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At Bedside

Insights into Visiting the Sick
For Family and Friends

By
Rabbi Dr. Maurice Lamm
President and Founder NIJH

#4

In Memory Of

Tod Michael Zipnick

"My Beloved Is Mine,
And I Am My Beloved"
-*Song of Songs*, Chapter 2, Verse 16

The National Institute for Jewish Hospice

is indebted to

Laurie Zipnick

She chose to remember Tod in this meaningful way

NOTE:
The masculine gender in this booklet is used in the generic sense.

At Bedside

has drawn upon three sources that
we recommend reading;

1. Joseph Levine, *The Delicate Mitzvah, Visiting the Sick*, Moment Magazine, Vol. 4, #5, pp.50-55.

2. *The Healing Visit*, Shofnos and Zwebner, Targum Press, Southfield, Michigan 1989

3. *Color The Twilight*, a lecture delivered by Rabbi Dr. Maurice Lamm and published by the Council of Jewish Federations, New York, 1982

At Bedside

When a friend or close relative dies, we confront feelings and situations which are new and uncomfortable. We are not quite sure how to handle the anger and guilt that often accompany this experience. We know even less about how to interact with someone who is dying. Many fears concerning our own death inevitably arise at such a time, and we may no be certain how to deal with these either.

The Jewish tradition has a wealth of experience in dealing with all facets of life, including severe illness and dying. In this context, the national Institute for Jewish Hospice has generated materials in an effort to disseminate information about Jewish values and conduct to people facing the death of relatives or friends, and to members of the helping professions. We hope that the information in this booklet will help to make the experience of dying more comprehensible.

Visiting the Sick

Visiting the seriously ill is not a uniformly pleasant activity. There is a natural reluctance to experience sadness and to "intrude" on someone's privacy. We may be unsure of what to say; we may fear making a mistake in judgment; we might be upset by the patient's physical appearance; and, in general, we may feel uneasy surrounded by sick people in a hospital setting. Certainly some of these concerns are understandable and even appropriate. Sometime patients do prefer privacy; sometimes you may have an awkward relationship with the sick party. It is even true that we can expect, from time to time, that visiting the sick will make s aware of our own vulnerability. All these considerations, however, should be overcome in order to fulfill the religious obligation of

visiting the sick. It can even serve as a positive feeling in the way it alerts us to the universal human condition.

Visiting the sick is an obligation of caring and moral people. It is recognized universally as an important good that the community quite properly demands of its citizens. To Judaism, such visitation is not simply a courtesy call, or even solely a moral obligation. It is a religious mandate – a mitzvah – actually an act of imitating God, who "visited" the Patriarch Abraham during his illness.

The visit, especially to a person who is terminally ill, is a much-needed antidote to the hospital's sterile environment and to the feelings of being abandoned. Gone are the family pictures, one's favorite music, the pet, the familiar books. Because of its intense focus on physical cure, the hospital is concerned primarily with tubes and needles, pills and monitors – dealing with parts rather than the whole of a person. The patient in a modern hospital is often made to feel like an object, punctured and pulled, sometimes treated for physical wounds with disregard for personal sensitivities, handled as a "humanoid" rather than as a human being. Visiting the sick can provide a religious and humane attitude that conveys warmth, sensitivity and personal interest. Understanding eyes and helping hands can go a long way toward restoring a sense of connectedness, of self-worth and esteem.

The visit, in order to fulfill its moral and religious obligations, needs to have therapeutic value. The visitor can try to provide support beyond medical care, such as physical assistance, psychological support, and spiritual enhancement. The visit itself reassures patients of their continuing worth as individuals. It reinforces their feelings of being integral members of the family and of the community.

to be visited. No one is so unimportant as to be ignored, and no visitor too distinguished to make that visit.

But family or friends who cannot control their sadness, or who are themselves frail or sick and cannot tolerate the taxing of their senses, should be judicious about when to visit or even whether to visit. Sometimes, in fact, family or friends are too concerned about an adverse effect of the visit on themselves.

Should enemies of the patient visit him? The sage advice of Jewish tradition is that they should visit only after checking with the family to determine the kind of impression it would make.

A pre-modern custom has it that relatives should visit immediately while more distant acquaintances should wait for three days after the onset of the illness. This custom is not binding on us today, and the visit should be made when it is most appropriate, especially when the illness is catastrophic. In all matters – whether involving restraint or extensive personal involvement – friends and relatives should be guided by the needs of the person who is sick.

The manner in which we die may have changed compared to days gone by, but the needs of the seriously ill and the dying remain the same – the need for comfort and care, of hope just ahead, of keeping faith with the patient as a human being until the very end. This is our gift and contribution to the patient when we are present at bedside.

the patient's unique suffering and circumstance.

Don't offer platitudes. Chances are the sick person knows the prognosis and the odds. An off-hand assurance that everything is just fine, may be too offensive to bear lightly.

Don't give spiritual counsel, or speak as if you know God's plan. Patients should never be made too feel guilty for their deteriorated condition. Sometimes, however, a person who is recuperating must be encouraged to take responsibility for his own rehabilitation.

Rather than ask general, vacant questions, such as "How are you feeling?" ask questions that elicit a specific response, "How are you feeling today?" Sometimes you can tell or ask something related to the patient's interest.

Don't wear a depressed face. He knows you are unhappy to see him in this condition. Be bright, without being euphoric. Create a pleasant ambiance.

When To Visit?

Neither too early nor too late in the day; not during doctors' visits or tests; not when physical needs are being attended to; not when spouse and children have just come to visit; not when it interferes with hospital routine.

If possible, the visitor should give the patient the option of choosing the time for the visit. In a place without clocks and calendars, time is measured in events. A visit can be a very pleasant event to anticipate.

Who Should Not Visit?

Virtually everyone should visit, and every patient deserves

In earlier, more traditional times, when a person was in his last moments, no one, except for those who were overwrought, left his presence. Indeed, a minyan of Jews was brought in to be close by in case of death. (A minyan (ten Jews) is a religious quorum required for public prayer service.) Why bring a minyan to the dying patient? On the contrary, one could counter: "Don't clutter the atmosphere, let him die quietly." but the tradition counseled that a person should die surrounded by family and friends. This is most frequently not possible in a contemporary setting, but it remains an important tradition, and it keeps us mindful of an important principle of health care.

Understanding the Seriously Ill

The primary requirement for successfully performing the mitzvah (good deed) of visiting the sick is understanding the person who is now seriously ill, confined to a 6' x 3' rectangle of mattress, who is power-less and often hope-less, and bewildered. He is trying to sort out where he might have gone wrong and how to cope with the depletion of energies and loss of control which he now perceives to be his lot.

Understanding and empathy are needed to enable visitors to make the call therapeutic. Try to gain some insight into the patient's physical and psychological condition. This will be helpful in your conversations with him, and will prevent your making inappropriate suggestions.

Powerlessness

The patient is usually in a passive condition. He is powerless to initiate certain significant actions and limited in carrying out decisions. A formerly industrious person is

now dependent on others. This may generate feelings of inadequacy and impotence. He is tested and turned, injected and cried over, spoken about and prayed for. By being rendered passive he has been effectively removed from the world of activity.

In a hospital, strangers freely enter his room. They are authorized to touch him, to wake him in the middle of the night, to stick needles into his body, to take blood, to command urination, to grant or withhold food. How the pattern of his life has changed. It alternates between periods of solitude broken by sudden intrusions – volunteers, library book carts, dietitians with menus, housekeepers, TV salespersons, chaplains, nurses, and culminated with the doctor, often accompanied by what appears to be a platoon of investigators. Figures in white solemnly stand nosing around while questions about body functions are discussed; the chart is consulted; heads nod in knowing cadence. The room may change from full to empty in a moment, followed by sounds of a hallway consultation which can be partially heard but seldom understood by the patient, with a predictable rise in anxiety. "Are they talking about me? Is there something I was not told?"

Is it any wonder that loneliness, boredom, fear, shock, anger, guilt, and inadequacy now assault the patient? And this list doesn't even touch on the actual illness, the prognosis, or the person's physical pain.

The Jewish tradition provides specific activities which return an element of power to the individual. While it is true that just keeping up with one's day-to-day progress is a source of some anxiety, there are thought to be managed, or projects that should be undertaken' the writing of an ethical will and/or an oral history, giving

experiences with them.

Humor is on place, if it is done with sensitivity and within the limits imposed by the hospital environment, the neighboring patient, the sick person's tolerance, and good judgment. Try to relate such humor to the natural flow in your regular relationship with the patient.

You need not speak of the illness at all, except in fleeting reference, unless it is the desire of the patient. One who becomes sick does not lose interest or intelligence, although the illness does dominate his thoughts. Ignorance does not automatically accompany disability. "Invalid" is not "in-valid."

What Not To Say

Do not tire the patient. It is not proper, no matter what the motivation, to cause the patient to speak constantly. Reassure him that you can stay close, even without conversing at all.

Have compassion, but do not be over-solicitous or press for information the patient may be unwilling to give.

Do not offer your own advice on medicine or doctors, especially when it is unsolicited. Someone once said that 30% of advice is not useful, 60% is repetitious; and 5% is dangerous. If you believe you fall into the category of the remaining 5%, give the advice – but with sensitivity.

Accept the person's feelings as legitimate, and also as unique. It is unique, since feelings depend on details of experience and attitude, religion and the psyche – all forming a composite of different proportions. Don't talk of other people's reactions – it only serves to dilute the

little space he does have in a hospital setting; neither at the head of the bed nor at the foot.

Unless the patient desires otherwise, sit alongside the bed within reach, at about the middle, and at eye level, in order to be able to convey intimacy and chat amiably, and to hold hands or hug, or stroke – warmth flows from person-to-person and is comforting.

What To Say? What To Do?

These are some of the things visitors might do, depending upon their relationship with the patient and the frequency with which they are likely to visit.

They can help connect sick friends back to the community from which they came. Sometimes, after all, being sick causes people to worry about whether or not they are forgotten at home. Without making the person feel bad for what he or she is missing, a visitor can bring new of their mutual organizations, or some knowledge of community, cultural, or sports events that interest the friend. Surely current events in world affairs is appropriate.

Sometimes it is helpful to keep your eyes open for ways to assist without being asked. Without intruding into people's privacy, you may be able to learn about some situation that needs tending to. Is proper food being provided? Is the patient being provided for meaningfully? Long-term patients – especially elderly people – can benefit from running errands for them, reading stories to them, or handling small business or administrative items, such as insurance questions and family responsibilities.

Speak of the patient's strengths and abilities – and try to provide him with proof of these positive qualities from

charity – projects which may make the patient feel like a human being because he is giving, not only receiving. (These matters are addressed in fuller detail in the NIJH booklet, Caring For the Terminally Ill.)

Anger

It is not unusual for patient and visitor, most often relatives, to experience anger toward one another. A matter that would be a minor irritation in the outside world might be magnified in the hospital setting. Remember, we are no longer dealing with two psychologically equal individuals. The patient has been placed in a very dependent role for almost all his needs. In the best of circumstances, resentment builds up on the part of the patient. He has lost control over so much of his life. In spite of prearrangement, the visitor may arrive in the middle of, or shortly after, some incident that bring these pent-up emotions to the surface. It is far safer for the patient to vent anger at someone who does not have physical control over his body, rather than at health professionals.

Therefore, neither party should be surprised at an outburst. And since the visitor has his or her anxieties and possible unresolved antagonisms that existed prior to the hospitalization, the potential for a flare-up is always present. This too is acceptable, as long as both parties keep in mind who and where they are. This is another reason why working at one's awareness of what is going on is important. If you can identify hostility early, you have a better chance of dealing with it before it erupts into anger or tears. Remember that just below the surface of a seemingly innocuous conversation, a deep river of emotion is silently flowing, carrying memories, hopes and fears for both of you.

The visitor might find himself buffeted by surprising feelings and emotions, like anger. This is likely to result from new demands put on him by the sickness of the patient, a hidden feeling that he is being abandoned by the sick person, perhaps even a suppressed sense of relief at soon being liberated from having to attend to the dying person. The visitor needs to understand that these are not monstrous and unnatural sentiments, and many people react this way in the face of having to deal with the oncoming death of a loved one.

Loneliness

That the terminally ill person is lonely is understandable. He is thrown back on his own resources. He will travel the road to his ultimate destiny totally alone, without any company. But he is lonely for other reasons.

First, he has already begun to mourn himself, his own dying, the world will go on without his presence, without his direction. In Hebrew, the mourner is *avel,* which means "one who withdraws." Not only does the *family* withdraw, and become *avelim* after the death of their beloved, but the *patient* himself begins to withdraw.

Second, he is not alone just because of his own withdrawal, but because he is suffering from what some might call today the "Pariah Syndrome." If death is a terminus of relationships and dying is its prelude, relationships already now begin to alter and to become strained. It is a candlelight that is preparing to be extinguished, it first flickers and sputters before it dies. Among the flickerings in relationships are well-meaning friends and relatives who shy away from the terminally ill because they don't know what to say or because they are being reminded of their own vulnerability and mortality.

the visitor may make reference to this ultimate form of hope. Nobody, of course, formally knows what happens after we die, and therefore it is not surprising that Jewish people through the centuries have entertained a variety of views on the subject. Some believe that the soul is immortal; traditional Jews believe that ultimately there will be a bodily resurrection; and still others that, at the very least, we live on in the memory of close ones and in the influence we have had in their lives.0

However one thinks on these matters, the patient can be comforted in knowing, that for Judaism, life does not lose its significance with bodily death, that one's hope for a continued existence before God and for those who live after our death is well-founded.

Practical Suggestions

There are specific kernels of advice found sprinkled throughout Jewish literature.

Where Should You Position Yourself

Body language communicates powerful subliminal messages, especially to one who is sensitive to these matters and has the time to spend hours thinking about such details. The Jewish code of practice, the *Shulchan Arukh*, suggests;

Don't stand over the patient. Everyone who tends to him, including medical personnel and family, stands over him and thereby assumes a superior posture of looking down and forcing the patient to strain to look up.

Don't sit too far, in the corner of the room, because you might appear disinterested; nor too close, invading what

between family and the dying person should know be increased in depth and quality. It should be a period when loved ones sustain and cherish the patient, overriding previous instances of dissonance and bickering in the relationship.

Rabbi E. Dessler, one of this century's greatest Jewish ethicists, asks which comes first – giving or loving? The usual answer is that one gives to a person whom one already loves. But the reverse may be true. The more parents give to a child who is in need, the more love grows. The mutual giving to one another of patient and family can intensify their love.

Particularly at a time of terminal illness, the family must give and love demonstrably. They should hug and stroke and touch the patient when appropriate and acceptable to him or her. The consequences of such an attitude may be the achieving of an even deeper level of love.

Hope

As one should not leave the room of a sick patient without offering a prayer in his presence, so should one avoid leaving without some offer of hope to the patient.

In the midst of an apparently hopeless situation one is nonetheless mandated to give hope. But what can one hope for? One could hope for less pain – people may not be afraid to die; they are sorely afraid of pain. One could hope for the happiness of a surviving mate and children; for the family's continuation of the values that one taught; for the amelioration of whatever is his most fearful concern.

Jewish tradition affirms belief in a life after death, and

Forgiveness

The Jewish tradition understands that the patient, in order to achieve a peace within himself, has the need for the process of *mechillah. Mechillah* generally means asking forgiveness of people one has wronged, and many terminal ill need that opportunity.

Pertinent to the dying is a second form of *mechillah* – permission to die. Despite the fact that dying is not an act of the patients will, many patients require forgiveness for leaving their families – in a sense abandoning them – and forgiveness for the pain and trouble they caused through the agonizing process of dying and death. Conversely, family members might need the patient's consent for allowing them to say, "it's alright for you to let go." There is also a permission they require of God, that He is permitting to do what they are doing, although, of course, it is not an act of will.

These forgivenesses are often beyond simple rationality, and are most often not articulated explicitly. Only open discussion can explore their needs.

What The Visitor Should Strive For

Design a Healing Climate

A shared history binds patient and visitor to one another. In this context, there is a good chance that constructive dialogue will take place and the blessing of comfort and insight may emerge.

Just because you are visiting a seriously ill person does not mean you have to adopt a solemn demeanor. The

attitudes. For example, if part of your relationship with the patient has revolved around swapping jokes, bring one along. It is reassuring in an atmosphere of so much uncertainty to know that some of your patterns of relating remain the same.

Heart speaks to heart. Eyes communicate. In a short time, in spite of the visitor's apprehension, the patient will know, perhaps not during the first visit but soon thereafter, that the visitor has come to "be with," rather than to "carry out an obligation." *You do not fulfill the mitzvah only with the presence of your body. You fulfill the mitzvah with your inner self.* And the wisdom of silence can also be helpful. But listening to understand is a discipline, for in the daily world we are more often valued for our ability to provide information or answers. In the sickroom, we serve best when we look and listen creatively; we are really not expected to provide "answers." Our value lies more in helping the patient to clarify thoughts and feelings about the significance of what is happening.

"**H**ow long should a visit last?' is a question that people often ask. It depends on both parties. When in doubt leave early. We have found that patients soon devise little parting speeches that usually begin with the phrase "It is very nice that you have taken the time to come see me".... that translates as "Good-bye for today. Take the hint.

According to Jewish tradition, a visitor carries away a portion of the patient's burden by virtue of his visit. The visitor often leaves the hospital richer in mind and spirit if he or she has successfully fulfilled the *mitzvah* of visiting the sick, *bikur cholim*, with sensitivity, trust and love.

Applying Jewish Spiritual Values

Prayer

Jewish tradition believes in the practical efficacy of prayer. Of course, prayer is never a substitute for medical care, but done well it can be an important supplement to it. The sick, particularly, may find a great source of comfort in prayer, and so may members of the family who are in the room during the visitation. Sincere personal prayer can be voiced as a hope addressed to God. Maimonides and other sages state that it is incumbent upon visitors to personally pray for the patient's recovery, or for his ease and relief from pain. One should do that in the language the patient understands best. For example, "I pray to God that..."

Many people might like to pray personally but do not know how to pray. In such a case it is appropriate to use a prayer book with an English translation. Obviously, you can pray in any language that is familiar to you. If a patient doesn't wish to participate in prayer, his wishes should be respected. Jewish tradition obliges us to cheer the patient up – even at the expense of omitting this important religious act. Perhaps an initial statement on the values of asking for God's assistance, in addition to the medical staff's help, might serve as a good starter.

Moses prayed for his sister Miriam's recuperation by saying five words; "*El na, refa na la*." "Please God; please heal her." (Numbers, XII, 13)

Love

Since time is limited for the dying, love becomes an even