The *Mitzvah* of *Bikkur Cholim*: A Model for Building Community In Contemporary Synagogues

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> *The LORD appeared to [Abraham] by the terebinths of Mamre; he was sitting at the entrance of the tent as the day grew hot.*
> (Genesis 18:1)
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> *Why is the story of Abraham's circumcision* [Genesis 17: 23-27] *followed by God's visitation? God came to visit while Abraham was recuperating, to make clear the importance of the mitzvah of* bikkur cholim *[visiting the sick].* (Babylonian Talmud Bava Metzia 86b)

The *mitzvah* of *bikkur cholim*, visiting the sick, is considered one of most important obligations in Jewish life. It is one of the means by which we imitate God, providing care, concern, compassion, and therefore healing to those who are sick.

Throughout the centuries that Jews lived in small, tight-knit communities around the globe, individuals in the community and *bikkur cholim* societies took responsibility for providing for the needs of those who were ill and their families. To this day, Orthodox communities continue to provide support within their communities: from prayer to meals to transportation. In most non-Orthodox communities though, the rabbi, who serves the community in a professional capacity, has taken over responsibility as the professional communal caregiver, visiting those who are sick. Yet with busy pastoral, teaching, programming and administrative responsibilities, rabbis are often unable to cope with the tangible (and often intangible, as well) needs of an individual or family felled by illness or other tragedies. Thus these needs have often been ignored or gone unmet by the synagogue community. In response to this, the past ten years or so has seen a marked rise in the number of *bikkur cholim*-type committees in non-Orthodox congregations. Hoping to bring a sense of healing community to those who are sick, committee members visit hospitals and homes, providing prayer and support. Often the committees also provide a programmatic element: Shabbat dinners, flowers and cards, or weekly calls to those who are unable to leave their homes.

This work that is being undertaken in our congregations is indeed an attempt at *imitatio dio*, imitating God. When it works well, it brings a powerful sense of community to both those who are serving as well as those being served. Unfortunately though, somewhere along the way, the best intentions too often have

gone awry. The following story is, unfortunately, a true composite from one synagogue setting:

> L was a middle aged family therapist who had lung cancer. She was extremely independent but when she developed metastatic disease in her brain she was unable to drive. L would need daily radiation therapy for 6 weeks. She was worried about how to get to the appointments as well as how she would take care of daily tasks such as getting to the supermarket. As L had no family and was concerned about taking advantage of her friends, the suggestion was made that the synagogue's Caring Community get involved with helping L. A call was made to the chair of the committee. The chairperson said that she knew that volunteers could be arranged to drive L to her appointments. It was made clear that since the radiation therapy appointments were difficult to arrange and had already been set-up, it would be helpful to contact L first to get the specific days and times that she would need rides. The chairperson also insisted that volunteers should deliver meals to L. L followed a macrobiotic diet and enjoyed cooking for herself.
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> L was contacted by the chairperson the next day. She was told that someone would be by to pick her up at 2 p.m. for her first appointment. L told the chairperson that her appointment was at 10 a.m. for that day. The chairperson told L that the man who would drive her had a golf game that morning and couldn't take her at 10. Further, volunteers had been scheduled to pick up L at various times for the next two weeks that had no relation to her appointment times. L became frustrated and then furious when the chairperson couldn't understand that her needs had been ignored. The chairperson considered L to be ungrateful when L politely but firmly declined prepared meals made by volunteers of the Caring Community.

The caring committees, *bikkur cholim* committees and other like-minded committees who reach out to those who are ill are a wonderful addition to our synagogues. Yet how often do we step back and think about to what extent the services being provided are chosen to fit the needs of the committee members rather than the needs of the people being served? Those who are on the receiving end of the services being provided are too often considered ungrateful, overly critical, negative… there are many adjectives that I have heard as a Jewish hospice chaplain

reaching out to ask synagogues to support their members in need. Yet the unfortunate truth is that too often caring volunteers are not really hearing the requests of synagogue members, and are responding in ways that only compound the feelings of isolation, helplessness and resentment that often accompanies illness.

In the spring of 2004, Wendy Bocarsky, who is a Jewish educator and Registered Nurse, and I developed a training program in the Southern California area to help encourage synagogues to look at *bikkur cholim* in a new way. The Kalsman Institute on Judaism and Health provided seed money for the project.

Wendy and I began with the concept of providing an Introduction to Congregational Nursing course. Similar to the Parish Nursing model developed in the Catholic community, most Congregational Nursing programs envision the hiring of an R.N. to provide services in the congregation such as blood pressure checks, health education programs, and information and referral services.

Through the development of our program, which we eventually named the *Chesed Project*, Wendy and I came to realize two things. First, the medical professionals who took our course developed a Jewish context for health and healing through our exploration of Jewish spirituality, the *mitzvah* of *bikkur cholim* and ethical decision-making and reported in their evaluations that the course provided them with a Jewish context in their professional lives. They perceived the course as personally beneficial and rewarding for them as healthcare professionals. Secondly, and perhaps more importantly, in the context of Jewish congregational life Wendy and I came to realize that, in most cases, it is more appropriate in synagogue settings to incorporate healthcare professionals into the Jewish model of *bikkur cholim* than to adapt the Catholic model of parish nursing into synagogues. The traditional model of *bikkur cholim*, in which all members of the synagogue are involved, each in his or her own capacity, can serve to help build community and foster a sense of care and concern for others that impacts the entire congregation. Taking into account what we have learned, the curriculum and 8-week course that we developed differs in four major ways from the way most non-Orthodox synagogues and Jewish communal institutions are approaching the concept of *bikkur cholim*:

1) We stress *teams and team-building* instead of *committees*.

2) We stress *needs-based* instead of *program-based* strategies.

3) We stress the importance of incorporating medical professionals into the teams for the expertise that they bring, particularly in the area of providing individualized needs assessments.

4) We stress the importance of each synagogue creating an individualized model that will work for them, instead of using a "cookie cutter" approach in creating their project.

Stressing *teams and team-building* instead of *committees*

What is the difference between a team and a committee? Many people often confuse teams with committees, and to simply change the name from committee to team does not address the differences between the two.

A committee tends to be more hierarchical in nature, and fits into a structured system of responsibility. Although not meant to be so, committees often tend to end up being about power and status. Teams are structured to focus on buy-in, response and action. On a team, individuals can participate on an ad-hoc basis, based upon their individual talents and availability.

A committee:

- Receives its assignment from an outside authority or board;
- Studies problems and formulates solutions;
- Works in isolation—represents a closed system of "membership;"
- Is led by a "chairperson" who is imbued with responsibilities of leadership;
- The committee itself is of primary importance, with individual committee members being subsumed within the structure of the committee.

A team, on the other-hand:

- Takes part in developing its own objectives within a larger system;
- Collaborates with others;

- Is fluid in its "membership;"
- Rotates shared leadership among "team members" and focuses on the individual talents of team members;
- Serves as a catalyst, linker, and facilitator within a larger system.

Too often, entities that begin as teams evolve (or devolve) into committees as a core group of people begins to set the agenda and the perception of a closed system grows. The "closed system" inherent in the committee approach means that rarely does a committee evolve into a team. Yet by its very nature, the team approach implies more of a sense of interpersonal cooperation and personal accountability—key components in the building and sustaining of community.

Stressing *needs-based* instead of *program-based* strategies:

What do we mean by differentiating between needs-based and program-based strategies?

In a program-based strategy, the development of a program or programs serves as the focal point for providing services to address needs. For instance, a *bikkur cholim* committee decides, through identifying a need, that it should initiate a program to provide Shabbat meals to shut-ins. The emphasis then shifts to finding a) people who can make or deliver Shabbat meals and b) people who want to receive a Shabbat meal. In the case of both giver and receiver, the committee begins looking for congregants who fit into the Shabbat meal program's criteria. If someone is unable to make or deliver a Shabbat meal, but might be available on Tuesday mornings to stop in and chat with a shut-in for half an hour, they are not appropriate for the program. Likewise, if someone who is shut-in doesn't need a Shabbat meal but would like a friendly visit once a week, their need doesn't meet the criteria for the program, and therefore will not be met. Of course, realizing this the committee might then decide to create a program to provide friendly visitors once a week to shut-ins, but enormous energy is being exerted in creating programs, instead of focusing on addressing needs.

Program-based strategies have the following attributes:

- Emphasis is on creating programs;
- Resources (primarily human) are static/stable and unchanging—developed to meet the needs of the program;
- Operate as "closed systems" in which decision-making resides within the closed structure of a committee.

On the other-hand, needs based strategies focus on needs on an ad-hoc basis and in an open format. For instance, it comes to the attention of one of the *bikkur cholim* team leaders that a member of the congregation is no longer able to get out the house due to age and infirmity. The team leader, often in consultation with the rabbi, calls a member of the synagogue who is a geriatric nurse, social worker or someone professionally trained in assessment, and asks if they will call the congregant and assess their needs. Often, a credible healthcare professional trained in assessment is the most appropriate person in the synagogue to begin to sort through the ways in which the congregation can be of assistance, while also knowing what is beyond the scope of lay-person involvement. Frequently, synagogue members are more willing to respond to a medical professional than to a congregant without medical credentials, or even the rabbi. The synagogue member with medical credentials then provides information back to the team leader who acts as a "clearinghouse coordinator" linking suitable members of the congregation to fulfill appropriate needs.

Needs-based strategies exhibit the following characteristics:

- Emphasis is on meeting needs;
- Resources (primarily human) are dynamic and available/utilized on an ad-hoc basis;
- Operate as "open-systems" in which decision-making is shared by all stakeholders (i.e. the people being served, the people providing service, clergy, lay leadership, etc.).

<u>Incorporating medical professionals into the teams</u>

As noted above, medical professionals are trained in assessment. The assessment format that Wendy and I present in our course, which goes by the acronym APIE, is one that Wendy learned as a nursing student and uses daily in her

professional life as a nurse. The acronym refers to the following steps that help medical professionals problem solve and process issues quickly:

Assessment
Planning
Implementation
Evaluation

We suggest implementing these four steps in a needs-based *bikkur cholim* project. Many synagogues have a wealth of medical professionals as congregants. It is often true that these congregants do not wish to sit on a committee or spend time outside of their professional lives acting in a professional capacity. Also, in Jewish settings, there is often concern about potential medical malpractice lawsuits arising out of medical professionals acting in a medical capacity outside of their professional practices. (Incidentally, this concern is one that seems to be unheard of in the Christian community, and in fact there has never been a medical malpractice lawsuit arising out of a congregational setting.) Yet almost all medical professionals act as sounding boards and information and referral sources for family and friends.

In the *Chesed Project* course, we ask the medical professionals (who have included nurses, social workers, occupational therapists, a doctor, and a physical therapist) to envision their synagogue as their community, and its members as an extension of their family—with all of the good and bad connotations associated with such an image! We also stress the fact that they are not to make any negative (or positive) comments about a congregant's medical care, and if asked to provide names for another diagnostic opinion, they should provide more than one name if possible. As Professor Marla Abraham, Associate Director of the School of Jewish Communal Service at Hebrew Union College-Jewish Institute of Religion in Los Angeles, has taught the students in our course, it is about discerning "the difference between caring and delivering care."

Through instituting a needs based, team approach to *bikkur cholim*, medical professionals in the congregation can be called upon on an ad-hoc basis to help provide the initial step of assessment in the APIE process model. In one congregation, a congregational family that was refusing any kind of support from the

synagogue began to open up to a congregant who was a nurse in the hospital in which their loved one was dying. Over time, going into the hospital room in her scrubs, on her coffee break, to see if the family was o.k. and whether they needed any help negotiating through the maze of the hospital setting, she was able to begin to break through the family's isolation and help them reconnect with synagogue members who could bring them a sense of comfort and provide some "in-hospital" respite care so family members would feel comfortable leaving their loved one for short periods of time—the only service that the family really needed or desired.

Creating an individualized model on a synagogue-by-synagogue basis, instead of using a "cookie cutter" approach in creating a project

Organizations are like human beings: each one is unique. There are small congregations, medium sized ones, large ones and everything in-between. There are congregations in which the lay community is already very active, and ones in which staff professionals are currently expected to provide all of the services. There are congregations in which the rabbi functions as CEO, and ones in which the rabbi primarily functions as teacher and pastor. The differences go on and on. Thus it is unrealistic to believe that there can be any one approach to creating a project.

There are four basic steps that Wendy and I suggest in helping synagogues begin the process of creating or reinvisioning a *bikkur cholim* project:

- Assemble a "core team" of interested congregants to work with the lay and professional leadership to shape a vision for your synagogue that is anchored in the core values of the congregation. (It is important to be careful that this "core team" does not end up functioning as a committee.) Some synagogues want to begin the process with a congregational survey, but in many synagogues surveys don't work (either they are discarded or people respond to them unrealistically). Many congregations have already undertaken this step as part of a long-range planning process.

- Decide what the ultimate goal is for the project. Is it primarily a means by which to get everyone in the congregation more involved? Is it primarily to better serve the needs of congregants during difficult times? Is there a larger goal that ultimately encompasses the community outside of your congregation?

- Create a time frame for getting the project up and running. Where do you expect to be next month, in six months, in one year, etc.? The APIE process can be used both on an individual basis as well as on an organizational basis. Assessing, planning, implementing and evaluating are all key components in a successful project. Don't forget the importance of on-going evaluation as you build and sustain your project.

- Who are your partners? How will you create buy-in? In getting the project off the ground, it is imperative that partnerships are forged within the synagogue that will work together to further the goals of the project in-step with furthering the goals of the congregation itself.

Although we do not provide a "cookie-cutter" model for creating a needs-based *bikkur cholim* project, we believe that the following components are required from the outset to ensure success:

- There must be buy-in for the project by the professional and lay leadership and this buy-in must be communicated to the congregation through sermons, letters, newsletter articles, dialogue and other appropriate means.

- There must be acknowledgement that the project will require a large time commitment at the "front-end" in developing a congregational list highlighting the abilities, knowledge and availability of synagogue members for the project.

- There must be a realization on the part of the synagogue community that a needs-based *bikkur cholim* project demands sensitivity to the needs of everyone in the congregation. If a family's expectations of what the congregation "should" be doing for them exceed the congregation's ability to fulfill the request, this must be addressed honestly and firmly.

- There must be a strong core of three or four people who, at the outset, will serve on a rotating basis as the "clearinghouse coordinators"—matching up people in need with those who can provide needed assistance. There must also be a process by which other synagogue members are nurtured to step into the coordinator slots, to address the very real concern of potential "burn-out" by coordinators.

- There must be an emphasis throughout the congregation on the importance of confidentiality. We suggest that everyone who participates signs a confidentiality and/or responsibility agreement. (One congregation refers to it as a *brit*, Hebrew for *covenant*, of confidentiality and responsibility.)

- There is no need for long, multi-part coursework for people who are going to be delivering a meal, fixing a broken computer, walking a dog or picking up the mail. Instead, Wendy has devised a 30-minute "training" replete with manual

for her synagogue. Wendy's training begins with Torah study; explains the project; reminds people to be aware of their own agendas; addresses the "how-to's" of listening, visiting and being part of a team; stipulates expectations including confidentiality, limit-setting, reporting back, and accountability; and suggests ways in which to deal with difficult or awkward situations. Over 80 people participated in the training in the first few months that it was offered by Wendy in her synagogue. For those congregants who wish to delve in a more "in-depth" fashion into Jewish spirituality and the mitzvah of *bikkur cholim*, adult education courses can be offered on a synagogue-wide or even community-wide basis.

Today's Jewish world, like the larger society in which we live, is replete with articles and books about spiritual healing. As healing of the spirit again becomes an important component in the therapeutic process, a needs-based *bikkur cholim* project helps not only mend the broken spirits of individual congregants, but of entire congregations as well. Particularly in today's large, urban congregations, members often feel isolated and alone. A successful *bikkur cholim* project serves to help foster the type of connections that are a traditional component of synagogue life. It serves as a catalyst for personal and communal revitalization and renewal as congregants feel the warmth and sense of satisfaction that comes from participating in a very ancient, Jewish form of *imitatio dio*.