnote

   Saunders, C. — Article in The Moment of Truth; Care of the Dying Person, Death and Dying, ed. L. Person, Case Western Reserve University, Cleveland, Ohio, 1969, p. 59

5. Feifel, Herman — Death, article in Taboo Topics, ed. Norman L. Farberow, Atherton Press, N.Y., 1963 p. 17

6. see Chapter 1, Part L

7. see Chapter 4, Introduction for further explaination of the term "systems"

8. Denburg, Chaim — Code of Hebrew Law--Shulhan Arukh, Jurisprudence Press, Montreal, Quebec, 1954, Yoreh De'ah 335:7. See also Chapter 1, Part B.

= represents an interview with a doctor whose name cannot be released

$ represents an interview with a nurse whose name cannot be released

& represents an interview with a psychologist whose name cannot be released

" represents an interview with a patient whose name cannot be released

@ represents an interview with a social worker whose name cannot be released.

CHAPTER THREE - THE FAMILY

The phrase, "No man is an Island unto himself", does well to describe man's situation as he plots his course through the maze of experience called life. We just do not appear in this world, but are born into a family -- a structure that most of us continue to live in, either by remaining with the original one, or creating our own, or perhaps both. Man is a social creature, he does not operate alone.

The most visible system and often the strongest is that of the family. Walter Buckley defines a system as a complex of elements or components, directly or indirectly related to at least some others in a more or less stable way within a particular period of time.[1] Certainly within the tenets of Judaism, the import of the family, and its significance is stressed repeatedly. For that matter, the entire life-cycle has been developed around the framework of the family, from birth to death.

Therefore, just as it is necessary to understand the medical setting in order to help the patient, it is equally important to understand the family and its role during this crisis. What becomes apparent, is that when dealing with a terminal patient, we are dealing with a number of different components, which must be seen in and by themselves, as well as in relation to the patient.

So it is with the family. It must be understood as being a part of the patient's environment. But there is also the other dimension that must not be ignored. This is what the second part of the chapter will deal with; the effect on the family and what such a crisis does to it. As one rabbi said, "The family in itself must also be seen as a primary concern. They are the ones who are going to survive and must ultimately face the reality of living in a world without their loved one."*

PART A - THE ROLE OF THE FAMILY

We should begin by examining what role, or rather roles, the family takes on during the crisis. To understand its function a little more succinctly, it is necessary to break up the crisis into four time episodes to see what it is that is expected from the family. What in fact might "happen" to the family is yet another issue which we will also examine later on in this chapter. For the time being, it is my intent to merely outline an objective timetable with an attached role description. I am not suggesting that this is what always is expected, though I feel it is safe to say that this is what we usually will find.

From the time that the patient becomes ill to the time he dies, is stage one. Though a number of things might happen, it is generally believed that during this time period, the family has a specific role to play. Its function is to give support to the patient. The family is placed in the situation of representing the outside world to the patient. It has the obligation of trying to help the patient cope with his ailment and to provide him with hope and encouragement.

Melvin Krant, director of Tufts University Medical Cancer Unit, suggests that the family is there to provide a sense of worthiness to the patient and to entrust an aspect of dignity in his time of horror. It combats the fear and lonliness of the patient and helps prepare him for his death.[2]

This is a brief sketch of what the family may be expected to do. Whether or not this happens is another matter which will be discussed shortly.

The next stage is the actual death of the family member. During this time, it is expected that the funeral arrangements will be made (if not done prior to this) and finalized. There is the notification of friends and other relatives, one or two meetings with the funeral director, and any consultation that is necessary with the rabbi for the service.

Decisions must be made at this time. Is an autopsy needed? How should the body be dressed? What type of coffin should be purchased? Arrangements for the funeral and service as well as the shiva also have to be completed. This episode is usually brief in time, but requires a great deal of organizing.

When the service is over, the shiva period begins. Here it is expected that the family will sit for a certain period of time and receive people. Day in and day out, the door opens and shuts and friends and acquaintances come to the home in order to help the family grieve. The family is required to do nothing more than sit and listen and talk. People expect the family to be sad and somber, and yet the family is also supposed to endure the jokes and the small talk that usually accompany a shiva.

This then ends the official mourning. After the shiva, the family is supposed to re-enter society. There might perhaps be a delay until the "sheloshim" period is over, and some people might decide to say "kaddish for eleven months". But eventually the work schedule is supposed to resume. Friends and relatives are no longer present. Within a few weeks, the death is not to be an obstacle any more. The family is again part of society and is once again to assume the normal

demands and responsibilities. This is then the post-shiva period.

We see that the role of the family changes. It shifts from that of supporter, to organizer, to mourner and then to normal citizen whose wounds have been healed and whose heart and mind are now capable of functioning properly once again.

PART B - WHAT DOES THE FAMILY EXPECT FROM THE RABBI?

Many of the families whom I have talked to, who have gone through this crisis really do not expect too much from the rabbi. While the odd hospital visit for a few moments with the patient is the rule, certainly no communication with the family itself is expected.

At the time of death, they expect to contact the rabbi and give him the necessary information.

Shiva is the time when his presence is most expected. It is during this episode that the rabbi is to be present at least once, in order to spend a little time with the mourners. At this juncture, the family feels that the rabbi might be able to provide some comfort and solice.

After the shiva, if the family goes to services, it is expected that the rabbi will come over to say hello and to ask how things are going. The family, I found out, feels it is expected to answer by saying, "everything is fine." The feeling here is that the grief is a private matter, not the concern of the rabbi. If there is a problem in the weeks or months that follow, the families said that they would get in touch with someone — maybe the rabbi. But for the most part, the rabbi certainly isn't required to call them.

Who is to blame here? Who's fault is it that during such a precarious time in one's life, the rabbi is used only superficially. Yes the rabbi can retort, the family should call him, he is not a mind reader. But why, time and time again, when I asked families, "would it have been helpful if the rabbi was there to talk and to assist you at times other than the shiva?" was the answer nearly always the same. "Yes, it would have helped, but I didn't expect him to be available." Why?

Because the rabbi has not made himself available previously and has thus trained his congregation not to expect him. In this case, the old cliche has been reversed, "you call me (which I know you won't) because I won't call you."

All too often, the families felt that they did not want to call, not because he would not help, but rather due to their not wanting to bother him. Many times the urge was there, but they could not pick up the phone.

How often does the rabbi chastize his people for being negligent in their duties and responsibilities towards Judaism? And often his words are justified. But here is a case in point where he has been negligent because of his lack of involvement and responsibility to his congregation.

The rabbi might think that the family has its roles and will subsequently play them quite well and without any major difficulty. That is his big mistake. It has its roles, but offtimes it does not want to play them out or it cannot. The rabbi's job, is to examine what happens to the family during the crisis and how its behaviour (at least during the first stage) affects the patient.

PART C - WHAT HAPPENS TO THE FAMILY PRIOR TO THE DEATH?

I have stated that the family, during this time is primarily there to provide support. But if the family is unable to cope with the situation any better than the patient, as so often happens, how can it be of any assistance? How can a family which has become so caught up in the situation that it finds it difficult to get a handle on things, in any way, hope to help the patient, who is usually disoriented himself?

Kubler-Ross,[3] states that the family might go through many of the same, if not the same stages that the patient goes through prior to death. With regard to this, I myself have met family members who have manifested the same type of anger and denial that we expect of the patients. I recall talking to an elderly woman. Her husband was in the hopsital and was being treated for cancer of the rectum. When we began to talk, it at once became obvious that this woman simply refused to acknowledge the fact that her husband, who had been in the hospital for six weeks now, was even seriously ill. "Oh", she said, "he will be home tomorrow -- he's just getting over a touch of the flue."[+]

There are serious side-effects to such denial. First, it might increase the anxiety of the patient, who realizing what is happening, feels he cannot discuss it with his own family. The family represents stability to the patient. It is that group which can best understand the feelings of the patient. Therefore, when the patient feels that he cannot approach the subject, it is no wonder that this situation creates a tremendous amount of strain on him.

The facade that so many people insist on perpetrating, was described as a "living hell" by one patient. "I can't even talk to my daughter who is all I have left."

But the anxiety is not all one sided. The family too, often exhibits signs of strain, even if it is the one who is refusing to admit what is occuring. It takes a great deal of energy to try to hide something of this proportion. Most of us are poor actors when it comes to this topic, and therefore we have to try harder which only tends to make the situation that much more difficult.

One might meet a highly motivated family which is able to look at the reality of the situation and discuss it. However, a problem remains if the patient refuses to talk, who in turn makes it unbearable for the family who have so much to say. At the same time, the patient might feel guilty because he is preventing his family from doing something that it desperately needs to do-- talk.

Then there are those family members who are angry. Their anger is directed, not only at the patient, because of what he is making them go through, but also at each other. One person might feel that someone else is not pulling his weight. You might think that during such a tragedy, families become closer and often this is true. But we also should be aware of the other situation. Erving Goffman,[4] accounts for both types of behaviour when he states that a time of stress, the established social distance between people may increase or decrease.

In instances where the distance between individuals increase, all sorts of hostility comes out. I remember the words of one patient who responding to such anger between his family members, said, "You know, it's often nice when they all leave -- at least the

yelling and the nit-picking stops." The patient was referring to his daughters and sons who found it necessary to fight about who was doing what for papa. "Don't they realize", he continued, "how I feel knowing that my death is causing such strife. It isn't enough that I must try to put certain things in order -- now I've also got feelings of guilt, not only about leaving them, but also about causing so much trouble."[5]

There are also families who sit in fear and are afraid to ask the doctor questions. Sometimes these people sit perhaps in a waiting room each day so that two or three times a day they can see their loved one for five minutes at a time, before being told that they must again leave.

If the hospital is the source of such consternation for the rabbi, imagine what it is like for the family. How frustrating and nerve-wracking it must be to try to track down a doctor or a nurse in order to get a piece of hope or information. And when it does what is the response? A statement which so many of them attested to, "Its hard to say" -- or -- "We're doing what we can".

The family who has to assume financial responsibility while their loved one is bed-ridden, presents another problem area. Take for example a young mother with children who now must seek some type of employment because there is not enough money coming in. In the midst of everything she must somehow learn to divide her time between the children, her husband and her job, and maybe sneak in a few hours of sleep as well.

This time prior to death is often a living nightmare for all

concerned. The support and the hope that the family is supposed to provide is likely to turn to anger and deep depression.

PART D - WHAT CAN THE RABBI DO DURING THIS TIME PERIOD?

The title of Arthur Mailing's novel, "The Go-Between", might well explain the rabbi's role during this critical period of time. Often the lines of communication have been cut or short-circuited between the family and the patient. This is then a time when the rabbi can be of great assistance. He may find out that both parties have a great need to talk and yet somehow fear the reaction of the other when broaching the subject of death. His encouragement and support is often all that is needed to get the two connected. However, let me caution, that every case is not this simple.

There are times when the rabbi will have to spend a great deal of time with the members of the family in order to help them reach the stage whereby it is able to discuss the topic with the patient. Since the family is often the first to know the diagnosis, what is needed is a kind, empathic ear, which is trained to listen to hardship that the family has to endure. This will often allow the family to release pressure that has been building up. If it is afraid to discuss the situation with the patient, the rabbi might want to discuss its fears and/or anger, as Avery Weisman says, "objectively and yet compassionately."[6] This will then give the family members an opportunity to deal with their feelings and let them know that there is someone who is concerned with the family as well as with the patient.

There is the possibility that the rabbi will meet a family who feels that it cannot discuss the situation with the loved one for good reason. Perhaps the terminal patient is not capable of discussing it and the family knows this. The job then becomes one of supporting these people during this crisis and again providing them with the occasion to ventilate.

The family will only open up to the rabbi if the rabbi is successful in conveying his sincerity and concern for them as people. At the same time he should also recognize that the family might fall into serious depression which he feels might require psychiatric help. If this be the case, he must first recognize his own limitations, (which will vary with each rabbi). If he feels that his professional services will not suffice and that others are required, then he has the responsibility to make the appropriate referral. This must be something that he always keeps in mind, whether working with the family or the patient.

The point here, is that all too often the family is left to fend for itself. The rabbi should be available to provide what is required, either by himself or by his arranging for someone else to help. In either event, his presence and his compassionate sincerity are pre-requisites. In this way he will provide support to the family who in turn must support the patient.

If such intervention is successful, then not only will the family be better off, so will the patient. Now at least the patient and the family might have an opportunity to get together to discuss and to relate to one another using something other than superficial overtures.

The rabbi acts as a go-between in another way. He stands between the doctor and the family. The rabbi might be the one who secures the information that the family might not have been able to obtain, or which it is scared to obtain. It must be remembered that many people view the doctor as not only an authority, but as someone who cannot be approached.

The rabbi can also sit and keep the family company while it sits in the waiting room. The hospital can be a de-humanizing place, not only for the patient, but also for his family. One person told me that it was so good to see the rabbi in the hospital because he brought with him a sense of dignity and with it, the sense that people and their feelings are important.

Let me make one final point. Just as I suggested that the rabbi might try to get in touch with the doctors after seeing a patient so the same is true with respect to the family. Again there must be the respect for confidentiality, but there are also things that might help everyone if they are communicated. A man who was unable to tell his daughter how much he loved her, told me. From his eyes, I knew that he desperately wanted her to know, and wanted the years of estrangement to finally end. When I met the daughter in the waiting room, I spoke to her and eventually told her how much her father thought of her, and also explained that her dad was not always able to verbalize what he felt. The next time I saw him, she was there and the two of them were talking openly and freely about their feelings towards each other.

In every one of these situations, the rabbi is able to

help ease the pressure. This in turn will help the patient. To know that someone is looking after his family will help to ease his burden.

Does the rabbi have a part to play? It goes without saying. But because he has trained his congregants not to ask him for help at this time in their lives, he will have to initiate the encounter. In this way, hopefully, he'll be able to retrain them.

PART E - WHAT HAPPENS TO THE FAMILY AT THE TIME OF DEATH?

There can be a variety of reactions when the patient finally dies. These reactions will not only depend upon the relationship between the patient and the family, but also upon the circumstances of the death, (e.g. was it a long and lingering death, and how prepared was the family?). Some people, even though they know death is inevitable, go into a state of shock and actually faint or become numb at the time of death. Others will scream and beat their breast. Still others will remain silent and do or say nothing.

For some people the death will be a relief and for others it will be the most horrid experience of their lives. In any event, it is the time that bereavement and grief normally begin. Robert Neale points out that sometimes the grief process will begin while the patient is still alive and therefore there will be very little to do afterward.[7] However, more often than not, grieving will begin at the time of death.

This process (grief) was first articulated by Erich Lindemann[8] based upon his study of the survivors of the people who perished in

the "Coconut Grove Fire in Boston". It is hard to predict just exactly what will happen to people, for as Lindemann says, the grieving process may be delayed and/or exaggerated, and in some instances apparently appears to be absent. Basically, however, he states that there are three various kinds of reactions which Robert Neale[9] has described as, physical, emotional and behavioral.

The physical reaction may manifest itself by a tightness in the throat, shortness of breath, an empty feeling in the abdomen, a lack of muscular power, and tension. These sensations may last from twenty minutes to an hour each time they occur, and may continue long after the death has taken place.

The emotional side of this process may appear in the form of guilt and anger. "How could he leave me?", was the comment of one widow, and yet in the next breath she stated that she had not done enough for him while he was alive, (which may or may not have been true). But in any event, her feelings of guilt were strong.

The third part of this picture is seen in terms of one's behaviour. An inability to perform the routine functions was discovered. A going through the motions, or state of inertia befell the mourner.

I mention these symptoms here, not that they will always occur at this time, (immediately following the death), but rather that the rabbi is aware of them in order to deal with them either at this point in time or at a later stage.

I should also state that in the midst of all of this, there is a tremendous mental strain that takes place. Certain practical affairs, which if not already looked after, must immediately be tended to. I refer here specifically to the funeral arrangements. If these arrangements have not been taken care of, what in effect happens, is

that the grieving process is delayed. Such a delay then becomes yet another cause for anxiety and frustration.

PART F - SO WHAT CAN THE RABBI DO?

At the time of death, the rabbi may not be present, and unless he phones the hospital or the family, he might not know until he receives THE CALL.

Let me stress the importance of establishing a relationship with the family so that in the event of death the family will feel comfortable in calling.

Does the rabbi go over right away or not? There is no one answer to this. Some people will want to be alone for a few hours and others will want the rabbi to be there. But a problem can arise if the person insists that he wishes to be left alone for too long a time. The person might not want to make the funeral arrangements because he has not accepted the fact that the patient has died. In not accepting his responsibility, he will be allowed to continue to deny the death. Avery Weisman suggests that this denial is a way of disguising and pretending that the death has not occured. This is done because of our psychological reticence and revulsion in dealing with the subject. Such denial only serves to delay the work that has to be done.[10]

I would therefore say to such a person, "All right, I understand, I'll see you later." "Later" for the mourners will usually suffice. It is then up to the rabbi to follow through and actually go over to see them a few hours later.

The rabbi's primary obligation is to be available. Perhaps he'll just sit and let a person reminisce. But he also has another responsibility and this is to ask whether or not the funeral arrangements have been made or are being looked into. He might find himself in a situation, (to which I can attest) where he is the one who will have to help out. In that case, he must be prepared. By this I mean that the rabbi must be acquainted with the funeral director before he has occasion to use him. In this way he won't have to fumble around at a time when speed is important. The faster the arrangements can be made, the sooner the person can begin to concentrate on his grief, which Lindemann describes as an exercise we must all eventually do.[11]

If the rabbi did not know the deceased well, for one reason or another, he'll need some information for a eulogy if one is to be delivered. Usually the mourner(s) will be talking about their relative, and if not, there is nothing wrong with asking them to tell you a little about him.

It is also not unusual to have people inquire as to what they should do about the funeral, the shiva, the yarzheit and so on. Quite often people whom the rabbi has thought had no religious concern at all, will suddenly request certain information. They might want to know about setting up a morning minyon or ask what to do about the mirrors, or whether or not they should go to work. The answers that a rabbi gives are very significant and he must be particularly sensitive to this. The rabbi is seen as the authority. People will long remember what he has said to them and how he said it during those months. In fact, I would estimate that the rabbi's words during a crisis of this proportion, are

infinitely more significant and therefore are remembered significantly more than any High-Holy Day sermon. A rabbi is speaking here to people who have been cut to the bone, and whose wound is still exposed. How he dresses it and takes care of it, is something he must carefully consider.

The rabbi might find that after the funeral, the family will want to pay him for his services. I recall the first time that it happened to me. Quite honestly, I was not sure what to do. Do I take the money for doing something that the congreation is already paying me to do? It was not until I was able to discuss the matter with psychiatrists that I was able to understand the rationale for the payment. It was not only because I may have done a good job. A funeral, they explained, like anything else is a service which you pay for. Anything that comes free in our society somehow is not considered legitimate. Therefore, when someone pays you for funeral services, it is fulfilling a need on their part to say, "Now that I've paid for it, its over." There is no unfinished business. "I've finished my obligation", says the mourner, "and now my relative can rest in peace." The rabbi can decide where he wishes the money to go, but I would see it as a disservice to outrightly refuse to accept it.

Again, it is the rabbi's availability and awareness that are essential at this time. What we must also realize is that he cannot wait to be invited. One's initiative thus becomes an essential ingredient in order for people to realize that he is concerned.

PART C - WHAT HAPPENS AT THE SHIVA?

The official period of mourning is often a time of continued confusion for the family. I have actually met people who told me that they couldn't remember the funeral, the shiva or anything. Often people are given prescriptions by doctors and are drugged for a great deal of the time during this period. Such practice thus becomes yet another form of denying the death.

Many people will try to spend part of this time sorting out various things about their life. Questions about life, and the philosophies of life are sometimes the subject of great and extensive personal debates. At this time some people are working through their grief and are trying to cope with a world that is now without their loved one. But as intense as this might be, the questions and the debates and the introspection are constantly being interrupted by other relatives and friends who are coming and going. As one person begins a conversation, another one is ended. I have observed on more than one occasion that the mourner has been left alone in a corner of the room to deal with his bereavement, while everyone else around him behaves as if they were at a party.

Then there are those mourners who feel a certain social pressure to elicit tears whether or not they want to. But even that can only go on for so long.

Others cannot mourn at a shiva and in no way pretend to. A rabbi might be shocked to enter a home and hear the mourners talking about a recent trip or a tennis game or whatever. He should not be

shocked. These people are telling him something. They are saying that they have finished their mourning either permanently or temporarily, or have not as yet begun.

Not all of us show grief in the same way and this must be kept in mind. The role that the family is supposed to play at the shiva is not always possible. Just because a few days have been set aside to mourn does not mean that mourning will in fact take place, or if it does, will take place in a way that one would expect it to.

PART II – WHAT IS THE RABBI EXPECTED TO DO?

As you recall, the shiva was the one time I found there was a minimum requirement of at least making an appearance. "People kept asking me if Rabbi X has come over yet and it was embarassing for me to constantly have to say "no". This response came from an individual who was definitely put out because of the absence of the rabbi.

This expectation of having the rabbi drop by was by no means uncommon. There were a number of persons who somehow equated the rabbi's presence with their own social acceptability. As one person said, "For years we've been paying dues to the temple and now is the time for the payoff. At the life-cycle events, and especially death, you want a return for your investment".

Such a return seems to imply the rabbi's being there at the shiva. If he does not come, people will often think that there is something wrong with them and they think that they are not as good as the "Levys".

The rabbi should keep this in mind so he can dispel this feeling of status loss. Many people with whom I spoke, were not sure what they wanted of the rabbi. Some however, said what they did not want, was to hear the latest jokes coming from the rabbi. (Does the rabbi tell jokes because he feels uncomfortable or is it that he refuses to take the necessary leadership?).

The shiva is a time to grieve and there are enough distractions without the rabbi adding to them. He must set the example and show the respect that is required. Does this mean that he has to sit with a long face? No. It means that he should be approachable, so that people can come to him to talk about whatever they want. For this reason it might be advisable for the rabbi to visit the shiva during the day time when not as many people are present. Then there is probably more of a chance to talk and to discover where the mourner really is, in terms of his grief.

The rabbi's job should not only be there to listen, he should be there to act as a catalyst by helping people reorganize and sort out their lives, if that is what they want at the time. During these moments of tremendous sorrow, often the meaning of life is called into question. There are many attempts on the part of the mourners to verbalize their philosophies. Confusion, terror, guilt and anger might find themselves mixed together as the person's expression of life begins to unfold. The rabbi must be ready to recognize this and help the person begin to realize what has happened and what will happen.

William Glasser states in his theory of "Reality Therapy"[12] that man has certain basic needs. One is the need to love and be loved.

The other is the need to feel worthwhile by himself, and by others. Throughout the life experience, we learn to fulfill these needs. Glasser also states that there are times where we must re-learn these needs. For a mourner, death is such a time.

The shiva then becomes a time to reorganize. Some people are naturally stronger than others and will not require help in doing this. Others will. The rabbi's presence might serve to help these people during this process, either by his direct intervention, or by his recognizing that the person might need further assistance from other professionals.

PART I - WHAT IS NEXT?

You might say that the shiva, because of all the confusion, is not the best time to help a person. That could be so. Nonetheless, the shiva is still an opportunity to provide comfort and solice.

The problem is that most rabbis stop at this point; at a time when as yet, many things have not been sorted out. It's been my experience that after the shiva, when the people go away and the mourner(s) is (are) left alone, a great deal of thought and concentration takes place. This is the time when the rabbi should see if he can be of any assistance. Offtimes people are not able to adjust as quickly as we would like to think them capable. They might continue to experience grief for an extended period of time. It might be part of some unfinished business that began at the time of the death, or it might be the beginning of the process which had been denied until this time.

I've met individuals who, five or six months after the funeral

have not yet begun to work through the death. Some were still trying to figure out what had happened at the funeral, and others were so full of guilt and anger that they didn't know where to begin.

Sometimes people actually feel that the person died because they (the mourner) at one time got angry and either told the person directly, or wished that they would drop dead. Earl Grollman[13] in, "Explaining Death to Children", gives us a script for re-assuring the children that their thoughts were not responsible for the person's death. Grollman's words are not for children only. The rabbi might very well find himself, at any time talking to a guilt-ridden person. An adult, who like a child, needs the comfort and assurance of knowing that he or she was not responsible.

A phone call or a visit to the mourner's home after the shiva is extremely important. First it lets him know that someone does care and secondly, it gives him the opportunity to talk. It is often at this time that one will be able to notice how the mourner is coping with the death. Again, the rabbi's judgement is called into play. He must decide whether he will see the person himself, or refer him to someone else.

The rabbi has a unique opportunity to give a person a chance to talk. One to one communication should be available at all times. But there is also the possibility of group communication. What this implies is that the rabbi might try to form groups in the synagogue or the community, as some rabbis have already done. The rabbi thus gives these people a further chance to work things out. These groups will consist of widows or widowers who are able to get together to discuss their lot and thereby help themselves by helping each other.

People will therefore not only have the chance to get out, (which is advantageous in itself) but the occasion to learn that they are not alone in their plight.

The rabbi might want to run the groups, if he feels qualified to do so, or enlist another professional to do it. But he still should take an active part in the setting up of the group and continue to watch what happens to it and its members.

Post-shiva counselling, as I call it, is something that has not really been explored by most rabbis, either individually or in groups. It is needed and the rabbi is the one who can make it work. The rabbi is the one who should make it work.

SUMMARY

The family is of interest to the rabbi not only because of its relationship with the patient, but because of its situation, in and of itself.

Sometimes the family will be able to provide the rabbi with some valuable information about the patient. The more the rabbi knows, the greater will be his understanding of what it is that is happening and how he might be able to assist.

It must also be remembered that the family as well as the patient is in a state of crisis. Certainly by helping the family, prior to the actual death, the rabbi will be helping the patient,(perhaps by relieving certain pressures or by opening up lines of communication) but he must also consider that the family by itself often needs assistance. In the later stages, the rabbi's purpose is to aid in the re-building

process that must inevitably take place.

In the previous Chapters, I discussed the concept of a team. What I was referring to was the joining together of the clergy and the medical profession. It should now be apparent that the family too, has a great deal to offer and should also be included as part of the team.

There now remains but one more member of our team.

FOOTNOTES

1. Buckley, Walter — Sociology and Modern Systems Theory, Prentice-Hall Inc., Englewood Cliff, N.J., 1967 p. 41

2. Krant, Melvin J. — "The Doctor, Fatal Illness, and the Family", article in Concerning Death: a Practical Guide for the Living; de. Earl A. Grollman, Beacon Press, Boston, 1974, p. 58

3. Kubler-Ross, Elisabeth — On Death and Dying, The MacMillan Company, N.Y., 1969, p. 149

4. Coffman, Erving — The Presentation Self in Everyday Life; Doubleday Anchor Books, N.Y. 1959, p. 167

5. Aitken, John — "The Gift of Death", article in "The Globe and Mail Weekend Magazine", Toronto, Vol. 25, No. 3, 1975.

6. Weisman, Avery — On Dying and Denying; Behavioral Publishers, N.Y. 1972, p. 11

7. Neale, Robert — The Art of Dying; Harper and Row Publishers, N.Y., 1971, p. 75

8. Lindemann, Erich — "Symptomatology and Management of Acute Grief" article in Pastoral Care of the Dying and Bereaved: Selected Readings; ed. Robert B. Reeves Jr., Robert E. Neale, Austin H. Kutscher, Health Sciences Publishing Corp., N.Y. 1973, p. 60

9. Neale, Robert — The Art of Dying; p. 73

10. Weisman, Avery — On Dying and Denying, preface xv

11. Lindemann, Erich — "Symptomology and Management of Acute Grief"

12. Glasser, William — Reality Therapy; Harper and Row Publisher, N.Y. 1965, p. 7-12

13. Grollman, Earl — Talking About Death; Beacon Press, Boston, 1970

FOOTNOTES (CONTINUED)

* represents an interview with a rabbi whose name cannot be released

\+ represents an interview with a family member whose name cannot be released

\# represents an interview with a patient whose name cannot be released

CHAPTER FOUR - THE PATIENT

Having explored various aspects of the rabbinate, the medical profession and the family, in relation to the topic of death, let us now turn our attention the the terminal patient himself. What does he feel about his situation? What are his needs and fears?

Though the rabbi, the hospital and the family may find it hard to handle this situation either before and/or after the death, it is still the patient that is the one who is dying. I mention this, not that we ignore the other aspects, but that we do not lose sight of the fact that however difficult it is for the others -- they are not the ones who ultimately must surrender the gift of life.

PART A - WITH WHAT TYPE OF SITUATION IS THE RABBI DEALING?

Throughout this study, I have used the term "crisis" to describe this entire situation. "Crisis Theory" was first examined by Erich Lindemann and Gerald Caplan. The latter offers a simple definition of crisis as being an "upset in a steady state."[1] Lydia Rapoport comments on this definition by stating: "This definition rests on the postulate that an individual strives to maintain for himself a state of equilibrium through a constant series of adaptive manouvres and characteristic problem-solving activities through which basic need-fulfillment takes place. Throughout a life span, many situations occur which lead to sudden results in a state of disequilibrium. In response to many such situations, the individual may possess adequate adaptive or re-equilibrating mechanisms. However, in a state of crisis, by definition it is postulated that the habitual problem-solving activities are not adequate and do not lead rapidly to the previously achieved balanced state."[2]

To put it in terms of "ego psychology", a crisis occurs when the ego, which normally is seen in terms of integrating inner desires and outside reality, is unable to function properly.[3] If the outer reality is such that the ego is unable to cope with it, (in such a manner as to maintain some type of behaviour within the total mechanism) various types of behavior are produced. A person might try to block out what it is that is bothering him. For some people, this might work quite effectively. Others will be unable to deny the situation. They force themselves to deal with it but may need assistance in doing so. Still others who cannot deny and cannot deal with whatever it is that has produced such turmoil, will be thrown into a state of despair and panic.[4]

When dealing with a crisis, there is the possibility that one person might be able to help another out of his dilema. The helper might be able to give the distraught person something that will ease the burden. Perhaps it will be advice, comfort, or in some cases, some material assistance. But all of the methods of helping are done with the message that eventually, THE CRISIS WILL BE SOLVED AND THE DISTRAUGHT PERSON WILL GET WELL. In normal crisis theory, it is implied that there is a solution.

Now let us look at our situation. Is it a crisis? Certainly. There is definitely an upset in a steady state. But this crisis is of a different nature. Gene Brockopp refers to death as "a developmental crisis."[5] By this he means a crisis that will inevitably occur and cannot ultimately be altered. With the family, certainly there is the pain and grief, but there is still the future which will provide a cure for its grief, if worked through properly. But what future is there for the patient? He will not get better. He will die!

This then becomes the situation within which the rabbi must work -- a crisis which unlike others, has no real solution.

PART B - HOW DOES THE PATIENT PERCEIVE THE ROLE OF THE RABBI?

Having asked rabbis, doctors and families what they felt the role of the rabbi was in this situation, it seems only logical that we should also investigate the patient's thoughts on this topic as well.

In the first chapter, I stated that some rabbis felt that they represented the "Angel of Death" to their patients.[6] We should accept this as some patient's perception of the rabbi as well. However, the patients that I specifically dealt with, were not scared about seeing the rabbi. But neither were they sure why he was there other than to pray for them. This applied to both religious and non-religious patients.

The rabbi's presence was generally welcomed by the patients, (though there were some exceptions). Nevertheless, such a visit was only expected out of courtesy. Most of my patients were somewhat amazed when they realized that I wanted to stay with them for more than the socially accepted five to ten minutes. Like the families (whom I discussed in Chapter 3) I found that the patients, whether religious or non-religious expected very little from the rabbi.

Again I would suggest that these expectations reflect the social conditioning that has gone on previously. We must now investigate what can be done to alter what has taken place, in order to change the patient's perceptions.

PART C - WHERE TO BEGIN?

The rabbi's first concern is to establish a relationship between himself and the patient. The first meeting should be spent with the rabbi conveying the message that he is concerned about the person. How is this to be accomplished?

First of all, the patient should understand that the rabbi's intent is to serve him. He will get this impression if the rabbi himself takes a genuine interest in the situation. To do this, the rabbi should take off his coat, (if he is wearing one) and SIT DOWN beside the patient and talk to him. This idea of sitting down is very important. Whenever someone comes into the patient's room, it is usually with the intent of asking him questions, examining him, telling him to do certain things, and so on. People are literally standing over him. One patient told me, "You know, rabbi, it's a welcome relief for me to have you sit down. It hurts my neck to always have to look up when someone enters the room."

The idea of taking off one's coat and sitting down also conveys the notion that you are going to stay awhile and that you are there to visit, not simply say, "Hello".

What the rabbi hopes to eventually do, is win the trust of this person. Trust does not come easily, but is something that must be built up. It can be won by showing an interest in the patient as an individual.

The rabbi must make the patient feel that the rabbi is sensitive to the patient's needs. He must also show his leadership ability.

The basic ingredient at the beginning is to listen with an empathetic ear and to establish in the mind of the patient, the notion that you care. This point cannot be emphasized enough.

The patient may be shy. He may be angry. But in spite of this, he must be led to understand that you, as a rabbi, still accept him and are interested in him. There may not be a great deal of conversation at this time. That is all right. Do not force yourself upon him -- rather let your relationship flow. It may take a number of visits before real conversation begins. Patience is the key. But again, let him know that you are available, and that you are capable of listening.

PART D - WHAT IF THE PATIENT ASKS THE RABBI TO LEAVE?

There may be a number of reasons why a patient might ask the rabbi to leave. Perhaps he is in pain and does not want the rabbi to see him in this state. He could be tired and want to sleep. Rabbis must consider the fact that not everyone wants to see them. Some people feel uncomfortable with rabbis, others as I have stated, may fear their presence. I myself had a patient say that he/she was not religious and had no use for me. The patient asked me to leave before I could say anything.

Listen to them and leave. Do not infringe on the little privacy that they have. A simple, "I understand", will suffice. Will your ego be hurt? Perhaps. But what would be accomplished by staying, besides upsetting the patient and losing any hope of inter-action?

What must then happen is a follow-up. A patient who asks you to leave is still a patient. By going a few days later to the hospital and seeing the patient again, you might again be asked to leave. But at least you have told the patient that you are still interested

in him. The patient will realize that his welfare is more important than the rabbi's ego, which may or may not have been hurt. Chances are, that the patient will not refuse to speak to you twice. But even if they do, it is not a cause for anger, but rather a time for understanding and patience.

PART E - WHAT DO YOU FIRST SAY TO THE PATIENT?

Carl Rogers[7] teaches us that in order to do effective counselling of any sort, you must begin where the person is in regard to his psychological state. With terminal patients, what this means is that it is necessary to find out what the patient thinks about his illness, or for that matter whether or not the patient is even able to discuss it.

It is one thing to know whether or not the patient has been told about his illness. It is something else to discover how the patient interprets the news and whether or not he is capable of talking about it.

The first time I visited a terminal patient, I had the good fortune to have an intelligent and sensitive psychiatrist accompany me. I still recall the first words of exchange after the introductions were made. The doctor asked the patient how he was. The patient replied that he was sick. The doctor then asked him what he had, to which the patient responded, "Cancer". At this point, the doctor then asked the man what that meant to him the patient paused for a moment, looked up at us both and declared, "It means I'm going to die."

Certainly not every patient is going to respond in this fashion.

Not everyone will be willing to discuss his illness. Some people may tell you that they are fine and that nothing is wrong with them. Others may tell you that they do not know what is wrong. Asking the patient, how they are, might not always yield a truthful answer, but the answer will nevertheless be important.

As the relationship continues, more and more pieces of information may be divulged. But at this first stage, you can only work with what you have. If you try to do more than the patient is willing, you run the risk of losing ALL Communication with him.

A patient's answer to, "How are you?", will help you to understand what that patient feels at that time. You might find out after further discussion that the patient was more aware than he first let on or was really telling you as much as he was aware of.

Glaser and Strauss[3] have helped to locate the patient in terms of the various types of awareness that one is liable to encounter. Briefly, they are closed awareness, suspicion awareness, mutual pretense awareness and open awareness. An example of closed awareness occurs when the patient does not know his condition but other people do. These others include the medical staff and perhaps the family. Suspicion awareness is when the patient suspects what he has, but everyone else around him who knows his condition, refuses to acknowledge it. The patient in this instance is confused and frustrated because no one will give him a straight answer. Mutual pretense awareness occurs when everyone concerned, including the patient, knows the situation but pretends that the patient is going to live. The facade is complete on both sides. Finally there is open awareness. Here, all concerned, know the situation and are willing to discuss it.

When the rabbi visits a patient, aside from establishing the relationship, it is necessary for him to try to find out how much the patient knows and is willing to discuss. If this is not done, the rabbi and the patient might very well find themselves talking on two different levels.

At the beginning, a rabbi must not assume too much. The fact that a patient mentions cancer and death, does not necessarily mean that the patient accepts or for that matter, understands what he is saying. A case in point was the patient to whom I referred at the beginning of this section. Although he told the psychiatrist and myself that he had cancer and was going to die, what became obvious through further investigation was the fact that his notion of "going to die" was quite different from the reality of the situation. He thought he had three years to live, when in fact he had only a few weeks.

It is necessary to check out everything. You cannot assume that the patient has the same understanding concerning things, that you have. By asking, "How are you?" you are liable to receive all sorts of answers and must be prepared for this. I should also point out that such questions must not be asked matter-of-factly, (as is usually the case when we meet people). Otherwise, a matter-of-fact answer will be produced and you will have nothing. The patient must receive the message that when you ask the question, you are asking because you care and because you want to know. How he answers it, will at least give you some indication as to his awareness, if only superficially.

Other introductory questions might be as follows; "How long do you think you will have to remain in the hospital?", "Have you been in communication with your doctor as to your treatment?", "Could you tell

me a bit about the type of treatment you are receiving?" Such open-ended questions might be ignored. Evasiveness can also be seen to be a type of answer. And if it is not ignored, it will give the rabbi yet further insight into the patient's understanding of his situation.

After asking the initial questions, it is then necessary to LISTEN to the responses. It is here that one will be able to pick up the concerns and the fears of the patient.

PART F - WHAT ARE THE FEARS AND THE CONCERNS OF THE PATIENT?

After having established the fact that you are there as an interested and concerned individual, it is imperative that you listen for cues to what is bothing the patient. By trying to find out how the patient feels about his illness, you might discover his concerns. Certainly not everything will be revealed at once. A patient must first decide if he can trust you. There might be a trial period where the patient will say something and see how you respond to it.[9] How the rabbi responds will determine if the relationship will be established at all.

Robert Neale[10] describes a number of different concerns that he has found patients possess. He states these concerns in terms of fears. They are; the fear of pain, indignity, being a burden, losing mastery over one's life, failure, separation, and the fear of the unknown i.e. what will happen to their body and/or their soul.

Pain is certainly a major concern. The patient might be in pain when the rabbi arrives or have anxiety over the thought of future

suffering. This concern has even driven some patients to suicide or a request for euthanasia,[11] in order to escape it.

A rabbi must remember that when he meets a person in the hospital, that person at least psychologically, feels as if they are at a disadvantage. (People usually meet the rabbi in the synagogue or at some function where they can at least have some control over how they look or how they present themselves). It is one thing to look terrible to you doctor, who you might think is used to seeing people not at their best, but it is embarassing for a woman to have to meet the rabbi without her make-up on or for a man to constantly clear his bowels while the rabbi is present. I recall a lady who for twenty minutes apologized for not having her hair combed. People are concerned about their feeling less than human. Their illness has robbed them of their personal dignity and they are forever resentful of this fact.

The fear of being a burden is very unpleasant for some, while for others it is not a concern at all. There are people who enjoy being catered to. Others, however, cannot bear the thought of having their wife or husband travel to the hospital every day in addition to the other daily functions, e.g. going to work, shopping, etc. To have to lie in a bed while others move about you is liable to produce anger as well as guilt. And if the family's savings are being drained in order to help the patient, the feelings are intensified even more.

C. W. Wahl[12] states that we all possess magical feelings of omnipotence in times of death, which help us to defend against anxiety. However, it is ironic, he states that it is these same feelings that cause the anxiety. Sooner or later we all realize that we are not omnipotent

and that we do not ultimately control our own destinies. This fear of loss of mastery, comes as a shock. Certainly, some people are more prepared to accept their limitations that others, but it is still an unpleasant aspect of life to have to accept this. This feeling of "helplessness", is as Jacques Choron[13] labels it, "a horrid sensation. It is man, who according to Genesis, rules the face of the earth".[14] Yet as death approaches, man is humbled. Such a realization is often devastating as well as fearful.

Allied to such fear of loss of mastery over life, is the fear of failure. Are not all of us dreamers? Who amongst us does not have aspirations and hopes? The thought that one shall soon die and never live to complete one's goals is something that weighs very heavily upon all of us. For some people, there is so much more to do when death calls and thus the feelings of failure and incompleteness loom large. Others are able to accept their lot, perhaps because they feel that they have completed their task.

This point relates to a statement by Mary Vachon, a psychiatric nurse at the Clarke Institute of Psychiatry in Toronto. Mrs. Vachon, who works quite extensively with terminal patients said that the hardest patients to deal with (whether old or young) are those who are involved with living.[15] Her point is well taken. For such a patient, death robs him of the chance to complete the tasks that he has set for himself.

The most common fear according to Robert Neale[16] is the fear of separation. My research also bears this out. Time and time again, I was told by patients how much they were going to miss their family and

friends. Here too, there is a feeling of incompleteness, an emptiness a fear that so much will remain unsaid. There is the concern of loneliness and of dying alone. A doctor once told me that a patient made him promise that he would be there when she died. She wanted him there to hold her hand at the moment of death. He could not promise her that he would be there, but said he would do the best he could. As fortune would have it, he was there. This meant so much to the dying patient.

A rabbi will not always be available at the moment of death, but the idea of loneliness is still something that must be kept in mind. So often a patient would be grateful to see me, if for no other reason than having someone to talk to. If for no other reason than to know that they are still part of a social context and have not been completely cut off.

When people walk into a dark room, they might be scared. Why? Because they are uncertain what is there -- or what is waiting for them. Such can be the case with a terminal patient as well. They do not know what lies in store for them and are liable to be quite apprehensive. What they will be entering at death, is for many unknown. What lies ahead is frightful. Some people are concerned about what will happen to their bodies, and the thought of decay is repulsive. For others their concern is specifically a theological one, yet nevertheless anxiety provoking.

These are only some of the fears and anxieties that a patient may possess. In each of these categories that I have listed, is an infinite number of specific conerns related to the specific life of a

patient. If a rabbi is aware that these categories of anxiety do exist, it will allow him to be better prepared to deal with the patient's concerns.

PART G - WHAT CAN THE RABBI DO TO HELP?

The first section in chapter one dealt with the rabbi's being aware of his own feelings and limitations when dealing with this entire topic.[17] I mention this here because I feel that it is important to state at the beginning of this section, that the rabbi might not be able to deal with all of the patient's needs. For example, part of this might be due to a specific need that the patient has such as wanting to see a relative or friend who is not available. (The patient in turn might feel very lonely because of this.) It might also be due to the rabbi's own inability to deal with the subject matter. This does not mean that the rabbi is useless -- on the contrary, his mere presence might help to combat loneliness. What I am saying is that one can only do as much as one can. A rabbi is not God. He has human limitations and must be able to live with them.

The notion of a "Co-Between"[18] which I spoke of in the last chapter, might also apply here as well. If the patient is in pain, the rabbi might be able to track down someone to see if anything can be done. If it is the anticipation of pain that is bothering the patient, again the rabbi might be of some assistance. The doctor is the one to know if there will be any pain. Doctors have told me that often there will be no pain involved, but that the patient thinks there will be some and therefore gets excited. If this is the case, the rabbi might try to bring the doctor and the patient together in order to discuss the

issue and in this way hopefully relieve the anxiety.

The rabbi can also act as a "Co-Between" in trying to bring the family and the patient together as I've already stated.[19] This act might again be able to help the patient in terms of the fear of separation.

The fact that a rabbi decides to come and visit a patient on a regular basis will also help the person combat his loneliness. There have been instances where the family has cut the ties with the patient and I have been the only person to see the patient outside of the hospital staff. Reconciliation with the family in these cases was impossible. The patients had only my visits to look forward to.

If the patient has a specific concern, the rabbi must decide whether or not he feels he is capable of dealing with it. By dealing with it, I mean, the rabbi's allowing the patient to ventilate on a subject and encouraging the patient to open up. But that is not enough. Once the issue is out in the open, it must not be left hanging. I am not saying that everything must be resolved at the end of every session. This is impossible to do all of the time. But the patient must know that he will have the opportunity to try to work the issue through -- otherwise it will be too painful for him to constantly deal with topics which will not be resolved and left unattended.

I recall an incident where a patient in telling me about her family would say something critical about her children, then follow it up by saying, "But they have always been kind to me." It reminded me of Mark Antony's speech to the crowd in the Shakespearian play "Julius Caesar",[20] when he continually told them that Brutus was an honourable man. At the end of the speech, it was obvious that Antony did not think

that Brutus was an honourable man. Similarly, after listening to this woman, it became apparent that her children were not kind to her. Somehow, she felt that she had to say this. After working with this woman, she was finally able to admit that she was angry at her children and that she had kept this inside of her too long. We discussed the issue further and finally agreed that she had good reason to be angry. During the interviews, she was allowed to let her anger out instead of keeping it sealed up inside. This relieved a great deal of pressure and she was finally able to work through her anger. For this lady, it proved to be much better to look at her children realistically then make them out to be something they were not and thus suffer the consequences of such denial.

Hospitals often place unrealistic demands on their patients. Mary Vachon[21] stated that offtimes patients need the opportunity to let off steam but feel constricted by the hospital. I agree with her. If the rabbi has built up a relationship with the patient, he might want to encourage him to go ahead and scream and cry. All too often I have met patients who feel as if they have to keep everything inside of them, when what they really want to do is cry and have someone acknowledge their feelings.

The rabbi's job is to deal with the patient in an empathetic and supportive manner. Yet there are occasions where he might not be to provide all the answers. Concerning the issue of the future, some rabbis feel comfortable (as I mentioned in chapter 1[22]) in talking about "Olom Ha Ba", whereas others might not. There might therefore arise the instance where a rabbi cannot give a solid answer but will

have to admit his own limitations. Is he failing the patient? No! He cannot always make the situation better but he must never make it worse. In fact by admitting to his own limitations, this might help bolster the patient's morale and sense of worth, by again impressing upon the patient the fact that he is not alone in his fear and concern.

By allowing the patient to talk, it is not only necessary to listen, but to occasionally interject supportive comments. When a person describes various parts of his life, which he is apt to do, it is important for the rabbi to help that person accentuate the highlights, in order to give him, at least some sense of worth and accomplishment. It might also be necessary to take a moment to discuss the bad times. Perhaps when opened up, they might not appear to be as horrible as was thought. Then again, there may be things which need to be resolved, and still yet, things that are best left untouched.

In all of this, the rabbi must be aware and mindful of the individual whom he is communicating with. He must also be sensitive to their needs and alerted to his own ability to deal with the issues. Again, if he cannot, he might try to get someone who can deal with those issues that he feels that he cannot effectively handle. But even if a rabbi decides to deal with only some topics, his presence is still very important and very much needed.

PART H - WHAT SHOULD THE RABBI NOT DO?

Just as there are things that the rabbi might decide to do, there are also a few things that should not be done. I am suggesting that there are things which could cause more harm than benefit.

I would consider the issue of denial a very major consideration.[23] Some people, as Mary Vachon states, have a need to deny. By taking this away from them, one is liable to strip them of their only means of dealing with the situation.

A rabbi must pay particular attention to the "awareness" of the patient and not attempt to place unrealistic demands upon him. What I am referring to here is "pacing" -- moving with the patient and not pushing him or dragging him. I had a woman who was unable to say the word, "die" but knew what was happening to her. If I had insisted on her using the word, our communication would have been destroyed. Instead we worked very slowly with what we had.[#]

Another thing which I feel is wrong is the idea of offering the patient "false hope". Though it may provide an easy solution for the rabbi, (who can say to the patient "you'll get better") eventually the patient will lose faith in the rabbi who is offering something that the patient knows he cannot attain, namely, health. The patient's confidence might turn to anger and frustration.[24] Feelings of anger and frustration are two things that definitely do not have to be encouraged, there is enough of this around without the rabbi adding even more.

To open up a patient to an issue and leave him hanging without any attempt at resolution could be devasting. The patient is in a tenuous position as it is. He will not be helped by a rabbi complicating the issue with queries that are left unattended. In short, if the rabbi is not prepared to deal with a subject, he should not discuss it.

It has been my experience that once a relationship has been established, patients will look to the rabbi as one in whom they can confide. Patients feeling sufficiently at ease are liable to expose very sordid details pertaining to their lives. The rabbi's job in such a situation, should not be to critize or condemn, or for that matter condone. He is not there to judge but should exercise as much compassion and understanding as he is capable of exhibiting. The rabbi is not with the patient to instill guilt, rather he should provide comfort.

SUMMARY

The patient is dying. The rabbi is there to help. In order to do this, he must be aware of the patient's needs and his own ability to deal with them. Establishing a relationship and being aware of the patient as a total human being (i.e. a person who has fears and needs and is part of a number of possible social systems) are the two necessary components that must be included in the helping process.

The situation as we have seen, does not involve the patient alone, but includes a number of different people, each with their specific roles). The rabbi's role is perhaps the most flexible and by this I mean that he might be the one who has to change his role or adapt it depending on the case and the people involved.

Nevertheless, I feel that the rabbi's part in all of this is very important. There is, within his role, the potential to do a great deal for all concerned. By the same token, it is also his role that is the most uncertain. For this reason, the rabbi must

accept the fact that if he hopes to be of any real assistance he is going to have to work to try to change the perceptions that many people have about his work. This is going to require a great deal of effort and a great deal of time.

FOOTNOTES

1. Repoport, Lydia — "The State of Crisis, Some Theoretical Considerations, article in Crisis Intervention ed. Howard Parad, Family Service Association of America, 1965 p. 24
2. ibid, p. 24
3. Garrett, Annette — Modern Casework, the Contributions of Ego Psychology and Dynamic Casework, ed. Howard Parad, Family Service Association of America, 1958, p. 45
4. Bowlby, John — "Separation Anxiety", International Journal of Psychoanalysis, Vol. 41, 1960 p. 89-113
5. Brockopp, Gene — working paper presented to the Erie County Medical Centre, Buffalo, N.Y. 1968
6. see Chapter One, Section A
7. Rogers, Carl — On Becoming a Person Houghton Mifflin Company, Boston, 1961, p. 38
8. Glaser, Barney G. and Strauss, Anselm L. — Awareness of Dying, Aldine Publishing Co. Chicago, 1965
9. ibid, p. 233
10. Neale, Robert — The Art of Dying: Harper and Row, N.Y., 1973 page 30-35
11. ibid, p. 32
12. Wahl, C. W. — The Fear of Death, article in the Meaning of Death, ed. Herman Feifel McGraw-Hill, N.Y. 1959, p. 23
13. Choron, Jacques — Death and Modern Man; Collier Books, N.Y. 1964, p. 77
14. The Holy Scriptures — Jewish Publication Society, Philadelphia 1966, Genesis 1:24
15. Vachon, Mary — Interview February 5th, 1974 at the Clarke Institute of Psychiatry, Toronto.
16. Neale, Robert — The Art of Dying, p. 34-35
17. see Chapter One, Section A
18. see Chapter Three, Section D

FOOTNOTES (CONTINUED)

19. ibid

20. Shakespeare, William — Julius Caeser, Act 3 Scene 2, The Complete Works of William Shakespear, Oxford University Press, Toronto, 1905, p. 834

21. Vachon, Mary — Interview February 5th, 1974

22. see Chapter One, Section G

23. Vachon, Mary — Interview February 5th, 1974

24. Claser and Strauss — Awareness of Dying, p. 57

represents an interview with a patient whose name cannot be released

= represents an interview with a doctor whose name cannot be released.

BIBLIOGRAPHY

Berne, Eric — Games People Play, New York, Ballantine Books Inc., 1964

Birnbaum, Philip — A Book of Jewish Concepts; New York, Hebrew Publishing Company, 1964

Brammer, Lawrence M. — The Helping Relationship: Process and Skills Englewood Cliffs, New Jersey, Prentice-Hall Inc., 1973

Buckly, Walter — Sociology and Modern Systems Theory; Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1967

Choron, Jacques — Death and Modern Man, New York, Collier Books, 1964

Denburg, Chaim — Code of Hebrew Law - Shulhan Arukh* Montreal, Quebec, Jurisprudence Press, 1954

Donin, Hayim — To Be a Jew; New York, Basic Books Publishing, 1972

Epstein, Isadore — The Babylonian Talmud; translated by I. Epstein London, Soncino Press, 1935-1952

Feifel, Herman — The Meaning of Death; ed. H. Feifel, New York McGraw-Hill Book Company, 1959

Freehof, Solomon B. — Reform Response; Cincinnati, Ohio, Hebrew Union College Press, 1960

Glaser, Barney G. and Strauss, Anselm L. — Awareness of Dying; Chicago, Illinois, Aldine Publishing Co., 1965

Glasser, William — Reality Therapy; New York, Harper and Row, 1965

Goffman, Erving — The Presentation of Self in Everyday Life New York, Doubleday Anchor Books, 1959

Grollman, Earl — Explaining Death to Children; ed. E. Grollman, Boston, Beacon Press, 1967

--- — Talking About Death; Boston, Beacon Press, 1970

--- — Concerning Death: A Practical Guide For The Living; ed. E. Grollman, Boston, Beacon Press, 1974

Harris, Thomas — I'm OK - You're OK; New York, Avon Books, 1973

Hendin, David — Death as a Fact of Life; New York, W. W. Norton and Company Inc., 1973

Holy Scriptures; Philadelphia Jewish Publication Society, 1966

Parad, Howard — Ego Psychology and Dynamic Casework; ed. H. Parad New York, Family Service Association of America, 1958

------- — Crisis Intervention ed. H. Parad, New York Family Service Association of America, 1965

Kavanaugh, Robert — Facing Death; Los Angeles Nash Publishing, 1972

Kubler-Ross, Elisabeth — On Death and Dying; New York MacMillan, 1969

Kutscher, Austin H. — But Not to Lose; ed. A. Kutscher, New York, Frederick Fell Inc., 1969

Lamm, Maurice — The Jewish Way in Death and Mourning: New York Jonathan David Publishers, 1972

Maier, Henry — Three Theories of Child Development ed. H. Maier New York, Harper and Row, 1965

Neale, Robert — The Art of Dying; New York, Harper and Row, 1971

Pearson, L. — Death and Dying; ed. L. Pearson, Cleveland, Ohio, Case Western Reserve University, 1969

Rogers, Carl — On Becoming a Person; Boston, Houghton Mifflin Company, 1961

Schauss, Hayyim — The Lifetime of a Jew; New York, Union of American Hebrew Congregations 1950

Sudnow, David — Passing On; Englewood-Cliffs N.J. Prentice Hall Inc., 1967

Weismann, Avery — On Dying and Denying; New York, Behavioral Publishing Inc., 1972

ARTICLES

Aitken, John — The Gift of Death; A New Outlook on Life, The Globe and Mail Weekend Magazine, Vol. 25 No. 3 and Vol. 25 No. 4, Toronto, Jan. 18/75 Part 1, January 25/75 Part 2

Bowlby, John — Separation Anxiety, International Journal of Psychoanalysis, Vol. 41, 1960

Brockapp, Gene — Working Paper delivered to the staff of the Suicide Prevention and Crisis Intervention Centre of Erie County, Buffalo, New York, 1970

Hackett, Thomas P. and Weisman, Avery D. — The Treatment of the Dying, The Journal of Pastoral Care, Vol. XVIII No. 2, Summer 1964

Harris, Edward G. — The Physician the Clergyman and the Patient in Terminal Illness; The Pennsylvania Medical Journal, June 1951

Hollobon, Joan — Widow to Widow, Toronto Globe and Mail, Toronto, February 1, 1975

Jackson, Edgar N. — Understanding Grief, Pastoral Psychology October 1957

Keen, Sam — The Heroics of Everyday Life: A Theorist of Death Confronts His Own End. Conversation with Ernest Becker. Psychology Today April 1974

Kidorf, Irwin W. — Jewish Tradition and the Freudian Theory of Mourning, The Journal of Religion and Health April, 1963

Knowles, Joseph W. — The Role of the Chaplain in Patient Relationships: Care of the Critically Ill The Journal of Pastoral Care, Summer 1953

Levendel, Lewis — Study of Death is the Study of Everyday Life The Canadian Jewish News, May 10, 1974

Lindemann, Erich — Systematology and Management of Acute Grief American Journal of Psychiatry; No. 101, 1944

Matz, Milton — Judaism and Bereavement, The Journal of Religion and Health, July, 1964

Michaelson, Michael G. — Death as a Friendly Option, New York Times Times Book Review, July 21, 1974

Michaelson, Michael G. — Newsweek Magazine, "Living With the Dying", December 2, 1974

Reeves, Robert B. Jr. — A Study of Terminal Cancer Patients, The Journal of Pastoral Care, Winter, 1960

Rogers, William F. — The Pastor's Work with Grief, Pastoral Psychology, September, 1963

-------- Grief - Erich Lindemann's Contribution to Our Understanding of It (and Ways of Dealing with It), Pastoral Psychology, September, 1963

Shapiro, Ben-Zion — Isaiah Project - (a study of Holy Blossom Congregation - Toronto, Canada) B. Z. Shapiro Executive Consultant, April 24, 1974

Simson, Judith — We're Trying to Learn the Art of Dying, Toronto Daily Star, October 9, 1974