

Rabbi Daniel Nevins

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Triage and the Sanctity of Life

Question:

On what basis should medical professionals determine which patient gets lifesaving treatment in a pandemic emergency setting?

Response:

The pandemic known as Covid-19 has caused extraordinary levels of illness, disruption, and death around the world. As I write in late March 2020, having survived my own mild bout with this disease, we do not know how much more destructive the novel coronavirus will be. The numbers are already overwhelming medical systems, and the world has responded with unprecedented efforts to isolate people and slow the spread of this virus. These efforts have included rationing of medical supplies and triaging patients in need of intensive medical care.¹ In hard-hit regions such as northern Italy, dreadful decisions have been made to determine which patients to treat intensively if at all, and which must be left to die.²

Unfortunately, this is not the first time that humanity has contended with the allocation of scarce medical resources. Ethical discourse in each crisis builds on the experience and lessons learned in prior pandemics. Over several such cycles physician and bioethicist Ezekiel Emanuel has been one of the more perceptive and forceful advocates for fair public health policy. With a team of collaborators he published an article on March 28, 2020 in *The New England Journal of Medicine* called, "[Fair Allocation of Scarce Medical Resources in the Time of Covid-19](#)."³ I will

¹ For an updated protocol on rationing care see Douglas White and Benjamin Lo, "[A framework for rationing ventilators and critical care beds during the COVID-19 pandemic](#)" *JAMA*. Mar. 26, 2020.

² Lisa Rosenbaum, MD. "[Facing Covid-19 in Italy — Ethics, Logistics, and Therapeutics on the Epidemic's Front Line](#)," *New England Journal of Medicine*, March 18, 2020. She shares a "a hypothetical scenario involving two patients with respiratory failure, one 65 and the other 85 with coexisting conditions. With only one ventilator, you intubate the 65-year-old. Dr. D. told me his hospital was also considering, in addition to the number of comorbidities, the severity of respiratory failure and probability of surviving prolonged intubation, aiming to dedicate its limited resources to those who both stand to benefit most and have the highest chance of surviving." This age-based approach is described as "soft utilitarianism."

³ Author list: Ezekiel J. Emanuel, M.D., Ph.D., Govind Persad, J.D., Ph.D., Ross Upshur, M.D., Beatriz Thome, M.D., M.P.H., Ph.D., Michael Parker, Ph.D., Aaron Glickman, B.A., Cathy Zhang, B.A., Connor Boyle, B.A., Maxwell Smith, Ph.D., and James P. Phillips, M.D. Published in *New England Journal of Medicine*, March 28, 2020.

present a summary of this important essay before presenting a different perspective based on Jewish legal texts and practice.

A. Soft Utilitarianism from Theory to Practice

Dr. Emanuel and his colleagues identify four fundamental values that they consider essential to developing a fair distribution of resources:⁴

- 1) Maximizing the benefits produced by scarce resources
- 2) Treating people equally
- 3) Promoting and rewarding instrumental value
- 4) Giving priority to the worst off

These fundamental values are not easily reconciled with one another. What follows is my synopsis of their explanations, which should be read in full. The first value, *maximizing benefit*, is essentially a utilitarian determination that emphasizes saving the most lives, or perhaps the most life-years possible. *Equal treatment* is based on an egalitarian account of justice and would assign resources to people without discrimination, perhaps by use of a random lottery, even if this would not yield the best results on the macro level (most lives saved). *Instrumental value* brings us back to utilitarianism. It acknowledges the popular conviction that especially in a crisis, people are not truly equal. Some people are more useful—for example, medical clinicians who can save the lives of others. Saving one doctor might allow for the saving of multiple lives, which would not be the case when saving a person in a “non-essential” field of work. Their fourth value, *giving priority to the worst-off*, brings us back to a justice-basis, helping people who are already most vulnerable, or perhaps those who have benefited least in life, even if this does not yield the greatest “utility.”

We have here a seesaw between what appears to be the greatest good, and what seems most just or fair. Yet Emanuel, et al, are not stymied. In their view, the first fundamental value they promote, *maximizing benefits*, is “paramount in a pandemic,” and overrides considerations of justice or fairness. They say, “saving more lives and more years of life is a consensus value across expert reports.” Their essentially utilitarian outlook drives the six policy recommendations of this article, from which I will excerpt (these are their words; readers are urged to consult their *NEJM* article for fuller explanations):

⁴ See also three prior articles: A) “Public health: who should get influenza vaccine when not all can?” Emanuel EJ, Wertheimer A. *Science* 2006;312:854-5. B) “Standing by our principles: meaningful guidance, moral foundations, and multi-principle methodology in medical scarcity.” Persad GC, Wertheimer A, Emanuel EJ. *Am J Bioeth.* 2010 Apr;10(4):46-8. And C) “Principles for allocation of scarce medical interventions.” Persad G, Wertheimer A, Emanuel EJ. *Lancet.* 2009 Jan 31;373(9661):423-31.

- 1) Operationalizing the value of maximizing benefits means that people who are sick but could recover if treated are given priority over those who are unlikely to recover⁵ even if treated and those who are likely to recover without treatment.
- 2) Critical Covid-19 interventions — testing, PPE, ICU beds, ventilators, therapeutics, and vaccines — should go first to front-line health care workers and others who care for ill patients and who keep critical infrastructure operating, particularly workers who face a high risk of infection and whose training makes them difficult to replace.⁶
- 3) For patients with similar prognoses, equality should be invoked and operationalized through random allocation, such as a lottery, rather than a first-come, first-served allocation process.
- 4) Maximizing benefits requires consideration of prognosis — how long the patient is likely to live if treated — which may mean giving priority to younger patients and those with fewer coexisting conditions.
- 5) People who participate in research to prove the safety and effectiveness of vaccines and therapeutics should receive some priority for Covid-19 interventions.
- 6) There should be no difference in allocating scarce resources between patients with Covid-19 and those with other medical conditions.⁷

Each of these policy recommendations is justified within the realm of the authors' fundamental values, and they are certainly correct that it is best to establish consistent ethical practices rather than leaving life and death decisions to spur of the moment decisions by clinicians at the bedside. As White and Lo recommend in their guide to triage, "The separation of the triage role from the clinical role is intended to promote objectivity, avoid conflicts of commitments, and minimize moral distress. The triage officer will also be involved in patient or family appeals of triage decisions, and in collaborating with the attending physician to disclose triage decisions to patients and families." Nevertheless, Emanuel acknowledges that operationalizing some of their recommendations will be "extremely psychologically traumatic for clinicians—and some clinicians might refuse to do so." For example, Emanuel's team states, "we believe that

⁵ In this article at least the authors do not define the key terms "likely/unlikely" and "recover." Does "likely" mean a greater than 50% chance? Does "recover" mean full restoration to pre-infection function, or being stabilized to allow weaning from ventilation and discharge from the ICU and perhaps the hospital?

⁶ Although a medical worker who requires ventilation will not likely return to clinical work during the present crisis, they may return to the medical field eventually. Moreover, knowledge that medical workers will receive priority care in a crisis may encourage them in their inherently risky work.

⁷ As Dr. Michael Paasche Orlow explained, this is not a realistic claim. The pandemic is being allocated resources unavailable to other types of patients, for example, catheterization for those experiencing heart attack, because the latter is not a contagious condition (personal communication).

removing a patient from a ventilator or an ICU bed to provide it to others in need is also justifiable and that patients should be made aware of this possibility at admission.”⁸

If the previous sentence did not catch your attention, it should. Removing a patient from a ventilator or an ICU bed, even without their consent, and perhaps over their desperate objections, will often result directly in their death. The authors do not limit this permission to end the life of a patient to a person who is actively dying or even terminally ill. They refer to patients whose prognosis is poorer than that of other patients. If patients have similar prognoses then, “equality should be invoked and operationalized through random allocation.” Understand their position: priority should not be given to those first to arrive at the hospital since that would discriminate against people who live farther from treatment centers and might hurt people whose “strict adherence to recommended public health measures” delayed onset of their own illness.

Each of these recommendations accords with the fundamental values that Emanuel, *et al*, have established, and sound reasonable. However, they would have the following radical results:

- 1) Patients living with disability or chronic health conditions might be denied intensive care in the presence of other patients with better overall health, or younger patients
- 2) Patients already being treated would not have priority to those newly arrived, but could be bumped from beneficial therapy in place of someone who could benefit even more
- 3) Triage officers or committees would be empowered to decide to terminate life-sustaining treatment for a patient who is not actively dying, directly leading to their death, even without the consent or over the protests of the patient and their family or health care proxy

Clinicians engaged in direct patient care would be spared the moral burden of making these decisions, but they would nevertheless be required to implement them. This too could cause moral injury, as Jennifer Senior has argued.⁹

Moreover, in the name of efficiency, important principles of justice would be abandoned. Disability rights scholars and activists have rightly sounded the alarm over the (greater than normal) devaluation of their lives in a crisis. Ari Ne’eman writes, “Even in a crisis, authorities should not abandon nondiscrimination. By permitting clinicians to discriminate against those who require more resources, perhaps more lives would be saved. But the ranks of the survivors

⁸ Here they presumably mean that by default patients would be assigned do not resuscitate (DNR) orders, an idea which has been advocated by various researchers. See “The Importance of Addressing Advance Care Planning and Decisions About Do-Not-Resuscitate Orders During Novel Coronavirus 2019 (COVID-19).” J. Randall Curtis, MD, MPH; J. Randall Curtis, MD, MPH^{1,2}; Erin K. Kross, MD; Renee D. Stapleton, MD, PhD

⁹ Jennifer Senior, [“The Psychological Trauma that Awaits our Doctors and Nurses.”](#) *NY Times*, Mar. 29, 2020.

would look very different, biased toward those who lacked disabilities before the pandemic. Equity would have been sacrificed in the name of efficiency."¹⁰

To their credit, White and Lo reject the use of "exclusion criteria" in their multi-principle priority score, and do not include disability other than dementia in their table of "Examples of Severely Life Limiting Comorbidities (Commonly associated with survival <1 year).¹¹ Still, their utilitarian analysis means that some patients will be denied treatment based on a utilitarian analysis of their life, and some patients who very much want to live could be forcibly removed from ventilation, causing them to die.

Before utilitarian recommendations for the allocation of scarce medical resources are accepted and operationalized we must pause and ask whether other ethical and religious values deserve consideration.

B. From Utilitarianism back to Sanctity

Jewish ethics begins with the theological belief in divine creation, the Torah's record of commandments designate to sanctify the people Israel, and the efforts of rabbis in the past two millennia to apply these beliefs and practices to contemporary life. Halakhah is a normative literature which is primarily deontological, or rule-based, though Jewish teachers have always believed that the ultimate consequence of Jewish normative practice is the sanctification of life, bringing blessing to the world. Halakhic sources are not generally consequentialist or utilitarian in the sense of deciding actions based on the actor's assessment of what will yield the greatest good for the greatest number of people.

Halakhic norms used to inform discussions of triage of medical resources are extrapolated from different contexts such as the redemption of captives, the allocation of water, prioritization in

¹⁰ Ari Ne'eman, "[I Will Not Apologize for My Needs](#)," *NY Times*, March 23, 2020.

¹¹ White and Lo write (7), "A central feature of this allocation framework is that it does not use categorical exclusion criteria to bar individuals from access to critical care services during a public health emergency. There are several ethical justifications for this. First, the use of rigid categorical exclusions would be a major departure from traditional medical ethics and raise fundamental questions of fairness. Second, such restrictive measures are not necessary to accomplish public health goals during a pandemic or disaster; it is equally feasible to assign all patients a priority score and allow the availability of resources to determine how many patients can receive the scarce resource. Third, categorical exclusion criteria may be interpreted by the public to mean that some groups are "not worth saving," leading to perceptions of unfairness and distrust. In a public health emergency, public trust will be essential to ensure cooperation with restrictive public health measures. Thus, an allocation system should make clear that all individuals are "worth saving" by keeping all patients who would receive critical care during routine clinical circumstances eligible, and by allowing the availability of beds and services to determine how many eligible patients receive them."

charity, negotiations during a siege, and the final Mishnayot in Tractate *Horayot* (3:7-8) that establish hierarchies in life-saving.¹² Rabbi Elliot Dorff provides an excellent overview of five Jewish discourses relevant to triage in chapter 12 of his 1998 book, *Matters of Life and Death* (esp. pp. 279-298), and in his new responsum addressing the Covid-19 pandemic, "Triage in the Time of a Pandemic" (CJLS, Mar. 30, 2020).¹³

As Rabbi Dorff has written, there is little discussion of medical triage in classical Jewish sources, perhaps because pre-modern medicine was so ineffective. Nevertheless, Rabbi Dorff derives significant guidance on medical triage from these classic sources, ultimately endorsing the most alarming policy proposal of medical utilitarians. Rabbi Dorff writes,

This will mean that some patients who would ordinarily receive and benefit from treatment may either not receive treatment, have the initiation of treatment postponed, or have treatment discontinued and, as a result, may die or suffer some other adverse health-related consequence. This is the tragedy of the necessity to triage.

He denies that his analysis is utilitarian, instead basing it on a novel interpretation of *pikuah nefesh* (the obligation to save life) which sees saving numerous lives as a more complete expression of the commandment than saving only one life.¹⁴ And yet the more relevant halakhic principle here is the cardinal rule, *one life may not be sacrificed for another*, אין דוהין נפש מפני נפש.

In the vast rabbinic canon, there is almost nothing to suggest this quantitative approach to *pikuah nefesh*. Almost, but not quite nothing. As Rabbi Dorff shows, the Jerusalem Talmud (with parallels in Tosefta Terumot and Midrash Bereshit Rabbah) recounts the biblical story of Sheva b. Bikhri in which a group of bandits demands the life of one person, or else they will massacre the entire caravan. This dilemma is also told with reference to a town under siege. There are some phrases and some positions within these stories that imply that one may be sacrificed lest the entire population perish. Yet these same stories can be read differently, that only if the one person was already sentenced to death, or actively dying, or specified by the attackers, could they be sacrificed to save the many. The sages do not justify the surrender of Sheva b. Bikri as an act of *pikuah nefesh*.

It is hard to extrapolate from this story to conclude that one patient who is currently receiving lifesaving treatment, who is not terminally ill, and who has not requested or authorized

¹² Mishnah *Horayot* claims that a Torah scholar should be rescued before anyone else (including the high priest), but this Mishnah has been nullified in practice by Rabbi Yisrael Meir Kagen, who writes, "there is no law differentiating Torah scholars today." Rabbi Auerbach confirms this position.

שער הציון סימן תקמו. מטעם דאין בזמננו דין תלמיד חכם, כן משמע מפרי מגדים.

¹³ Other halakhic resources include Aryeh Dienstag, "[Rationing During a Pandemic Flu](#)," *Verapoh Yirape* (undated YU journal, perhaps 2009, No. 2) and Avraham Steinberg, "Allocation of scarce resources," *Encyclopedia of Jewish Medical Ethics* (Feldheim, 2003).

¹⁴ Rabbi Dorff discusses *pikuah nefesh* in his book, pp. 15-18 and p. 328, n.3, but does not argue there that there is a quantitative aspect to this mitzvah.

discontinuation of a treatment that is causing them anguish – that such a person could nevertheless be forcibly extubated in order to give another person a chance.

As far as I know, the early rabbinic discussion of Sheva b. Bikhri is not cited in the codes of Jewish law or responsa and has not been used to establish practical religious law, much less national public policy. Rabbi Dorff offers it as a basis for instituting a policy in which some patients could be denied scarce medical resources or even removed from them in order to treat other patients (say, younger ones, or ones with fewer medical complications) who have a better prognosis. I would need to see much more support in the halakhic literature to reach the same conclusion.

As it happens, halakhic literature is not entirely silent on the question of the allocation of scarce medical resources. In the eighteenth century Rabbi Yosef b. Meir Teomim (1727-1792, Lemberg, known for his collection, *Pri Megadim*) establishes a general principle of medical triage in Jewish law: “If there are two patients, one in greater danger than the other, and resources sufficient for only one of them, then the patient in certain danger has priority over one in possible danger.”¹⁵ This principle is cited and applied to bioethics scenarios by twentieth century *poskim* Rabbi Moshe Feinstein and Rabbi Shlomo Zalman Auerbach.

Regarding the prioritization of care (דין קדימה בריפוי) between two needy patients, Rabbi Feinstein rules in a pre-treatment scenario that if one patient is not expected to live out the year due to other medical impairments (comorbidity), then a second patient with a better prognosis may be given priority, for he has not relinquished “his presumption of life” (חזקת חיים שלו). If both are likely to live a year with treatment, then whoever arrived first claims the required resource. If it is not known which patient has made prior claim, then the conflict should be settled by lottery.¹⁶

Rabbi Auerbach cites *Pri Megadim* to justify allocating resources to the patient with greatest medical need. However, he then questions whether it would be permissible to remove a ventilator from one patient and attach it to another who is in greater immediate danger, or to one who has greater chances of recovery. He suggests that the first patient has “claimed” the

¹⁵ פרי מגדים אורח חיים משבצות זהב סימן שכח ס"ק א. מכל מקום אם יש אחד שוודאי מסוכן על פי הרופאים וכדומה, וזה ספק, ורפואה אחת אין מספקת לשניהן, הוודאי דוחה הספק.

¹⁶ שו"ת אגרות משה חושן משפט חלק ב סימן עה. אם יש לפנינו שני חולים ושניהם אפשר שיתרפאו בדרך הטבע ממחלות אחרות שאירע להם, יש להקדים החולה ששייך שיתרפא שיחיה יותר משנה שהוא לא אבד חזקת חיים שלו מחולה האחר שלפי דעת הרופאים לא יחיה יותר משנה שהוא בחשיבות טרפה להרופאים ועוד גרוע שלא יוכל לחיות יותר משנה וטרפה באדם הא שייך שיחיה אפילו הרבה שנים, אבל כשנידון הוא בשומת חייו שלהרופאים לא יחיה יותר משתי שנים אין נוגע שוב כלום להלכה דשניהם שוין לחשיבות דחזקת חיים, ואמירת הרופאים שלא יוכל לחיות לא מגרע כלום החזקת חיים שלו, וליכא בשביל זה דין קדימה וצריך הרופא לילך למי שנקרא תחלה ולמי שקרוב לביתו יותר וכששוין בזה צריך להקדים לפי סדר מתני' דהוריות (י"ג ע"א) ואם לא ידוע זה להרופא יהי גורל, כן נראה לע"ד.

resource and is not obligated to relinquish their claim. Yet Rabbi Auerbach concludes his discussion with great trepidation: "I have not nailed down what I have written, for the questions are very serious, and there are not clear prooftexts [in halakhic literature].¹⁷

I share the sense of trepidation and doubt expressed by Rabbi Auerbach, and I regret that this crisis prevents me from conducting a fresh and full inquiry into this urgent topic. Nevertheless, even with my incomplete research, I would make the following general statements with reference to medical triage in halakhah:

- 1) A person may never intentionally end the life of another, except in self-defense, justified war, and in very narrow and largely theoretical forms of capital punishment. To do so would violate the cardinal rule of halakhah, "we do not sacrifice one life to save another" (אין דוחין נפש מפני נפש).
- 2) If an action does not endanger one's own life, then they are obligated to save the lives of others, even at personal loss. This idea is taught in the story of two villages that are watered by one meager stream. The residents of the upstream village may use all the drinking water they need even if this does not leave enough for the second village. However, the upstream village can't use all the water for their animals but must leave enough to sustain the second village (B. Nedarim 80b). This idea derives from the command, "Do not stand [idly] over the [spilled] blood of your companion" (Levit. 19:16).¹⁸
- 3) A person may endanger themselves to rescue others who are in mortal danger, for example in confronting a terrorist or volunteering to serve in the army. Yet a person is not required to sacrifice themselves to save others. As Rabbi Akiva teaches in the famous canteen story, "your life is prior to the life of your companion" (B. Bava Metzia 62a). The background principle to these stories may be that the burden of proof lies on the one who does not have current possession of the goods (המוציא מחברו עליו הראיה). One's own life is a good over which one has been assigned responsibility. This perspective would justify providing front line medical workers with extra protections such as scarce PPE and vaccines so that they not be forced to endanger themselves when helping others.
- 4) The principle about current possession implies that it is forbidden to take away a life-sustaining resource from one person in order to give it to another. If the current

¹⁷ שו"ת מנחת שלמה תניינא (ב - ג) סימן פו. אולם להעביר מכשיר הנשמה מחולה לאחר שהוא במצב יותר קשה או שיש לשני יותר סיכויים להצלה מסופקני מאד, כי יתכן דחשיב כאילו הראשון כבר זכה במכשיר והחולה עצמו ודאי פטור מליתן מכשיר שלו לאחר אף אם השני יותר מסוכן, וכן אם כבר התחיל הרופא להתעסק עם חולה מסוכן מסתבר דכמו שהעוסק במצוה פטור מן המצוה, כך הוא פטור - ואולי אסור - מלהניח את הראשון ולהתעסק עם השני כששניהם בסכנה אף אם יש יותר סיכוי להציל את השני. אגיד לו נאמנה שאין אני קובע מסמרים בכל מה שכתבתי כי השאלות הן חמורות מאד, ואינני יודע ראיות ברורות.

¹⁸ There is a middle example of laundry, and a debate about whether the upstream villagers may use up all the water for laundry since dirty clothes may cause physical discomfort and perhaps disease. See comments of Ra"N.

possessor is suffering from the therapy and in their own estimation is not benefiting, then they or their authorized representative may choose to discontinue the therapy in order to focus on palliative care. Rabbi Feinstein acknowledges that extended suffering is a valid cause for ending life-sustaining treatment. However, medical authorities may not remove a vital resource such as a ventilator in order to serve the interests of a different patient whose prognosis they consider to be better. Some solutions have included the use of timers, or the assignment of limited sessions (say 12 hours) of ventilation, so that at the end of each session a new decision must be made to initiate ventilation with Patient A, or to assign this resource to a different patient. Still, Rabbi Auerbach argues that the first patient may not have relinquished their claim to the equipment, and they are not obliged to sacrifice themselves to save another.

- 5) In general, there is an egalitarian approach to lifesaving, with all human life treated as equally sacred. The Rabbis famously state, "Whoever saves one life is as if they saved an entire world." (M. Sanhedrin 4:5; Avot DR"N A 31)
- 6) If it comes to rescuing either Person A or Person B, and only one can be saved, several factors may be considered:
 - a. Who is in most immediate and grave danger? (Pri Megadim)
 - b. Is one victim terminally ill? Jewish law differentiates between brief survival (חיי שעה), and long-term recovery (חיי עולם), with a year of survival as the criterion. (R' Feinstein—cf. White and Lo's survival > 1 year)
 - c. Who has claimed the resource first? (R' Auerbach)

We may not remove a vital medical resource from one person in favor of another on the grounds that the latter is younger, healthier, or somehow more valuable to society. This would betray our foundational belief that all people are created in the divine image, and that life has infinite worth. It would run counter the cardinal rule of halakhah, "we do not take one life to save another."

These arguments would apply to the allocation of ventilators, and to other scarce medical resources such as vital organs. In the presence of numerous patients demanding a scarce resource, we should prioritize a patient who urgently needs the resource over one whose need is less urgent, then a patient who has a chance of surviving over one who has no chance of surviving, then one who has established their claim first over the one who has come second. If all the above are equal, then a random lottery might be employed.

It seems to me that Jewish law does not permit the removal of lifesaving equipment such as a ventilator from Patient A in order to save the life of Patient B unless Patient A or their proxy requests cessation of ventilation due to the suffering caused by their extended illness and the likelihood that they will not survive long even with such support. In this I respectfully disagree with the conclusions of Dr. Emanuel and his colleagues, and of my colleague and teacher Rabbi

Dorff (who calls such a case tragic) and agree with the anguished conclusion of Rabbi Auerbach.

P'sak Din: Halakhic Conclusion¹⁹

In the throes of a pandemic, in which clinicians must choose among patients (or have a committee choose for them) to receive intensive medical treatment, utilitarian analysis is not the only ethical option. Jewish law provides several criteria for the prioritization of care based on the sacred obligation to heal those who are ill. Patients who have the most urgent need should be the first to receive treatment, unless they are unlikely to survive, in which case patients who are expected to survive with intensive therapy should receive priority. After that, the first patient to request the resource has priority. If all the above criteria are equal, then the tie can be broken by lottery.

If a patient who is currently being sustained through artificial ventilation decides (themselves, through advanced directive, or through proxy) to discontinue this therapy due to their experience of futile suffering, then they may be extubated, and the ventilator reallocated to another patient based on the criteria above. However, it is forbidden to remove a patient from a ventilator, causing their death, based only on the assessment that another patient has a better prognosis. Even physicians who advocate such actions concede that they would cause clinicians "moral distress" (White and Lo) or be "extremely psychologically traumatic for clinicians" (Emanuel, et al). Clinicians and ethics committees should refuse orders which would make them into instruments of death and focus instead on healing and saving lives with all available resources.

כנלע"ד

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