

# *Jewish Medical Ethics and Halacha*

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## From the Editor's Desk

I am pleased to present to our readers a timely, interesting and relevant selection of topics in this current issue.

With the ever increasing use of *in vitro* fertilization and other technological interventions in the formerly natural birth process the issue of paternal identity has become a subject of intense interest and some controversy. Societal attitudes and approaches vary from country to country and have shown dramatic changes over the years. Mordechai Halperin surveys the topic in detail and demonstrates how the newer societal, personal and ethical demands are moving closer to the traditional halakhic approach whereby parental identity is critical.

The major advances in reproductive endocrinology have been of great assistance to observant couples in planning their wedding dates to avoid the stressful occurrence of *chuppah niddah*. Deena Rachel Zimmerman brings to the discussion personal experience as a physician dealing with this issue on a regular basis as well as knowledge of the appropriate halakhic considerations.

The next two articles deal with very current issues which have affected the performance of *brit milah*. There has been an increasing demand on the part of parents for the use of some anesthesia during circumcision, and some parents have turned the procedure over to physicians instead of *mohalim* in order to obtain anesthesia. Avraham Steinberg brings to bear his halakhic knowledge and experience as a pediatric neurologist to survey all aspects of anesthesia in circumcision.

The several widely publicized incidents of babies who have contracted herpes virus infections shortly after being circumcised using *metzitzah b'peh* have reawakened the controversy about the procedure. David Shabtai uses this controversy to elaborate on the entire concept of risk taking in *halakhah*, not merely in the circumcision arena, but in a variety of situations.

At the other end of life the subject of organ transplantation remains as acute as ever with hundreds of Israelis on waiting lists for organs and with the percentage of Israelis willing to donate organs among the lowest in the Western world, in part because of halakhic considerations involving the determination of the moment of death. Some important *poskim* do not accept brain death as valid. Rav Yitschak Shilat reviews the halakhic controversy, and comes down firmly on the side of the *psak* of the Israeli Chief Rabbinate, supporting the validity of brain death.

Finally, syphilis, which seems to have made a significant comeback clinically in the past decade, is reviewed from its medical, halakhic and ethical aspects by Abraham Ofir Shemesh.

I hope you find this issue interesting and stimulating. I encourage you to write us with your comments and to send us your manuscripts.

Prof. Shimon Glick, M.D.  
Editor-in-Chief

# *Donor Anonymity and The Right to Know – Ethics and Jewish Perspectives*

**Mordechai Halperin, M.D.**

**Translated by David Fink, Ph.D.**

## **1. The Halachic Obligation to Preserve the Parent's Identity**

The right to information regarding the identity of one's biological parents is a regularly recurring problem. This touches on a person's right, after growing up, to trace his genetic roots, in effect preventing incest and the possibility of birth defects which might result from the union of close relatives.<sup>1</sup>

Jewish law absolutely prohibits producing children when it is clear that their legal father's identity will remain secret.<sup>2</sup> Thus, for example, a widow or divorcee is prohibited from remarrying within three months of the end of her previous marriage.<sup>3</sup>

This is intended to prevent any uncertainty regarding the biological father of any child which the woman might bear at the beginning of the second marriage.

There are also convincing ethical reasons in support of preserving the identity of the genetic father. Among them are:

- (a) A fundamental human right to trace one's origins.
- (b) The prevention of incest and genetic birth defects which might result from the union of close relatives.

***Jewish law absolutely prohibits producing children when it is clear that their legal father's identity will remain secret***

## **2. The Fundamental Human Right to Trace One's Origins**

In 1984 Swedish legislation established the right of a child born as a result of artificial insemination to learn, on reaching maturity, the identity of his biological father. Swedish law, considered among the most advanced in the Western world, recognizes the unreasonableness of irreversible separation between a person and his biological roots.<sup>4</sup> So this fundamental human right is preserved in Sweden so that any adult person, whether naturally conceived or born of donated sperm, can know his genetic father.

This clear position underlying the Swedish law declares that "neither of these interests [of the adoptive parents and the natural parents] seems strong to deny a person essential knowledge about his own identity should he wish to have it. There can be few personal rights more fundamental than the right to know one's parentage."<sup>5</sup>

4. See *Act (1984:1140) on Insemination; Regulation and General Recommendation* - of 27 March 1987 - of the National Board of Health and Welfare on Insemination.

This legislation was based on the recommendations of a governmental commission which evaluated the rights of newborn children who were conceived by medical intervention. The commission determined in 1983 that there is a clear parallel between the fundamental rights of adopted children and those born of donated sperm.

5. Eekelaar John, *Family Law and Social Policy* (London, F. B. Rothman & Co., 1978), 272-273. (first ed.: 1978; second ed.: June, 1984. Quoted by Pinchas Shifman, *Dinei ha-Mishpacha be-Yisrael* (Jerusalem, Heb. U. Law Fac., Sacher Inst. for Legislation and Comparative Law, 1989; vol. 2, p. 62, note 9; p. 114, note 50.)

1. See Mordechai Halperin, "Preserving Parental Data," *Assia* 65-66 (vol. 17:1-2), Elul 5759, pp. 83-93.

2. *Iggerot Moshe, Even ha-Ezer* I:71 and II:18.

3. *Yevamot* 4:10.

There are negative psycho-social ramifications to not knowing the identity of one's parents. More and more adopted children are expending efforts to trace their biological parents in order to complete their sense of personal identity.<sup>6</sup> One clinical study points to emotional tension observed in adopted children, resulting from the absence of clinical genetic data regarding their biological parents.<sup>7</sup> Other studies also point to medical damage resulting from not knowing one's biological parents.

It seems that even without these studies we would conclude that the essential human need to build an individual identity includes the right to know one's genetic parents even in the absence of any potential medical damage, for in the absence of information identifying one's parents, no one can complete his self identity. So a fundamental human right in enlightened society would be abrogated.

***the essential human need to build an individual identity includes the right to know one's genetic parents***

Thus, new regulations were instituted in England regarding provision of information on donors of sperm, eggs and fetuses, which became valid on 1 July 2004. These regulations differentiate between information received from a donor before April 2005 and that received afterward. Regarding information received from a donor

before April 2005 that is held by the Human Fertilization and Embryology Authority (HFEA): HFEA must provide information on the donor following a request presented by a person born through donation of sperm/egg/fetus, who has reached 18, without providing information that

6. P. Turnpenny, "Introduction", in P. Turnpenny (ed.), *Secrets in the Genes: Adoption, Inheritance and Genetic Disease* (London: British Agencies for Adoption and Fostering, 1995), 1-8.

7. See S. Michie & T. Martteau, "Knowing Too Much or Knowing Too Little: Psychological Questions Raised for the Adoption Process by Genetic Testing", in P. Turnpenny (ed.), *Secrets in the Genes: Adoption, Inheritance and Genetic Disease*, 166-175.

might reveal the identity of the donor. Regarding information received after April 2005, the Authority will also provide, on request, details on the identity of the donor, such as surname and first name of donor; donor's date and place of birth, a physical description of the donor and his last known address.<sup>8</sup>

Claims to the contrary, supporting sperm donor's anonymity despite the damage done to their offspring, generally rely on the donor's right to privacy. The donor's right to privacy may indeed be weighed against the more fundamental right of the offspring to preserve his identity.<sup>9</sup> The offspring's right is, of course, more fundamental.<sup>10</sup> Indeed, the Swedish experience demonstrates that it is possible to establish a set of normative laws which prevents conflict between these two rights: Prior to the donation, the donor is made aware of the offspring's legal rights. His agreement to donate under the framework of the law thus constitutes his willingness to have his identity revealed in the future. The Swedish experiment demonstrates that a set of normative laws can preserve the right of the offspring to identify biological parents without reducing the willingness of the donor to donate, although the donors' socioeconomic profile might indeed be affected.

In the State of Israel, the Aloni Commission at first proposed in its interim report that this universal right should be preserved in Israel as well. Accordingly, any child conceived of donated sperm would have the right, upon attaining maturity, and after receiving appropriate guidance, to learn basic details concerning his biological origins. Further, this right to knowledge would not

8. Human Fertilization and Embryology Authority (Disclosure of Donor Information) Regulations 2004, on the official British legislation site: <http://www.hmso.Government.uk/acts.htm>, date of entry: 16 February 2005, quoted by N. Mei-Ami, "Sperm Donation in Israel", *Jewish Medical Ethics* Vol. V, No. 2 June 2006, pp. 14-25.

9. For a relevant discussion of personal identity and bibliography, see Barbara B. Woodhouse, "Are You My Mother: Conceptualizing Children's Identity Rights in Transracial Adoptions", *Duke J. Gender L. & Policy*. (1995), 107. (<http://www.law.duke.edu/journals/djglp/djgv2a7.htm>)

10. M. Shamgar, The Chief Justice of the Israeli Supreme Court, Case 5942/92, *John Doe vs. Jane Doe et al.* Court Reporter, vol. 84, pt. 3, 1994, pp. 839-846, sect. 7c and the summary in sect. 8.

impose any legal obligations on the donor. This suggestion was indeed more limited than the liberal Swedish approach and called for establishing the right of the offspring to receive unconditionally non-identifying information regarding his biological parents. Receipt of identifying information was to be dependent on the consent of the biological parent.

Acknowledging this right of the offspring requires a registration system encompassing both the identity of genetic parents and the identity of the legal parents who raised the child. The Aloni Commission even indicated that such arrangements are already mandated by legislation in England and in Australia.<sup>11</sup>

After publication of the Aloni Commission's interim report, two gynecologists appeared before the Commission and informed it that the Swedish law led to a significant decrease in sperm donation. They did not provide the Commission with any details regarding the degree of this decrease. Nor did they provide any data regarding changes in the characteristics of the donors or the ramifications of financial compensation paid to the donors. The common claim that granting a future right to receive information regarding the donor's identity would lead to a drastic decrease in the number of potential donors remained unsupported by any documentary evidence.<sup>12</sup>

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In order to clarify the matter in a more definitive manner, I met with Prof. Lars (Lasse) Dencik<sup>13</sup> in Copenhagen in January 1996. Prof. Dencik was involved in the debate and the recommendations prior to the Swedish legislation. According to him, reports disseminated around the world regarding the situation in Sweden were simply incorrect. In fact, there was no decrease in available donors. The one change which did occur involved the donors' socioeconomic profile. Instead of young, poor donors who donated sperm for financial compensation, donors after the passing of the new law the donors were older, financially better off and more responsible because they were not concerned with producing another

offspring who might, upon attaining maturity, track them down. In effect, there was no decrease in the number of donors and there were no new difficulties in finding donors after the passing of the new law.

We are left with the impression that the uncalled for conclusion that Sweden suffered a decrease in sperm donation was disseminated by certain parties wishing to block liberal tendencies which would protect the right of offspring to track down their roots and to maintain the *status quo ante* according to which finding one's genetic father was purposely rendered impossible.

In fact, the strongest reason to maintain the status quo is the operational convenience of the fertility clinics. Strict adherence to the law regarding the preservation of adoption information and the maintenance of an orderly, regulated adoption register would be highly inconvenient for

(mistaken, as the Swedish experience has proven) that the absence of anonymity "will in the majority of cases put an end to sperm donation thereby preventing fertilization in many cases," p. 39 in *Ha-Praqlit*.

11. The Aloni Commission Report, sect. 4.4, p. 25, reprinted in *Asufat Maamarim liqrat ha-Kinnus ha-Beinleumi ha-sheini le-Refuah Etika, ve-Halacha* (Schlesinger Inst., Jerusalem, 1996), p. 152. For the Aloni Commission interim report see *Assia* 65-66 (Elul, 5759), pp. 94-111. For background regarding the Aloni Commission, see *ibid.*, pp. 83-84.

For an international comparison of legislation on Donor Anonymity, see *Third Party Assisted Conception Across Cultures*, E. Blyth and R. Landau eds., Jessica Kingsley Publishers, London, 2004; N. Mei-Ami, Sperm Donation in Israel, *Jewish Medical Ethics* Vol. V, No. 2 June 2006, pp. 14-25.

12. Schiffman, *ibid.* (n. 5), p. 152, note 52; the Chief Justice, Meir Shamgar, "Sugiyot be-Noseh Hafrayya ve-Leidah," *Ha-Praqlit* 39, 21-43, barely agreeing to anonymity only on the basis of an estimation

13. Director of the Program for Comparative Research at the "Centre for Childhood and Family Research" at the Roskilde Universitetscenter, Denmark.

the clinics which, without legislation mandating such a register, operate without the need to keep such records.<sup>14</sup>

Those who wish to deny the offspring's right to knowledge regarding his biological parents claim that adoption cannot be used as a model because in cases of adoption there is greater risk of the offspring's discovering the fact of adoption from his peers even if his parents try to maintain the secret. In such a case the offspring will perceive the fact of adoption as a double betrayal encompassing both his birth parents who appear not to have wanted him and his adoptive parents who hid the facts from him. In medically assisted fertility cases, on the other hand, the chances of maintaining secrecy are much greater and revealing the facts would entail no element of rejection or abandonment.

14. "In recent years social workers and others in the field of mental health have been encouraging openness within non-biological families, unlike the conspiracy of silence and secrecy which was the rule in the past. In the light of experience, primarily in the area of adoption, it has become clear that suppressing information regarding the circumstances of a birth entails a certain denial of the uniqueness of familiar relationships and is liable to adversely effect the child's emotional development. Further, the right of adopted children, upon reaching maturity, to find their biological origins is today recognized. Among other reasons this is because of the fundamental need to complete an independent identity" (from the Interim Report [*Assia* 65-66, pp. 94-111], ch. 2:3). Indeed, "on this matter the interests of the adoptive parents and the natural parents seem to coincide in opposition to those of the adopted person... But neither of these interests seems strong to deny a person essential knowledge about his own identity should he wish to have it. There can be few personal rights more fundamental than the right to know one's parentage." as has already been made clear in Eekelaar John, *Family Law and Social Policy*, London, F. B. Rothman & Co., 1978, 272-273, (2<sup>nd</sup> ed. 1984). A proper register is required in order to guarantee this right. The Israeli Law of Adoption (originating in the year 1960) was among the first in the world to establish the government's obligation to maintain an adoption register, granting the adopted child the right of access to the register upon reaching the age of eighteen. According to Israeli Marriage and Divorce Law, which prohibits sibling incest, the registrar of marriages is also entitled to examine the adoption register in order to verify that the proposed marriage suffers no impediment of incest. This liberal approach of Israeli law, recognizing the right to trace one's biological roots, is accepted today in many enlightened states. The right of the adopted child to trace his roots upon attaining majority was almost unique in Israeli law when first legislated in 1960, as only Scotland and Finland had similar laws at that time (Shifman, *ibid.* note 5). In the course of the years, more western nations have recognized the human right to trace one's roots.

In my opinion, these claims are baseless. These are my reasons:

1. The fundamental human right to know one's biological parents is in no way dependent on the possibility or impossibility of maintaining secrecy. We are speaking about a fundamental human right, which is unconditional, as understood by the Swedish legislature.

2. In modern times it is impossible to hide from a child the fact that he is the product of medically assisted fertilization with donated sperm even if the procedure were conducted in the utmost secrecy. The reason for this is simple: HLA and DNA testing is quite common and shows definitively that the offspring is the product of donated sperm.<sup>15</sup> Discovery of this fact after it had been hidden for many years would certainly not contribute to a person's mental health.

It is similarly claimed that after more than forty years of experience in sperm donation there is no verifiable evidence that offspring have any emotional need to know who their biological parents are despite clear indications that adopted children do have such a need.

This claim too, which is based on the absence of evidence, cannot subvert the fundamental human right to know who one's biological parents are. Remember too that forty years ago similar claims were heard in opposing granting adopted children this right. Then too "there was no verifiable evidence that children have a need to know." Only in the course of time has this need become apparent, as is codified in Israeli law, one

***the official  
United Nations  
"Convention on  
the Rights of the  
Child"  
recognized the  
child's rights to  
maintain its  
identity and  
familial lineage***

15. Such testing is becoming more and more common for various medical purposes. With the completion of the Human Genome Project, genome mapping will almost surely become routine. See M. Halperin, Human Genome Mapping: a Jewish Perspective, *Jewish Medical Ethics III*, 2:30-33 (1998).

of the most advanced in the Western world, and as has recently been legislated in other liberal countries.

The fundamental human right to know who one's biological parents are was acknowledged in 1989 in the official United Nations "Convention on the Rights of the Child."<sup>16</sup> This Convention recognized the child's rights to maintain its identity and familial lineage. It follows that the change accepted by the majority of the Aloni Commission<sup>17</sup> does not accord with the International Convention of 1989.

The will of a human minor to know his/her origin "in order to maintain its human, familial and property rights" was recognized as a fundamental right by the Supreme Court as well in 1994. The Chief Justice of the Supreme Court of Israel, M. Shamgar, expressed the majority view of the Court:

"Minor enjoys the right to human dignity. Among other things, he is privileged, for the sake of maintaining personal human dignity and for the sake of guaranteeing his legal rights according to his personal law and the laws of property rights, to reject categorization as children-without-known-fathers. Rather, he may demand to know who his father is... Further, proper regard to the benefit of the child is one expression of human dignity....

The minor's objection to anonymity is reasonable and accepted. There are those who claim that man's superiority over animals consists, among other things, in man's knowledge of his origin. This means that the right to know one's immediate origins is part of our charge in guaranteeing human dignity.

...In balancing these rights, the minor's right prevails as he is liable to remain entirely devoid of the right to dignity and benefit and to be seriously damaged in his human personal and property

16. See *United Nation Convention on the Rights of the Child*, art. 8, Nov. 20, 1989, I.L.M. 1448, 1456.

17. Report of the Aloni Commission, ch. 4, Registration.

rights if someone else's right "not to be known" is allowed to prevent or even prohibit a reasonable decision by the court of jurisdiction which is responsible for balancing between the benefit of the plaintiff and that of the minor."<sup>18</sup>

### 3. Preventing Incest and Congenital Defects resulting from the Union of Close Relatives

The Aloni Commission also considered the possibility of using a register in order to prevent incest. From a biological point of view there is no doubt that the offspring's genetic characteristics are inherited from its biological parents. Similarly, it is known that the union of biological siblings greatly increases the incidence of serious birth defects in their offspring. Such offspring are "highly exposed to illness and death".<sup>19</sup> Although our concern here is with marriage of paternal siblings with no maternal relationship and although the risk of severe birth defects is smaller in such cases than in full siblings, genetic calculations show that the risk is still rather high. This fact as well supports keeping a record of the genetic father in order to avoid incest and the union of genetic siblings.

Some people feared that allowing the civil registry office full access to a person's data, as is the case with adopted children seeking a marriage license, might adversely and unnecessarily effect the fundamental right to privacy. Therefore, as a compromise, the Aloni Commission agreed in its interim report to limit the right to access so as not to adversely effect the principle of privacy, while simultaneously preventing incest. The solution agreed upon in the Commission's report included the right of access to computerized information which would cross match the data of couples

18. Case 5942/92, *John Doe vs. Jane Doe et al.* Court Reporter, vol. 84, pt. 3, 1994, pp. 839-846, sect. 7c and the summary in sect. 8.

19. 17-38% mental retardation, 37-69% congenital defects, 10-23% neonatal death. See A. Pinhas-Hamiel and B. Richman, "Incest -- The Sin of the Fathers upon the Children," *Ha-Refuah* 121 (Oct., 1991), pp. 252-253.

seeking a marriage license and either verify or reject any genetic relationship. The computerized report would not provide any additional information in cases where there is no genetic impediment to marriage.

In order to avoid stigmatizing children born as a result of medical fertilization, the interim report agreed to include children not born through medical fertilization in the register as well. The central register, according to this proposal, would be intended to identify any and all cases of inappropriate genetic correlation between candidates for marriage.

After publication of the interim report, the Aloni Commission heard further opposition to maintaining the child's right of determining, upon attaining majority, his biological origin. Some claimed that the probability of incestuous marriage as a result of artificial insemination is no greater than the existing risk of incestuous marriage in the general population, where adulterous unions could have the same result. No factual support could be brought to support this claim.<sup>20</sup> Indeed, even according to this claim, the risk of incestuous marriage must increase. Further, this increase is

20. Analysis of Israeli data indicates a significant likelihood of random mating between genetic siblings. Assuming 100 decedents from a single sperm donor (the number is higher in some fertility clinics), the chance that siblings will meet is very high. This takes into account the fact that every young person in his or her 20s meets thousands of other youths from the same age group. Therefore, in a small country like Israel the chance of meeting a genetic sibling is real. It is however difficult to estimate the probability that a romantic union will result from such meetings because we have no established data regarding the influence of genetic relationship upon romantic attraction between siblings who did not grow up in the same family. In all likelihood, the chances of incest are not small. Therefore, we should reject statistical calculations which do not take these data into account as well as calculations of the likelihood of sibling meeting in other, larger countries.

A simple calculation demonstrates the high probability of random meeting of genetic siblings in Israel: A sperm donor can produce 100 offspring in a situation where there is no overall control, as in Israel. Assuming that the population of young people between the ages of 16 and 26 is around 500,000 (among whom the 100 offspring of the single donor are distributed), it follows that the in average one such offspring will be found in each group of 100/500,000. This means that one offspring of the donor is to be found in each random group of 5,000 young people. If we assume that an average young person meets in this period of his life around 5,000 young people of the opposite sex, the probability of random meeting with a biological sibling is almost 100%.

not due to personal, uncontrollable factors but rather to medical technology which can be easily monitored to prevent any breach. It seems that this claim must be rejected in the face of the offspring's right to seek its roots and society's obligation to prevent, as far as possible, incestuous marriage and preventable birth defects.

Some respondents claimed that even in the face of risk of genetic disease resulting from the relatedness of the candidates for marriage, given expected technological advances the couple can choose to undergo genetic screening,<sup>21</sup> thereby eliminating the risk of incest and genetic disease. In fact, it is clear that as long as such screening is not obligatory, most of the population will choose not to be tested. Thus the possibility of screening cannot be relied upon to prevent incest. It follows that this claim too does not justify a rejection of the register which is intended to prevent medical problems arising from the union of relatives.

Others claimed that we can significantly reduce the risk of incest by limiting the number of pregnancies which a single sperm donor can effectuate. Such a limitation would act to eliminate "professional" sperm donors.<sup>22</sup> This claim also must be rejected because, among other reasons, such limitation cannot be enforced without a complete central register such as exists in Great Britain. Today there already exist guidelines which limit the number of donations a single sperm donor may make. But professional conventions in Israel have shown that such guidelines are not followed and cannot be enforced.

Still others were concerned about the "inevitable" possibility of error in the register or in the computerized routing of the data. They were further concerned about the possibility of illicit hacking of the computerized data base.<sup>23</sup>

In my opinion, these claims cannot alter the Commission's recommendation to preserve parental data because there already exist today

21. The Report of the Aloni Commission, *ibid.* sect. 4.7.

22. The Report of the Aloni Commission, *ibid.*

23. The Report of the Aloni Commission, *ibid.* sect. 4.8.

extremely sensitive data bases where any leaking would constitute a danger to national security or national economy. Nonetheless, none of these data bases has experienced any leakage. Today we have very effective technological solutions to prevent the loss of sensitive data. There is every reason to assume that similar solutions will be effective for the parental data base.

We can also overcome, without causing irreversible damage, the claim that errors might be made.

It is therefore clear that there is no real basis for the opinion that the damage which might result from operating a central register would exceed the benefit which would accrue in protecting the offspring's right to knowledge. Such an opinion is not based on facts or real data, but rather on subjective speculation and irrational fears.

***the absence of a supervised registry system recording genetic parents conflicts with the values of an enlightened society, the rights of the individual and the benefit of the offspring***

The natural conclusion is that both on the basis of the fundamental human right to trace one's genetic origins and on the basis of public health policy intended to prevent congenital birth defects resulting from the union of family members:

a. The right of the offspring produced as a result of sperm donation must, upon attaining maturity, have the right to know his genetic parents. This right is to be preserved through the registry system described above.

b. The data relating to the genetic identity of the sperm donor must be held in a secure system in order to enable the offspring to realize his right to know who his father is and to identify his genetic roots. This will prevent incest as well.

#### 4. Summary

It would not be wrong to say that a uniform registry system for sperm donors and their offspring can in effect solve the two problems and enable realization of the offspring's right to find his biological roots<sup>24</sup> regardless of which parent donated the reproductive cell.

It follows that the absence of a supervised registry system recording genetic parents conflicts with the values of an enlightened society, the rights of the individual and the benefit of the offspring.

It would seem that within a few years we will look back in amazement to this period when the fundamental rights of offspring are infringed.<sup>25</sup> Modern legislatures and legal systems must guard the fundamental human rights including those elements which touch on the individual's identity. This surely includes the right of every person to know his parents and to fully grasp his identity.

24. Discussion of the a parent's right to trace his or her children (especially an only child) is beyond the scope of this article. The parent's rights ought to be addressed separately.

25 See: Eric Blyth, Donor anonymity and secrecy versus openness concerning the genetic origins of the offspring: international perspectives, *Jewish Medical Ethics* Vol. V, No. 2 June 2006, pp. 4-13.

# *Hormonal Intervention for the Prevention of Chuppah Niddah*

Deena Rachel Zimmerman, M.D.

Although the Rambam (Hilchot Ishut 10:6) indicates that a wedding that takes place when the wife is *niddah* is not valid, this is not the accepted opinion in halacha (Shulchan Aruch E.H. 61:2) Nevertheless, having a wedding when the wife is *niddah* is something that most couples try to avoid as 1) it requires minor changes in the ceremony that indicate that the wife is *niddah*<sup>1</sup> 2) physical contact is forbidden at this point and 3) the couple will not be allowed to be alone unchaperoned until such time as the wife immerses in the mikveh. In recent years, medical intervention has been used to prevent this phenomenon. It can be used either to change the date of menses if the wedding inadvertently comes out at the wrong time of the month or it can be used to prevent changes in the cycle. The second use, or relying on hormonal manipulation and thus not scheduling the date according to the natural menstrual cycle is becoming more and more common<sup>2</sup>. The wisdom of this phenomenon needs to be carefully examined.

## **Medical Background**

Menstruation is due to an orderly buildup of the uterine lining orchestrated by hormones from

1. While efforts are made to keep this as private as possible with the minimum of people knowing, it still can be somewhat embarrassing to the bride and groom.
2. In a recent book on hilchot niddah [Shaare Orah by Rav Sholomo Levi], it stated that since most women today use the pill to regulate their cycle prior to the wedding, there was no longer the need to plan the wedding date around the brides menstrual cycle.

the pituitary gland. At first, a hormone known as FSH (follicle stimulating hormone) stimulates the ovaries to build follicles containing ova (eggs). Later in the cycle (about day 14 in a classic 28 day cycle but it can vary markedly between women) a surge in a second hormone LH (lutening hormone) causes the egg of one of these follicles to burst out of the ovary in a process known as ovulation. The egg is swept up by the fallopian tubes and makes its way over a number of days to the uterus. In the meantime, the cells surrounding this follicle (now known as the corpus luteum or yellow body) secrete progesterone. This leads to a buildup of the uterine lining in anticipation of the implantation of a pregnancy. In the absence of fertilization, after approximately 14 days the ovarian lining is shed. This shedding is known as menstruation. This natural process can be overridden by external hormones. This type of manipulation is what is done

when pills are given to prevent *chuppah niddah*.

There are two categories of pills that are used to change the natural menstrual cycle for the purpose of preventing *chuppah niddah*. One is progesterone only and the other is one of a number of combinations of estrogen and progesterone.

## **Progesterone only**

The common drugs used are norethisterone acetate (Primolut-Nor) or medroxy-progesterone acetate (Aragest, Provera). As progesterone helps maintain the uterine lining, giving external

progesterone starting at least 5 days prior to the anticipated date of the next period will most likely succeed in delaying the onset of menses. Thus, if the woman has a fairly predictable menstrual period and what is needed is to just push off the menses by a few days progesterone only may be used. After the first episode of intercourse, the hormone is stopped leading to a withdrawal bleeding after about 2-4 days. This bleeding is likely to be heavier than usual. In the absence of pregnancy, the uterine lining is meant to shed; thus with prolonged use of progesterone (more than about 10 days) there is likely to be breakthrough bleeding. An alternate approach when longer delaying of the cycle is needed and it is a few months prior to the wedding is to gradually delay menses over a number of cycles.

### Combination pills

The combination pills were designed primarily for use as contraceptives. By exposure to an artificially high level of estrogen, the pituitary is fooled into thinking that the woman is pregnant and the FSH remains low. There is thus no ovulation and pregnancy cannot result. The progesterone in the pill leads to some build up of the uterine lining (although often less than in a natural cycle). When the pills are stopped, the uterine lining is shed in what is known as withdrawal bleeding. This generally occurs 2-4 days after taking the last pill.

The difference between the pills is slightly different formulations both in the type of estrogen or progesterone and in the quantity of each. Combination pills are generally categorized by the amount of estrogen they contain. Those containing 15 mcg (such as Minesse) are known as very low dose, 20 mcg (Feminet, Harmonet, Mercilon), as low dose, 30 mcg (Gynera, Microdiol), Microgynon, Minulet, Nordette, Yasmin) as medium dose (Ortho-cyclen has 35 mcg) and 50 mg as high dose (This is no longer available in Israel). The lower the estrogen, the more likely the breakthrough bleeding. This is an important point: when chosen for contraception (longer term use) the medical

tendency is to choose the lowest dose estrogen possible in the hopes of having the fewest side effects. When being used for preventing *chuppah niddah* (short term use without too many cycles to make adjustments) a medium dose should probably be the place to start.

As the combination pills completely override the natural cycle, one can completely change the time that a woman is going to be *niddah*. One way to use this to prevent *chuppah niddah* is for a woman to remain on this pill until after *beilat mitzvah* (first intercourse). She then stops taking the pill and has a withdrawal bleed within 2-4 days. If the pill is started a few months prior to the wedding this can also be used to change the time that she expects her period.

### Considerations in the decision to medically intervene to prevent *chuppah niddah*

When the wedding date has already been set at what will clearly be the wrong time of the month, or a woman's cycle has changed and now will clearly have a *chuppah niddah*, there is little debate about the use of hormonal intervention to prevent this if possible. There is a growing trend, however, to encourage question the prophylactic use of hormones for women with regular cycles or not to take the natural cycle into account when setting the wedding date. In these cases, a number of points should be taken into consideration.

#### 1. Risk of the pill

An underlying medical principle is "first of all do not harm." In the use of any medication, there is always the possibility of unwanted side effects. For oral contraceptives, there are a number of severe possible

***For oral contraceptives, there are a number of severe possible complications such as heart attack, stroke and pulmonary embolism***

complications such as heart attack,<sup>3</sup> stroke<sup>4</sup> and pulmonary embolism<sup>5</sup>. While these are rare, they do happen. These complications are less common when progesterone alone is used but still can happen. When discussing the use of hormones as a contraceptive method, it is generally pointed out that these are side effects of pregnancy as well and in fact the incidence during pregnancy is greater than that from hormonal contraceptive usage. However, we are talking about a bride who is not planning to prevent pregnancy at this point and thus this is not a justification. If this particular bride is the one case, we have created an unnecessary tragedy.

Many women have less serious but nonetheless unpleasant reactions, nausea, vomiting, emotional changes such as irritability or depression and weight gain. The last two in particular may be just what a woman does not want right before her wedding. The woman for whom the possibility of not using hormones exists should be fully aware of these possibilities as she makes an informed choice as to what to do.

***it should be remembered that breakthrough bleeding occurs 10-30% the time***

A particular point should be kept in mind for women getting remarried. Estrogen is known to decrease libido and lead to dry vaginal lining that can make intercourse

uncomfortable. While a woman who is getting married for the first time may not realize this,

3. Twice the risk of non-users.  
Khader YS Riic J John L Abueit O. Oral contraceptives use and the risk of myocardial infarction: a meta-analysis. *Contraception* 2003 Jul;68(1):11-17.
4. Two-five times the incidence of non users.  
Tanis BC Rosendall FR. Venous and arterial thrombosis during oral contraceptive use: risks and risk factors. *Semin Vasc Med* 2003 Feb;3(1):69-84.  
The risk for a 20 year old woman who suffers from migraines is 10/100,000 and for one who is 40 it is 100/100,000  
The Contraception Report Volume 14 No 1 June 2003 p 9
5. The risk is 1.72/100,000.  
Hedenmlm K Samuelson D Spigset O. Pulmonary embolism associated with combined oral contraceptives: reporting incidences and potential risk factors for a fatal outcome. *Acta Obstet Gynecol Scand* 2004 Jun;83(6):576-85.

women with previous marital experience may be acutely aware of the difference and should be counseled about this effect as well.

## **2. Efficacy in preventing *chuppah niddah***

In making the decision to use hormonal manipulation of the menstrual cycle, it should be remembered that breakthrough bleeding occurs 10-30% the time. This more likely the first cycle or two that the pill is used but can persist longer.

## **3. Time left until the wedding**

It is very important to remember that individual women may react differently than expected. Thus the fact that a particular pill is reported to cause minimal breakthrough bleeding, it still may do so for an individual woman. Sometimes, changing the brand (and thus composition) will solve the problem. Sometimes, trials of a number of different formulations are needed. There is no way to know what will happen before one tries. Thus it is often best to stick to the natural cycle when ever possible.

## **When should the decision be made?**

A physician should be approached for advice as soon as possible after engagement. A complete history should be taken to assure that there are no historical factors (previous history of blood clots, current liver disease for example) that contraindicate the use of estrogen or progesterone. It is also important to observe the body habitus of the woman as heavy women have a higher incidence of breakthrough bleeding (due to the natural estrogen secreted by fat cells) and this may influence the pill chosen. Furthermore, questions should be asked if in the past stressful events (trips etc) have caused changes in her cycle. A baseline blood pressure should be taken as hypertension is a relative contraindication for oral contraceptive pill (OCP) use. This should be repeated after a month of use to see if the OCP cause a significant BP elevation which might put her at greater risk of complications.

As breakthrough bleeding is a common occurrence, especially with the first cycle of use, it is best to start at least 3 months in advance to allow the body to adjust to the new hormonal milieu and allow for changes the next cycle in case the problem does not resolve. The fact that we do not know how a particular woman will react to the pill is yet another reason, when hormonal manipulation is chosen, it is so important to start the process EARLY to allow time for manipulation if needed.

### Summary of recommendations:

A woman with a predictable cycle who can schedule her wedding on about the third week of the cycle (late enough to assure that she will be able to finish the required seven “clean” days but prior to the earliest days that she generally sees her period) is best off NOT using hormones to change anything. If there is a change in her regular cycle then she should reconsult the physician to see if hormones may be needed at that point to delay a period at an unexpected time. Setting the wedding

date based on the natural cycle without the need for medicinal intervention should be encouraged as much as possible.

***it is best to start at least 3 months in advance to allow the body to adjust to the new hormonal milieu***

A woman with a menstrual cycle that can vary as much as week may need OCP to help assure that she does not have a *chuppat niddah*. In this case, the intervention should be started at least 3 months in advance to allow the body to adjust to the hormones being given and for changes in formulation if needed.

If a woman consults the physician after the date has been set, and it turns out that the date will most likely be a *chuppat niddah*, or for whom there are other reasons the wedding has to be scheduled for an inappropriate time, she should be given OCP to prevent *chuppat niddah* unless clearly contraindicated. The further in advance that the therapy can be started the better, to allow for gradual rather than sudden changes.

# *Anesthesia in Circumcision – Medical and Halachic Consideration*

Avraham Steinberg, M.D.

## **I. Medical Background**

### **History**

Historically, circumcision has always been performed on infants without any anesthesia. This is true both with respect to halachic Jewish circumcision and to surgical removal of the foreskin, as performed in many parts of the world.<sup>1</sup> This continued to be the case even after anesthesia was developed and used extensively in various medical procedures, including surgery and childbirth.

There were several assumptions underlying this approach:

The assumption that newborns do not feel pain to any significant sense as do grownups.

The assumption that surgical removal of the foreskin is done quickly, with little associated pain.

The assumption that newborns quickly forget the sensation of pain, leaving no emotional problems.

The assumption that no procedure should be undertaken that might endanger the infant, since the risk of circumcision itself is very low.

### **The Situation at the End of the Twentieth Century**

This period saw some changes, in light of certain developments:

1. Medical science came to recognize and the public became aware, that even infants suffer from

pain and have a negative experience as a result of pain.<sup>2</sup>

This assumption, that even newborns suffer from pain, was proven in a number of ways: studying babies' behavior (face and eye movement, body movement, etc.) while subjecting them to a painful stimulus; timing the length of their crying and studying the nature of their crying; measuring the levels of various substances that the body secretes as a reaction to pain.<sup>3</sup>

2. The development of effective and safe palliation and anesthesia, which permit reducing and/or avoiding pain, even in infants.

In light of these developments the American Academy of Pediatrics recommended anesthesia in performing painful procedures in infants.<sup>4</sup> In addition there were suggestions, requests, and recommendations regarding pain reduction for the newborn during circumcision.<sup>5</sup>

***Historically,  
circumcision has  
always been  
performed on  
infants without  
any anesthesia***

Several specific suggestions were made to reduce pain during circumcision:

**Local injection of 0.5-1 ml/kg of the anesthetic lidocaine (1%) at the base of the penis at 10 and 2**

1. See the article on circumcision in the author's *Encyclopedia of Medicine and Halacha* and Wiswell TE, *N Engl J Med* 336:1244, 1997.

2. Anand KJS & Hickey PR, *N Engl J Med* 317:1321, 1987; Butler NC, *Bioethics* 3:181, 1989; American Academy of Pediatrics, *Pediatrics* 103:686, 1999; Maxwell LG and Yaster M, *Arch Pediatr Adolesc Med* 153(5), May 1999  
3. Owens ME, *Pain* 20:213, 1984; Attia J, et al, *Anesthesiology* 67:A532, 1987; Weatherstone KB, et al, *Pediatrics* 92:710, 1993  
4. Poland RL, et al, *Pediatrics* 80:446, 1987  
5. American Academy of Pediatrics, loc. cit.

**o'clock.**<sup>6</sup> This method was first suggested in 1978.<sup>7</sup> Its advantages: good, complete anesthesia in 50-70% of the cases.<sup>8</sup>

Disadvantages of this method: significant pain in administering the injection at a particularly sensitive location;<sup>9</sup> the effect attenuates quickly, leaving discomfort after the circumcision; possible complications, such as hemorrhage, necrosis, and absorption of lidocaine into the circulatory system, which can cause irregularities in heart rhythm, hypotension, convulsions, and auditory disorders; and the need of a physician to perform the circumcision.

Weighing the benefits and the potential dangers in using lidocaine, the American Academy of Pediatrics refrained from recommending it in performing circumcisions on infants.<sup>10</sup> At a later date, however, the Academy formulated a policy mentioning only some of the disadvantages without rejecting the use of lidocaine.<sup>11</sup> Other researchers dissociated themselves from the use of lidocaine in circumcision for other reasons.<sup>12</sup>

**Injection of 1 ml of lidocaine (1%) in a ring around the circumference of the middle of the penis or the base of the foreskin for local anesthesia.** In this procedure the same concentration of lidocaine is used as above.<sup>13</sup>

Advantage of this procedure: better anesthesia than any other local method. Disadvantages: local pain due to the injection itself. According to the few reports available regarding this method, no

complications were observed.<sup>14</sup> In theory the same complications resulting from injection of lidocaine at the base of the penis are likely to arise in this method as well.

**Spreading a cream with various concentrations of lidocaine locally on the area of the foreskin about an hour before the circumcision.** Some practitioners used a 4% concentration of lidocaine in an acidic cream.<sup>15</sup> The efficacy of the method is not high. Others used a 30% concentration of lidocaine<sup>16</sup> with better results.

Still others used EMLA cream (i.e., eutectic mixture of local anesthetics)<sup>17</sup> containing 2.5% lidocaine and 2.5% prilocaine with good results.<sup>18</sup> This method requires topical application of 1-2 gr of the EMLA cream about 1-1.5 hours before the circumcision.

Advantages of this method: good anesthesia in many patients; complete absence of side effects because the active ingredients are not absorbed into the blood stream as long as no more than 2 gr are applied;<sup>19</sup> the anesthetic effect lasts for several hours after application, thus reducing discomfort even after the procedure; ease of application; appropriate for use by ritual *mohalim* who are not physicians. Disadvantages: lower success rate than local injection of anesthetic; waiting time between application and the circumcision procedure.

**Administering sucrose with a vinyl nipple.** In this method a nipple is dipped into 50% solution of sucrose. A gauze pad dipped in the sucrose is also inserted into the nipple. The circumcision procedure is begun around two minutes after the infant has begun to suck on the nipple with the sugar solution. During the entire procedure, the nipple is held in place in the baby's mouth. From

6. DPNB = dorsal penile nerve block

7. Kirya C & Werthmann MW, J Pediatr 92:998, 1978

8. Taddio A, et al, N Engl J Med 336:1197, 1997; Taddio A, et al, Arch Pediatr Adolesc Med 154:620, 2000

9. Weatherstone KB, et al, loc. cit. ; Taddio A, et al, loc. cit.

10. American Academy of Pediatrics, Pediatrics 84:388, 1989

11. American Academy of Pediatrics, Pediatrics 103:686, 1999

12. Schoen EJ, N Engl J Med 322:1308, 1990; Weatherstone KB, et al, loc. cit.

13. Lander J, et al, JAMA 278:2157, 1997

14. Masciello AL, Obstet Gynecol 75:834, 1990 American Academy of Pediatrics, Pediatrics 103:686, 1999

15. Mudge D & Youngner JB, J Nurse Midwifery 34:335, 1989

16. Weatherstone KB, et al, loc. cit.

17. EMLA = Eutectic Mixture of Local Anesthetics

18. Benini F, et al, JAMA 271:274, 1994; Taddio A, et al, loc. cit.; Wiswell, loc. cit.

19. American Academy of Pediatrics, Pediatrics 103:686, 1999. When, however, some of the cream remains on the site of the circumcision, it is likely to be absorbed. In such cases, hemolysis has been observed in babies with G6PD deficiency.

time to time, the gauze pad is dipped again in the sugar solution and returned to the nipple.<sup>20</sup>

Advantages of the method: high efficacy in preventing pain throughout the procedure; ease of application; complete absence of complications; no waiting time between the application and the procedure; appropriate for use by ritual *mohalim* who are not physicians. Disadvantages: the efficacy of the method is somewhat less than that of locally injection anesthesia.

**Administering palliative medication.** In this method 15 mg/kg of acetaminophen (paracetamol)<sup>21</sup> are administered orally every 6 hours beginning two hours before the circumcision and continuing 24 hours after it.<sup>22</sup>

Advantages of this method: from the medical point of view, the medication is safe even for newborns, without any side effects; the medicine is in general palliative for mild to moderate pain in small children. Disadvantages: no positive indications have been found that pain levels during the procedure and immediately after it are affected. However, there is a positive effect beginning a few hours after the circumcision.<sup>23</sup> These disadvantages can probably be overcome by two changes: increasing the dosage or by administering the medicine more frequently; but this has not been investigated, and there are no data regarding the efficacy or safety of these changes.

**Combining methods.** Some have demonstrated that no one method is sufficient. They recommend combining lidocaine injections, EMLA cream, acetaminophen and a sucrose nipple. This combination has been found to be more effective in reducing pain than any individual method.<sup>24</sup>

*it is now possible to perform the procedure without any sensation at all or with greatly reduced levels of pain*

## II. Halachic Background

### Historical Background

All agree that circumcision as a Jewish ritual was traditionally performed without any form of anesthesia. This is true both for the circumcision of eight-day-old infants and adults, as in the case of converts or Jews who were not circumcised as infants. It is also clear that since the introduction of various methods of anesthesia, it is now possible to perform the procedure without any sensation at all or with greatly reduced levels of pain. Today, the use of anesthesia is quite common in adult circumcisions. There are places where general anesthesia is used; and there are places where general anesthesia is used only for children, local anesthesia being reserved for adults. In the world of medicine the first suggestions for using local anesthesia in the circumcision of infants were made in the first two decades of the twentieth century.<sup>25</sup>

First, let us consider the position of the *posekim* regarding the use of anesthesia in the circumcision of an adult.

The earliest discussion of this question appeared in *Tel Talpiot* (1896).<sup>26</sup> There rabbis disagreed on the permissibility of using chloroform as a general anesthetic in the circumcision of an adult Jew or convert. There was further discussion regarding general anesthesia in the circumcision of converts in *Ha-Me'assef* (1913-14).<sup>27</sup>

Rabbi Meir Arik wrote the first systematic responsum dealing with the question<sup>28</sup> of local anesthesia in the area of the circumcision for a thirty-year-old patient.

The question of anesthetizing an eight-day-old infant for circumcision was first raised recently.

Summary of the opinions of the *posekim*:

20. Blass EM & Hoffmeyer LB, *Pediatrics* 87:215, 1991; Smith BA, et al, *Dev Psychol* 26:731, 1990; Herschel M, et al, *Arch Pediatr Adolesc Med* 152:279, 1998

21. acetaminophen

22. Howard CR, et al, *Pediatrics* 93:641, 1994

23. Howard CR, loc. cit.

24. Taddio A, et al, *Arch Pediatr Adolesc Med* 154:620, 2000

25. See the medical background above.

26. *Tel Talpiot*, vol. 4, 5756, pp. 61 ff. The positions discussed there are summarized in Reichman E and Rosner F, *Tradition* 34(3):6, 2000.

27. *Ha-Me'assef* 18(1-2); 19(1).

28. *Resp. Imrei Yosher* 2:140, sect.3.

Some *poskim* discuss anesthesia only in connection the circumcision of newborns. Others add adults to the discussion. Some discuss only general anesthesia. Others discuss local anesthesia. Some discuss both.

In short, those who prohibit anesthesia in adults certainly prohibit it in newborns. But some of those who prohibit it in newborns permit it in adults. Similarly, those who prohibit local anesthesia certainly prohibit general anesthesia. But some of those who prohibit general anesthesia permit local anesthesia.

Some prohibit both general and local anesthesia, both in newborns and in adults.<sup>29</sup>

**Anesthesia constitutes an innovation, a change with regard to earlier practice** Some prohibit both general and local anesthesia, both in eight-day-old babies and in adults. But they allow anesthesia in adults in certain circumstances, for example in older people, in cases where the procedure is more complicated and would cause great pain, or in correcting awkward presentations where the surgery requires more time than ordinary circumcisions and would therefore cause great suffering. In such cases, they see no problem with local anesthesia.<sup>30</sup> Similarly in the case of an adult who, through no fault of his own, was not previously circumcised as, for example, in the case of man whose older brothers had died because of circumcision.<sup>31</sup>

One authority prohibits all forms of anesthesia, even local anesthesia, in newborns up to one year

old. But he permits local anesthesia in adults or in babies over one year of age.<sup>32</sup>

Other authorities prohibit both general and local anesthesia in newborns, but are in doubt about the permissibility of anesthesia for adults.<sup>33</sup>

Some *posekim* prohibit all forms of anesthesia, even local anesthesia in the routine circumcision of a newborn. These *posekim* did not express an opinion regarding adults.<sup>34</sup>

There is an opinion prohibiting general anesthesia in adults, without expressing an opinion regarding local anesthesia.<sup>35</sup>

Some prohibit general anesthesia both in adults and babies, but permit local anesthesia in both.<sup>36</sup>

Others permit anesthesia in adults, even general anesthesia, without expressing an opinion with regard to newborns.<sup>37</sup>

Still others permit local anesthesia for babies as long as it entails no threat to the baby's life.<sup>38</sup>

32. R. M. Bransdorfer in the addenda to the Hebrew version (*ibid.*).

33. R. M. Eliyahu, addenda to the Hebrew version (*ibid.*).

34. *Resp. Tsits Eli'ezer* 20:73; R. Y.Sh. Eliashiv and R. Moshe Halberstam in the addenda to the Hebrew version (*ibid.*). Regarding R. Eliashiv's position, see note 38 *infra*.

35. *Koret ha-Brit, Nahal Brit* 261:4.

36. *Resp. Seridei Eish* 3:97; *Resp. Teshuvot ve-Hanhagot* 1:490, 2:510 and 3:308. See *Sha'arei Halacha u-Minhag* 3:97, which prefers local or epidural anesthesia rather than general anesthesia in an adult so that he will be conscious and aware during the procedure.

37. *Resp. Maharsham* 6:85; *Resp. Da'at Kohen* 194; R. Y. Weingarten in *Yarhon Ohel Mo'ed*, Fasc. 1:7; *Resp. Ma'archei Lev*, Y.D. 53; *Resp. Kappei Aharon* 19 (who wrote that this was the practice in Munkasz); *Resp. Helkat Yo'ev, Ohel Mo'ed* 1:7; *Resp. Pitchei She'arim* 4:5; *Resp. Rabaz* 125; *Resp. Mi-Ma'amakim* 2:15; *Resp. Hemdat Tsevi* 4:48; O. Yosef in *No'am* 12, pp. 1 ff.; *Resp. Yabbia Omer* 5, Y.D. 22, according to which R. Yosef acted thusly with the approval of the Rabbinic Court in the year 5723. R. Y.Sh. Eliashiv has also told me that he approves of general anesthesia in adults.

38. *Resp. Iggerot Moshe* Y.D. 4:40, sect. 2; R. Sh.Z. Auerbach and R. Y.Sh. Eliashiv quoted in *Nishmat Avraham* 5:260, sect. 1 (end). See, however, *Resp. Iggerot Moshe, ibid.*, which quotes a letter by R. Sh.Z. Auerbach to R. Sh. Frankel, according to which no changes should be made in the procedure of circumcision even if there is no halachic problem involved. This contradicts his opinion as quoted in *Nishmat Avraham*. Further, I have met with R. Eliashiv, who told me that although he objects to anesthetizing an infant by injection when he is circumcised on the eighth day, he does not in principle object to the use of a cream. In addition, he did not want to publicize a clear and sweeping permissive opinion. Rather, he preferred that I inform *mohalim* orally that if the families insist on using cream, it is permitted to do so. In his opinion, the principal problem is changing the procedure of circumcision, not the pain or other incidental prohibitions. This, too, contradicts his opinion as quoted in *Nishmat Avraham*. See further note 47a *infra*.

29. *Resp. Imrei Yosher, ibid.*; *Resp. Tsur Ya'akov, be-She'erit Ya'akov* 5 (who only wrote: "Since the Rabbi from Tarna in his *Resp. Imrei Yosher* wrote that the practice is not to use any drug, I cannot raise any objection to that practice." He did not, however, explain his understanding of the basis of the prohibition.); *Resp. Erets Tsevi* (Frommer) 1:56; R. A. Shapiro in the addenda to the Hebrew version of this article, published in "*Medicine & Halacha: Practical Aspects*" Ed. Rabbi Dr. Halperin 2006, pp. 348-370

30. *Resp. Tsits Eli'ezer* 20:73; *Resp. Shevet ha-Levi* 5:147, sect. 2. Regarding R. Wosner's position, see note 39 *infra*.

31. *Resp. Erets Tsevi, ibid.*

## Objections to Anesthesia in Circumcision

**Innovation** – Anesthesia constitutes an innovation, a change with regard to earlier practice. It is inherently prohibited to change traditional practice and we ought not try to be clever and innovate new procedures in opposition to the will of the Creator and Jewish practice. “The Torah prohibits innovation.”<sup>39</sup>

**Pain** – Circumcision requires pain, as is clear in the Midrash:

R. Levi said: It is not written that Abraham circumcised [himself]. Rather it is written “Abraham was circumcised.” He examined himself and saw that he had no foreskin.

R. Abba bar Kahana said to R. Levi: You are a liar; he felt [the pain of circumcision] and suffered in order to increase his reward from God.<sup>40</sup>

It follows that circumcision was originally instituted with suffering.<sup>41</sup> It has further been written “that everyone should consider his own suffering when [the baby] cries from the pain of circumcision because his voice rises without the impediment of any evil that his prayer might include.”<sup>42</sup>

**The Covenant with God** – The commandment of circumcision might indeed be fulfilled when the foreskin is painlessly removed. But the fulfillment of the covenant between the newborn and God requires that he feel the cutting away of the foreskin and some bleeding. Without this, there can be no fulfillment of the covenant.<sup>43</sup>

**The Sages were Familiar with Anesthesia** – In the Talmud we learn:

We must calculate how much one would pay to have one’s arm amputated with a drug.<sup>44</sup>

39. Rabbis Sh. Wosner, M. Halberstam, and M. Eliyahu in the addenda to the Hebrew version of this article, published in “*Medicine & Halacha: Practical Aspects*” 2006, pp. 348-370.

40. *Bereishit Rabba* 47:11.

41. See *Resp. Imrei Yosher, ibid.*; *Sha’arei Halacha u-Minhag* 3:97; *Resp. Tsits Eli’ezer* 20:73; *Resp. Shevet ha-Levi* 5:147, holding that pain is a principal consideration in circumcision.

42. *Olelot Efrayim* 446, quoted in the notes of R. A. Gutmacher on Tract. Shabbat 130a.

43. R. A. Schapiro in the addenda to the Hebrew version (*ibid.*).

44. Baba Kama 85a.

Rashi explained: *With a drug* – with a drug there is no pain in amputation.

Although it is clear that they were familiar with them, anesthetic drugs were never used in conjunction with circumcision. It follows that pain is a requisite element in circumcision according to the earlier authorities.<sup>45</sup>

**Agency** – The *mohel* is the agent of the person he is circumcising. If the person being circumcised is not conscious, he cannot appoint the *mohel* his agent.<sup>46</sup>

**Intention** – Fulfillment of the commandment of circumcision requires intent. If the person being circumcised is asleep, he cannot have the requisite intention to fulfill the commandment.<sup>47</sup>

**God’s Will** – God intended the commandment of circumcision to be performed with pain. If so, we surely cannot do anything to lessen the pain. God wants the infant to understand at his tender age that it is impossible to attain virtue without suffering. All spiritual improvement involves pain.<sup>47a</sup>

**Danger** – There is some threat to life in all forms of anesthesia. It is entirely prohibited to endanger the person being circumcised.<sup>48</sup>

## Rejection of the Objections against Anesthesia

**Innovation** – It is true that the great Orthodox rabbis strongly opposed any changes in the performance of ritual circumcision because reform leaders in the past repeatedly tried to introduce such changes. Therefore, they went to length to reject any such innovations. Here are a few examples:

Opposition to cutting the foreskin with any instrument except a metal knife; opposition to use of any kind of shield; opposition to uncovering the

45. *Resp. Imrei Yosher, ibid.*; R. M. Eliyahu in the addenda to the Hebrew version of this article, (*ibid.*).

46. *Resp. Seridei Eish, ibid.*

47. *Koret ha-Brit, ibid.*; *Resp. Seridei Eish, ibid.*; *Resp. Shevet ha-Levi, ibid.*

47a. *Sefer Tuvecha Yabbi’u* (R. Y. Zilberstein) vol. 1, p 98.

48. *Resp. Iggerot Moshe, ibid.*; R. Sh.Z. Auerbach and R. Y.Sh. Eliashiv in *Nishmat Avraham, ibid.*; *Resp. Shevet ha-Levi* in the addenda to the Hebrew version of this article, (*ibid.*).

corona by any means except using the fingernail; opposition to any method of suction except using the mouth.<sup>49</sup>

Nonetheless, many authorities have agreed to innovations in certain limited circumstances when it is clear that the innovation is justified and does not conflict with any halacha. For example, many permit uncovering the corona with an instrument instead of the fingernail.<sup>50</sup> And many have agreed to suction with an instrument instead of the mouth.<sup>51</sup>

Further, some have objected only to innovations that involve the essential elements of circumcision while permitting incidental changes like introducing antiseptic methods for preventing infection despite the fact that in previous generations such methods were unknown.<sup>52</sup>

Use of local anesthetic seems to be quite far from any infringement against the commandment of circumcision. If there is a rational reason for such anesthesia and if there is no substantial prohibition and no connection to the essential elements of the commandment, why should anesthesia be prohibited?

According to those who object to anesthesia in circumcision because it conflicts with fulfillment of the commandment it is clearly prohibited to use any form of anesthesia. But if using anesthesia does not conflict with fulfillment of the commandment and if the purpose behind anesthetizing the patient is to reduce pain

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49. Regarding these opinions see the article on circumcision in the author's *Encyclopedia of Medicine and Halacha*.

50. See *Resp. Maharats Chajjoth* 60; *Resp. Ahi'ezer* 3:65, sect. 12; *Resp. Iggerot Moshe*, Y.D. 1:155; R. Sh.Z. Auerbach, quoted in *Nishmat Avraham*, Y.D. 264:2.

51. See *Resp. Maharam Schick*, O.H. 152; *Resp. Divrei Malchi'el* 4:87; *Resp. Beit Yitshak*, Y.D. 89; *Resp. Da'at Kohen* 141-142; *Resp. R. Y.I. Herzog*, Y.D. 84; *Hazon Ish*, quoted in *Resp. Shevet ha-Levi* 6:148, sect 2. See in *extenso* the author's *Encyclopedia of Medicine and Halacha*, s.v. *mila*.

52. R. A.M. Yisra'el in *Ha-Ma'or* 27(6):4, 5735.

rather than to adversely affect the performance of the commandment, there is no reason to object to this innovation more than to any other innovation.

In addition, those who prohibit local anesthesia in routine circumcision because it is an innovation and nonetheless permit anesthesia in certain complicated cases or for adults must in any event approve of some innovation unknown in previous generations. Anesthesia was, of course, unknown in earlier generations even in complicated cases. If so, we must conclude that it is acceptable to discuss which innovations are permitted and which are prohibited.

Although there are some contemporary authorities who object to any form of anesthesia for adults, it is in fact the common practice to use local or general anesthetic in every circumcision of a child or adult. A large scale study of circumcisions performed on immigrants from the former Soviet Union who had not been circumcised in their country of origin and who were subsequently circumcised in Israel in accord with the guidelines of the Israeli Chief Rabbinate presented the following data: In the years 1990-92 there were 2,857 males between the ages of 1 and 64 circumcised at the Soroka Medical Center in Beer Sheva. Fourteen percent of them were circumcised under local anesthesia and 86% under general anesthesia.<sup>53</sup>

Therefore, it would seem that the decision must be based on the consideration of whether the innovation of anesthesia does not conflict with any halachic principle.

**Pain** – There is no source in the Torah, in halacha, or in *kabbala* requiring that circumcision be accompanied by pain. There is no source in talmudic literature, the *Zohar*, or the medieval or modern authorities that considers pain to be part of the fulfillment of the commandment of circumcision.

The *posekim* adduce only one source regarding pain in circumcision. It is a Midrash<sup>54</sup> according to

53. Sh. Wahlfisch *et al.* in *Ha-Refu'ah* 127:119, 1994.

54. Bereishit Rabba 47:11.

which Abraham desired pain in circumcision in order to increase his reward for performing God's commandment. There are, however, two reasons why this source cannot serve as proof:

(1) The Midrash implies that Abraham desired to increase his pain in order to increase his divine reward, but it follows that simple fulfillment of God's commandment does not require pain. This is certainly not a proof that pain is obligatory,<sup>55</sup>

(2) Abraham's greatness and righteousness are incomparable; he surely accepted pain upon himself wholeheartedly and with pure intention. This surely does not imply that he was obligated to do so. The great patriarchs determined to accept an extra measure of pain in fulfilling God's commandments because of their love for the commandments. Thus it was with Abraham. This cannot imply any objection to anyone else avoiding pain in circumcision.<sup>56</sup> Abraham acted out of supreme love of God. His behavior cannot mandate that we too perform God's commandment with a similar level of devotion.<sup>57</sup>

Since Abraham circumcised himself, one may argue that he desired to increase his divine reward by increasing his pain. But there is no reason to call upon a father to increase the suffering of his baby son in order to increase his son's divine reward.<sup>58</sup>

Although the commandment of circumcision was first performed by Abraham, its principal authority does not derive from Abraham. Rather, the principal authority for the commandment of circumcision derives from God. Therefore, it is not necessary that the commandment be performed as Abraham did it. We do not, for example, call upon anyone to circumcise himself as Abraham did.<sup>58</sup>

***There is no source in the Torah, in halacha, or in kabbala requiring that circumcision be accompanied by pain***

Further, there are other, opposing opinions in the Midrash regarding Abraham's pain in circumcision. In a different passage<sup>59</sup> we read that Abraham was circumcised by a scorpion that God sent to him. Further, the earlier authorities<sup>60</sup> make clear that God assisted Abraham in circumcising himself. These authorities make no mention of pain; it is reasonable to assume that God would not Himself cause pain.

The second source, "that everyone should consider his own suffering when [the baby] cries from the pain of circumcision because his voice rises without the impediment of any evil that his prayer might include,"<sup>61</sup> is surely not sufficient to block palliative treatment of the person being circumcised. The thrust of the passage is simply that a person who is suffering should raise his voice in prayer because such prayer will be heard on high without any impediment. Even this idea has no earlier source.

Further, the leading kabbalist of Jerusalem has been quoted as saying that he searched the *Zohar* and other kabbalistic works and did not find any special mention of the infant's pain during circumcision. On the contrary, the *Zohar* clearly indicated that the pain of childbirth atones for the sin of Eve. Nonetheless, no one has ever objected to efforts to minimize that pain.<sup>62</sup>

It would further seem clear that those who favor pain in circumcision in order to increase divine reward are only referring to adults who can understand the significance of pain and its purpose. But what purpose can pain in newborns have? Newborns have no understanding at all! It is incomprehensible that some authorities require

55. *Resp. Erets Tsevi* 56; *Resp. Hemdat Tsevi* 4:48; Rabbi M.D. Tendler in Carmy S (ed), *Jewish Perspectives on the Experience of Suffering*, 1999, pp. 79-83.

56. *Resp. Yabbia Omer* 5, Y.D. 22:4.

57. R. Moshe ha-Levi Steinberg, *Hukkat ha-Ger* 15, n. 31

58. R. A. Baron in *Ha-Darom* 58:13, 5749.

59. Tanhuma, *Lech Lecha* 17.

60. See Rashi *ad* Gen. 17:24; *Da'at Zekeinim mi-Ba'alei ha-Tosafot*, *ibid.*, 26

61. *Olelot Efrayim* 446, quoted in the notes of R. A. Gutmacher on Tract. Shabbat 130a.

62. *Nishmat Avraham* 5, Y.D. 260:1.

pain only in newborn circumcisions but not for adults. This position is indeed problematic.

In light of all this, we can understand the opinion of the rabbi who wrote:

There is no need for the circumcision to cause pain. It is impossible that halacha would require the act of circumcision to cause pain. This idea has no source. Since none of the principal authorities and none of the *posekim* mentioned such a fundamental idea as requiring pain in circumcision, we may conclude that there is absolutely no reason to require pain in circumcision.<sup>63</sup>

Another great rabbi wrote:

We have found no source for a commandment to cause pain in circumcision. Abraham desired divine reward for the pain he suffered in his circumcision in accord with the principle “as the pain is great, so is the divine reward.” But there is no compelling reason to require pain in a child who has no capacity to understand the meaning of the pain he experiences.<sup>64</sup>

One contemporary *posek* concluded:

***there is no compelling reason to require pain in a child who has no capacity to understand the meaning of the pain he experiences***

One should not use general anesthesia because it is unhealthy. Therefore, general anesthesia is not used in circumcising children. The objection to general anesthesia is not based on halachic grounds, nor is it based on mystical considerations when we know of no obstacle and no hindrance, for the sages in every generation

know both the literal and the mystical principles of fulfilling the commandment.<sup>65</sup>

Even those who require pain in circumcision prohibit only a drug that would entirely eliminate

sensation in the penis.<sup>66</sup> But applying a local anesthetic cream, and certainly administering sucrose, can only reduce, but not entirely eliminate, the sensation of localized pain. No one has proposed that there is a specific level of required pain. Therefore, even according to this opinion, it is sufficient that the infant experience some pain.

**The Covenant with God** – The approach here is similar to the approach regarding pain. Although there is some reason and proof that pain must accompany circumcision, the palliative methods mentioned above in the section on medical background do not completely eliminate sensation. They merely reduce the level of pain and its duration. It would seem that those who require experiencing pain do not have in mind any specific level of pain. It follows that according to them even reduced levels of pain should be sufficient to fulfill the covenant between the newborn and God.

**The Sages were Familiar with Anesthesia** – The Sages’ refraining from using anesthesia with which they were familiar proves nothing in our case. There are several reasons why no proof can be brought in this case from the Sages:

The drug mentioned by the Sages was used in the amputation of a limb. A straightforward reading of the talmudic passage indicates that they were referring to a drug that would accomplish the amputation,<sup>1</sup> not an anesthetic drug.<sup>68</sup> This is consequently no proof that they were familiar with anesthetic drugs.

In a similar vein we can explain the talmudic passage mentioning a drug in connection with the boring of a hole in the ear of a slave.<sup>69</sup> This too should be taken to refer to a drug that, when placed on the ear, causes a hole to form.<sup>70</sup> This

66. As made clear in *Resp. Imrei Yosher, ibid.* This is the principal source requiring pain in circumcision.

67. As Rashi wrote: “to amputate it by means of a drug”. Rambam (*Hovel u-Mazzik* 2:10) wrote: “to cut it off by means of a drug.”

68. *Resp. Hemdat Tsevi, ibid.*

69. *Kiddushin* 21b.

70. Rashi, *ibid.*, s.v. *mi’et sam*.

63. *Resp. Ma’arachei Lev, Y.D.* 53.

64. *Resp. Seriede Eish, ibid.*

65. *Resp. Iggerot Moshe, ibid.*

interpretation fits with the other means of forming the hole that are mentioned in that passage.

The surgery of R. Elazar b. Shimon<sup>71</sup> is at first glance a clearer source for anesthesia in the days of the Sages since the drug mentioned induced sleep. This however is also no proof that they were familiar with anesthesia because the drug mentioned was probably dangerous. Such a drug is of course prohibited in circumcision; only in major, essential operations like the surgery of R. Elazar b. Shimon would it be permitted.<sup>72</sup> It is further unlikely that the drug was commonly available.

In fact, the drug was rarely used and circumcision was of course quite common.

Even if the Sages were familiar with anesthesia and refrained from using it in circumcision, it must also be true that they refrained from using it in childbirth as well. Further, they refrained from using it to palliate Rabbenu ha-Kadosh's great pains and let him die rather than suffer.<sup>73</sup>

In a similar vein R. Hanania b. Tardion was not treated with any anesthesia.<sup>74</sup> There are numerous other examples of talmudic passages describing pain with no mention of anesthesia.

In any event, there is no source in halachic literature prohibiting anesthesia or other palliative treatment for pain in childbirth, where it would seem more reasonable to be strict because of the verse: *In pain shalt thou bear children.*<sup>75</sup> Nor is there any source prohibiting anesthesia or pain relief in suffering terminal patients.<sup>76</sup>

71. Baba Metsia 83b.

72. *Resp. Avnei Zikkaron* 3:3.

73. Ketubbot 104a.

74. Avoda Zara 18a.

75. Gen. 3:16.

76. See the extensive discussion on the permissibility of palliative treatments in terminal patients in the author's *Encyclopedia of Medicine and Halacha*, s.v. *noteh lamut* (1), n. 302 ff.

In general, the Sages opposed unnecessary suffering, aside from some extraordinary cases.<sup>77</sup> It follows that the Sages would permit preventing the pain of circumcision whenever possible.<sup>78</sup> The Sages' silence regarding the use of anesthesia in circumcision can clearly not prove that they prohibited it.

**Agency** – Some authorities have proven that even an adult can fulfill the commandment of circumcision while under general anesthesia. There are several reasons why unconsciousness does not detract from the fulfillment of the commandment:

Although the subject is asleep, the deed of circumcision is still performed. It follows that if someone appointed an agent prior to going to sleep or prior to undergoing anesthesia, the appointment is valid and being unconscious does not detract from the fulfillment of the commandment.<sup>79</sup>

This conclusion seems inevitable because if a man appoints an agent to betroth a woman for him in some distant place and the agent goes and does it at a moment when the man who sent him is asleep, the betrothal is surely valid.

Agency is invalid in commandments that depend on the one's person, but the commandment of circumcision merely requires that a person be rid of his foreskin. Further, the act of circumcision does not require a valid agent since a minor is qualified to do it<sup>80</sup> although minors are disqualified as agents.<sup>81</sup>

If all this is correct with respect to the circumcision of an adult, is it all the more correct with respect to the circumcision of an eight-day-old baby, since in such a case it is the baby's father who appoints the agent. Now the father is certainly

77. See the author's *Encyclopedia of Medicine and Halacha*, s.v. *yesurim*, n. 176 ff.

78. *Resp. Mi-Ma'amakim* 2:15; R. A. Baron in *Ha-Darom* 58:13, 5749.

79. *Resp. Maharsham* 6:85; *Resp. Yabbia Omer*, *ibid.*

80. *Tur Y.D.* 264:1.

81. *Resp. Yabbia Omer*, *ibid.*

conscious even if the baby is asleep or anesthetized. It follows similarly that local anesthesia does not detract from the fulfillment of the commandment.

**Intention** – The *posekim* have proven that absence of intention to fulfill the commandment of circumcision does not detract from the fulfillment of the commandment. There are several reasons for this:

Intention expressed prior to undergoing anesthesia is sufficient.<sup>82</sup>

Since the deed is performed by someone other rather than the person being circumcised, it is sufficient if the *mohel* has intention to fulfill the commandment.<sup>83</sup>

Circumcision requires no special intention.<sup>84</sup> This follows from the permissibility of a minor performing the circumcision.<sup>85</sup>

These reasons are needed only in cases of general anesthesia. In local anesthesia of a newborn none of the reasons are needed because local anesthesia of an adult does not block him from intending to fulfill the commandment, and newborns have no intentions at all.

**God's Will** – Everything that happens to us happens because of God's will. Nonetheless, we intervene in cases of illness and suffering and the halacha of healing requires us to alleviate pain and suffering as far as we can. The fact that circumcision involves pain proves nothing. Therefore, alleviating pain does not contradict God's will any more than does alleviating of any other suffering. There is no special significance to the suffering of an eight-day-old infant, who can surely not understand that "every spiritual acquisition requires pain."

Circumcision does indeed involve pain. But if the purpose of that pain were to inculcate the idea that every spiritual acquisition requires pain, then

anesthesia would equally be prohibited in adults. In fact, most authorities permit anesthesia in adults. It follows that there can be no special will of God that the infant suffer.<sup>86</sup>

Several more general points can be adduced:

We have seen authorities who permit even general anesthesia in adults<sup>87</sup> without requiring any pain at all and without prohibiting newly developed methods of anesthesia despite the Sages having refrained from using them. These same authorities also permit even general anesthesia in newborns.

In principle "its ways are ways of pleasantness, and its paths are peaceful." If it is clear that there is significant pain in circumcision and that the pain can be prevented without violating any prohibition, it would seem that we should be lenient, not strict.

It follows that the only acceptable reason to be strict is the possibility of endangering the person being circumcised. We should therefore permit only those forms of anesthesia that are, from the medical point of view, definitively not life threatening.

On the other hand, it must be emphasized that there is a significant difference between "surgical removal of the foreskin" as performed for medical purposes (even by non-Jews) and "ritual circumcision" as performed by *mohalim* for the purpose of fulfilling the commandment.

In surgical circumcision, a clamp is used to prevent bleeding from the incision. This can lead to necrosis of the foreskin and ongoing severe pain. This surgical procedure is routinely performed by young house officers who do not have much

86. R. Y. Zilberstein is the authority who prohibits anesthesia in infants because of God's commandment. See his *Tuvecha Yabbi'u* as referenced above in note 47a. R. Zilberstein in his *Torat ha-Yoledet* 34:8, however, permitted anesthesia for a woman in childbirth, even on Shabbat, in order to prevent her experiencing pain. It follows that the principle "in pain shalt thou bear children" refers only to childbirth. Although there is room to say that preventing pain in childbirth is therefore a violation of divine will, such cannot be said about circumcision, regarding which neither Scripture nor rabbinic literature requires pain (as explained in note 62 above). R. Zilberstein's position remains to be clarified.

87. See *Resp. Maharsham* 6:85; *Resp. Da'at Kohen* 197; *Resp. Ma'archei Lev Y.D.* 53; *Resp. Kappei Aharon* 19; *Resp. Hemdat Tsevi* 4:48; *Resp. Yabbi'a Omer* 5, Y.D. 22; R. Moshe ha-Levi Steinberg, *Hukkat ha-Ger* 15, n. 31.

82. *Resp. Shevet ha-Levi*, *ibid.*

83. *Resp. Yabbi'a Omer*, *ibid.*

84. *Minhat Hinnuch* 2. See also *Ha-Ketav ve-ha-Kabbala*, Gen. 17:13

85. *Tur Y.D.* 264:1. See also *Yalkut Yosef, Sova Semahot* 2, *Hil. Mila* 15:1.

experience, and the procedure is slow. The experienced, professional *mohel*, however, performs the procedure very quickly without a clamp. In this way the duration and intensity of the pain is much lower than in the cases described in the American medical literature.<sup>88</sup>

We should also distinguish between two cases:

(1) Injected anesthesia that fully anesthetizes the penis. This procedure involves some danger and must be performed by a qualified physician;

(2) Using anesthetic cream, which attenuates the pain but does not eliminate it entirely. This procedure involves no danger and can be performed by a *mohel*.<sup>89</sup>

88. See Shechet J, et al, *JAMA* 279:1170, 1998; Reichman E and Rosner F, *Tradition* 34(3):6, 2000.

89. This follows from *Iggerot Moshe*, *ibid.*, and from oral communications from R. Y.Sh. Eliashiv and R Sh. Wosner. R. Y.Sh. Eliashiv told me that he opposes using a syringe to anesthetize infants circumcised on the eighth day. But he does not in principle object to using an anesthetic cream; in addition, he did not want to publicize a clear and sweeping permissive opinion. Rather, he preferred that I inform *mohalim* orally that if the families insist on using cream, it is permitted to do so. In his opinion, the principal problem is changing the procedure of circumcision, not the pain or other incidental prohibitions.

## International Responsa Project

*When a medical procedure raises ethical, moral, or halachic questions, advice from a reliable source is needed. The International Responsa Project provides this service to people all over the world who send their questions – some of general and theoretical, some specific and technical – via e-mail (irp@medethics.org.il), website (www.medethics.org.il), telephone, fax, and post. The questions are answered as quickly as possible by one of the rabbi-doctors at the Institute. The following are samples of recent questions and their answers. Please note that these are answers to specific questions and no general halachic conclusions should be drawn. A competent halachic authority should always be consulted.*

**Subject:** Brain Death

**Date:** August 2007

**Q:** *An elderly Jewish gentleman with a history of sick sinus syndrome has a permanent pacemaker placed in 2000. His most recent pacemaker interrogation shows the patient is 100% pacemaker dependent with no underlying rhythm. He now suffers a massive hemorrhagic stroke and herniates. He is pronounced brain dead after appropriate testing. He is requiring pressors for BP support and is paced at 60 BPM. The family would like to know if they can turn the pacemaker off.*

**A:** *The Halachic question of brain death is not a simple one. It is still a controversial issue among the great Jewish scholars (Poskim).*

*For some legal aspects of such controversy please see Braindeath.org Legal Resources; New Jersey Statute.*

*Therefore, the only way to handle such questions is to ask personally the Rav of that Jewish gentleman for instructions.*

*Nevertheless, it is allowed to gradually reduce the BP pressors. See A. Steinberg, “Halachic Guidelines for Physicians in Intensive Care Units” (JME Book Vol. II, pp.376-378 (2006) ; originally- JME 4,1 pp.5-6 (2001))*

Continuation of the IRP section on p. 48

# *Metzitzah b'Peh - Paradigm for Halachic Risk Taking*<sup>1</sup>

David Shabtai  
Raymond Sultan, M.D.

While the mitzvah of *brit milah* may be kept by a larger percentage of world Jewry than any other mitzvah, it does not preclude it from controversy, the most recent of which centered on the practice of *metzitzah b'peh*. This traditional third step in the *brit milah* process in which blood is orally suctioned from the wound, is admittedly unfamiliar to many. In the past few years, a number of babies have contracted the herpes virus (HSV-1) shortly after circumcisions that included *metzitzah b'peh*, and controversy arose as to whether the virus was transmitted through the *metzitzah* procedure. The controversy that has made headlines recently with the herpes virus, made similar headlines 20 years ago with HIV and was similarly newsworthy in the 19th century when some questioned the association between *metzitzah* and various illnesses. Today we know that a *mohel* could never transmit HIV to a child, and the chances of a child transmitting to the *mohel* are in fact quite minimal – the risk is now understood to be far less than in the past.<sup>2</sup>

The forthcoming analysis will focus on three issues: (1) What level of risk must (or may) one take upon himself in performing *mitzvot*? (2) Does

***In the past few years, a number of babies have contracted the herpes virus (HSV-1) shortly after circumcisions that included metzitzah b'peh.***

halacha view all risks equally? Is there some minimal threshold that must be reached for the risk to become relevant? (3) How does halacha view competing risks? When can one risk outweigh the next?

## **I. What is *metzitzah b'peh* and why perform it at all?**

Three components of *brit milah* are enumerated in the Mishna (*Shabbat* 19:2), explaining that the requirements of circumcision on Shabbat is no different from that during the week: “One may perform all actions necessary for circumcision on Shabbat: *mohalin* (cutting and removing the foreskin), *por'in* (folding back the underlying membrane) *u-motzetzin* (sucking blood from the wound). As such, it

would appear that *metzitzah* is part of the mitzvah, similar to the other two actions with which it is grouped, namely, *milah* and *peri'ah*. However, while the Mishna (19:6) states that without *peri'ah*, a circumcision is invalid, it makes no such claim regarding *metzitzah*.<sup>3</sup> On the other hand, the Gemara (*Shabbat* 133b) quotes Rav Papa saying that a *mohel* who does not perform *metzitzah* creates a danger (*sakkanah*) and we remove him from his position.

1. A shortened version of this article was published in *The Journal of Halacha and Contemporary Society* 49, 2005. The full version is being first published here with the editor's full permission.

2. There are no documented cases of HIV transmission through saliva (assuming that the *mohel* does not have a bleeding oral lesion). The risk of transmitting HIV through the digestive tract are reported to be quite minimal – especially when considering the fact that the blood is diluted in wine and then immediately expelled.

3. See R. Y. B. Goldberger (*Brit Kerutah li-Sefatayim* (Brooklyn, NY: 1990), 104) however, where he cites the *Tzofnat Pa'aneach* and R. Moshe Mordechai Epstein (*rosh yeshivah* of Slobodka) who in fact believe that without *metzitzah*, the circumcision is invalid.

From the days of the Ran and throughout the generations, *posekim* have analyzed the nature of *metzitzah* and generally understood it in one of two ways: It is either meant as a therapy, solely to prevent an impending danger (*sakkanah*) to the child, or aside from the therapeutic benefit, there is additionally some element of mitzvah as well.<sup>4</sup> Based upon how the obligation is viewed, *posekim* have different opinions as to whether to allow a change from traditional *metzitzah b'peh*, and if so, how and when.<sup>5</sup> The requirement for *metzitzah b'peh* despite a potential danger seems to hinge upon this debate. For the many *posekim* who take the former view that *metzitzah* was instituted solely as a medical therapeutic practice (and therefore not a *mitzvah*), there seems to be no reason to continue with *metzitzah b'peh* today, when performing *metzitzah* may entail a greater potential medical risk than abstaining from its performance.<sup>6,7</sup> Moreover, even for those *posekim* who view *metzitzah* specifically *b'peh* as being an element of mitzvah and part of Jewish heritage, there are a great many *posekim* who explain that applying oral suction via a tube (usually an inverted syringe) is equivalent to performing *metzitzah* directly *b'peh*. Using such a tube would completely prevent transmission of any pathogen from the *mohel* to the child.

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*Why specifically use the mouth?*

The very question is relevant only for those *posekim* who are of the opinion that *metzitzah* is an integral part of the *milah* process (whether as a *halacha le-Moshe mi-Sinai* or otherwise) and that it must specifically be performed by direct oral suction.<sup>8</sup> The argument made for direct *metzitzah b'peh* usually takes one of 4 forms: 1. There is a halacha le-Moshe mi-Sinai that *metzitzah* must be specifically performed in this way (*Shu"t Maharam Shick* Y.D. 245);<sup>9</sup> 2. Kabbalistic rationales having to do with tikkun, a correction, or gematria, numerical value of numbers and their hidden meaning (Chida); 3. Oral suction is the only effective means of performing *metzitzah*, since using a tube forms an ineffective suction<sup>10</sup> and might be considered a *bizuy* (denigration) *ha-mitzvah*.<sup>11</sup> 4. The need to

4. *Hiddushei ha-Ran, Shabbat* 132b.

5. Techniques for performing *metzitzah* without the mouth include using cotton wool or gauze with or without wine, using a vacuum-like device, or most commonly, using a wide tube or inverted syringe that can form an airtight seal against the baby's skin.

6. In 1888 the Orthodox Jewish community of Frankfurt issued a statement allowing *metzitzah* using a glass tube. This statement was signed by R. S. R. Hirsch (*Shu"t Shemesh Marpeh* 55) and agreed to by Rabbi Yitzchak Elchanan Spector and Rabbi E. Hildesheimer. R. Chayim Ozer Grodzinski, R. Kook and others have also written response allowing for use of the glass tube and it is frequently quoted that R. Chayim Soloveitchik insisted on using a tube as well. Recently, the Rabbinical Council of America issued a statement saying that "the normative halacha undoubtedly permits [suction generated by the mouth using a tube] ... and that it is proper for *mohalim* to conduct themselves in this way given the health issues involved [with *metzitzah b'peh*]." For a listing of these and other sources, see *Sefer ha-Brit* in the addendum on p. 222

7. However, please see the position of R. Moshe Feinstein related in section B (V) below.

8. Following an attack on the practice throughout the 19<sup>th</sup> century, a fierce debate erupted and continues to this very day regarding the necessity of direct oral contact. The *Sedei Chemed* (vol. 8 *Kuntres ha-Metzitzah*) cites a proclamation signed by over 42 rabbis proclaiming that *metzitzah* may only be performed by direct oral contact and not via a tube. Closer to our times, after the outbreak of the AIDS epidemic, a similar proclamation was signed by many of the *gedolim* of America, Israel and worldwide prohibiting the use of a tube (*Brit Kerutah li-Sefatayim*, 108). It is important to note, that contrary to popular assumption, many of the signatories are not of Hassidic background (i.e., R. Avrohom Pam, R. Elya Svei, R. Mordechai Gifter and R. Shlomo Zalman Auerbach). While it is abundantly clear that the historical circumstances surrounding the original controversies were far different than the current reality, this article will not address that complex area and the halachic conclusions arrived at will be taken at their face value.

9. Also see *Shu"t Yehudah Ya'aleh* (Assad) Y.D. 1:248.

10. The Rambam (*Milah* 2:2) states that *metzitzah* is meant to suction blood from *ha-mekomot ha-rechokim* (the distant places), and while he does not explain further, these *poskim* understand that the *mohel* must create a vacuum around the wound to accomplish this task.

11. Based on *Pesachim* 57b, relaying the story that a cry [among others] was heard in the *azarah*: "Take out Yisachar *Ish Kefar Barkai*, who honors himself and disgraces the *kodshim*" as he would wrap silk on his hands and perform the service (*avodah*)." Rashi (s.v. *karich yadei*) explains that wearing gloves creates a *hatzitzah* (separation between the *shochet* and the animal) and is also a *bizayon ha-mitzvah*. It is beyond the scope of this article to analyze the scope of *bizuy ha-mitvah*. For further analysis see *Pitchei Teshvuah* (Y.D. 271:19), *Birkei Yosef* (Y.D. 271) and *Iggerot Moshe* (Y.D. 2:16).

maintain the unchanged integrity of revered traditions, *minhag Yisrael*.

Those *posekim* who disagree, argue about the three rationales. Many, even amongst those *posekim* prohibiting the use of a tube, discount the Maharam Schick's contention that *metzitzah b'peh* is derived from a *halacha le-Moshe mi-Sinai*. Furthermore, the role of kabbalistic sources in shaping normative halacha is a contentious matter and is subject to much halachic discussion.<sup>12</sup> Third, these *posekim* contend that using a tube for hygienic reasons in no way represents a *bizayon* since its sole purpose to protect both the *mohel* and the baby from any harm<sup>13</sup> and that furthermore, that using a tube can indeed provide effective suction, when placed correctly.<sup>14</sup>

***Most people with HSV-1 do not even know they harbor the virus and yet viral particles could be isolated from the oral secretions of such asymptomatic individuals***

## II. Medical facts – Herpes

There are two common subtypes of the herpes simplex virus: HSV-1 and HSV-2. HSV-1 most commonly infects and resides in the oral cavity whereas HSV-2 is associated with the genital area, though each type can be found in both regions. Viral spread of infection occurs via infected salivary secretions during close contact with mucous membranes, with the recent controversy stemming from genital HSV-1 infection in children who underwent *metzitzah b'peh*. Successful transmission results in either a symptomatic mucocutaneous infection in the mouth (cold sores) or an asymptomatic subclinical infection, as the virus hibernates behind the mouth in the trigeminal ganglion, where it can remain for life in

a phase known as latency. Subsequently, reactivation of the virus into the oral cavity can occur at anytime or not at all, triggered by physical or emotional stress, fever, or even ultraviolet light. However, it most commonly occurs in the complete absence of symptoms in a select group of individuals with variable frequency.<sup>15</sup>

HSV-1 infections in the adult are frequently asymptomatic, but even with clinical symptoms, are rarely a serious systemic illnesses.<sup>16</sup> In contrast, HSV-1 infection in newborn usually develops in one of three patterns, which occur with roughly equal frequency: (1) Localized to the skin, eyes and mouth; (2) localized central nervous system disease, or encephalitis (15% mortality); and (3) disseminated disease involving multiple organs (57% mortality).<sup>17</sup> HSV infection of the newborn even just 25 years ago was associated with a case fatality rate of 60%;<sup>18</sup> today however, medications are available to alter the course of the infection if caught at an early enough stage.<sup>19</sup>

Most people with HSV-1 do not even know they harbor the virus and yet viral particles could be isolated from the oral secretions of such

12. See *Shu"t Yabi'a Omer* (O.C. 2:25:14; Y.D. 2:20:4; E.H. 2:7:3; Y.D. 3:13:6; O.C. 4:2:11; O.C. 7:7:3).

13. See *Yalkut Yosef* (*Issur ve-Heter* 1, 6) and *Iggerot Moshe* (Y.D. 2:16) who explain that the Gemara in *Pesachim* does not refer to a person who wears gloves as a means of hygienic protection..

14. The writers have indeed confirmed this last point with several *mohalim*. One was confident that by using a tube he created an airtight vacuum at least 95% of the time while another was confident 100% of the time.

15. The frequency ranges from once per month to twice per year in infected individuals. Klein R, "Epidemiology of herpes simplex virus type 1 infection," [www.uptodate.com](http://www.uptodate.com); *The Red Book, American Academy of Pediatrics report of the committee on Infectious Disease*, 25<sup>th</sup> edition, 309-319

16. These symptoms include oral or perioral lesions, ocular infections, non-genital skin lesions and genital skin or mucous membrane lesions.

17. Whitley R, "Predictors of morbidity and mortality in neonates with herpes simplex virus infections," The NIAAD Collaborative Antiviral Study Group, *New England Journal of Medicine* 324 (1991):450-4.

18. Committee on Fetus and Newborn, Committee on Infectious Diseases, "Perinatal Herpes Simplex Virus Infection," *Pediatrics* 66 (1980):1.

19. High dose Acyclovir therapy was associated with a trend toward an increased likelihood of the infant being developmentally normal at 12 months of age. However, less than 30 percent of patients were developmentally normal and approximately 60 percent had moderate to severe disability (Kimberlin DW, "Safety and efficacy of high-dose intravenous acyclovir in the management of neonatal herpes simplex virus infections," *Pediatrics* 108(2001):230-8.

asymptomatic individuals. These people harbor the virus in its latent state and experience asymptomatic shedding of viral particles into their mouths throughout their lives. Such shedding occurs on 1% of days among previously symptomatic 9% of adults and 5-8% of children were asymptomatic salivary excretors of HSV-1.<sup>20</sup> Only about a third of seropositive individuals suffer from recurrent cold sores. The shed virus can be infectious and has been recorded as persisting for an average of 1.2 days for a healthy control group.<sup>21</sup>

HSV-1 infection is quite common. Data from 1986 showed that 40-63% of all people in the United States were seropositive for HSV-1. Seropositivity in this context means having antibodies in the blood against some part of HSV-1 and is an indication that the particular host has previously encountered the virus which now likely resides within that host in latency; more recent data suggest the incidence may be as high as 70%.<sup>22</sup> A 2005 Israeli paper found the unadjusted HSV-1 seroprevalence to be 59.8%.<sup>23</sup> These numbers vary so greatly because of their reliance on different types of tests to determine infection rates. Recently, with the advent of technologies able to detect rather minute amounts of virus in oral secretions, it remains questionable whether such amounts are infectious to others.

To put these numbers into perspective: In a room of 500 people, 300 would have the antibody in their bloodstream and therefore the virus in

**40-63% of all  
people in the  
United States  
were seropositive  
for HSV-1**

latency. 100 would have occasional cold sores associated with the virus. On any given day 1 person would have detectable levels of virus in his mouth shedding asymptotically. If that one person were a *mohel* performing *metzitzah b'peh* and transmitted a viable infectious virus (though he had saliva and wine in his mouth as he made only momentary unidirectional contact), which did not simply hibernate in latency and cause the usual subclinical asymptomatic carrier state in the child, but rather overwhelmed the child's immune system (60% of children should have protective antibodies), then 2/3 of such cases pose a combined 24% mortality which could potentially be reduced by early intervention with antiviral medication. The risk therefore, is indeed quite minimal. Moreover, there is some question as to the applicability of the quoted rates of asymptomatic shedding of virus amongst individuals who, although infected, have never been clinically symptomatic.<sup>24</sup>

Currently, the medical literature is limited to three articles of isolated case reports demonstrating an association between the practice of *metzitzah b'peh* and infection.<sup>25,26</sup> Retrospective case reports demonstrating association, border on speculation and do not prove causation. Indeed, the HSV-1 virus is known to be quite hardy,<sup>27</sup> but it would be difficult to assess what role, if any,

24. Slacks SL, "HSV Shedding," *Antiviral Research* 63 (2004):S19-26.

25. Rubin LG, "Cutaneous neonatal herpes simplex infection associated with ritual circumcision," *Journal of Pediatric Infectious Disease* 19 (2000):266-8; Distel R, "Primary genital herpes simplex infection associated with Jewish ritual circumcision," *Journal of the Israel Medical Association* 5 (2003):893-4; Gesundheit B, "Neonatal genital herpes simplex virus type 1 infection after Jewish ritual circumcision: modern medicine and religious tradition," *Pediatrics* 114 (2004):e259-63.

26. Since HSV is known to incorporate itself into the host genome, a DNA analysis between an asymptotically infected *mohel* and an affected child could show that they are indeed one and the same strain. Such a test would greatly increase the aforementioned association, but has not been performed (or is simply not part of the public record).

27. HSV remains viable for several hours on skin, cloth or on plastic. (Turner R, "Shedding and survival of herpes simplex virus from fever blisters," *Pediatrics* 70 (1982):547-9). HSV-1 virions have been recovered for up to 2 hours from door handles on which HSV-1 in saliva and in water had been inoculated (Bardell D, "Survival of herpes simplex virus type 1 on some frequently touched objects in the home and public buildings," *Microbios.* 63 (1990):145-50).

20. Corey L, "Infections with herpes simplex viruses," *New England Journal of Medicine* 314 (1986):686.

21. Scott DA, "Oral shedding of herpes simplex virus type 1: a review," *Journal of Oral Pathology & Medicine* 26 (1997):441-7.

22. Schillinger JA, "National seroprevalence and trends in herpes simplex virus type 1 in the United States, 1976-1994," *Sexual Transmission of Disease*, 12 (2004):753-60.

23. Also noteworthy was that the prevalence increased with age in both genders. Davidovici BB, "Seroprevalence of herpes simplex virus 1 and 2 and correlates of infection in Israel," *Journal of Infection* (2005):1-7.

salivary inhibitors of HSV-1<sup>28</sup> or wine with alcohol as an antiseptic (as is taken into the mouth of the *mohel* prior to *metzitzah*) may play in prevention of person-to-person transmission. However, if a host harbors an active cold sore the risk of transmission is known to be elevated. We will therefore assume that all *mohalim* will follow the *pesak* of R. Yosef Shalom Elyashiv and refrain from performing *metzitzah b'peh* if they have an exposed oral lesion or are knowingly symptomatically shedding virus.

This is not the proper forum to debate the merits of these scientific studies. It is important to note however, that there are still many unanswered questions and that many of these articles are not conclusive and may contain several epidemiological flaws. Nonetheless, the rest of this article will assume that there may exist some potential, as yet to be determined, risk of HSV transmission through *metzitzah b'peh*, with the understanding that such a risk is considered questionable (*safek sakkanah*).

### III. Halachic Analysis

When properly employed, suction generated by the mouth using a sterile tube conveys no risk of infectious disease traveling from *mohel* to child or child to *mohel*, yet some level of risk does exist in performing direct *metzitzah b'peh*. All of the subsequent analysis assumes that a *mohel* who knows that he is infectious, will not perform *metzitzah b'peh* for fear of endangering the child. Similarly, it assumes that in accordance with the *pesak* of R. Yosef Shalom Elyashiv, a *mohel* with an exposed oral lesion, will not perform *metzitzah b'peh* either, even without any other systemic symptoms or awareness of illness. The only cases to be analyzed are those involving seemingly healthy

*mohalim* who may nonetheless be asymptomatic carriers of infectious disease. According to the great number of *posekim* who feel that *metzitzah* need not require direct oral contact, there seems to be no reason to continue to practice this method in the face of any danger whatsoever. *The Shulchan Aruch* (C.M. 427:10, Y.D. 116:5) records the prohibition against actively harming oneself and therefore, the question arises only for the previously mentioned *posekim* who argue that *metzitzah* is integral to the *milah* and additionally must be [according to some only optimally] performed by direct oral contact. How and why this may be allowed will be presented below.

***Currently, the medical literature is limited to three articles of isolated case reports demonstrating an association between the practice of metzitzah b'peh and infection***

**A. What level of risk must one take upon himself in performing *mitzvot*?**

Must a person literally “make himself sick,” so that he can perform a *mitzvah*? How far does preserving one’s health go in exempting a person from performing *mitzvot*? This issue arises a number of times in halachic discussions, in the unfortunate case where a person must choose whether to fulfill a certain *mitzvah* and in doing so, become physically uncomfortable or even worse, seriously ill.

a. Saving a friend’s life

The issue in question is reflected in the classic case of whether or not one may (or must) save a friend’s life from certain death when the rescue itself entails uncertainty to the life of the rescuer. Rescuing a friend from danger is a component of the *mitzvah* of *va-hasheivota lo* – “and you shall return to him”<sup>29</sup> – and the broader question really hinges upon the risk that one must take in performing this *mitzvah*.<sup>30</sup> The *Beit Yosef* (C.M.

28. Saliva contains factors, in addition to anti-HSV immunoglobulins, that neutralize HSV and may indirectly contribute to the control of recurrent Herpes labialis (Valimaa H, “Salivary defense factors in herpes simplex virus infection,” *Journal of Dental Research*, 81 (2002):416-21).

29. While the simple meaning of this verse refers to returning lost objects, the Gemara *Sanhedrin* 73a explains that this *mitzvah* also includes “returning” a friend’s health, when it may be at risk of being “lost.”

30. It must be noted however, that the prohibition of “*lo ta’amod al dam rei’echa*” – loosely translated as “you shall not stand idly by

426) cites the Hagahot Maimoni (*Rotzeach* 1:14) quoting an unreferenced *Yerushalmi* that a person indeed must enter a situation of *safek sakkanah* (uncertain danger) to save his fellow from a *vaday sakkanah* (certain danger).<sup>31</sup> Although the *Beit Yosef* quotes no other sources on this issue, he makes no mention of this requirement in the *Shulchan Aruch*. The *Sema* (426:2) explains that since this halacha does not appear in the *Rif*, *Rosh*, *Rambam* or the *Tur*, the *Beit Yosef* concluded that this stance, while noble, is not to be considered normative.

The *Radbaz* (*Shu"t Radbaz* 3:627) takes this position somewhat further when asked about a rather terrible incident where a non-Jew threatened to kill a Jew unless the victim's friend allowed his hand to be cut off or his eye gouged. Even assuming that severing a limb entails no life threatening circumstance, the *Radbaz* argues that such an action on the part of the friend is not required but is nonetheless considered a righteous deed. The *Radbaz* argues that since the Torah's precepts are described as "*darchei no'am*" – ways of pleasantness – it is impossible to assume that the Torah would require a person to have his eyes gouged or his arm severed to save somebody else's life.<sup>32</sup> The *Radbaz*

***Normative halacha does not require a person to risk his own life to save his friend's, even when the risk to the rescuer is only possible (safek) while the risk to the friend is certain (vaday)***

is clear however, that if the amputations involves a risk to life (as it probably did in the early sixteenth century before the advent of antibiotics and sterile technique), then one who goes through with such an action is a *hassid shoteh* – a deranged pious person.<sup>33</sup> Many *posekim* derive from this responsum that normative halacha does not require a person to risk his own life to save his friend's, even when the risk to the rescuer is only possible (*safek*) while the risk to the friend is certain (*vaday*).<sup>34</sup>

#### b. "Three cardinal sins"

There are well known instances however, where one is obligated to risk one's life or even give up one's life so as not to violate certain *mitzvot*, namely the "three cardinal sins" of murder, idolatry and forbidden sexual relations (*Shulchan Aruch* Y.D. 157:1). It must be noted that even the very formulation of this category of *yehareg ve-al ya'avur* – be killed rather than violating the prohibition, applies specifically to passively refraining from performing these prohibitions. Halacha does not demand that a person give up his life in the active performance of a *mitzvah*. Regarding such instances the *Gemara* (*Sanhedrin* 74a) explains that the Torah (*Va-Yikra* 18; 5) requires "*ve-hai ba-*

while your friend's life is in danger" – is also operative in this context. As will be explained later, more is required of a person in avoiding violating a prohibition than in performing a positive *mitzvah*. While this might be a rationale for the *Yerushalmi*'s position, the *Beit Yosef* does not suggest it.

31. The *Beit Yosef* then quotes the familiar *Gemara* in *Sandhedrin* 37a that a person who saves the life of one Israelite is considered to have saved (established) the entire world, with no further comment. Perhaps this is meant as his justification of the *Yerushalmi* – the calculus must not be risking one's life to save another's from certain death, but rather risking one's life to save the entire world. The halacha in other areas recognizes a difference between saving the life of an individual versus saving the lives of many people. See *Yerushalmi Terumot* (8:4) where the *Gemara* discusses giving up one person's life to save an entire city.
32. The *Radbaz* seemingly assumes that by the three cardinal sins that one must give up his life to fulfill, the Torah must specifically mandate that by these sins but not others, even *darchei no'am* has limits.

33. It is important to also see the *Radbaz*'s other [often overlooked] responsum (5:218) where he states that a person is obligated to risk his life to save his fellow's when the risk to the rescuer is less than 50%. This responsum clearly limits the applicability of the former principle.

34. See *Tzitz Eliezer* (12:57; 13:100) and *Yabi'a Omer* (H.M. 9:12) and the sources cited therein. It is possible to say however, that the *Radbaz* did not mean to establish a general rule by all *mitzvot*, but rather dealt only with the specific case in front of him. Perhaps the *Radbaz* felt that it was a violation of *darchei no'am* principle to purposely not set a very dangerous precedent of Jews being threatened with sacrificing their limbs to save their fellows from imminent death. Alternatively, he felt that *darchei no'am* would prohibit a person from risking his life for a seemingly frivolous purpose – namely to prevent a assailant from harming another person. Perhaps however, for the constructive purpose of positively saving a friend's life, the *Radbaz* may have indeed felt that such actions were permitted and perhaps required. Furthermore, see *Shu"t Afarkesta de-Anya* (H.M. 4:320) who argues that other *poskim* do not necessarily arrive at the same conclusion.

*hem ve-lo she-yamut bahem*" – [these are the *mitzvot* that] one should live through [by] them and not die by them. However, certain *posekim* maintain that while halacha does not require one to risk one's life to fulfill a positive commandment, certain people may nonetheless elect to do so. *Tzaddikim* or other Torah leaders may take upon themselves a life-threatening danger when they feel that performing the *mitzvah* despite this risk will have some benefit to the greater community, especially when death is not a certainty.<sup>35</sup> This permission is not widely accepted nor extended to the general public and as such has limited applicability with regard to *metzitzah b'peh*. It seems clear therefore, that a person need not accept a risk of death in performing *mitzvot*.

### c. Dwelling in a *sukkah*

There are other, more mundane applications of this question as well. The Gemara already provides a model for exempting a person from performing a *mitzvah* based on level of pain or discomfort that he must endure. *Sukkah* 26a relates that a person who is *mitzta'er* (pained), is exempt from dwelling (eating, sleeping) in the *Sukkah*.<sup>36</sup> The *Shulchan Aruch* (640:4) limits this exemption and explains

***One is obligated to risk one's life or even give up one's life so as not to violate certain mitzvot, namely the "three cardinal sins" of murder, idolatry and forbidden sexual relations***

that it does not apply on the first night of the festival. The *Acharonim* debate whether the exemption of *mitzta'er* is a model to be used throughout halacha even though it is only mentioned here, or is limited to the *mitzvah* of *sukkah*.<sup>37</sup> The *Chelkat Yo'av* (*dinei ones, anaf* 7) explains that for *sukkah* there is a unique exemption for even somebody who is suffering [or perhaps would suffer] from only minor discomfort. However, for all other *mitzvot* there is also an exemption of one who is also *mitzta'er*, albeit requiring a more substantial pain / discomfort (*tza'ar gadol*). Therefore, he exempts a *holeh she-ein bo sakkanah* – a bedridden sick person whose malady poses no risk to life – from *mitzvah* performance. The *Chelkat Yo'av* agrees with Ramo (640:4) that a *mitzta'er* is only exempt from dwelling in the *sukkah*, when refraining from doing so will alleviate his *tza'ar*. However, if one's ailing health will not deteriorate by dwelling in the *sukkah* and the *sukkah* does not cause him any additional *tza'ar*, he is obligated to dwell in the *sukkah*. A similar paradigm should apply throughout all areas of halacha.<sup>38</sup>

The *Binyan Shelomoh* (47) following the rationale of Rabbeinu Manoach (Hil. *Sukkah* 6:2) argues that a *mitzta'er* is exempt only from the *mitzvah* of *sukkah* (at all times except for the first night), but is nonetheless obligated in all other *mitzvot*. In a similar manner to the *Chelkat Yo'av* above, the *Binyan Shelomoh* parallels a *holeh she-ein bo sakkanah* to a *mitzta'er*, but because of his understanding of the exemption of *mitzta'er* by

35. See sources cited in *Yabi'a Omer* Y.D. 6:13:5.

36. The exemption lies in the nature of the *mitzvah* of *sukkah*. The Gemara (*Sukkah* 26a) explains that one must dwell in the *sukkah* in the same manner in which one dwells in a house (*teishvu ke-ein taduru*). Just as a person would not dwell in a house where he experiences discomfort, similarly he is exempt from dwelling in a *sukkah* in such a scenario. However, the nature of this *mitzvah* is different on the first night. The Gemara explains that the requirement to dwell in the *sukkah* on the first night is derived from a *gezeirah shavah* from the *mitzvah* of eating matzah on the first night of Pesach and not from *teishvu ke-ein taduru*. Therefore, there is no reason to exempt a *mitzta'er* on the first night of *Sukkot*. There is indeed a controversy regarding the source of this pain or discomfort and will be dealt with shortly.

37. One of the only other places that there is an exemption for one who is *mitzta'er* is by *tefillin*. The Ramo (*O.C.* 38:1) explains that a sick person who is *mitzta'er* is exempt from wearing *tefillin* since, as the *Mishnah Berurah* (38:5) explains, the discomfort will prevent him from properly concentrating on the *mitzvah* of *tefillin*. This certainly seems like a local ruling regarding the specific requirement of *yishuv ha-da'at* by *tefillin* and cannot be extrapolated from here to other areas of halacha.

38. The Taz (*O.C.* 640:8) however, believes that even where refraining from dwelling in the *sukkah* will not prevent an increase in *tza'ar* a person is nonetheless exempt from the *mitzvah*. He explains though that this is because of the unique requirement of *sukkah* of *yishuv ha-da'at* for the proper *kavannah* of dwelling in the *sukkah*, and therefore would seem to agree that this paradigm is valid in other areas of halacha.

*sukkah*, obligates a *holeh she-ein bo sakkanah* in all other *mitzvot*.<sup>39</sup> The Maharam Schick (Shu"t Maharam Schick O.C. 260) goes slightly further and explains that even when performing a *mitzvah* will certainly entail some physical harm, albeit not posing a risk to life, one is obligated to perform that *mitzvah*.

#### d. Drinking four cups of wine at the *seder*

This issue also arises with the requirement to drink four cups on wine at the *seder*. The *Shulchan Aruch* (O.C. 472:10) writes that even a person who greatly dislikes wine or does not normally drink wine because it harms him (*maziko*), must nonetheless push himself to fulfill the *mitzvah* of drinking all four cups. The *Mishna Berurah* (472:35) limits this harm to causing physical discomfort and / or developing a subsequent headache; the obligation does not go so far as to require pushing one's self so far becoming bedridden (*yipol le-mishkav*). Subsequent *posekim* debate whether this rule is applied to all *mitzvot* or is limited to drinking wine at the *seder*.

The *Sha'ar ha-Tziyyun* (472:52) explaining the reason for the *Mishna Berurah*'s limitation, says that such consequences would label the drinking as not in the manner of [exhibiting] freedom (*derech cheirut*). It seems logical to conclude therefore, that in all other areas of halacha where this unique characteristic does not apply, one must indeed perform any *mitzvah* even knowing that

***Even when performing a mitzvah will certainly entail some physical harm, albeit not posing a risk to life, one is obligated to perform that mitzvah***

consequently he will become so sick that he will become bedridden. R. Tzvi Pesach Frank<sup>40</sup> and R. Moshe Shternbuch<sup>41</sup> reject this conclusion and claim that the *mitzvah* of drinking the four cups of wine differs in other aspects as well and therefore has a unique limiting factor. The *Shulchan Aruch* (O.C. 472:10) records that one is required to go to great lengths not ordinarily required by other *mitzvot* to secure wine to drink at the *seder*. One would have therefore thought that the stringent nature of this *mitzvah* would permeate all aspects of its performance and would require exerting one's self further than required by any other *mitzvah*, even to the point of becoming bedridden. The requirement of *derech cheirut* is a reason for leniency in this stringent *mitzvah* that reduces the level of required exertion by drinking the four cups to the level required by all other *mitzvot*. The *mitzvah* of the four cups, in their opinion, is similar in character to all other *mitzvot* – none of which require pushing one's self so far as to become bedridden.

R. Chayyim Pinchas Scheinberg argues against Rabbis Shternbuch and Frank's logic.<sup>42</sup> He cites numerous examples where the level of exertion required for fulfilling the *mitzvah* of the four cups is compared and otherwise viewed in parallel to several other *mitzvot*. If, as Rabbis Shternbuch and Frank claim, the *mitzvah* of the four cups is unique in its stringency, no parallel could be made between it and other *mitzvot*. R. Scheiberg therefore concludes that the limiting factor of *derech cheirut* functions to lessen the level of required exertion only by the *mitzvah* of the four cups.<sup>43</sup> In all other *mitzvot* however, where this factor is irrelevant, one must exert himself so

39. Interestingly, the debate between the *Chelkat Yo'av* and the *Binyan Shelomoh* surrounds their different readings of the Gemara's question of Rava's claim that a *mitzta'er* is exempt from *sukkah*. The Gemara questions Rava by claiming that the Mishnah only exempted a *choleh* from dwelling in the *sukkah* but not a *mitzta'er*. The Gemara responds that by a *choleh*, even his attendants are exempt from dwelling in the *sukkah*, whereas the attendants of a *mitzta'er* are nonetheless obligated.

40. *Mikra'ei Kodesh Pesach* 2, no. 31

41. "Im Adam Chayyav Lehachnis Atzmo le-Choli Lekayyem Mitzvat Aseh," *Halacha u-Refu'ah* 4, 147.

42. "Be-din Choleh u-Mitzta'er be-Mitzvot," *Halacha u-Refu'ah* 4, 125.

43. See *Shu"t Chazon Ovadiah* no. 4 where Chacham Ovadiah Yosef extends the application of *derech cheirut* to other *mitzvot* of the *seder* as well, namely *matzah* and *marror*. He therefore argues that similar exemptions should apply to these *mitzvot* as well and one need not exert himself so much in their performance that he become bedridden.

much, that he would even become bedridden as a result of performing the *mitzvah* at hand.

### e. Spending money on *mitzvot*

R. Scheinberg raises a global argument relating to the nature of the performance of positive commandments. The Ramo (O.C. 656:1) explains (based on Ketubot 50a) that a person need not spend a substantial sum of money (*hon rav*) to obtain the means to perform a positive commandment since a person should generally not spend [waste] more than 20% of his net worth. It follows that a person is nonetheless obligated to spend up to 20% of his wealth. The Rambam (*Erchin va-Charamim* 8:13) explains that this limit was set so that a person should not run the risk of becoming poor. R. Scheinberg points out that Chazal viewed the risk of poverty with great severity (*ma'aviro al da'ato ve-al da'at Konoh*) and therefore exempted a person from *mitzvot* in which such a risk was apparent. Based on Shabbat 118a, the *Mishna Berurah* (242:1) explains that one must “make Shabbat as a weekday and not rely on receiving charity from others” means that one who is in dire financial straits is exempt from having three meals on Shabbat. The *Bi'ur Halacha* (656 s.v. *afilu*) explains that the limits and regulations regarding how far one must exert himself for Shabbat purposes apply to all other *mitzvot* as well. R. Scheinberg quotes the famous Gemara of Berachot 61a which explains why the Torah requires us to love Hashem both “with all our soul [body]” as well as “all our resources” (Devarim 6:5). The Gemara explains that the Torah’s admonition includes all sorts of people, those that prefer their bodies to their wealth and those that prefer their wealth to their bodies. R. Scheinberg therefore concludes that the Torah is aware of some individualistic component in this regard, and therefore is reluctant to offer a concrete method of balancing the two values.

R. Scheinberg therefore argues that there is a difference between the risk of poverty and the risk of a curable illness, with the former being far more serious. By the risk of poverty, Chazal were willing

to allow the violation of a given *mitzvah*, because otherwise a person may unfortunately become so poor that he will be unable to fulfill any of the other *mitzvot* anyway.<sup>44</sup> R. Scheinberg posits that an illness that “undermines the entire life of a person in all ways” and presents a risk of a person “losing his mind” (*ma'aviro al da'ato ve-al da'at Konoh*) is parallel to the risk of poverty and one is exempt from performing any *mitzvah* that engenders such a risk. However, the risk of a curable illness is indeed not parallel to the risk of poverty and therefore a person must perform a *mitzvah*, knowing going in that there is a risk that he will become curably ill.<sup>45</sup>

### B. Does halacha view all risks equally? Is there some minimal threshold that must be reached for the risk to become relevant?

*The halacha also seems to have some minimum threshold of risk that is acceptable or even ignored in certain cases*

Every action we perform entails some element of risk. Even such mundane acts as crossing the street to get to shul involve the risk of being hit by a car.

Such a risk however, seems to fall off our radar, and we take no cognizance of it during our daily lives. Many people practice the custom of kissing the sefer Torah (either directly by mouth or by touching the sefer and then kissing their hand) while it is being taken to the bimah, completely disregarding the reality that numerous people have done so before them, and the sefer’s montel (cover) appears as an ideal breeding ground for various bacteria. Similarly, the halacha also seems

44. R. Scheinberg formulates this in a manner familiar to many from the laws of Shabbat. The Gemara in *Yoma* 85b attempts to find a source for the permission to violate the laws of Shabbat in saving a life by deriving from *Shemot* (31:16) that it is preferable for a person to violate one Shabbat so that he may [live to] fulfill the *mitzvah* of Shabbat in the future.

45. Several specific *mitzvot* however, have different local parameters that govern the exertion required in their fulfillment such as *sukkah* and *tefillin*.

to have some minimum threshold of risk that is acceptable or even ignored in certain cases, as is evident in numerous discussions.

## I. Background

The Talmud enumerates various procedures which are technically forbidden, because they are dangerous, yet, since so many people do these things anyway, it has become common practice to permit them. Thus, the Gemara in Shabbat (129b) mentions specific days when one is forbidden from bloodletting (“leeching”). Although Fridays should be included in this list as well (similar to Tuesday, it is a multiple of three), the Gemara relates that the common practice was to perform bloodletting before Shabbat and since “many have already trodden upon it [this path]” (*keivan de-dashu beih rabbim*) – “Hashem protects the simple-hearted / minded” (*shomer peta'im Hashem*) (*Tehillim* 116:6). Similarly, in *Yevamot* (72b) there is discussion about prohibiting making a brit on cloudy days or days with a strong south wind as these circumstances present some risk of danger. Once again, the Gemara rationalizes with the same phrase – *keivan de-dashu beih rabbim, shomer peta'im Hashem*. In a more complex scenario, the Gemara (*Yevamot* 12a) records a dispute between R. Me'ir and the Sages regarding the use of certain contraceptives (*moch*) for women for whom pregnancy was strictly contraindicated for fear of death to her, her fetus, or her young child whom she is nursing. The Sages argue that despite this risk, such women may not use a *moch* and “from the Heavens they will have mercy on her,” as the verse says, “*shomer peta'im Hashem*.”<sup>46</sup>

***The Gemara describes other instances when despite a perceived danger, a person may nonetheless continue a given action, relying upon divine protection***

The Gemara describes other instances when despite a perceived danger, a person may nonetheless continue a given action, relying upon divine protection. The rationale is that “people engaged in a *mitzvah* are not harmed” - *sheluchei mitzvah einam nizokim* (*Pesachim* 8b). Thus, the Gemara concludes that pilgrims ascending to Jerusalem for the festivals need fear no physical or monetary harm since they are engaged in a *mitzvah*. Similarly, *posekim* allow and perhaps even require performing certain *mitzvot* despite a known risk, since “a person who keeps the *mitzvot* will know no harm” (*shomer mitzvah lo yeda davar ra*). The *Sefer Maharil* permits using water left exposed overnight at the start of tekufat Nissan, despite the general prohibition of using such water, since the matzot are to be used for a *mitzvah* (at least matzot for the first night of Pesach<sup>47</sup>), the principle of *shomer mitzvah lo yeda davar ra* applies.<sup>48</sup> The *Shuchan Aruch ha-Rav* (O.C. 455:16) goes so far as to say that one is forbidden to discard this water even if other water is available since by doing so such a person denigrates the idea of *shomer mitzvah lo yeda davar ra*. The great majority of *posekim* use the phrases *shomer peta'im Hashem, shomer mitzvah lo yeda davar ra* and *sheluchei mitzvah einam nizokim* interchangeably. All three convey the conviction that a person engaged in a *mitzvah* has a certain measure of divine protection.

In the discussion that follows, we will attempt to analyze various uses of these themes and uncover some systematic approach to their application, with an eye towards determining whether the ideas expressed may legitimately be invoked for performing *metzitzah b'peh*.

## II. Mechanism and rationales

46. From the first cases discussed by the Gemara it may seem that because *dashu beih rabbim*, we may apply the principle of *shomer peta'im Hashem*. However, from this last case it seems clear that there is no requirement of *dashu beih rabbim*, but rather, it is only a reason to apply the principle.

47. See *Shu"t Yabi'a Omer* O.C. I (23:5) as to how this idea might be applied to matzot prepared for the latter days of the festival.

48. *Sefer Maharil, hilchot maya de-lishat ha-matzot*, [7] s.v. *tekufat*.

In the course of *Torat Chesed's* (Lublin) (E.H. 44) discussion of contraceptives, he attempts to provide a mechanism for the idea of *shomer peta'im Hashem* through a discussion of a dispute between Rashi and Ritva. He explains that Rashi believes that the three women listed in *Yevamot* 12b are **prohibited** from using moch contraceptives, since *shomer peta'im Hashem* and therefore, *min ha-Shamayim yerachamu*. The Ritva (*Ketubot* 39b) rejects this approach since he does not believe that Chazal would force women to accept such risks upon themselves. The Ritva opines that these women **may** take the precaution of using a contraceptive (moch) or alternatively, may rely upon *shomer peta'im Hashem* and have normal relations; the choice is left to the woman. *Torat Chesed* points out that there should be a parallel disagreement by performing a *milah* on a cloudy day (*Yevamot* 82a), and indeed Ritva (ad loc.) explains that on such a day a person has the option whether or not to perform the *milah*.<sup>49</sup> The *Torat Chesed* argues that Rashi would disagree and, consonant with his previous stance, would argue that a person is obligated to perform a *milah* on a cloudy eighth day, even if it were Shabbat. This position is accepted by the *Shulchan Aruch* as normative.<sup>50</sup>

*Torat Chesed* suggests that the basis for the disagreement between Rashi and Ritva is how to evaluate the reality of danger (*sakkanah*) once Chazal invoke *shomer peta'im Hashem*. It would seem that according to Ritva, although there is a

***The principle of sheluhei mitzvah einam nizokim does not apply and may not be relied upon in cases where danger is prevalent (shechiach [kevia] hezeika)***

general prohibition to engage in risky behavior, once Chazal invoke *shomer peta'im Hashem*, one is permitted to continue this activity despite the inherent risk. There is no absolute requirement to perform the action, since invoking this principle does not actually diminish the real risk in any way.

Rashi, on the other hand, would argue that once Chazal invoke *shomer peta'im Hashem*, it is as if the risk is non-existent. Although the statistical probability of incurring the danger remains, risks below some probability threshold are simply ignored by halacha. "*Shomer peta'im Hashem*" means that a person may engage in normal activities and not be constrained or concerned by the minute risks continually involved. This "halachic reality" is so strong as to create an obligation for a father to perform *milah* on his son even on a cloudy day (and even on Shabbat).<sup>51</sup>

### III. Calculating minimal risk-thresholds

Since, as noted previously, the *Shulchan Aruch* seems to be in accord with Rashi's approach, it is important to quantify the risk-thresholds that scan below the halachic radar. Quantitatively, there are certain guidelines to apply. The Gemara (*Pesachim* 8a, *Kiddushin* 39b) is clear that the principle of *sheluhei mitzvah einam nizokim* does not apply and may not be relied upon in cases where danger is prevalent (*shechiach [kevia] hezeika*) and the *Torat Chesed* (*ibid.*) easily extends this limitation to the question of prohibiting certain contraceptives and relying on *shomer peta'im Hashem*.<sup>52</sup> Since he does not quantify the risk-threshold that qualifies as "prevalent," we may (rather conservatively) assume that any risk-threshold, below the level of *mi'ut ha-matzui* (a prevalent minority) is certainly included. This value normally ranges between 10-14.5%.<sup>53</sup> R. Chayyim Ozer Grodzinski (*Achi'ezer*

49. He also advises that on a cloudy Shabbat, it is proper to not perform the *milah*. See the comments of R. Refael Yasfan (footnote 219) in the *Mossad ha-Rav Kook* edition of the Ritva (72b) as to why *milah* on a cloudy Shabbat is only not advisable but not forbidden.

50. As per *Shu"t Hayyim Sha'al I* (59).

51. For a variant on this approach, see R. Stanley Boylan, "*Chashash Sakkanah le-Ohr ha-Halacha*," *Ohr ha-Mizrach* 32 (1984):48-59.

52. See also *Shu"t Avnei Nezer O.C.* (454), *Shu"t Mishneh Halachot* 15 (81).

53. The *Mishkenot Ya'akov* (Y.D. 17) goes to great lengths to prove that *mi'ut ha-matzui* is defined as a 10% occurrence and R. Shlomo Zalman Auerbach is oft quoted as endorsing the *Mishkenot*

1:23) insists that *shomer peta'im Hashem* certainly overrides a *mi'uta de-mi'uta* – a minority of a minority, and in a different context, the Chatam Sofer (Y.D. 338) argues that halacha takes no cognizance of events that occur only once in a thousand years (although from the historical context of the responsum it seems that he used the phrase as hyperbole).<sup>54</sup> Even assuming a more robust calculation of the risk involved in performing *metzitzah b'peh*, while it may occur more than once in a thousand years, it likely comes in beneath the halachic risk-threshold.

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#### IV. General limitations and localized application

There is a trend among *posekim*, starting with the early medieval commentators, of reluctance to apply *shomer peta'im Hashem* broadly. The *Terumat ha-Deshen* (211) very reluctantly permits behavior that the Rabbis had labeled as “dangerous” but was practiced anyway, without apparent harm. Some scholars were marrying women who had already been widowed twice previously (a *katlanit*), although Rambam had ruled (*Issurei Bi'ah* 21:31) that such marriage is to be avoided (forbidden) due to some assumed danger. Despite the lack of statistical risk

availability for this type of danger, the *Terumat ha-Deshen* frowned upon this practice and was uncomfortable in invoking *shomer peta'im Hashem*. He begrudgingly approved of the practice because otherwise these women could never marry again (*mishum iguna*) and he was worried that these non-marriageable women might succumb to “undesirable lifestyles” (*tarbut ra'ah*).

##### a. Relying on miracles

Similarly, the Maharil (cited above) argued against using water left exposed overnight at the start of *tekufat Nissan* to bake *matzot*. While the Mordechai and Rokeach held that such water may be used because *shomer mitzvah lo yeda davar ra*, the Maharil preferred the common practice of avoiding this situation by sealing the water in metal containers, insisting that “we do not rely upon miracles.” Although here too there is no calculation of risk probabilities, the choice of the term *nes*, would make it seem that there was some level of observable danger in drinking such water. Perhaps Maharil felt that relying on divine protection was not warranted when such situations could easily be avoided.

##### b. Requisite “counterweights”

Other later *posekim* were similarly disinclined from liberally applying the notion of *shomer peta'im Hashem* and explain each instance of Chazal's usage of this idea rather conservatively. The *Divrei Yatziv* (Y.D. 31) explains that we may rely upon *shomer peta'im Hashem* only when there is a rather compelling reason / counterweight to permit or even require the action in question, such as the mitzvah of *milah be-zemanah* (in its appropriate time) despite the danger perceived in doing so on a cloudy day. Similarly, Chazal relied upon *shomer peta'im Hashem* in allowing the three women of *Yevamot* 12b to have normal relations because of the dual ‘counterweight’ of the mitzvah of *onah* (marital relations) and the fear of *hashchatat zera* (wasting of seed). However, absent any compelling reason to do so, he is reluctant to apply *shomer peta'im Hashem* without adequate precedent.

<sup>54</sup> *Ya'akov's* opinion (see *Bedikat ha-Mazon ka-Halacha*, p. 181 who quotes R. Yosef Shalom Elyashiv as well as endorsing the 10% approach). R. Hershel Schachter frequently cites R. Yosef Dov Soloveitchik's opinion that *mi'ut ha-matzui* should be approximately 14.5%, based on what he determined was the actual incidence of *sirchot* in cow lungs in his time. See however, *Shu"t Shevet ha-Levi* Y.D. (4:81) who seems to adopt a more subjective approach.

54. This responsum deals with the German law that required that a body be left for three days since declared dead by a physician before burial. There were apparently instances in which a person, who had been previously declared dead and subsequently buried, was later found to calling for help from his grave. From the very fact that this legislation was deemed necessary, it seems that it was to prevent an occurrence of some noticeable frequency, certainly much greater than once in a thousand years. These types of events are the subject of the Chatam Sofer's statistical estimate.

### c. Danger stemming from the mitzvah itself

The *Beit She'arim* (Y.D. 320) goes to great lengths to further limit the application of *shomer peta'im Hashem* even in his understanding of Chazal's usage of the idea.<sup>55</sup> He explains that one may not rely on such ideas when the risk of danger is constant and always present, since protection from such danger would qualify as a miracle and the Gemara (*Pesachim* 50b) informs us that miracles are not everyday occurrences (*lav kol yoma mitrachish nissa*). While he does not provide proof for this explanation, it seems that he took a very literal reading of both the Gemara and Maharil's usage of the word *nes*. The *Beit She'arim* also provides a rather novel suggestion that the idea reflected by *shomer mitzvah lo yeda davar ra* only applies when the mitzvah per se is the sole cause of the danger. He explains that the danger of a *katlanit* arises only from her marriages; a man who would have relations with such a woman without marrying her however, would be free from harm. Since the danger arises only from performing the mitzvah, one can rely upon *shomer mitzvah lo yeda davar ra* to protect him from this danger when his intentions are for the sake of the mitzvah.

The *Beit She'arim* goes on to explain the opposite case. The *Shulchan Aruch* (Y.D. 263:2) rules that a woman who has had two sons die from their *milah* should not perform a brit on her third son lest he die like his brothers. The danger is commonly assumed to be some form of hereditary blood clotting disorder and the fear is that the child will bleed to death from his *milah* wound. The *Beit She'arim* explains that even though performing a *milah* is a mitzvah, there is no divine protection afforded since the danger does not result from the mitzvah per se. The same level of

risk would exist if a non-Jew were to perform the circumcision and thereby not fulfill any mitzvah. Even though the cause of the danger is the performance of the mitzvah (without any circumcision there is surely no risk at all) the existence of the danger does not stem solely from the mitzvah performance (*ma'aseh ha-mitzvah*) and therefore one cannot rely on *shomer mitzvah lo yeda davar ra*.

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While this is a rather novel approach, it seems likely to be a post facto explanation for the application of *shomer mitzvah lo yeda davar ra* in a few limited instances. It does not explain why R. Papa invoked *shomer peta'im Hashem* to allow performing *milah* on

cloudy days when the risk inherent in the weather does not seem to be dependent on whether or not one fulfilled the mitzvah of *milah* with this specific circumcision. It also does not explain why the Chazal relied upon divine protection in prohibiting the three women of *Yevamot* 12b from using a moch during marital relations. The Gemara details the dangers that would befall these women (death to themselves, their fetus or their newborn child) and none of them seem to be dependent on whether or not the mitzvah of *onah* is fulfilled during marital relations. While not addressing this point directly, R. Menashe Klein explains that his grandfather meant to distinguish between the concepts of *shomer mitzvah lo yeda davar ra* and *shomer peta'im Hashem*.<sup>56</sup> He claims that the former applies only and provides protection from those dangers that result from divine intervention in this world and not natural occurrences (*derech ha-teva*). From the previous discussion it would seem that this protection is further limited to

55. The *Beit She'arim* was written by R. Amram Bloom, grandfather of R. Menasheh Klein, the *rav* of Ungvar and *rosh yeshivah* of the institution bearing the name of his grandfather's book.

56. *Shu"t Mishneh Halachot* (4:190, 15:70, 81). The authors were unable to find a responsum directly addressing this point in the *Beit She'arim*.

dangers that arise from mitzvah performance per se. When the danger is natural consideration however, one may rely on *shomer peta'im Hashem* when the danger is not prevalent (*lo shechiach hezeika*). One could therefore argue that the *Beit She'arim* (320) meant to discuss only the halacha of *shomer mitzvah lo yeda davar ra* and did not mean to address *shomer peta'im Hashem* at all in that responsum. Therefore, he would say that whatever the principle of *shomer mitzvah lo yeda davar ra* leaves out, *shomer peta'im Hashem* picks up the slack. While he claims that this in fact what his grandfather held, it makes much of the *Beit She'arim*'s discussion merely theoretical if all of the cases excluded from *shomer mitzvah lo yeda davar ra* are included in *shomer peta'im Hashem*. This makes the *Beit Shearim*'s nuanced distinctions entirely unnecessary and does not seem to be a very plausible reading of the text of the responsum. It does however, provide answers to the rather fundamental challenges posed above.

#### d. Unique characteristics of *milah*

When dealing with *milah* however, there might be more reason to be stringent when it comes to accepting risks. The Rambam (*Milah* 1:18) lists various conditions that require delaying performing the *milah* past the eighth day and concludes that “We only perform *milah* on a child who is free from illness, since [even] questionable risks to life override all [*mitzvot*]; we can perform the *milah* at a later time but we cannot return one [lost] Jewish soul.”

Based on the Rambam's ruling, the Chatam Sofer (Y.D. 245) suggests that a potential risk can delay a *milah* only when the *milah* could be performed in the future, presumably when the risk will be alleviated or sufficiently mitigated. However, if the potential risk were consistently present throughout one's lifetime, one could not delay the *milah* on account of that risk, since doing so will insure that the *milah* will never be performed. The Chatam Sofer bases this upon the various reasons provided by the Gemara as to why risks of danger override mitzvah performance, but

it remains somewhat ambiguous whether or not he accepts this idea as final.<sup>57</sup> If this logic is accepted however, it would seem to apply to the situation of *metzitzah b'peh* quite well since there is ample reason to assume that the rate of asymptomatic carriage of HSV-1 will not change in the near future and therefore, the possible inherent risk would be consistently present throughout one's life. It would stand to reason that according to this view, there is no reason not to perform *metzitzah b'peh*. Even if the Chatam Sofer would conclude differently however, it would appear that the statement of Rambam should have little to no bearing on the issue as discussed above.

***When dealing with milah however, there might be more reason to be stringent when it comes to accepting risks***

#### V. The nature of the risks in question and possible applications

While the reductionist trend does appear among *posekim*, many are willing to at times rely upon *shomer peta'im Hashem*. It is important to note that the Gemara applies *shomer peta'im Hashem* to a variety of different cases, including several that involve a direct risk to life. While the Gemara does not detail the harm that may befall a baby circumcised on a cloudy day, it does specifically mention the different risks of **death** to

57. He explains that according to the view that one may “desecrate one Shabbat so that he may keep more *Shabbatot* in the future” (*Yoma* 85b), the permission to desecrate the first Shabbat is contingent upon the ability to perform that very same mitzvah (keeping Shabbat) in the future. When the possibility to perform the specific mitzvah in question is not possible, there is no permission to violate the halacha in the first place. He notes that the Rambam himself accepts the alternate rationale of violating halacha for *pikuach nefesh* of “*ve-hai bahem*” and that according to this view, the violation of halacha is not contingent upon possible future performance. The Chatam Sofer notes however, that ‘elsewhere’ he discusses that in practice we require both of these rationales to permit mitzvah violations. He seems to discuss this issue in *Shu”t Chatam Sofer O.C.* (85), but does not provide a conclusive answer and explicitly mentions that that discussion is meant only theoretically. His conclusion therefore, seems somewhat ambiguous.

each of the three women of *Yevamot* 12b arising from a possible future pregnancy. It would seem therefore, that the level of risk is decisive in determining the application of the principle, not the consequences of the danger being avoided.

#### a. From where does the danger stem?

Some *posekim* address the nature of dangers directly. The *Beit She'arim* (*ibid.*) explains that one may only rely upon *shomer mitzvah lo yeda davar ra* when the danger is not part of the natural world (*eino be-teva*). Because this unique divine protection of *shomer mitzvah lo yeda davar ra* is itself outside the boundaries of the natural world, it may only be relied upon when the

***That the level of risk is decisive in determining the application of the principle, not the consequences of the danger being avoided***

danger is similarly beyond the scope of nature. This seems to include dangers that do not have an obvious causal relationship with the action from which they arise. When the risk of danger however, 'seems' to be 'entirely' natural, such as the myriad cases of *pikuach nefesh*, one may not rely upon divine protection and must not participate in the action in question. Practically, it seems rather difficult to determine how to apply these two categories and is instructive to see the examples cited. The *Beit She'arim* claims that the danger inherent in marrying a *katlanit* is beyond nature and as such, *posekim* are willing to rely upon *shomer mitzvah lo yeda davar ra* in permitting such marriages. The danger that circumcision may pose to a child whose two brothers had died as a result of theirs, is within the scope of the natural world and therefore, the circumcision is not performed since there is no room for reliance upon *shomer mitzvah lo yeda davar ra*. This seems difficult, since the danger posed to the three women of *Yevamot* 12b seems to be well within the scope of nature, and the Gemara, at least according to Rashi, requires reliance upon *shomer peta'im Hashem*.

The simplest answer would be to argue as above that the *Beit She'arim* incorporated natural events within the rubric of *shomer peta'im Hashem* and not *shomer mitzvah lo yeda davar ra*, but this answer is fraught with the same difficulties noted above.

R. Menashe Klein adopts his grandfather's approach and provides examples of dangers that fit into each of these two categories that may shed light onto how to classify the possible risks inherent in performing *metzitzah b'peh*.<sup>58</sup> The *Shulchan Aruch* (O.C. 433:7) writes that a person is exempt from checking for *hametz* in a hole shared with his non-Jewish neighbor, since the neighbor may become enraged from mistakenly thinking that the Jew is performing some sort of witchcraft against him and the matter may come to great danger.<sup>59</sup> Shortly thereafter, the *Shulchan Aruch* (O.C. 433:8) writes that a person is not required to check for *hametz* under a collapsed wall that previously housed *hametz* for fear of scorpions amongst the rubble. The Gemara (*Pesachim* 8a) explains that there really is no fear of scorpions during the act of *bedikat hametz* since the person is in the midst of mitzvah performance and *sheluchei mitzvah einam nizokim*. Rather, the fear is that perhaps during the *bedikah* the person may drop a needle into the rubble and after having completed the *bedikah* may return to retrieve that needle. Since the mitzvah is completed, there is no longer any special divine protection and the risk of scorpions abounds.

Many of the *posekim* wonder why in this latter case (433:8), if not for the external concern about the needle, was there a willingness to rely upon *sheluchei mitzvah einam nizokim*, but in the former case (433:7) of a hole shared with a non-Jewish neighbor, was there no attempt to rely upon this principle? R. Menashe Klein applies his grandfather's distinction to understand the

58. *Shu"r Mishneh Halachot* 4 (190).

59. The *Mishnah Berurah* (433:30) explains that the non-Jew will misunderstand why the Jew is walking around with a candle at night checking locations throughout his house since the next morning, such checking could be done much more easily.

difference between the cases.<sup>60</sup> He explains that the danger posed by the non-Jewish neighbor is within the scope of the natural world, while the danger posed by scorpions is not (*lo al pi derech ha-teva*). Therefore, one may only apply *shomer mitzvah lo yeda davar ra* to the latter, and not the former case. One may have previously assumed that the danger presented by the scorpion should fall within the realm of the natural world. Placing such a danger outside of the natural framework, makes it very difficult to systematically group other types of danger. While the possible danger inherent in *metzitzah b'peh* is initiated by a person's actions, there is certainly no attempt to harm and not even any active knowledge that one is causing any harm at the time. It would be interesting to see whether R. Klein thinks that *metzitzah b'peh* is more similar to the danger presented by the non-Jewish neighbor or by the scorpion beneath the rubble.

#### b. 'Naturally' encountered risks

R. Moshe Feinstein provides some guidelines as to different types of danger and how they relate to *shomer peta'im Hashem*.<sup>61</sup> In discussing which types of women may not use contraceptives, he explains that there is more room to be lenient for a woman for whom pregnancy may be life threatening. Reliance on *shomer peta'im Hashem* (and therefore strictly prohibiting contraceptive use) is legitimate for dangers that are "natural" for all women to experience, such as childbirth itself, when offset by an appropriate counterweight, such as mitzvah performance. He explains that this is not reliance upon miracles since the danger is minimally and equally present for all women.

60. The *Magen Avraham* (433:12) and others explain that in the case of the shared hole, the danger was rather prevalent (*shechiach hezeika*), and as mentioned previously, in such circumstances, reliance upon divine protection is inappropriate.

61. *Shu"t Iggerot Moshe E.H.* (1:63:1-2, 4:73:1).

Chazal (*Yevamot* 12b as per Rashi and *Shulchan Aruch* as per Hidda [n. 37] as understood by *Torat Chesed* [Lublin]) prohibited the use of contraceptives despite the rare unfortunate cases of tragedy. R. Feinstein uses the term "naturally" to denote a status equal for all – actions that present risks of this stature may be performed, when properly offset, relying upon *shomer peta'im Hashem*.

It would be interesting to see how the *posekim* understand the possible risk inherent in *metzitzah b'peh* in light of R. Feinstein's distinction. If we are to assume that the prevalence of sub-clinical shedding of HSV-1 by asymptomatic carriers hovers around 60-70%, then one might argue that the possible risk posed by performing *metzitzah b'peh* applies to all infants

equally and can therefore be dispensed with by relying upon *shomer peta'im Hashem*. If some specific child would have a unique condition that would make him unusually sensitive to HSV-1 transmission, this would parallel the risk of pregnancy in a woman for whom it is lethally contraindicated – in both cases, R. Feinstein would not permit reliance upon *shomer petaim Hashem*. Practically, one may suggest that a *mohel* who has a bleeding mouth sore would fit into this category and as such should not perform *metzitzah b'peh*, while all other healthy *mohalim* may continue the practice.

#### c. Normal societal practices

R. Elchanan Wasserman also distinguishes between the natures of different risks and posits that *shomer peta'im Hashem* applies only to those dangers that are not within the person's control.<sup>62</sup> However, when a person can protect himself from

62. *Kovetz Shiurim, Ketubot* no. 136.

the danger but chooses not to – he is liable for his own tragedy. R. Wasserman clearly does not mean this to be taken literally, because in all of the cases cited by the Gemara, the risk could have been avoided by abstaining from the action, but nonetheless the Gemara relies upon *shomer peta'im Hashem*. He therefore goes on to explain that a person need not abstain from acting in accordance with “normal” societal practices and actions (*ein ha-adam hayyav lehimana mi-minhag derekh erez*). Therefore, dangers that arise from such actions are categorized as those that are beyond his control and not within his capacity to protect himself from; in such cases, reliance upon *shomer peta'im Hashem* is appropriate. Understood in this way, both R. Wasserman and R. Feinstein differentiate between that which is normal and common and that which is deviant, although they couch these distinctions in different terms. In R. Wasserman’s view, the *posekim* will have to decide whether or not the practice of *metzitzah b'peh* is within the realm of “normal societal practices” (*mi-minhagei derekh erez*) or is considered something beyond normal events that a person is obligated to protect himself from. In theory, R. Feinstein and R. Wasserman disagree as to whether the risk to all people involved must be equal or that the manner in which people actually perform this action must be equal. Practically, however, the approaches seem very similar – if *metzitzah b'peh* is considered to be the normal practice, then by extension, the possible danger inherent in its performance is posed equally to all infants and *shomer peta'im Hashem* can be invoked and relied upon.

#### d. Modern application

Perhaps the most revealing approach to this question is a story recounted by R. Romi Cohen when he performed *milah* on R. Moshe Feinstein’s great-grandson approximately two weeks before R.

**R. Moshe responded,  
“Heaven forbid  
changing a holy minhag  
that Jews practice, and  
this too is encompassed  
within shomer mitzvah  
lo yeda davar ra.”**

Feinstein’s passing in 1986.<sup>63</sup> He recounts that after the *milah*, R. Feinstein was asked whether it was advisable to continue the practice of *metzitzah b'peh* in light of the rampant AIDS epidemic, for fear of the child infecting the *mohel*. It must be stressed that in 1986 very little was known about HIV transmission, let alone therapeutics, and the fear of transmission was very real and very scary.<sup>64</sup> R. Moshe replied emphatically, “Heaven forbid that [*metzitzah b'peh*] should be abolished, since *shomer mitzvah lo yeda davar ra!*” R. Cohen describes the astonishment of all those present to this unequivocal proclamation and reports that several people tried to press R. Moshe on the very real danger that could come from this decision. R. Moshe simply repeated “*shomer mitzvah lo yeda davar ra.*” R. Cohen relates that R. Reuven Feinstein continued to press R. Moshe on the point that R. Moshe had elsewhere decided that *metzitzah* is not an inherent part of the *mitzvah* of *milah* but rather only a *minhag* and therefore should not be continued in the face of possible danger.<sup>65</sup> R. Moshe responded, “Heaven forbid changing a holy *minhag* that Jews practice, and this too is encompassed within *shomer mitzvah lo yeda davar ra.*” He qualified this by stating that in the rare instance of a specific reason to worry about the risk of AIDS, only then is it forbidden to perform *metzitzah b'peh*. With the understanding of R. Feinstein’s previously cited formal responsa in mind, this rather powerful anecdote is merely an application of R. Feinstein’s systematic approach to *shomer peta'im Hashem*. It would stand to reason that R. Feinstein would feel the same way today regarding the potential risk of HSV-1 infection.

63. *Brit Avraham ha-Kohen*, 199-200.

64. See Boffey P.M., “U.S. counters public fears AIDS,” *The New York Times*, 20 September 1985; Levine J, “AIDS: prejudice and progress,” *Time Magazine*, 8 September 1986; Korcock, M, “AIDS hysteria: a contagious side effect,” *Canadian Medical Association Journal* 133 (1985):1241-8.

65. See *Shu"t Iggerot Moshe Y.D.* (1:223).

## VI. To whom does *shomer peta'im Hashem* apply?

Many of the *posekim* cited previously required some element of counterbalance when taking upon one's self any level of risk – be it, that such actions are simply understood as natural and everyday occurrences, or be they elements of a mitzvah. When it comes to the latter, it is important to analyze who is performing the mitzvah and who is obligated in its performance.

### a. *Milah* of a child whose brothers died from their *milah*

The *Beit She'arim* (*ibid.*) explains that *shomer mitzvah lo yeda davar ra* does not allow [require] performing *milah* on a child whose two older brothers died from their *milah*, since the risk of danger is posed to the child and children are generally not obligated in *mitzvot*. It is the father who is obligated to perform *milah* on his eight day old child and it is he who performs the mitzvah.<sup>66</sup> Whenever there is a discrepancy between the person performing the mitzvah and the person to whom the mitzvah poses a danger, the *Beit She'arim* posits that we may not apply *shomer mitzvah lo yeda davar ra*. However, it is important to remember that R. Menashe Klein argues that despite the limitations that the *Beit She'arim* incorporated in the application of *shomer mitzvah lo yeda davar ra*, he nonetheless believed in an expansive definition of *shomer peta'im Hashem* and this case may be possibly covered by the latter principle. Presumably however, since this child's brothers died from their *milah*, there is some element of *chazakah*, that something may go wrong with this child's *milah* and therefore the danger is considered *shechiach hezeika* and not covered by *shomer peta'im Hashem*.

### b. The participants in the mitzvah of *milah*

Aside from the previous case of *shechiach hezeika*, (where harm is common) it seems that

*shomer peta'im Hashem* should apply in the case of a *milah* of a [genetically] healthy child. While the mitzvah per se is incumbent on the father, the child is integral to the mitzvah; the father cannot perform the mitzvah without him. The *Avnei Nezer* (Y.D. 321) seems to assume this position in discussing delaying the *milah* of a child with some leg deformity, when physicians state that therapeutic surgery must be done immediately and cannot wait until after the eighth day. After the

### *The risk of a permanent ambulatory disability overrides the mitzvah of performing the milah bi-zemanah, at its proper time*

surgery the child would be considered a *holeh* and his *milah* delayed until he recovers completely. While he decides that it is proper to delay the *milah* in this case, he analyzes the question in terms of how much suffering and / or risk a person must endure for the sake of performing a mitzvah. In the end he believes that the risk of a permanent ambulatory disability overrides the mitzvah of performing the *milah bi-zemanah*, at its proper time. Nonetheless, the question he poses relates to the baby himself – how much risk must the baby endure, despite the fact that the mitzvah of *milah* is incumbent upon the baby's father.<sup>67</sup>

The Rogachover Gaon (*Tzofnat Pa'aneach* 152) presents a very complex view of the different aspects of *milah* where he explains that *metzitzah* is really part of the child's mitzvah that he is to fulfill when he becomes of age, but we assume that he would allow his father to perform that mitzvah for him during his *milah*. Even though the mitzvah of *milah* is incumbent upon the father and not the child, since any risk to the child delays the mitzvah (since he is not obligated in its performance) –

66. *Shulchan Aruch* Y.D. (260:1).

67. This explanation is somewhat difficult however, since elsewhere, the *Avnei Nezer* (O.C. 444) states that specifically by *milah*, *shomer mitzvah lo yeda davar ra* can only apply to the father since it is only he who is obligated in the mitzvah. This apparent contradiction is left unresolved.

practically, it is equivalent to saying that the father's mitzvah is dependent upon the child's acceptance of risk. While indeed, these are two separate halachic actors (the father is obligated and the child is not) – they are intrinsically bound together. Therefore, both the *Avnei Nezer* and the Rogachover consider the mitzvah of *milah* to be considered somewhat 'belonging' to the child, at least enough to apply the dictum of *shomer mitzvah lo yeda davar ra*.

### c. Applying *shomer peta'im Hashem*

While the concept of *shomer mitzvah lo yeda davar ra* depends on the concomitant obligation and risk of performing a specific mitzvah, the *posekim* do not always require such a vigorous 'counter balance' to the application of *shomer peta'im Hashem* as mentioned previously. It is appropriate to refer to the *Torat Chesed's* (*ibid.*) understanding of the two different schools of thought regarding the nature of this principle – whether the risk is ignored because it is considered miniscule (Ritva) or because it is no longer considered to be halachically existent (Rashi). If we are to assume Rashi's position (and indeed the Hida showed that this was the position of the *Shulchan Aruch*), then it would appear that *shomer peta'im Hashem* applies to the possible risk incurred by the baby during *metzitzah b'peh*. If the risk is no longer considered existent, then even if we assume that one person's mitzvah obligation cannot override an unobligated person's risk of danger – the father may nonetheless perform the *milah* despite the possible risk, since it is no longer considered meaningfully existent. It would appear therefore, that many of the *posekim* that still require [optimally] performance of *metzitzah* specifically by oral suction, believe that any possible risk is below the halachically meaningful 'risk-threshold' – rendering such a potential risk as halachically non-existent and invoking the principle of *shomer peta'im Hashem*.

### C. How does halacha view competing risks? When can one risk outweigh the next?

The Gemara (*Shabbat* 133b) declares that a *mohel* who neglects to perform *metzitzah* puts the child at risk and 'we' depose the *mohel* from his position. As mentioned previously, *posekim* disagree as to the purpose of *metzitzah* and within both camps, there are various opinions as to the nature of the danger of neglecting *metzitzah*.

***The Gemara (Shabbat 133b) declares that a mohel who neglects to perform metzitzah puts the child at risk and 'we' depose the mohel from his position***

### I. What is the danger that *metzitzah* attempts to alleviate?

Throughout history, *posekim* have understood that after a *milah* the baby is in some type of danger and that performing *metzitzah* [properly] alleviates this risk. Many have argued that *metzitzah* comes to solve a medical or physiological problem – with various opinions attempting to identify the specific risk. Many of these opinions seem to reflect the 'contemporary' understanding of medicine of their respective generations.

#### a. Historical medical opinions

The Rambam (*Milah* 2:2) requires that the *metzitzah* be of sufficient strength to draw blood from 'the distant locations' (*ha-mekomot ha-rechokim*) but does not give a more accurate description of his requirement. From a modern medical perspective, one could speculate that since sterilization was not possible, the purpose of *metzitzah* was to remove any bacteria that may have accumulated on the wound during the *milah*. This would also explain why the Gemara (*Shabbat* 129a) views the third day after *milah* as the most 'dangerous' – despite *metzitzah's* best efforts, a bacterial infection, takes on average, three days to establish a systemic disease. The *Tiferet Yisrael*

(*Shabbat* 19, *Yakhin* 1) cites the ‘current’ medical opinion that *metzitzah* is meant to prevent swelling of the surrounding areas, while others mention the risk of inflammation if *metzitzah* is not performed properly.<sup>68</sup>

### b. Current medical opinion

Medical science today however, does not recognize any medical benefit to performing any sort of *metzitzah*, let alone *metzitzah b'peh*. Consequently, doctors who circumcise infants in hospitals do not apply any suction upon completing the incision; vacuum suction actually delays hemostasis, or the cessation of bleeding. While it is useful to clean the area of clots, ultimately in order to promote optimal healing conditions, direct pressure to occlude the source of bleeding and cleaning of the area with gauze is usually sufficient. Much of the scientific literature from the late nineteenth and early twentieth century adduced to defend the practice is no longer considered valid and is not relied upon medically.<sup>69</sup> Therefore, according to those who view *metzitzah* solely as preventive medicine, there seems to be little reason from a medical point of view to continue its practice today. For those who see two roles for *metzitzah*, with elements of both mitzvah and prevention, it seems appropriate to continue the practice because of the ritual aspects.

The question about *metzitzah* arises only when the procedure itself may pose a danger, as is contended by some today. It would seem that

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warrants violation of these  
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according to the first view, the two medical risks should be weighed against each other – the risk of not performing *metzitzah* vs. the risk of performing *metzitzah* and take the route of least risk. For those *posekim* who see some element of mitzvah as well in the act of *metzitzah*, the discussion of section B above is vitally important in deciding what risks may, or must be accepted in performing *mitzvot*.

### c. Other types of risks

Other *posekim* cite different types of dangers that *metzitzah* protects against – mostly non-medical risks. There are several mystical / kabbalistic descriptions of the risks that *metzitzah* alleviates with various explanations for the mechanism of this protective measure.<sup>70</sup> These *posekim* understand that the Gemara (*Shabbat* 133b) means to say that although performing *metzitzah* prevents only some supernatural or otherwise non-medical danger, it is nonetheless so important that we depose of any *mohel* who neglects the practice.<sup>71</sup> According to this view, it is impossible to weigh the risks of performance vs. non-performance against each other since the latter are supernatural and hence non-quantifiable. This equation would seemingly depend on how these *posekim* understand the reasons for *metzitzah*. If seen solely as a function of preventive medicine, it would appear that the possible medical risk of performing *metzitzah* would outweigh the mystically derived risk of non-performance. However, for those who view *metzitzah* as more than just preventive medicine, the equation is more complex as alluded to above.

68. See *Kovetz Dam Brit*, 1-2.

69. Many of these authorities were unaware of many of the myriad infectious agents known today and therefore could not have considered their effects appropriately. R. Goldberger quotes extensively (p. 26) from Dr. Sherhai (*Meishiv Nefesh*) indicating the ‘current’ medical opinion of 1906 that was unaware of blood borne pathogens. Today we are aware that many pathogens live, replicate and cause infection in the blood, making Dr. Sherhai’s discussions no longer relevant but nonetheless cited by R. Goldberger as authoritative.

70. Commentary of the Vilna *Ga'on* to the *Tikkunei Zohar* (37) and *Tikkun* 18 as well as *Sha'arei Orach* (*sha'ar* 5 in analyzing *Tehillim* 118) both cited by R. Goldberger, 82.

71. See R. Chayyim Vital, *Ta'amei ha-Mitzvot* (end of *parshat Lech Lecha*) and R. David Lida (*Sefer Sod Hashem*) cited by R. Goldberger, 96.

## II. The weighing of risks

R. Kook disagrees with these conclusions in one of his classic responsa dealing with medical science.<sup>72</sup> He argues that science and especially medical science cannot make absolute claims about health. It is a continuously changing field, with “one generation destroying what the previous had built.” He claims that by its very nature, medical science can at best only provide its current assumption for certain causes and effects and does not even view itself as the final arbiter of truth. Nonetheless, we rely on the best medical knowledge of our time when required to violate Shabbat or *Yom Tov*, since even a case of doubtful risk warrants violation of these commandments. However, in other areas of halacha, R. Kook claims that there is no solid proof that medical evidence can cause the abrogation of any Torah ordained mitzvah. His understanding is even more apparent today as we witness the most rapid progress of medical sciences in history. Harrison’s Principles of Internal Medicine, often considered the “bible of internal medicine,” begins with a Notice: “Medicine is an ever-changing science ... [the] information ... is complete and generally in accord with the standards accepted at the time of publication ... However, in view of ... changes in medical science ... neither the editors nor contributors ... of this work warrants that the information contained herein is in every respect accurate or complete.”<sup>73</sup> This “notice” forms the basis of modern medical education. Therapies that were thought to be beneficial are now understood to be harmful and surgeries that were routinely performed are now shunned for their recently discovered potential harm.

72. *Shu't Da'at Kohen* (142). In responsum 140 he elaborates further and attempts to prove that medicine is always halachically viewed as only possible truth.

73. Kasper, D.L., et al, *Harrison's Principles of Internal Medicine*, 16<sup>th</sup> ed. (New York: McGraw-Hill, 2005), vi.

### a. How to weigh potential dangers

R. Kook argues that since the Torah can and does provide absolutes, when Chazal declared that neglecting to perform *metzitzah* poses a risk to a child – they ‘knew’ this to be absolutely true.<sup>74</sup> In terms of halacha, this type of danger is considered a certain risk (*vadai sakkannah*), while medical risks are halachically defined as posing only possible risks (*safek sakkannah*). Therefore, any possible risk posed by *metzitzah* cannot be assumed to be ‘more dangerous’ than non-performance unless proven otherwise. Since the majority of the *posekim* cited throughout understand *metzitzah* to have both ritual and preventive medical elements and the possible risk of HSV transmission is far from proven – according to R. Kook’s logic it would seem appropriate to continue the standard practice of *metzitzah b'peh*.<sup>75</sup>

### b. Understanding medicine

The previous discussion assumes that any risk discussed by the Gemara must be taken very seriously and heeded to even in spite of contradictory medical opinion. The basic understanding is that since Torah is eternal, its dicta cannot be subject to contradiction by medical opinion, which by its very nature is transitory and non-absolutist. Such logic would be very cogent for the Maharam Schik and R. Yehudah Assad cited previously who believe that *metzitzah b'peh* derives from a *halacha le-Moshe mi-Sinai*. The same conclusion may not hold true for risks and precepts established by the rabbis. Authorities as early as R. Shereira Ga'on already claimed that the sages of the Talmud were indeed just that, sages and not

74. See also *Meshech Chochmah*, *Bo* quoting the Gra in explaining that the reasons expressed by the Sages for various laws are not exhaustive and, that for some reason, the Sages chose not to publicize other considerations.

75. It is important to note that R. Kook himself however, did not see any problem with using a tube to perform *metzitzah* and therefore recommended its use in any case of possible danger.

physicians and therefore, one should not employ their suggested medical therapies.<sup>76</sup> Many *posekim* however, do take many of these talmudic proclamations at face value and an even greater number adopt R. Kook's understanding of medical science and apply it practically in their halachic decisions. R. Kook's analysis is not without precedent as the Chatam Sofer, who preceded R. Kook by many years similarly explained that medical science is an empirical study and therefore can only establish theoretical, possible doubts (*sfek sefeikot*) but never anything absolute.<sup>77</sup> This understanding has formed the basic assumption about the practice of medicine in much of the current halachic-medical discussions. R. Ovadiah Yosef, R. Eliezer Yehudah Waldenburg and R. Yitzchak Ya'akov Weiss all adopt R. Kook's understanding of medical science and elaborate on it, issuing their *pesakim* accordingly.<sup>78</sup>

### c. Non-medical risks expressed by the Gemara

Aside from adopting R. Kook's approach, many *posekim* understand many of the talmudic discussions of specific dangers to be applicable in our times. Such an approach is not necessarily at odds with R. Shereira Ga'on's understanding, since frequently the reasons behind these dangers remains hidden. Therefore, one cannot assume that these dangers are necessarily medically understood and as such be dismissed based on R. Shereira Ga'on's dictum. Rather, there are many examples of these pronouncements that are taken quite literally by current *posekim* and require abstaining from such activities even today.

1. The Gemara (*Shabbat* 129a) states that a woman who has just given birth is considered to be a *holah she-yesh bah sakkannah* for first 72 hours post-partum. As such, Shabbat restrictions are set aside and she is exempt from fasting on Yom

76. *Otzar ha-Ge'onim X, Gittin* 68b. Such a trend is found throughout the rest of halachic history in many areas but it is beyond the scope of this article to trace this line of thinking.

77. *Shu"t Chatam Sofer Y.D.* (175).

78. *Shu"t Yabi'a Omer O.C.* (7:53), *Shu"t Tzitz Eliezer* (8:15:10, 14:89) and *Shu"t Minhat Yitzchak* (3:145).

Kippur. R. Ovadiah Yosef (*ibid.*) writes that despite a physician's opinion that such a woman is healthy enough to fast and the fast will not harm her or the baby in any way – she is still forbidden from fasting since Chazal already decided that she is in a state of *sakkannah*.

2. When a baby suffers from jaundice, the halacha (*Yoreh De'ah* 263:1) requires that the *milah* be postponed; the length of postponement depends on the type of jaundice present.<sup>79</sup> In addition, many *mohalim* have a tradition

***Many mohalim have a tradition (mesorah) as to postponing a milah based on the shade of the baby's skin***

(*mesorah*) as to postponing a *milah* based on the shade of the baby's skin. R. Yitzchak Weiss (*ibid.*) explains that if even if expert physicians claim that there is no risk in circumcising such an infant, it is still forbidden to do so, since the halacha categorically considers such a child to be in a state of *sakkannah*.

3. In defining how one ascertains whether or not some danger requires the violation of Shabbat regulations, the *Shulchan Aruch* (O.C. 328:3-4) states that certain injuries always mandate a necessary violation – such as injuries to the back (dorsal surface) of the hand or foot, as well as a disease known as *tzafдина*, a certain type of tooth disease. While doctors may decide that any such injuries are in fact non-threatening, the *Peri Megadim* (O.C. MZ 328:2) and *Bach* (O.C. 328:2) explain that since Chazal declared such dangers as *sakkannot*, Shabbat violations are still appropriate. The *Tzitz Eliezer* (*ibid.*) expands upon this principle and expands it to several other specific maladies mentioned by Chazal, which in spite of current medical opinion to the contrary, still permit Shabbat violations.

79. See R. Joshua Flug, "Jaundice and Circumcision," *JME* 5 (2004):40-8.

#### d. Possible applications

Assuming the *posekim* understand and take seriously Chazal's concern for the danger of not performing *metzitzah* – there is legitimate concern for performing it accurately and correctly. While there is a possible medical risk of danger to the infant through this procedure, these *posekim* nonetheless view the process as definitely halachically therapeutic. In our case, the therapy that halacha demands poses a dilemma: action entails a potential medical risk whereas inaction would result in a definite risk. This discussion therefore should then relate to how halacha views using a potentially risky therapy (*safek sakkanah*) to treat a more dangerous (*vaday sakkanah* as per R. Kook) underlying condition. Such a discussion is beyond the scope of this paper, but see *Nishmat Avraham* 2 (155:2) for a thorough analysis and review of applications of this topic.

#### IV. Conclusion

The halacha demands that a person extend great effort in performing its precepts – possibly laying out large sums of money and undergoing personal hardships. These demands include accepting certain levels of risk as outlined above, relying on the framework of *shomer peta'im* Hashem. We hope that this article has provided a proper framework for assessing how the potential risks involved with *metzitzah b'peh* fit into the general understanding of risk-taking in halacha as a starting point for further discussion.

## International Responsa Project

**Subject:** BRCA

**Date:** August 2007

**Q:** *Does Jewish law permit a healthy woman who has tested positive for a mutation in the BRCA 1 gene to undergo a prophylactic bilateral mastectomy? If so, what are the halachic grounds by which we permit a currently healthy woman to take on the risks of surgery and unknown possibly deleterious long-term consequences of surgery?*

**A:** 1. Jewish law does permit a healthy woman who has tested positive for a mutation in the BRCA 1 gene to undergo a prophylactic bilateral mastectomy.

2. A person is allowed to put himself at risk in order to avoid more severe risk in the future.

See also Tr. *Avoda Zara* 27 ב"ב עמוד ב'.

**Subject:** Feeding with a tube on Shabbat

**Date:** August 2007

**Q:** *I'd like to ask a shaalah.*

*My niece is severely braindamaged, and feeds with a tube through her intestines in her stomach. She is 2.5 years old. My brother's family is not religious, but I will be visiting and want to know whether on Shabbat I will be able to feed her turn on and off the machine that feeds into her stomach. Am I allowed to charge the machine on shabbos if the battery is dead (I realize that this should be done before Shabbat but in the case that it isn't).*

*Also, is the machine considered muksah when she is not feeding? If I want to take her for a walk with an eiruv, can I take the machine too, in case I need to feed her later?*

**A:** If possible you should ask a non-Jew to turn the machine on and off. If not, do it with the knuckle of your finger.

Similarly, ask a non-Jew to charge the battery or, if not able do so using both hands at the same time to attach and remove it from the charger.

The machine is not *muksah* and you may take it with you.

*Tizke l'mitzvot*

Continuation of the IRP section on p. 64

# *Establishing the Moment of Death in Transplantation Procedures\**

Yitschak Shilat

translated by David Fink, Ph.D.

## **I. Introduction**

The question of establishing the moment of death according to halacha is still a question of public interest. The question has become more pressing in the course of the last few decades because of the impressive advances in transplantation techniques, including heart, liver, and lung transplantation. Otherwise hopeless cases have been successfully treated, leading to vastly increased life-expectancy. There is therefore an urgent need to establish the halachic moment of death in a clear and definitive manner since only after that moment can the donor's organs be removed.

The question has been widely discussed. The Schlesinger Institute recently published a collection of articles under the editorship of Rabbi Dr. Mordechai Halperin dealing with the moment of death (Jerusalem, 5766). The collection contains basic articles which have appeared in Hebrew together with up-to-date surveys reprinted from the new edition of Rabbi Prof. Avraham Steinberg's *Medical-Halachic Encyclopedia*.

Controversy among the *posekim*, even in the most serious matters, is not surprising to anyone familiar with rabbinic literature. Halachic controversy exists in every area, including matters of life and death. Study of the Talmudic passages dealing with

martyrdom and "standing idly by while one's neighbor is endangered" suffices to demonstrate the existence of controversy from the days of the Mishna through the contemporary authorities.

In those historical periods when we had a supreme halachic authority accepted by Jews everywhere, such as the Sanhedrin in late antiquity, such controversies would be resolved and a binding halacha would be established for all Jews. Without such a supreme halachic authority, there are principles for correct halachic conduct. Such principles are of course halachic themselves. For example, when two rabbinic authorities, or two rabbinic courts, disagree in the absence of the Sanhedrin or prior to the decision of the Sanhedrin, it does not matter if they are contemporaries or from different times. If one decides "pure" and the other "impure" or if one decides "prohibited" and the other "permitted" and you do not know who is right, follow the stricter opinion in matters of biblical origin and the follow the lenient opinion in matters of rabbinic origin.

***There is therefore an urgent need to establish the halachic moment of death in a clear and definitive manner***

(Rambam, *Hilchot Mamerim* 1:5, following Tract. A.Z. 7a)

Another well-known principle permits any individuals or any community to follow the opinion of their rabbi or their local authority even if many disagree with him. This is the opinion of the Chazon Ish:

\* The original article was first published in Hebrew with extensive footnotes in the second addition of *Establishing the Moment of Death, Collection of Essays*. Rabbi Mordechai Halperin M.D. (Ed.) (Jerusalem, 2007) pp. 277-295.

The principle calling for strictness in matters of biblical origin applies only if none of the contending authorities is your rabbi. But if one of the authorities is your rabbi, follow him even if he is lenient. Your rabbi is the one to whom you are close and to whom you listen in most mitzvah matters... This rule applies both during the lifetime of your rabbi and after his death, as long as his opinions are known either through his writings or through his disciples. One may act leniently following one's rabbi even in matters of biblical origin and even if he is in the minority as long as no rabbinic court has adjudicated the matter and determined the halacha definitively. This is the meaning of what the Sages said (Tract. *Yevamot* 14a): In Rabbi Eliezer's locale they chopped down trees to make charcoal on Shabbat, etc. In Rabbi Yosi's locale they ate fowl and milk together.

(Chazon Ish, *Shevi'it* 23:1; *Y.D.* 150:1)

This article is firstly a brief summary of the well-established principles that permit, and therefore require, organ transplantation. Several great Torah scholars of our generation have permitted such procedures. They have explained the basis of their permissive ruling in the above-mentioned collection of articles published by the Schlesinger Institute.

In addition, I shall comment on the position of those quoted in the collection of articles as opposing transplantation and explain my objections to them.

However, my main purpose in this article is to shed some light on the topic from another point of view which has until now been considered relatively unimportant but which in my opinion has great halachic weight. My point revolves around the relationship between the prohibition of killing and the destruction of the image of God inherent in every man.

## II. Cardiac Death and Brain Death

Let us first examine the medical terms and concepts which pertain to our topic. Then we can proceed with the halachic analysis.

In the world of medicine there are two current standards for establishing death:

1. Cardiac death: terminal and irreversible cessation of the beating of the heart.
2. Brain death: terminal and irreversible cessation of brain stem function.

The brain stem is the lower part of the brain, connecting the brain to the spinal column and to other parts of the body and transmitting the instructions of the brain to them. Part of the brain stem is responsible, among other functions, for operating the muscles used in breathing. Breathing "control" therefore depends on the brain stem, without which autonomous breathing would be impossible.

The heart, on the other hand, has its own internal "control" center which regulates the heart beat. That is why the heart can continue to beat for a certain time even if disconnected from the brain and even if the heart is completely removed from the body.

If the brain stem is destroyed and ceases to function irreversibly, terminal and irreversible cessation of autonomous breathing results. It remains possible, however, to ventilate the lungs with a mechanical respirator in order to maintain the flow of oxygen into the blood system.

The gap in time between brain death and cardiac death is generally not long. Experience has shown that when the brain and the heart and the other parts of the body are no longer connected, it is difficult to maintain circulatory function for more than a few days, after which time the heart stops beating despite its internal "control." Cardiac function, as well as other systems in the body, depends largely on brain function. Other systems in the body therefore shut down shortly after brain death.

The duration of this gap in time is critical for transplantation procedures because most vital organs are fit for transplantation only when they are removed from a dead body whose cardiac and circulatory functions are being maintained artificially.

Shortly after cardiac death, most vital organs (aside from the kidneys) are no longer fit for transplantation. Since the preparation of the patient who is to receive a transplanted organ is itself a time-consuming surgical procedure, it follows that there is no practical way to transplant central organs after cardiac death.

Therefore, it is critical to establish whether brain death is a sufficient standard. We must tread carefully in this discussion, deviating from the truth neither to the left nor to the right. Unjustified strictness would prevent lifesaving in cases where patients require transplantations; unjustified leniency would lead to killing the donor. We need a clear-cut halachic decision in accord with the clarity of the rabbi's awareness and the depth of his prayers that he not err.

### III. The Talmudic Passage in Yoma and the Moment of Death

Here is the principal talmudic passage dealing with our topic:

The possibility of lifesaving supersedes Shabbat. If someone might or might not be trapped under a collapsed structure and, assuming that he is there, might or might not be alive, we violate Shabbat to excavate him. If he is found alive, we continue the excavation. If he is found dead, we leave him [until after Shabbat].

(Mishna, *Yoma* 83a)

In the Talmud (*Yoma* 85a) the question is asked: "If he is found alive, we obviously continue the excavation. So why, then, did the law have to be stated? And is answered: we continue the excavation even if he will live only briefly."

The Talmud continues:

The Sages taught: How far does one check? To his nose. Some say: to his heart. (This is Rashi's reading. But according to the reading of Rabbenu Hananel, Rabbi Alfasi, and Rabbenu Asher, some say "to his navel.")

(If there were several people trapped under the collapse, and) the higher ones were found dead, do not say that the ones trapped lower down are also already dead.

***Life resides in the nose, as it is written "In whose nose was the breath of life (Gen. 7:22)"***

It once transpired that they found the upper ones dead and those lower down were still alive.

Perhaps these authorities agree with those who taught: Where does the fetus

begin growing? From its head, as it is written "You took me from my mother's womb (Psalm 71:6)" and it is written, "take your hair and cast it away (Jer. 7:29)."

Abba Shaul says: From its navel which sends its roots in every direction. One might say that (the first view agrees with) Abba Shaul because Abba Shaul spoke only with regard to the first formation as everything develops from its middle. But regarding lifesaving even Abba Shaul would agree that life resides in the nose, as it is written, "In whose nose was the breath of life (Gen. 7:22)."

Rav Pappa said: This dispute pertains only if the examination proceeded from the feet toward the head. But if he is examined from the head down then checking his nose is sufficient, as it is written "In whose nose was the breath of life (Gen. 7:22)."

(Tractate *Yoma* 85a)

Rashi explained: "This dispute pertains only if the person was examined from the feet towards the head" - the dispute between those who say that one checks to his heart and those who say that one checks to his nose. According to one opinion, checking his heart will determine whether he is alive if his "soul beats there." According to the other opinion, one checks to his nose because sometimes life can be perceived in his nose when it cannot be perceived in his heart.

According to Rashi, those who require checking to his heart are interested in determining whether he has a perceptible pulse. But according to Rav Pappa, who taught that everyone agrees that it is sufficient to check the nose of a victim if the examination begins at the head, it follows that absence of breathing determines death even though the Sages must have known what is known to any trauma clinician, namely that there are cases where the patient is not breathing but still has a pulse. If pulse by itself were an essential indication of life, it would be insufficient to rely on the absence of breathing at the nose in establishing the victim's death.

It appears, however, that when Rashi mentioned checking whether "his soul beats there," he was actually referring to a method of checking respiration. He meant that one checks the area of the chest to see whether the victim is breathing. If the victim's chest rises and falls, there is a dispute whether such a determination is sufficient or whether one needs to check the victim's nose specifically since everyone agrees that checking the nose is more reliable as "sometimes life can be perceived in his nose when it cannot be perceived in his heart."

Therefore if the examination begins at the head, everyone agrees that checking the nose is sufficient.

[Rashi's phrase "sometimes life can be perceived in his nose when it cannot be perceived in his heart" also indicates that he is not referring to what we call pulse because there is no respiratory pulse. In *Resp. Haham Tsevi* (No. 77, s.v. *u-mishnato*) it appears that Rashi was indeed referring to what we call pulse since the pulse is sometimes very shallow and cannot be detected in the chest area. Therefore, one must further check the victim's nose to determine whether there is any breath. Even according to this understanding, it is clear that Rashi can still adhere to respiration as the definitive criterion.

But those who require checking the heart when beginning at the legs are of the opinion that a beating heart indicates that there might be indications of breathing. The absence of cardiac beating would indicate that the victim is surely not breathing.

Those who require checking the nose are of the opinion that checking the heart is unreliable because breathing is possible with no signs in the heart.

This responsum of the *Haham Tsevi* is discussed further *infra*, sect V.]

Whatever Rashi might have meant, the reading of Rabbenu Hananel, Rabbi Alfasi, and Rabbenu Asher "to his navel" corresponds to the reading of all known manuscripts of the Talmud (see *Dikdukei Soferim*). This reading is also explicitly supported by the Palestinian Talmud (*Yoma* 8:5) as well as implicitly by the Babylonian text: "Abba Shaul says:

***The conclusion to be drawn from the Talmud is that terminal cessation of breathing is the sign that a person has died***

From its navel it sends its roots." Now it is clear that checking the area of the navel can only be related to respiration, not cardiac function. According to this, the principal reading of the text, the Talmud mentions no sign of life other than breathing.

According to the *poskim*, we must check the nose of a victim caught under a collapsed structure. Maimonides wrote (*Shabbat* 2:19): If someone is under a collapsed structure and found alive, one excavates him even though he is crushed, cannot recover, and will only live a brief time. If they checked his nose and found no life, he is left where he is because he is already dead.

The *Tur* and the *Shulchan Aruch* (O.H. 329:3-4) wrote: If someone is under a collapsed structure and found alive, one excavates him until his nose is exposed even though he is crushed and cannot live more than a moment. If no life is perceived at his nose, he is surely dead whether his head or his feet were uncovered first.

Today, it must be emphasized, modern medicine has methods like mouth-to-mouth resuscitation which restore autonomous breathing to a patient whose respiratory function has failed. It follows that a victim must be excavated even if he has no sign of breathing at his nose because if the cessation of breathing occurred shortly before he was found, there is a chance to save him. The rule is: the possibility of lifesaving supersedes Shabbat.

The conclusion to be drawn from the Talmud is that terminal cessation of breathing is the sign that a person has died (because if he is not dead it is correct to violate Shabbat to lengthen his life, even though he will certainly die soon). Can we further conclude that the moment that breathing stops is the moment of death? Apparently, such a conclusion does not necessarily flow from the halacha based on the Talmud because it is possible that death precedes the cessation of breathing and the cessation merely constitutes a sign that the person is already dead. However, the proof text adduced in the Talmud "*In whose nose was the breath of life (Gen. 7:22)*" does indeed imply that the moment of death coincides with the moment of cessation of breathing because the verse refers to the breath of life. This means that as long as a person is breathing, he is alive. Similarly, the Torah says regarding things living on dry land that "*all creatures with the breath of life in their nostrils upon the dry land... died.*"

If a person is halachically dead when he stops breathing, it follows that terminal cessation of breathing is the definition of death. It is obvious that in cases of temporary, reversible cessation of breathing it is possible that the patient might recover his ability to breath. In such cases, the patient is not to be considered dead. As mentioned above, whenever techniques exist to restore breathing, Shabbat is superseded to save the patient's life. Death is terminal, irreversible cessation of the ability to breath.

Now, medical science establishes with absolute certainty, both on the basis of the theory of

physiology and on the basis of practical experience in thousands of cases without any exception, that destruction of the brain stem means terminal and irreversible loss of the capacity to perform autonomous breathing. In this situation, there is no mechanical respirator which can restore autonomous breathing. The respirator's pump can force air into the patient's lungs, causing them to rise and fall; artificial breathing can take place, preserving blood circulation and cardiac function for a time. But autonomous breathing will never be restored. (On the other hand, in cases where cessation of breathing is not due to the destruction of the brain stem, artificial respiration might save the patient's life, enabling the body to continue functioning until autonomous breathing can be restored when the body overcomes the disease from which it is suffering.)

Artificial respiration can surely not be considered breathing. It is not "*the breath of life in his nostrils.*" The mechanical ventilator pumps oxygen rich air into the patient's lungs. After an exchange of materials which takes place in the lungs, carbon dioxide rich air is pumped out of the lungs. In a person's "nostrils," *i.e.*, in his facial orifices through which the air passes, there is no perceptible breath of life because the air passes to and from the ventilator through a sealed tube. It therefore seems reasonable that the case of a mechanically ventilated cadaver does not correspond to what the Torah calls "*the breath of life in his nostrils.*"

A further proof can be adduced from the Mishna:

A person conveys no ritual impurity until his soul departs, even if his arteries are cut open and even if he is on the verge of death... Similarly, an animal conveys no ritual impurity until its soul departs. If they are decapitated, they are impure even if they are still twitching as the tail of a lizard twitches.

Tractate *Ohalot* (1:6)

According to this Mishna, decapitation constitutes death even if the body continues to move. In *Iggerot Moshe* (Y.D. 3:132), Rabbi Moshe Feinstein compares the state of brain death and the severing of the connection of the brain to the rest of the body with decapitation where even subsequent artificial respiration and circulation of blood do not constitute life.

#### IV. The Contemporary Controversy

There have been two stages in the public debate over establishing the moment of halachic death: (1) Around two hundred years ago at the end of the 18th century the law in the Duchy of Mecklenburg in Germany required delaying burial for three days after a physician had certified death. The delay was intended to prevent errors, and some wanted to accept the three day delay in burial as halachically correct. In opposition, several great *poskim at the end of the 18<sup>th</sup> century and the beginning of the 19<sup>th</sup> century* claimed that we can rely only the signs of death established by the Sages, and delaying burial violates the halacha. (2) The question of establishing the moment of death has arisen a second time in our days in connection with transplantation procedures, especially heart transplantation. The failure of early heart transplantation led to initial, widespread rabbinic opposition. The rabbis spoke of “double murder,” since the procedure killed both the donor and the recipient. In the course of time, however, there occurred two great medical advances enabling: (a) clear and absolute determination of irreversible brain death pursuant to which there is no autonomous breathing; and (b) transplantation procedures became more successful and lengthened life (due to the introduction of a drug to suppress rejection of the transplanted organ).

As a result of these developments it became possible to remove the beating heart from a brain-dead donor. Although the donor is indeed brain dead, his heart continues to beat due to the oxygen provided by a mechanical respirator. In view of this,

it is of critical importance to determine whether brain death is halachically considered death.

***Artificial respiration can surely not be considered breathing. It is not “the breath of life in his nostrils.”***

The Chief Rabbis of Israel, Rabbi Shapiro and Rabbi Eliyahu, set up a special committee of great Torah scholars and medical specialists to analyze this issue. The committee was chaired by Rabbi Shaul Yisraeli and in the year 5747 concluded that brain death is to be considered death allowing the removal of organs for the purpose of transplantation into the body of patients with life threatening conditions. This conclusion resulted from a series of detailed and extremely reliable tests which proved beyond a doubt the irreversible condition of the brain stem.

Rabbi Moshe Feinstein essentially concurred with this position even though a number of his published responsa left some doubt regarding his opinion (see *Iggerot Moshe* Y.D. 2:146, H.M. 2:72, Y.D. 3:132). In a letter written subsequent to his published responsa he explained his final opinion: “Although the heart is still able to beat for a number of days, as long as the patient has no autonomous breathing he is nonetheless considered dead as I explained in *Iggerot Moshe* Y.D. 3:132.”

Rabbi Feinstein’s son, Rabbi David Feinstein, and his grand son-in-law and editor, Rabbi Sh. Rappaport, similarly testified that this represented his opinion correctly.

The final opinion of Rabbi Sh.Z. Auerbach also recognized complete brain death as being equivalent to decapitation. However, he viewed “brain death” as currently defined as a state of dubious death (*safek met, safek goses*).

On the other hand, some great contemporary *poskim* (Rabbi E.Y. Valdenberg, Rabbi Sh. Wosner, and Rabbi Y.Sh. Eliashiv) are of the opinion that without cardiac death, that is cessation of beating, no one can be considered dead.

Their principal sources are: Rashi in *Yoma* 85a, *Resp. Chacham Tsevi* 77, and *Resp. Chatam Sofer* Y.D. 338. We shall discuss their proofs based on these sources below.

## V. Responses to the Claims against Brain Death

1. In section III above we dealt with the passage in Tractate *Yoma* and Rashi's commentary. We saw there that Rashi's words "the master says that one discerns life at the heart, where the soul beats" prove, even if Rashi refers to heart beat, only that when the pulse has stopped a man is certainly dead. But Rashi does not say that without the absence of pulse death is not present. Indeed, the opposite is implied by Rav Pappa's conclusion that everyone agrees that when checking begins at the head checking the nose is sufficient. According to this, cessation of respiration is sufficient, even when the pulse continues.

Rabbi E.Y. Valdenberg explained the position of the Sages that death depends on the cessation of breath of the nose as really intending a strict position when cessation of breathing occurs after the heart stops beating (*i.e.*, cessation of both the pulse and the breathing are required). Rashi explicitly formulated this idea in his commentary on *Yoma* (*ibid.*): The master said "to his nose" because life is occasionally noticeable at his nose but not his heart." This is the point of the Talmud in requiring no more than checking the nose when the victim is found erect because in such a case it is to be assumed that there is no sign of life at the heart.

But I beg to suggest that Rabbi Valdenberg's explanation is not consonant with the facts because

in the absence of a pulse no respiration is possible. It is therefore impossible to consider cessation of breathing as an additional, strict requirement. According to the understanding of Rashi presented in the *Haham Tsevi*, as adduced by Rabbi Valdenberg himself, we have already concluded that there is no proof that cessation of the pulse is required.

Rabbi Sh. Wosner wrote:

***The Chief Rabbis of Israel, Rabbi Shapiro and Rabbi Eliyahu, concluded that brain death is to be considered death allowing the removal of organs for the purpose of transplantation into the body of patients with life threatening conditions.***

Regarding the passage in Tractate *Yoma*... it is obvious that they said to check as far as his nose. Even according to this opinion, not only the breathing of the nose is intended. Rather, they said to check as far as his nose, for if he is found under a pile of rubble and his body is crushed and his brain entirely severed he is definitely dead. Thus one checks as far as his nose by examining his temples and the tendons of his neck for, as is well known, the beating of the heart is

observable there. If there is no beating at his temples or in the tendons of his neck, the victim's death can be established by examining the absence of breathing at his nose... We need not fear for the extraordinary possibility that after all these tests have been done, life in the heart will subsequently be observed.

(*Assia* 42-43 pp. 92-94, 1987)

If one checks the victim from the head down, Rabbi Wosner requires examining the pulse at the neck. In my humble opinion, this cannot be the sense of the passage because the nose is higher than the neck.

Further, his requiring examination of the temples is not mentioned anywhere in the Talmud. Why should such an examination be required without a talmudic source?

Furthermore this position requires another innovation namely that examination of the pulse at the temples is not equivalent to examination of the pulse at the heart, for according to the opinion that one examines a victim from the legs up to the heart it is sufficient to examine the heart. But if one examines from the head down it is not sufficient to examine the pulse at the temples. Rather, everyone agrees that one must check “as far as the nose.”

Furthermore, both Rabbis Wosner and Valdenberg espouse a novel, non-obvious understanding. According to their understanding, checking up to the nose of a victim caught under collapsed rubble relies on the likelihood that absence of breathing at the nose indicates cessation of beating of the heart even though they simultaneously assert that cessation of cardiac function is part of the definition of death. In their opinion we ignore the possibility that the victim’s heart is still beating.

In addition, consider the following essential point. According to Rabbenu Hananel, Rabbi Alfasi, and Rabbenu Asher, “up to his navel” is the correct reading. This reading is supported by the Palestinian Talmud and the simple meaning of the context. The Talmud mentions nothing about the heart and its beating. Indeed, it discusses only the checking of breathing.

2. Regarding the responsum of the Haham Tsevi (number 77): This responsum deals with the kashrut of a chicken which seemed to have no heart. Haham Tsevi discussed the question at length and demonstrated that in fact neither person nor animal nor fowl can live without a heart because life depends on the heart. It follows that the chicken in question surely had a heart which was lost after cutting it open.

The position of Haham Tsevi that it is impossible to live without a heart is obvious from a scientific point of view because the heart is the source of circulation and without circulation neither the brain nor any other organ can live. Without a functioning heart, the organism dies.

Haham Tsevi adds, however: “because all agree that the seat of a creature’s vital spirit is in the heart, as I shall explain. The organs cannot live or be nourished without the vital spirit which resides in the heart (s.v. *ve-ani*).”

Further: “It is well known that the heart is the seat of the vital spirit (s.v. *ve-ha-rav*).” He also wrote (s.v. *ma*) that the gentile scholars disagree regarding the source of mobility of the limbs. According to Galen, the source is in the brain; according to Aristotle, it is in the heart; and according to Maimonides, Aristotle had it right: “Even those who ascribe the source of motion to the brain must agree that life depends only on the heart. No one ever rejected this view.”

***The Talmud mentions nothing about the heart and its beating. Indeed, it discusses only the checking of breathing.***

Following the opinion of Haham Tsevi, Rabbi Valdenberg wrote\*\*:

The ancient gentile scholars disagreed regarding the dependence of life on the brain or the heart. Galen established that life depends on the brain; Aristotle believed that life depends on the heart. Our great Teacher, Maimonides, decided the issue in favor of Aristotle. As long as there is life in the heart, the creature is considered to be alive. It is clear that we adhere to Maimonides’ decision; his opinion is final and binding upon us. Haham Tsevi in his responsa (number 77) definitively established Maimonides’ opinion as normative and added that even those who believe that motion originates in the brain

\*\* See: Rabbi Eliezer Yehuda Valdenberg, *The Prohibition of Heart and Liver Transplantation*, Establishing the Moment of Death, ed. M. Halperin, p. 207, 2007; republished from *Assia* book 7 pp. 149-162, 1993

agree that life depends on the heart because no one ever rejected this view.

First of all, there is an internal contradiction in his position because he begins by writing that the gentile scholars disagreed about life depending on the heart or the brain. But he ends by writing that this controversy relates to the source of mobility and that all authorities agree that life depends on the heart.

The principal question, however, is what they meant when they said that the heart is “the seat of life.” Does the moment of death in humans indeed depend on the heart? Later we will deal with this question.

Further, Haham Tsevi wrote:

Breath departing from the heart is apparent through the lung as long as the heart be alive. It is perfectly clear that there is no breath without life in the heart, from which and for the purpose of which there is breath. Thus wrote Rabbi Abraham ibn Ezra on the verse “he breathed into his nose the spirit of life (Gen. 2:7)”: *The reason the verse mentions “nose” is because man lives by his nose because the nose removes warm air that gets its warmth from the heart and brings in fresh air.* Ibn Ezra implies that life depends on the nose because the nose expels hot air from the heart and brings in cool air to cool the heart. Without a heart, there is no respiration.

(s.v. *u-mishnateinu*, end)

Haham Tsevi is claiming, and from the scientific point of view he is entirely correct, that respiration is impossible without the heart. When the talmudic sages determined that breathing is a sign of life, they relied on the underlying fact of cardiac function. (The correctness of the theory of respiration as conceived in the days of Rabbi ibn Ezra and Haham Tsevi is irrelevant.)

Further, all this proves only that cardiac death is certainly death. But we have not yet proven that death cannot be defined by terminal cessation of breathing prior to cardiac death.

(3) Let us now turn to the responsum of Hatam Sofer (*Y.D.* 338). In its first part, this responsum deals with the permissibility of delaying burial in order to verify the fact of death. According to Hatam Sofer, not a single Torah authority is lenient in this regard. The only reason some people delay burial to verify the fact of death is a royal edict requiring such delay. But this is not the Torah position. According to Torah law, it is prohibited to delay burial unnecessarily. If you ask how the talmudic sages knew exactly when death occurred, the answer is:

The measure of death was necessarily transmitted to us. Perhaps there was a tradition among the early natural scientists which has since been forgotten by contemporary physicians.

The talmudic Sages relied upon those early scientists in many Torah matters, as explained in Tractate *Shabbat* (folio 85a). There they referred to the verse “do not trespass your neighbor’s border as established by those of old (Deut. 19:14).” Or, if they had no tradition from the early scientists, they must have received a tradition defining the measure of death as passed on by the sages since the revelation at Mount Sinai. Or perhaps they relied on their understanding that the verse “all who have the spirit of life in their noses” implies that life depends on the breath of the nose, as is clear in Tractate *Yoma* (folio 85b), Maimonides, *Tur*, and *Shulchan Aruch*.

It is very interesting that Hatam Sofer suggested that the halacha regarding the moment of death could have been based on one of three sources: (a) knowledge gleaned from the natural

***contemporary scientific  
knowledge which regards brain  
death and irreversible  
cessation of respiration as  
equivalent to death squares  
perfectly with the opinion  
ascribed by Hatam Sofer to the  
ancient natural scientists.***

scientists; (b) knowledge based on a tradition originating with the revelation at Mount Sinai; (c) biblical exegesis.

The reason for this rests in Hatam Sofer's uncertainty regarding the validity of the exegesis of the verse "all who have the spirit of life in their noses" for the verse only states that all who breathe are alive. But the verse seems not to state that absence of breath is a certain sign of death. How, then, can we say that checking up to the nose is sufficient? Rather, Hatam Sofer tells us, the traditionally transmitted halacha originating from Mount Sinai establishes breathing as a criterion. Knowing that, the Sages associated the knowledge with the verse. Alternatively, the Sages knew what they knew on the basis of the wisdom of the early scientists and accordingly associated that knowledge to the verse.

In any event, Hatam Sofer did not decide the matter because it is still possible that the halacha truly derives from the verse implying that breath is a sufficient and necessary condition for life.

Hatam Sofer adds:

It is untenable to claim, as my dear friend has, that a victim caught under collapsed rubble is different because the verse "all who have the spirit of life in their noses" is referring to such a case. Further, the converse is well known, namely that in apparent sudden death there is more concern of error because of the panicked nature of the event. This is similar to the case of paralysis, generally called a stroke. Never the less once breathing stops, it is no longer permitted to violate Shabbat to save the patient. It necessarily follows that the rule applies to all deaths: the measure of death has been accepted in Judaism since our becoming a holy nation; all the winds in the world will not displace us from following the rules of the Torah.

Hatam Sofer is clearly referring to irreversible cessation of respiration because he himself adduced

the examples "apparent death" where breathing stopped for a short time due to panic or due to passing paralysis. In these examples, breathing might be restored. But irreversible cessation of respiration is the criterion of death accepted in Judaism, and all the winds in the world will not displace from this rule.

***in order to verify that the cessation of breathing is not temporary, we consider the patient's general condition.***

We are led to the conclusion that contemporary scientific knowledge which regards brain death and irreversible cessation of respiration as equivalent to death squares perfectly with the opinion ascribed by Hatam Sofer to the ancient natural scientists.

Now Hatam Sofer quotes Maimonides (*Hilchot Aveilut* 4:5) prohibiting closing the patient's eyes as his soul departs. "Instead, one waits a short time lest the patient have merely fainted." Hatam Sofer proves from the use of the phrase "a short time" that Maimonides did not mean hours or days. Rather, he required a brief waiting period because some cases of apparent death with cessation of breathing and pulse can persist for a short time after which the patient recovers.

On the other hand, Hatam Sofer quotes Maimonides (*Guide* 1:42) as mentioning certain diseases, such as paralysis or hysteria, where no breathing is apparent and no determination of death can be made for a day or two.

This seems contradictory. If there are cases where respiration can appear to cease for a day or two and where, therefore, no determination of death can be made, why is it sufficient to wait a brief time "lest the patient have merely fainted?"

The answer seems simple: Consider a patient who is not suffering from any of the rare conditions like paralysis or hysteria, or an unidentified victim caught under the rubble of a collapsed building.

Cessation of breathing for a short time in such a case is sufficient evidence of death. In such a case we need not be concerned with the improbable situations described above. In general, therefore, a short waiting time is sufficient to establish that cessation of breathing is irreversible rather than temporary.

It is clear that a brief wait is mandatory in order to check all the patient's signs to the best of our ability, lest the death be only apparent and not real. Temporary cessation of breathing is reversible. Therefore Hatam Sofer writes:

But after he appears to be stone dead without pulse, if subsequently the respiration arrests, we follow the principles of the Torah and consider him dead. Therefore, we do not delay his burial.

This means that in order to verify that the cessation of breathing is not temporary, we consider the patient's general condition. If he is lying still as a stone without reacting to any stimulus, and if he has no pulse and no signs of breathing, we wait a brief time to verify his condition, then we know that the cessation of breathing is irreversible and the patient's death can be established.

On the other hand, if the patient has a pulse, or if his body displays mobility, we cannot establish his death on the basis of the absence of breathing because he might start breathing again.

It is clear that Hatam Sofer does not mean that the condition of being "stone dead" is a necessary condition for establishing death because the Mishna (Tractate *Ohalot* 1:6) makes clear that a person who has been decapitated, but who is still convulsing, is not yet considered "stone dead" although he is indeed already dead.

Haham Tsevi (s.v. *u-mishnateinu*) adduces a proof from Tractate *Sota* (folio 45b) that a person who is decapitated while running will continue running a brief time until he collapses. Therefore, just as the requirement of being "stone dead" is not an essential condition for establishing death in every case, similarly the requirement of cessation of pulse is not necessary in every case. In our days, when

ventilating machines maintain the patient's pulse even after the death of his brain stem, cessation of pulse is not a necessary condition even though autonomous respiration will never be restored.

In such a case Hatam Sofer did not require total cessation of pulse. Continued pulse is merely an indication of the possibility of restoring respiration in routine cases.

## VI. The Image of God and the Prohibition of Murder

Let us return to the position of Haham Tsevi, who said that everyone agrees that the seat of the vital soul (*i.e.* the vegetative soul) is in the heart. What, exactly, is the vital soul?

Maimonides wrote:

You must know that man has a single soul with many distinct faculties. Since some of those actions are called souls, it might be thought that man has multiple souls. Physicians believed this until the chief of physicians declared that there are three souls; the natural (nutritive) soul, the vital (sensitive) soul, and the psychic (imaginative) soul. At times they are called potentials and diverse parts so that they are said to be parts of the soul. This nomenclature is used by many philosophers.

(*Comm. Shemona Perakim, ch. 1*)

According to Maimonides, as opposed to the physicians he mentions, man's soul is one. In fact, one ought not speak literally of "the natural soul," "the vital soul," etc. Rather, one should speak of the soul's diverse forces. Maimonides accepted the division of "natural force," "vital force," etc. associating their source and venue to the three principal organs: the liver, the heart, and the brain. See *Guide* 3:46 (end); *Pirkei Moshe* in *Refu'ah* art. 7:15 (ed. Muntner, publ.: Mosad ha-Rav Kuk, p. 94).

The "natural force" is a force for metabolic exchange, nutrition, and procreation. It exists both

***Man's image  
of God rests  
therefore in the  
brain.***

in animals and plants. The “vital force” is a force of motion, attraction, and repulsion. It is characteristic of all animals. The “psychic soul” is a force of thought, education, memory, and consciousness. It is especially characteristic in man, but exists in part in lower animals as well.

Maimonides also believed that inhaled air is absorbed in the three principal organs: the liver, the heart, and the brain. The absorption is in the form of what he calls “fumes” which influence the functioning of these central organs. Thus Maimonides:

For what the physicians call “spirits” are subtle fumes found in the bodies of living creatures. They originate, and they have their principal substance, from inhaled air. The “fume” found in the blood of the liver and in the ducts growing from it is called the “natural spirit.” The “fume” found in the blood of the heart and the pulsing ducts is called the “vital spirit.” And the “fume” found in the belly of brain and its derivatives in the neural sinuses is called the “psychic spirit”... The natural spirit is denser than the vital spirit, and the vital spirit is denser than the psychic spirit. As the air changes a bit, so the corresponding matters of the soul change accordingly. Loss of [quality of] air leads in so many people to spiritual loss. This explains why people experience panic, failure of understanding, and loss of memory even though their vital and natural activities are unchanged.

(*Hanhagat ha-Bri'ut*, sect. 4, p. 65 in the Muntner ed.)

Maimonides associates the power of thought and understanding to the seat of the “psychic spirit,” namely the brain. This accords with the

Talmudic view (*inter alia* in Tract. *Yevamot* 9a.), where the expression “he has no brain in his head” means “he has no intelligence, no power of thought.”

The term “psychic force” or “psychic spirit” (in Arabic *nafsaaniya*), as opposed to “natural” or “vital,” indicates the superiority of the force ascribed to the brain over the forces ascribed to the heart and liver because the force ascribed to the brain is “the force in man with which he cogitates, with which he contemplates, with which he acquires wisdom, and with which he distinguishes between good and bad (*Shemona Perakim*, ch. 1).”

Further, the intellectual force together with acquired knowledge constitutes the active intellect which is identified with “the form of man” The spirit of all flesh is the form which God gave it, and the superfluous knowledge found in man’s spirit is the form of a man perfected by knowledge. Regarding this form the Torah says “Let us make man in our image” (*Hilchot Yesodei ha-Torah* 4:8; cf. *Shemona Perakim*, ch. 1, end; *Guide* 1:1).

Man’s image of God rests therefore in the brain. Maimonides writes, however, in his *Guide* 1:39 (as quoted by Haham Tsevi) that life begins in heart for all creatures which have a heart. All the organs, including the liver and the brain, receive their force from the heart (see *Comm. Avot* 2:8, *Intro. to Mishna*, p. 31; my comments, *ibid.*, p. 298). In modern terms, we would say that the heart is the source of circulation and that all the organs depend on blood supplied by the heart.

Now let us compare Maimonides with the *Zohar* (also quoted by Haham Tsevi).

Come and see! When the Holy One, blessed be He, created man in the world, he made him similar to what is supernal. He gave him force and power in the middle of

***It seems that we should conclude from the verse that brain death, which is the nullification of the divine image in man, constitutes halachic death even if circulation of blood continues to parts of the body lower than the head.***

his body, where the heart resides. This is the power and sustenance of the whole body; from there all the body is sustained. The heart seizes and holds tight to a higher place in the brain in the head which resides above. These are thus connected.

(Zohar Num. 161a)

Note that the Zoharic discussion pertains to the actual body of man. Following that, the *Zohar* discusses the lower world, and then the aggregate of all worlds.

The heart supplies force and life to the whole body. But the superior part of man is the brain. Brain and heart are connected. In our terms: the heart, which is the source of circulation, gives the power of life to the whole body, including the brain. But the seat of human consciousness is the brain, not the heart.

What is the prohibition of murder? Why does the verse instruct us that “*he who strikes an animal shall pay,*” but “*he who smites a man shall be put to death?*” The Torah answers this question first time it mentions murder: “*he who sheds the blood of man -- by man shall his blood be shed for He made man in the image of God (Gen. 9:6).*”

In the Tosefta (*Yevamot* 8:5) we find:

Rabbi Akiva says: anyone who sheds blood nullifies the image, as it is said “*he who sheds the blood of man -- by man shall his blood be shed.*”

In the Midrash (*Gen. Rabba* 34:14) we find:

Rabbi Akiva expounded that anyone who sheds blood is considered to have lessened the image. What is the reason? “*He who sheds the blood of man -- by man shall his blood be shed.*” Why? “*because He created man in the image of God.*”

We see here that the Talmudic sages, following the explicit words of scripture, associated

the prohibition of murder with the nullification of the divine image of man. Although the *tanna'im* in general differed on the question of expounding the reason underlying scripture, in a case where scripture explicitly states a reason everyone agrees that that reason is of halachic significance. See Tractate *Sanhedrin* 21a and parallels.

***Perhaps one ought say that the connection between soul [neshama in Hebrew] and breathing [neshima in Hebrew] implies that the seat of consciousness, namely the brain, is also the source of man's capacity to breath.***

Now it is clear that the foundation of the prohibition of murder is the removal of the divine image from man. This means destroying the life of the brain. However, like the rest of the body, the life of the brain depends on the supply of blood from the heart. That is why murder is called “shedding blood,” as it is written: *he who sheds the blood of man -- by man shall his blood be shed.*

It seems that we should conclude from the verse that brain death, which is the nullification of the divine image in man, constitutes halachic death even if circulation of blood continues to parts of the body lower than the head.

Now it is clear why the Mishna in *Ohalot* establishes that decapitation is tantamount to death despite continued convulsions and despite continued pulse and circulation of blood. The reason is that the body is considered alive only as long as the head is attached. In the words of the *Zohar*: *The heart seizes and holds tight to a higher place in the brain in the head which resides above.*

## VII. The Seat of the Soul

Furthermore, the ancient medical and philosophical use of terms like “vital soul” residing in the heart, “natural soul” residing in the liver, and their association with passions and drives cannot stand the test of reality. Consider the case of heart transplantation where we knew the recipient before and after the procedure. His personality does not change at all! He exhibits the same thoughts, the

same emotions, the same drives, the same consciousness. He remains the same Jewish soul we knew before the transplantation.

On the other hand, a trauma to the brain, heaven forbid, can profoundly alter the victim's consciousness, emotions, desires, etc. The victim of brain trauma (Heaven forefend!) is called in every day parlance "not the same man." This is well known.

Transplantation operations, new in our generation, have provided an unambiguous proof that the heart is merely a "mechanical" pump which circulates blood. The liver is merely an instrument which cleans the blood. It is understood that the life of the body depends on both the heart and the liver because without fresh blood flowing to the organs life is impossible. But a man's personality resides entirely in his brain, not his heart and not his liver.

One could even say that the "personality" of lower animals, their emotions, memory, etc., reside in their brains. In animals too death is the disassociation of the head from the body, as the Mishna in *Ohalot* says: Similarly animals and fowl convey no ritual impurity until their souls depart. If they are decapitated, they convey impurity even though they are still convulsing.

Killing an animal is of course not murder because murder is the nullification of the divine image which is unique to man.

We should also contemplate the words of the Torah regarding man's essence. In Genesis 2:7 we learn: *And God formed man from dust of the earth and breathed into his nostrils the spirit of life. And he became a living soul.* Changing a lump of matter into a living being is described as breathing the spirit of life into his **nostrils**. The emphasis is on the connection between the concepts "spirit of life" and "soul of life" on the one hand, and the concept of respiration on the other.

Why is life described by means of respiration? Simply stated, the life of the body depends on the supply of blood to the organs "because the blood is the soul (Deut. 12:23)." But blood by itself is insufficient. The blood must contain oxygen, which

it obtains through the lungs which inhale oxygen. It follows that the process of respiration supplies something basic which life requires: oxygen.

This is the Creator's primary mercy in sustaining all his creatures: *He breathed into his nostrils the spirit of life.* The Midrash (*Gen. Rabba* 14:9) says regarding this verse:

Rabbi Levi said in the name of Rabbi Hanina: for each and every breath a man takes he ought praise his Creator. What is the reason for this? "*Every soul shall praise the Lord; every breathing shall praise the Lord.*" [The biblical word for "soul" is based on the Hebrew root meaning "breath".]

Man's soul is, however, spiritual in addition to being respiratory. The spirit of man is "the spirit of speech (Onkelos)" or "knowledge and speech (Rashi)," not simply air. Breathing is a **sign** of life, but not the **essence** of life. Therefore, the expression "*and man became a living soul*" means, as Onkelos translates, that man acquired the power of speech because the life of man can primarily be ascertained by his capacity to speak and react. It follows that "*He breathed into his nostrils the spirit of life, and man became a living soul*" was accomplished by introducing living breath into the speaking creature because speech is the breathing of air. Perhaps one ought say that the connection between soul [*neshama* in Hebrew] and breathing [*neshima* in Hebrew] implies that the seat of consciousness, namely the brain, is also the source of man's capacity to breath.

## VIII. Summary and Halachic Analysis

Let us return to the halachic analysis with which we began. We have seen that the Sage's sign for establishing the moment of death is the cessation of breathing. This was learned from the verse "*all who have the spirit of life in their nose.*" Further, we have seen that the Mishna in Tractate *Ohalot* establishes that even if a person's arteries are cut open, even if he is on the verge of death, he is considered to have the status of a living person. But if he is decapitated, he is considered to be dead.

As explained above, the reason for this could be not only because a decapitated person no longer breathes, but also because severing of the brain from the body constitutes a loss of life and loss of breath is merely an indication of death.

In the commentary of disciple of the Gaon of Vilna on the Mishna in Tractate *Ohalot* we find:

**Even if his arteries are severed:** such that he cannot live any more. Nonetheless he does not convey ritual impurity because his mind is lucid.

**Even if he is on the verge of death:** such that his mind is not lucid. He does not convey ritual impurity because he might continue to live.

*the essence of life is  
consciousness, and  
breathing is merely  
a sign of life.*

This means that if a person's arteries are severed, it is impossible to return him to life. Within a short time his cardiac and respiratory functions will cease due to loss of blood. Nonetheless for the time being, he is conscious and lucid.

On the other hand, a person on the verge of death is unconscious or only partially conscious but there might be a small chance that he can return to life. As the Sages have said that the "majority of those on the verge of death die." Although the majority die, some survive.

The Gaon of Vilna says that a person whose arteries are severed is not considered to be dead because his mind is lucid, and a person on the verge of death is not considered to be dead because his condition is reversible. It follows that a person who has irreversibly lost his consciousness is considered to be dead.

This is a more far-reaching conclusion than that of the great contemporary authorities mentioned above who admit destruction of the brain stem as a criterion of halachic death because if only parts of the upper brain are destroyed while the brain stem continues to live, the patient can still breath even

though he is unconscious and will never regain consciousness. According to the conclusions drawn from the commentary of the Gaon of Vilna, such a dieing patient is halachically dead, unlike the opinion of the other great authorities who require cessation of breathing in order to establish halachic death.

In any event, even if we refrain from relying on the implications of the commentary of the Gaon of Vilna, his interpretation supports the idea we developed above, according to which the essence of life is consciousness, and breathing is merely a sign of life.

In section III above we referred to the opinion of Rabbi Moshe Feinstein (*Iggerot Moshe Y.D. 3:132*) who compares the state of brain death to decapitation. In his last letter on this matter, mentioned above in section IV, he explicitly said that death depends on the loss of the capacity to breath, not on death of the whole brain: "even if the heart can still work for a few days, as long as the patient has no autonomous breathing capacity, he is halachically considered to be dead.

In his ultimate opinion, Rabbi Sh.Z. Auerbach also tends to accept the idea that brain death is tantamount to decapitation. But he limited this in two ways: (a) In his opinion the whole brain must die for the comparison to be valid. Death of the brain stem alone is insufficient; (b) As long as it is not definitively known that the whole brain has died, a brain dead patient has the status of *safek* (doubt) because he might be halachically dead and he might be halachically on the verge of death. It follows that he may not be moved for non-therapeutic purposes.

Rabbi Sh.Z Auerbach's requirement that the whole brain be dead, not only the brain stem which is responsible for respiration, proves that he felt that the concept of decapitation is unrelated to the concept of respiration. Instead, decapitation counts as death because the center of life and consciousness is in the brain.

This opinion, however, is questionable because if one is concerned with the loss of life and

consciousness, what difference does it make if the whole brain dies or not? In any event, death of the brain stem alone means irreversible unconsciousness and unconsciousness is the state in which a person has no capacity to act willfully and no capacity of conscious thought. If so, even in cases of destruction of less than the whole brain there is no living consciousness. According to the Gaon of Vilna, such a dieing patient is to be considered halachically dead.

And if one is concerned with the state of respiration, why is the absence of autonomous respiration and the impossibility of restoring it insufficient to categorize the patient as halachically dead in accord with the sole sign mentioned by the Talmudic Sages, cessation of breathing?

Rabbi Auerbach required a strict position in viewing the patient as dubiously on the verge of death, thus prohibiting moving him for non-therapeutic purposes. Rabbi A.A. Shapiro has commented on this position in two ways: (a) Examinations performed to verify brain death are likely to be of benefit to the patient because they might reveal signs of life, thereby enabling the medical staff to treat him and perhaps restore him to life; (b) A brain dead patient attached to a ventilating machine does not exhibit signs of being on the verge of death (*goses*; see Rema, *Even ha-Ezer* 121:6; *Choshen Mishpat* 212:2). Therefore, he does not have the status of a person on the verge of death.

We can conclude that the permissibility, and indeed the great obligation, of donating organs from a brain dead donor for transplantation in lifesaving procedures is well founded and sturdy. There is no reason to object to anyone who relies on the great authorities who established this position for they are the ordained chief rabbis of Israel, as Hazon Ish wrote (see *supra*). On the contrary, it is very meritorious for a person to save a life even after his own death, and it is a great mitzvah for the family of the donor which gives their consent for the procedure.

## International Responsa Project

**Subject: Euthanasia**

**Date:** April 2007

**Q:** *There is a patient who is on a ventilator for two weeks. She is completely sedated and her blood pressure is maintained by an adrenaline infusion pump, to raise the blood pressure. The question asked is if the doctor can stop this adrenaline because the patient is beyond being healed.*

*In the guidelines by Professor Steinberg it says in 6a, "to gradually lower dopamine dosage."*

*Bechavod rav*

**A:** Shalom,

From halakhic point of view the following issues have to taken into account:

The patient is terminal, *i.e.*, his life expectancy is less than 12 months;

The treatment is intermittant in nature, *i.e.*, there is a need to re-start the dose or the mode of treatment periodically;

The amount of suffering.

From the details of the question it seems that the patient is indeed a dying patient with *chayye sha'ah* only.

The dopamine is by nature an intermittant treatment so that when the dose finishes one is permitted not to add another amount of it.

The issue of suffering is a debate between the *poskim*. According to R. Eliashiv the suffering has to noticeable, *i.e.*, we should see actual signs of suffering in the dying patient. Also according to his opinion the treatment has to be such that causes suffering otherwise it is not permissible to withhold it. Hence, according to this opinion the dopamine ought to be continued. According to R. Feinstein and R. Auerbach any patient who is dying is by definition suffering even if doctors don't realize it. Also the suffering is regarded by mere contiuous life of suffering regardless of the mode of treatment. Hence by this opinion one is permitted not to resume the next dose of dopamine.

# *Syphilis in Jewish Sources: Medical, Halachic and Ethical Aspects*

Abraham Ofir Shemesh, Ph.D.

## **Abstract**

Syphilis is a sexual disease which is rare today. This article discusses the historical and medical-halachic discussions of syphilis in Jewish medieval literature. For the first time in the history of Jewish law, sages in the 16th century discussed the implications of syphilis for the relationship between the syphilitic husband and his wife.

In the documented sources of this period, syphilis was described as a skin illness that caused lesions covering the patient's body. It was difficult for the ancient physicians to distinguish between syphilis and leprosy. Many sages claimed that the syphilitic patient must divorce his wife when he exudes a foul odor or his skin peels off. Others claimed that divorce should be forced on leprosy patients because the disease is incurable, in contrast to syphilis patients who can be cured.

It is reasonable to assume that many of the rabbinical discussions about syphilis were triggered by the outbreak of the syphilis epidemic in Europe in the late 15th and early 16th centuries.

This paper discusses syphilis in view of several halachic queries directed to Jewish sages who were active in Jewish Mediterranean communities in the 16<sup>th</sup>-17<sup>th</sup> centuries. This paper examines the historical, medical and ethnic-halachic background to their responses.

## **Syphilis - Medical Background**

This dangerous disease, which is currently relatively rare, is caused by *Treponema pallidum* bacteria that are transmitted through sexual contact. In the first stage of the disease, an ulcer-like lesion develops at the site of the bacteria's penetration into the body. The lesion is not painful

but it is extremely contagious. Lymph nodes adjacent to the groin may also swell. Sometimes the lesion is not noticeable at all and it disappears spontaneously in the course of several weeks.

The second stage of the disease begins several weeks after the appearance of the lesion, and in approximately 75% of the cases, it is manifest as a non-itchy rash that covers the entire body, including palms of the hands and soles of the feet, and is sometimes accompanied by painless swelling of the lymph nodes and moist, lump-like growths surrounding the anus and/or the armpits.

This rash also disappears spontaneously within several weeks, when the disease enters its third stage, known as the latent stage, due to the absence of any symptoms. Today, in almost all cases, the latent stage is the final stage of the disease, due to the use of antibiotics. In very rare cases of inadequate treatment, however, the disease progresses to a stage characterized by severe complications such as aortic insufficiency, aortic aneurysm or neurological disorders.<sup>1</sup>

*many of the rabbinical discussions about syphilis were triggered by the outbreak of the syphilis epidemic in Europe in the late 15th and early 16th centuries*

1. See T. Smith, *Handbook of Family Health*, Am Oved, Tel Aviv, 1988, pp. 612-613 (hereinafter, Smith Handbook) [Hebrew]. For the background of the disease and its characteristics in Israel, with an emphasis on the last twenty years, see A. Hodek, "Trends of Morbidity of Syphilis in the State of Israel," *Family Physician*, 12 (1984), pp. 336-338 [Hebrew]

## Syphilis in the 16<sup>th</sup> and 17<sup>th</sup> Centuries: Historical Background

An outbreak of syphilis occurred in Europe in the late 15<sup>th</sup> century, around the time of the exile of the Jews from Spain (1492). Syphilis began to spread when the army of Charles the VIII of France invaded Italy, and first became known as the Napolitan disease.<sup>2</sup>

According to one theory of the period, the disease was brought from America to Europe by Christopher Columbus' sailors. Although syphilis apparently existed from time immemorial in the Old World, the bacteria underwent a worldwide mutation in the late 15<sup>th</sup> century.<sup>3</sup>

Medical texts from the Middle Ages, and as we see below, rabbinic sources as well, describe syphilis as a sexually transmitted disease that is similar to and sometimes indistinguishable from leprosy. Several sources discuss treatment of the disease using mercury, which in fact had no effect

*is the disease of one  
spouse sufficient  
grounds, being a grave  
and dangerous disease,  
to order a divorce?*

at all and even caused grave harm due to its toxicity.<sup>4</sup> *Guaiacum officinalis*, "the holy tree," was used by native Americans to treat syphilis and was perceived as an effective cure, but had no medical value whatsoever.<sup>5</sup> The first effective treatment of the disease was made possible only with the discovery of salvarsan by Paul Ehrlich in 1910. Before this discovery, many cases ended in complications.<sup>6</sup>

## Syphilis in Questions and Responses of Rabbis in the 15<sup>th</sup>-16<sup>th</sup> century

Use of the Hebrew term "עגבת" for syphilis is relatively new.<sup>7</sup> In the Responsa literature, the disease is mentioned as "*mal di Franca*" (מאל די פראנקה), French pox, or in Hebrew, "חולי צרפתי". This name was coined by the Italians who blamed the French for bringing the disease with them during the French conquest by Charles the VIII. The French believed that the Italians were the source of the disease and therefore called it "the Italian disease." The Russians called it "the Polish disease," and various countries similarly attributed syphilis to their adversaries.<sup>8</sup>

The basis of the halachic discourse in each presentation of the disease was a discussion of the fundamental ethical issue - is the disease of one spouse sufficient grounds, being a grave and

- Extensive research on the historical background to syphilis is available. Several of the prominent studies are; H. W. Haggard, *Devils, Drugs and Doctors, The History of the Science of Healing from Medicine-Man to Doctor*, New-York 1929, pp. 243-270 [hereinafter Haggard History]; C. Quetel, *The History of Syphilis*, The Johns Hopkins University Press, Baltimore 1992; M. S. Amsteys, "The Political history of Syphilis and its Application to the AIDS Epidemic", *Womens Health Issues*, 4 (1) (1994), pp. 9-16; Y. Or, *Syphilis vs AIDS - Historical and Social Aspects*, Korot, 11(1995), pp. 73-87 [Hebrew]; R. Marguta, *History of Medicine*, Hed Arzi, Jerusalem 2001, pp. 80-81 [Hebrew. hereinafter Marguta History].
- The problematics regarding the origin of syphilis in Europe have been discussed extensively in M. D. Grmek, *Diseases in the Ancient Greek World*, (trans. M. Muellner & L. Muellner), Baltimore 1989, pp. 51-131. See also Haggard History, pp. 245-246. On early findings of the disease in Israel, see G. Zeas, "Diseases and Cures in Ancient Israel in view of Paleo-Pathological Research", *Kadmoniyot*, 133 (1997), pp. 54-59 [Hebrew]. Note that some scholars believe that leprosy mentioned in the bible and rabbinic literature is syphilis. On this suggestion and other suggested skin disorders including scabies, fungal infections, and leprosy, see Katzenelson, *The Talmud and Medical Wisdom*, p. 304 ff., and p. 371 ff. [Hebrew]; Julius Preuss, *Biblich Talmudische Medizin*, Berlin 1911 (=J. Preuss, *Biblical and Talmudic Medicine*, (trans. F. Rosner), Northvale, New Jersey and London 1994, pp. 323 ff. [hereinafter, Preuss Biblical Talmudic Medicine]; A. Steinberg, *Halachic Medical Encyclopedia*, Jerusalem 1996, pp. 175-180 [Hebrew. hereinafter, Steinberg Encyclopedia]. On skin disorders in biblical and rabbinic literature, see Z. Muntner, "Terms of Skin Disorders in Ancient Hebrew Literature", *Harefua*, 15 (1938), 1-2, pp. 1-16 [Hebrew. hereinafter, Muntner Terminology].

- Mercury treatments for syphilis was first used by Swiss physician Paracelsus (1493-1541) although the origin of this treatment is not clear. See R. Kalder, *Medicine and Man - The History of Medicine from its Beginning to Our Times*, Jerusalem 1969, pp. 27-28 [Hebrew]. Mercury treatments are mentioned, for example, in the 16<sup>th</sup> century, in a medical essay by Daoud al-Antaki, *Tathkarat al-Antaki*, Cairo 1928, 1, p. 169. See also M. Plessner, "On the Medical and Magical *Encyclopedia of Daoud al-Antaki* and on Several of its Origins," *Eretz Yisrael*, 7 (1964), p. 139 [Hebrew].
- Marguta History, pp. 80-81. On the medicinal uses of guaiacum see A. Penelope, *Medicinal Herbs*, Am Oved, Tel Aviv 1997, p. 180 [Hebrew].
- On this discovery and modern treatment of syphilis, see D. Erlik, *Medical Breakthroughs*, Jerusalem, 1990, pp. 114-116 [Hebrew].
- The term "syphilis" is taken from a poem written in Latin by the Italian Girolamo Fracastoro. The protagonist, Syphilis, contracted the disease as a punishment for insulting Apollo. See Haggard History, p. 252.
- Haggard History, pp. 250-251; R. H. Major, *Classic Descriptions of Disease*, Charles C. Thomas, Springfield 1959, pp. 15-16.

dangerous disease, to order a divorce. In the course of the halachic debate, additional related aspects of the issue were raised and became embedded in the responses, from which we learn of the disease and the attitude toward the disease at the time.

### Syphilis in view of Rabbi Elihayu Mizrahi's Answer

The response of the Turkish sage, Rabbi Elihayu Mizrahi (Reem, ר"מ, Kustha 1450-1526) is one of the first and major sources that address the issue of syphilis.<sup>9</sup> This disease was not discussed in either of the two basic halachic books of the 16<sup>th</sup> century: *Shulchan Aruch* by Rabbi Yosef Karo, or the commentary of the Polish sage, Rabbi Moshe Iserliss (Rema, רמ"א),<sup>10</sup> which explains the significance of Reem's response as the basic response in Jewish Law.

Following is the content of the query that was addressed to Rabbi Eliyahu Mizrahi:

“On your query in the matter of the wife whose husband contract at the disease known in our language as “mal di Francesca” in which the patient's body breaks out in sores with secretions (”בהולי” הנקר' [א] בלשונו' [נו] מאל די פראנצה שהוציא קצת

(אבעבווע' [ת] בגוף ויוצא מהם שחיין” and the wife regrets the fact that she cannot suffer her husband and wishes to divorce him. Is this disease included in the “מוכה שחיין” law that is mentioned in the Mishna that compels the husband to divorce his wife? And is any person who has a skin disease with sores that “ooze pus” considered a “מוכה שחיין”? Or is he compelled to divorce the wife only if specific, special sores appear<sup>11</sup>?

The exact date of the query is not known. It may be assumed that it was directed to Rabbi Mizrahi sometime between the late 15<sup>th</sup> century and the early 16<sup>th</sup> century, a timing that was related to the propagation of the major epidemic that erupted in Europe in the late 15<sup>th</sup> century.

The query before us recounts the unfortunate story of a woman whose husband contracted syphilis. She complains that she cannot have intimate relations with him. The query contains the name and description of the disease; various parts of the husband's body are covered with some type of blister (“אבעבוועות”). Based on a description of the symptoms, it appears to have been secondary syphilis, in which a rash covers the body.<sup>12</sup> Although the symptoms should disappear by the third and latent stage of the disease, we can presume that the disease was known to worsen and develop complications without proper treatment, which explains the reason for the woman's appeal to the court.

From the formulation of the query, we infer that the woman did not refer her query directly to Rabbi Mizrahi's court, but rather to another rabbi, who presumably was also an important legalist but who was interested in a decision by a higher rabbinic authority, perhaps because it was a relatively new halachic issue.

The fundamental question posed to Rabbi Mizrahi was whether the law concerning syphilis was similar to the law concerning diseases and

9. According to Rabbi Yosef Miterani (Israel, 16<sup>th</sup> century), syphilis was discussed by Rabenu Asher (Rosh (ר"א)). Spain and Ashkenaz, 13<sup>th</sup> century):

“The Lord brought to my hands the Book of Responses of the Rosh in handwriting, and it contains several responses that were not printed, and I found there a discussion of a man who contracted the French disease (“בהולי הצרפתי”), and the question arose whether this disease is included in the law concerning “מוכה שחיין” who must divorce his wife.” (*Responsa Maharit*, Tel Aviv, 1949 (facsimile Lemberg 1861), Section 2, *Even Haezer*, 14). However, it is extremely doubtful whether this is an authentic reply or a later response that was appended to the Book of Questions and Responses that Rabenu Asher wrote.

10. The opinions of the halachic judgments concerning diseases which require the husband to divorce his wife were summarized in *Shulchan Aruch*, *Even Haezer*, siman 154. In this chapter, Rabbi Yosef Karo, concentrated a variety of medical problems that raise concerns regarding the future of the marital relationship, such as improper behavior of the wife or husband, such as insanity of the husband or wife, fertility issues, disability, etc. The discussion of syphilis was raised by interpreters of the *Shulchan Aruch* several hundred years later. See for example, *Baher Hetev*, *Even Haezer*, 154, 3.

11. *Responsa, Mayim Amukim*, Jerusalem 1970 (facsimile, Berlin 1778), 1, 19

12. See *ibid*, Medical Background.

disorders mentioned in Sages' literature, which compel the husband to divorce his wife, even against his will, due to the impossibility of maintaining proper marital relations with the husband.<sup>13</sup>

**Rabbi Eliyahu Mizrahi argued that if an individual inflicted with syphilis exudes foul odors and his flesh sheds when he conducts conjugal relations, he must be compelled to divorce his wife**

individual who works in copper casting) and a "בורסקאי" (tanner).<sup>15</sup> All these individuals share the characteristic that they suffer from severe aesthetic defects (according to Rashi, they exude foul odors), and they are repulsive ("מאוס") to others in general and to their wives in particular.

The applicant focuses the query on the similarity between syphilis and boils ("שחין"). He

The diseases and disorders mentioned in early Hebrew literature in this context are: "מוכה" (stricken by boils)<sup>14</sup>, "בעל פוליפים" (an individual who suffers from halitosis or a bad smell from the nose), "מקמץ" (an individual who collects dog feces to prepare fertilizer etc.), "מצרף נחושת" (an

questions whether boils mentioned above is a specific disease of the skin, apparently festering lesions (in his own words: "אבעבועות היוצא מהן שחין" - "blisters exuding boils"), or whether it is also a different serious skin disease such as syphilis.<sup>16</sup>

The term "מוכה שחין" ("stricken with boils") mentioned in rabbinic literature is a general term for severe, pervasive gangrenous diseases that require amputation.<sup>17</sup> Modern scholars have suggested to identify this ailment with various diseases including syphilis, leprosy, bubonic plague<sup>18</sup> or eczema - an inflammatory skin disease accompanied by redness, scales and tiny pustules, and generally accompanied by itching.<sup>19</sup>

Rabbi Eliyahu Mizrahi responds that the talmudic issue (*Bavli, Ketubot 77a*) defines two conditions for compelling a diseased husband to divorce his wife. The first is if sexual relations cause shedding of tissues from the diseased individuals' body ("המקת בשר"),<sup>20</sup> a symptom that is familiar in leprosy;<sup>21</sup> the second condition is if the

13. According to Jewish halakha, divorce could be performed only by the husband.

14. An example of the problematic of marriage with a "מוכה שחין" is found in a halachic essay by Rabbi Shmuel di Modina: "Reueven contracted a serious extended disease and became bedridden and had no sons. Relatives of his wife Dina feared that he might die and his wife would be required to marry his brother Shimon, who was "stricken with boils" ("מוכה שחין") with an incurable disease ill" (Responsa Marshadam, New-York 1949 (facsimile, Lemberg 1862), Even Haezer, 183).

15. In Mishna *Ketubot 7*, 10 and in the corresponding Talmudic tractate 77a. Parenthetically we note that questions of a similar type evidently appeared in other rabbinic texts. For example, for Radbaz, another 16<sup>th</sup> century Sage of Zfat, it was sufficient to know whether a husband who defecates or urinates in his bed is considered a foul man ("אדם מאוס") from whom a wife has a right to demand divorce: "You asked my opinion about a woman who claims that her husband defecates in his bed and is unaware of this. This occurred several times due to "חולי קרירות" (a cold?) and the question is whether he should be forced to divorce his wife and grant her Ketuba similar to the other individuals mentioned in the Mishna." (Responsa *Radbaz*, Jerusalem 1972 (Warsaw 1882, facsimile), Section 4, Mark 260, 1031).

16. In fact, in ancient sources, the term "שחין" ("boil") is a term for a variety of skin disorders. Rabbinic sources distinguished between three types of boils: dry inside and outside; moist inside and outside; dry inside and moist outside (*Bechorot*, 41a). See for example Tosefta *Ketubot* (R.S. Lieberman edition), 7, 11: "Raban Shimon ben Gamliel said, we met on old man, one of the "stricken with boils" ("ממוכי שחין") adjacent to Zippori and he told me that there are twenty [four] types of boils, and the most harmful to women are "בעלי ראתן" only"). Compare to *Bavli Ketuvot 77b*. The Sages also noted the names of several types of boils such as "גרב" "ילפת" "הכרך" (Bavli *Bechorot 41a*). Z. Muntner notes that the meaning of the word "שחין" is hot or burning, and refers to a variety of inflammatory skin diseases. On the likely nature of the types of boils, see Muntner Terminology, p. 2 cf.; Steinberg Encyclopedia, 5, pp. 180-181.

17. Keritut 83, 48.

18. Summary see Steinberg Encyclopedia, ibid p. 180.

19. Summary see Smith Handbook, pp.253 - 254.

20. And in his words: "Diseases such as the French pox ("פראנסיש"), if the physicians affirm that intercourse has an adverse affect on the patient's body and pieces of his flesh and skin fall off" (שתשמיש "ממיקתו ומופל בשרו התיכות התיכות" (ממיקתו ומופל בשרו התיכות התיכות). Responsa Mahari Ben Lev, Jerusalem 1949, Section 1, 30). Compare to Responsa Mayim Amukim, Jerusalem 1970 (facsimile, Berlin 1778), 1, 19: "when intercourse adversely affects the flesh and pieces of it are cut. The disease melts the skin like bees' wax near a fire".

21. Leprosy is an infectious bacterial disease that deforms the physical appearance and leads to disability. Its symptoms include: thickened and discolored dermis, lumps under the skin as a result of thickening surrounding affected nerves, loss of sensation in the organs controlled by affected nerves, especially hands and feet. As a result, patients feel no pain when their limbs are injured. See Smith, Handbook, p. 565.

husband exudes foul odors that the wife is unable to tolerate, similar to the other diseased individuals mentioned by the Sages. In the opposite case, when the wife is stricken with boils, the situation should be treated similarly.

Consequently, Rabbi Eliyahu Mizrahi argued that if an individual afflicted with syphilis exudes foul odors and his flesh sheds when he conducts conjugal relations, he must be compelled to divorce his wife even if she wishes to continue to live together. However, if his foul odor is not severe and his presence can be tolerated, and conjugal relations do not cause his flesh to “fall off,” he is not compelled to divorce her.

### **Syphilis in the Response of Rabbi Yosef Ben David Even Lev**

Another case involving a woman's demand for divorce due to her husband's syphilis, is presented in a judgment rendered by the court of Rabbi Yosef Ben David Even Lev (מהר"י בן לב, Yugoslavia 1505-Kushta 1580) on 10 Tevet 1543, when he served as a rabbi and judge in the local rabbinical court of Saloniki for some time. This case concerns an appeal to the local rabbinical court by a woman named Duna Dola, through her lawyer, to compel her husband, Rabbi Baruch, to divorce her. Due to the significance of the details contained, the query is presented in entirety:

“We the undersigned court were requested by Duna Dola, wife of Rabbi Yosef Baruch, through her counsel, to investigate and examine the matter of the her husband's aforementioned disease, because she wishes to separate from him, and the question is whether she is justified. At her request, we met with the physicians whose names appear below to examine the aforementioned individual to study his disease to examine his condition for us, according to their opinion. After several days they examined him and touched his body, and responded to us. Initially the supreme sage the physician Don Yitzhak came before us and said that he saw the

aforementioned Yosef and investigated his disease and according to his opinion, he is a leper [...] Also appeared before us the specialist Rabbi Yitzhak Ben Alzo and that after examining and investigating the matter of the said Rabbi Yosef's disease, he decided that he is afflicted with “bubas mal de francia” [“בובאש שקורין מאל די פראנסיא”] and this was his opinion and belief. Also appeared before us the specialist Rabbi Abraham Gaggi who said that for several days he has been treating Rabbi Yosef and has not seen any sign of leprosy other than “ulcera du narices” [“אולסירה די נאריזיש” = ulcers in the nasal cavity] that are caused by a head disease known as “catarrho” [קאטארר] and since when Rabbi Yosef was cured from one disease another disease appeared, he suspects that this is caused by “bubas disease” [“מהולי די בובאש”] and he believes that if he has a serious disease, it is “bubas” and no other [...] After the aforementioned investigation, we drafted and signed the statements of the aforementioned physicians to determine whether, based on the physicians' opinions, if the law sides with the wife or the husband. This was in Saloniki on the 20<sup>th</sup> day of Shvat, the year 1543.<sup>22</sup>”

The following facts are implied in the above passage: in view of Mrs. Donna Luna's complaint, the court appointed three qualified physicians to diagnose her husband's illness. After conducting a series of tests, the physicians presented their findings. The first physician, Don Yitzhak, diagnosed Yosef as leprosy. The second physician, Rabbi Yitzhak Ben Alzo suggested a completely different diagnosis. He claimed that the husband contracted syphilis (in his words, “bubas mal de francia”). The third physician, Avraham Gagi who apparently had treated the patient for some time prior to the appeal to the court, also suggested that the illness in question was syphilis. He found no

22. Responsa Mahari Ben Lev, Jerusalem 1949, Section 1, 30 .

indications of leprosy other than ulcers in the nasal cavity originating from headaches, that is, that radiated to the nasal area. He claimed that the husband, after having been cured of this illness, contracted “mal du bubas” - syphilis. However, there did not appear to be any connection between the two medical conditions.

The physicians’ dispute on whether the illness was leprosy or syphilis illustrates the difficulties physicians encountered in distinguishing between the diseases. We have already noted above that when the syphilis epidemic erupted in the late 15<sup>th</sup>-early 16<sup>th</sup> centuries, some viewed syphilis as a leprosy-like skin disease. It is appropriate to emphasize here that although the physicians in this source, as in early sources in general, discussed “leprosy” it is impossible to ascertain which illness was actually indicated. They may have used this term to cover a broad range of illnesses<sup>23</sup> including itching, psoriasis, fungal skin infections, ergotism (that, *inter alia*, caused gangrene), and syphilis, whose clinical symptoms are also related to skin disorders.<sup>24</sup>

***The physicians’ dispute on whether the illness was leprosy or syphilis illustrates the difficulties physicians encountered in distinguishing between the diseases***

Similar to Rabbi Eliyahu Mizrahi’s decision, Mahari’s Even Lev court deliberated on the question of whether only individuals “stricken with boils” were obligated to divorce their wives, or whether individuals with syphilis were also obligated to do so. On one hand, Mahari claimed that the very fact that the Rambam limited the identification of “מוכה שחין”<sup>25</sup> exclusively to lepers indicates that he believed that divorce should be compelled specifically in leprosy, whose symptoms are well known. In contrast, with respect to other skin diseases, in the absence of a clear diagnosis or identification of the type of boil, the judges cannot resolutely determine when to compel a husband to divorce his wife when and when not to do so. On the other hand, Rabbi Eliyahu Mizrahi already determined (above) that a person who is afflicted with syphilis and suffers from halitosis and his organs slough off during conjugal relations, is also obligated to divorce his wife.

Thus, it was clear to Rabbi Even Lev that leprosy requires a man to divorce his wife. In the case before us, however, the physicians did not agree on whether Rabbi Yosef, Dona Luna’s husband, was a leper or syphilitic and therefore the duty to divorce her was in doubt. In view of this, he proposed:

“From now on I will say, according to my humble opinion and knowledge: all the

23. Julius Preuss, one of the most important scholars of ancient Hebrew medicine, has already written that the term leprosy caused much confusion. See Preuss, *Biblical Talmudic Medicine*, p. 323.

24. On leprosy in biblical or Sages literature, see for example Y. Tess “Leprosy,” *Biblical Encyclopedia*, VI, Jerusalem, 1981, pp. 774-778; Preuss, p. 323 cf. On biblical leprosy as a disease through which God punishes sinners, see M. Bar Ilan, “On Sacred Diseases,” *Korot*, 15 (2001-2), pp. 27-36 [Hebrew. hereinafter, Bar Ilan Sacred Diseases]; S. G. Browne, *Leprosy in the Bible*, London 1974; R.R Willcox, “Venereal Disease in the Bible”, *British Journal of Venereal Disease*, 25 (1949), pp. 28-33; E. V. Hulse, “The Nature of Biblical Leprosy and the use of Alternative medical Terms in Modern Translation of the Bible”, *PEQ*, 107 (1975), pp. 87-105. On leprosy in rabbinic literature see Y.L. Katzenelson, *The Talmud and the Wisdom of Medicine*, Berlin 1928, pp. 304-340 and p. 271 cf. [Hebrew]; Steinberg, A. *Medical Halackic Encyclopedia*, Jerusalem, 1996, V, pp. 175-180 [Hebrew]; M. Michael, “The syndrome of leprosy of human skin according to the Mishna,” *Korot*, 6 (1972), pp. 77-84 ["]; and recently, Z. Amar, “What are boils in the words of the sages,” *Asia*, 75-76 (2005), pp. 65-69 [Hebrew]. On leprosy and the attitude toward leprosy in the classical world, see M. Grmek, *Diseases in the Ancient Greek World*, Baltimore-London, 1989, pp. 152-176.

25. As we can understand, the group of judges adhered to Rambam’s identification, that “stricken with boils” in the Mishna is a leper. See: Interpretation of Rambam’s Mishna, *Ketubot* 8, 7. It is justified to suggest that the Rambam (1138-1204) who was a famous physician, adhered specifically to this identification because, according to the Talmud, an individual “stricken with boils” could lose parts of his body while performing the sexual act (apparently because this involved friction of the affected parts of the body), a symptom that is well known in leprosy. On the symptoms of leprosy, see above footnote 21. On the identification of leprosy in the bible and rabbinic literature, see Steinberg Encyclopedia, *ibid* footnote 3; Hebrew Encyclopedia (Y. Leibovitz, editor), Jerusalem 1971, “Leprosy”, pp. 887-889.

physicians of this city should assemble. If the majority decides that this man is a leper, they will force him to divorce his wife against his will. If they agree that he has the French pox or another disease of the "bubas" type [ "חולי הצרפתי או בחולי אחר ממיני ה"הבובאש", even if a minority of the physicians are hesitant in determining whether an individual afflicted with French pox has these signs, in any case, since the situation is not clear and several physicians believe that it is not the French pox, I cannot be lenient and compel the man to divorce his wife other than in the case of leprosy and according to the opinions of specialists. And may God save us from our errors...<sup>26</sup>”

In other words, to obtain a clearer diagnosis of Rabbi Yosef's disease, a larger forum of qualified physicians must be convened. If the physicians conclude that the man is a leper - he will be compelled to divorce his wife.

This case may possibly involve a different disease that is accompanied by swelling (bubas).<sup>27</sup> However, if the physicians diagnose the disease as syphilis, he will not be forced to divorce his wife, even if the disease also involves sloughed off skin and foul odors.

### Syphilis in Rabbi Yosef Tirani's Response

Syphilis was also discussed in another query that was presented to Rabbi Yosef Tirani, one of Zfat's most important sages (Maharit, מהרי"ט, Zfat

1568-Kushta 1639).<sup>28</sup> His discussion focused on the conditions in which a wife of a leper could demand a divorce, but he also addressed syphilis in this discussion.

One of the major points in Tirani's discussion was whether there were two necessary conditions for divorce (foul odor and gangrenous body) or whether one was sufficient to compel divorce. He claimed that individuals afflicted with boils suffer from both afflictions, and that is also the identifying mark of the disease. In the case of a leper, his wife can clearly demand a divorce, and from the perspective of the halacha, physicians are capable of diagnosing this disease to determine the divorce because it is a well known disease with familiar symptoms. However, it is doubtful, as the sages before him doubted, whether a female leper can also demand the same treatment:

"Indeed it is the French pox [ חולי 'הצרפתי' [...] because several abscesses were discovered on the patient's body and they secrete discharge, but it remains doubtful whether the disease is classified under "afflicted with boils" ["מוכי שהין"], because this disease is curable. Just as we see in reality that physicians who treat these patients succeed in curing them completely. However, some cases are difficult to cure and the affliction remains for a long time, while others are cured easily. Therefore, the Rabbi [Rabbi Eliyahu Mizrahi] determined that even though the patient was not a leper, it is possible that he is included under "afflicted with boils", who should be compelled to divorce their wives".<sup>29</sup>

The Maharit offers an additional argument to distinguish between syphilis and leprosy. Leprosy has no effective cure, while syphilis can be cured, and there are known cases of people who were cured. Therefore this is not a hopeless case that

26. Responsa Mahari Ben Lev, Section 1, 30 .

27. As noted above in the Medical Introduction, syphilis begins with a swelling of the lymph nodes.

28. Responsa Maharit, Tel Aviv 1949 (Lemberg 1861 facsimile), Section 2, Even Haezer, 14.

29. Responsa Maharit, ibid.

requires divorce. The source of Maharit's distinction between the diseases is not clear. To the best of our knowledge, the early sages had no effective cure for syphilis either.

Although the Maharit was no physician, he specified the medical reasons for gangrene that developed in individuals afflicted with various skin diseases during conjugal relations, such as were known to medical sciences in his time. The affliction of the skin is related to prolific conjugal relations. The disease itself incites the patient's passion for sex (?) and therefore such activity should be restricted. According to the medical perspective in his time, which does not meet the test of current medical knowledge, the skin lesions stem from a blood-related defect in the liver and the secretion of toxic substances to the skin.<sup>30</sup> Conjugal relations debilitate the body's ability to separate between positive substances that should remain in the body, and noxious substances which should be eliminated from the body. The body is affected by noxious substances and responds by sloughing off tissue.

### Summary and Discussion

For the first time in the history of Jewish law, sages in the 15<sup>th</sup> and 16<sup>th</sup> centuries addressed the halachic attitude towards the continuance of marriage between syphilitic individuals and their wives, on the backdrop of the severity of the disease which, like other skin diseases, had an adverse affect on couples' lives.

The sources of that period describe syphilis as a skin disease accompanied by sores covering the

body. As we have seen, physicians of the period found it difficult to make a medical distinction between syphilis and leprosy. This difficulty was also expressed by sages of the 16<sup>th</sup> century who found it difficult to determine whether syphilis was included under the definition of one who is "stricken with boils" (מ"כ שחין) according to the

Rambam: leprosy) mentioned in early Hebrew literature, which requires a divorce.

Several sages argued that the syphilitic individual, like the leper, is required to divorce his wife when he exudes a

foul odor or when his skin sloughs off. However, according to a different approach, divorce was compelled only in the cases of leprosy, whose diagnosis was well-known. Some argued that there was a substantive difference between these two diseases: leprosy was incurable and therefore divorce should be compelled, while syphilis could be cured and therefore the couple's problematic relationship was merely temporary.

It was the nature of the rabbinic sources to discuss a specific halachic issue in a focused manner, frequently understating or obliterating geographical, historic or other background factors. Although the sources before us do not mention, or even hint, about a connection to any specific syphilis epidemic, it is presumable that the foundation for some of the discussions noted above resulted from the syphilis epidemic that spread throughout Europe in the late 15<sup>th</sup> and early 16<sup>th</sup> century. The fact that several discussions on this new issue emerged within a relatively short span may attest to the circumstantial connection.

A very small number of queries appear on this issue. This may be related to two reasons:

A. The geographic location of the origins of the responses was far removed from the sites of the epidemics and the number of cases of infection could be presumed to be smaller.

30. Tuvia Katz, a 17<sup>th</sup> century Jewish physician presents a similar reason: "On the causes of the French Disease ["החולי הצרפתי"], there are many opinions [...] The members of the Galen group [based on statements by Galen, one of the most important physicians of the Classical period, 130-200 CE] say that the disease is caused from the stench of blood and the nutritional power of the liver, and some say that it is caused by some infection in the blood..." (*Maase Tuvya*, Venice 1707, 107b).

B. More significantly, the traditional Jewish population had few ties of marriage or sexual liaisons with the non-Jewish population; as a result syphilis could be expected to occur less frequently. The Jews' strict sexual morals of were documented in various historic sources, including by A. Russell, a naturalist who lived in Aleppo in the mid-18<sup>th</sup> century and reported the rarity of syphilis in the Jewish community there, in contrast to the prevalence of the disease among Muslims and Christians.<sup>31</sup>

Assuming that the cases before us illustrated the dissemination of the syphilis epidemic in Europe, the sites at which the issue was discussed in the Responsa literature may

***the sites at which the issue was discussed in the Responsa literature may serve as historic indicators of the course of the epidemic from Europe to the Mediterranean***

serve as historic indicators of the course of the epidemic from Europe to the Mediterranean - Turkey, Greece and the Land of Israel.

Syphilis is a sexually transmitted disease. In the rabbinic discussions noted above, the rabbis made no reference to the cause of the disease, that is, the concern that one of the marriage partners had extra-marital sexual relations. This may stem from their lack of knowledge regarding the manner of transmission of the disease, or their desire to discuss the disease *per se* rather than be diverted

into secondary issues. Another possibility is that the sages assumed that members of the traditional community as a rule avoided sexual relations with the surrounding non-Jewish population.

An exception to the lack of reference to the source of the disease was Rabbi Tuvia Katz of Mitza (17<sup>th</sup> century). In his medical volume, "Tuvia's Practice", first published in Venice in 1707, Tuvia Katz devotes a chapter to the "French pox its symptoms, causes and cures." He argues that this disease began to spread after Columbus' conquests, and is a direct result of God's punishment for prostitution:

"French pox [חולי הצרפתים] is new in these countries although it is an old disease in India or the New Land [=America], because in 1493, the great traveler Christopher Columbus returned to his country from the New Land. He and his crew began to have sex with the women of Italy, and God was angry with them and therefore brought this severe disease upon them. And the French army was then fighting along the border of Naples and they also contracted the disease, and therefore it is called the French pox [מאל פראנצויז]."<sup>32</sup>

Rabbi Tuvia emphasizes the connection between the disease and improper sexual conduct. He also describes the sites of affliction on the body, alluding to the sinner's punishment "measure for measure":

"and his poison [of the infected man] is the poison of the actual epidemic, because the poison infects a person who sleeps with an impure woman [...] the poison spreads through his reproductive organs and causes a stench. It begins from the site of the sin, where the semen seeped, and blisters develop on the man's penis and the woman's vagina."<sup>33</sup>

31. A. Russel, *The Natural History of Aleppo*, Vol. II, London, 1794, p. 84. Also see Burstein-Makovtzky, "The Jewish Woman in Aleppo in the Ottoman Period", in T. Cohen and S. Regev (eds.), *Women in the Orient*, Women from the Orient, Ramat Gan 1995, p. 59 [Hebrew]. There is much more available historical data on the prevalence of syphilis in the region of Syria and Israel in subsequent centuries. For example, we can learn of the prevalence of the disease in the 19<sup>th</sup> century from the descriptions of the traveler, Titus Tobler, who notes that despite the relatively moral lifestyle in Israel compared to Europe, the disease was prevalent, probably due to a lack of proper treatment. See T. Tobler, *Nazareth in Palastina*, Berlin, 1868, pp. 266-280 and compare to N. Shur, *Book of Travelers to Israel in the 19<sup>th</sup> Century*, Jerusalem 1988, p. 68.

32. *Maaseh Tuvia*, *Bayit Hadash*, Section 3, Chapter 11, 107a-109a  
33. *Maaseh Tuvia*, *ibid.*

In other words, this is a sexually transmitted disease that afflicts the individual specifically in the genitalia.

Tuvia Katz argues that medical innovations are required for its cure because the disease is new and not previously known. Consequently, he enumerates the treatments and substances to use at each stage of the disease. One of the most important therapeutic substances noted is the Guaiaco (*Guaiacum officinalis*) which, as noted above, had little genuine medical value.<sup>34</sup>

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34. See *ibid*, historical background to the disease.

# ASSIA Abstracts

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*ASSIA* Nos. 78-90 appeared in Hebrew in Tevat 5767 (January, 2007). The following articles are of special interest to readers of *Jewish Medical Ethics*.

## Brain-Computer Interface

by Shlomy Raiskin

Survey of latest developments in cybernetics and BCI, raising halachic questions touching on a wide range of issues including Shabbat, marriage and divorce, financial transactions, *tefillin*, *nidda*, and *tsedaka*.

## The Tradition of Metsitsa: a Medical Battle in a Cultural War

by Rabbi Dr. Mordechai Halperin

Survey of the status of *metsitsa be-pe* in ritual circumcision, including a detailed discussion of the procedure from the medical and the halachic points of view; the opinions of Rambam, R. Yaakov ha-Gozer, the Hatam Sofer, and Rabbi Wosner; the controversy in the nineteenth century, the current situation in Israel and New York, AIDS, and herpes. The full *Circumcision Protocol* of the New York State Department of Health is appended.

## Eye Inflammation and Eye Disease on Shabbat: Practical and Clinical Aspects

by Dr. Arie Nameth

Analysis of halachic sources relating to ophthalmologic practice on Shabbat, including an explanation of the scientific basis of those sources. Conclusions are drawn regarding mild and severe dryness of the eye, improving vision, mild and severe pain, internal and external inflammation, non-inflammatory conditions that threaten vision, and life-threatening conditions.

## Nephrolithiasis: Pre-modern Treatments and Halacha

by Rabbi Dr. Avraham Ophir Shemesh

A study of pre-modern treatments for stones in the kidneys and urinary tract with an analysis of problems related to *nidda*, impotence, marital intercourse, cleanliness during prayer, instructional autopsy, and testicular excision.

## Medicine Containing Hamets

by Rabbi Avraham Dori

The permissibility of patients deriving therapeutic benefit from prohibited substances in an irregular way (*derekh shinnyu*),

swallowing medicine that was rendered inedible before Pesach, the principle of imputing significance to an otherwise insignificant ingredient (*achsheveh*), the opinion of the Chazon Ish and other recent authorities, the status of Viagra, and the obligation to seek *hamets-free* medicines. The full text of Rabbi Shmuel Eliezer Stern's *Warning Regarding Medicines Containing Hamets* is appended.

## Hormonal Intervention to Prevent Chuppah Nidda

by Drs. Dina Rachel Zimmerman and Elchanan Bar-On

A woman with a regular menstrual cycle should schedule her marriage in the third week of her cycle. If she experiences a change in her cycle, hormonal intervention should be considered. Hormonal treatment beginning three months before the marriage is indicated for a woman with an irregular cycle. If her menstrual period is expected at the time of her scheduled marriage, hormonal treatment is likewise justified.

## Positive Hormonal Intervention

by Dr. Chana Catane

Response to the previous article, arguing that intervention

is indicated also for women with long or short cycles, women with intermenstrual bleeding, women with bleeding at ovulation, and women who do not know the length of the cycle.

**In-Vitro Fertilization**

by Rabbi Eliezer ben-Porath

i. Does a woman become *nidda* after extracting an oocyte or after implanting a fertilized ovum? ii. Should artificial insemination be recommended before IVF? iii. Is IVF permitted for a couple which already has a boy and a girl? iv. How should semen be collected?

**Epidural Injections during Labor**

by Rabbi Shlomo Aviner

Responsum permitting palliative epidural injections during labor despite the negligible danger associated with them.

**Medical Support in the Rabbinic Tradition**

by Dr. Yechiel M. Bar-Ilan

Thorough analysis of traditional rabbinic sources on the relationship between physician and patient, proposing that their relationship be viewed holistically and include both

spiritual and physical care. Comparison of rabbinic and modern, western views on the nature of the physician-patient relationship.

**Bibliography of Medical-Halachic Literature**

by Rabbi M. Wunder

Annotated bibliography of 361 Hebrew books, articles, and responsa which appeared in 5762 (2001-2002), arranged by topics and indexed by the author.

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