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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. Hard-hit regions such as northern Italy have faced dreadful decisions to determine which patients to treat intensively if at all, and which must be left to die.[1]

Unfortunately, this is not the first period in which bioethicists or *poskim* (rabbis who decide questions of halakhah) have contended with the allocation of scarce medical resources. Ethical discourse in each crisis builds on the experience and lessons learned in prior pandemics. Douglas White and Benjamin Lo have established a rating system for the allocation of resources.[2] Over the course of the past fifteen years, Ezekiel Emanuel has developed bioethical foundations for such ratings, with a recent update to address the Covid-19 pandemic.[3] I will present a summary of this essay, and of the White and Lo scoring system—both of which are utilitarian at heart—before presenting a different perspective based on Jewish legal texts and practice, with their emphasis on the sanctity of life.

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[1] Lisa Rosenbaum, "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."

[2] Douglas White and Benjamin Lo, "A framework for rationing ventilators and critical care beds during the COVID-19 pandemic," *JAMA*, March 26, 2020.

[3] Ezekiel J. Emanuel, et al., "Fair Allocation of Scarce Medical Resources in the Time of Covid-19," *New England Journal of Medicine,* March 28, 2020.

A. 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 method 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,* returns us to a justice-basis, helping people who are already most vulnerable, or perhaps those who have benefited least in life, even if this allocation 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 their article, from which I will excerpt (these words are theirs; readers are urged to consult their *NEJM* article for fuller explanations).

[4] See also prior articles: "Public health: who should get influenza vaccine when not all can?" Emanuel EJ, Wertheimer A. *Science* 2006;312:854 5; "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; "Principles for allocation of scarce medical interventions." Persad G, Wertheimer A, Emanuel EJ. *Lancet*. 2009 Jan 31;373(9661):423-31.

Synopsis of Emanuel, et al., policy recommendations for triage in a pandemic:

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 recover[5] 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. Still, Emanuel, et al., acknowledge that operationalizing some of their recommendations will be "extremely psychologically traumatic for clinicians—and some clinicians might refuse to do so." For example, they state, "we believe that removing a patient

[5] In their 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. There is no disagreement about priority allocation of personal protection equipment to health care workers. The argument here is more of a reward for workers if they fall sick that they will receive priority treatment.

[7] As Dr. Michael Paasche Orlow explained, this claim is not realistic. 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).

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 viable 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. Their fourth policy recommendation uses age as a factor, with younger patients given priority even over viable older 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 policy 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.

These recommendations accord 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 terminally ill, 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 requirement could also 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 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 would look very

[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.

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

The most fully articulated guide to triage is found in the work of Douglas White and Benjamin Lo. In pursuit of fairness, and to relieve front line clinicians of the moral burden of decision making, they call for the designation of triage officers: "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."

Triage decisions are, in White and Lo's proposal, to be based on a scoring system whose core component is SOFA, the Sequential Organ Failure Assessment score, which "is used to determine patients' prognoses for hospital survival." "In addition," they write, "the presence of life-limiting comorbid conditions, as determined by the triage team, is used to characterize patients' longer-term prognosis." Only if there is a tie between two patients on prognosis to survive their hospitalization and the presence of life-limiting co-morbid conditions are other criteria such as age or profession considered. In this regard they are "soft utilitarian."

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 an assessment of their life prospects, and some viable patients who very much want to live could be forcibly removed from ventilation, causing them to die. Before even "soft" 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.

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[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."

B. From Utilitarianism to Sanctity

Jewish ethics begins with theological beliefs in divine creation, the fashioning of humans in the divine image, the Torah's record of commandments designed 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 immediate and quantifiable good.

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 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, April 17, 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 classical sources, ultimately endorsing the 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 states that the underlying principle is to "maximize the number of lives saved," but denies that this analysis is utilitarian, basing it instead on a novel quantitative interpretation of the obligation to save life (פיקוח נפש). Rabbi Dorff understands saving *numerous* lives as a more

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[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 (following Pri Megadim, OH 240, Eshel Avraham, who writes, וצ"ע בזמן הזה לית תלמיד חכם). Rabbi Kagan states, "there is no law differentiating Torah scholars today" (**שער הציון סימן תקמז.** מטעם דאין בזמננו דין תלמיד חכם, כן משמע מפרי מגדים). Rabbi Auerbach, among other 20C poskim, confirms this position.

[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).

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 דוחין נפש מפני נפש).[15]

In the vast rabbinic canon, there is almost nothing to suggest Rabbi Dorff's quantitative approach to *pikuah nefesh*. Almost, but not quite nothing. As he shows, early rabbinic sources recount 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.[16] Although the primary position prohibits sacrificing one to save the many, and this is normative practice, 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, or certain to die with the rest of the group, and only in the context of a war, could one be sacrificed to save the many. The Sages do not justify the surrender of Sheva b. Bikri as an act of *pikuah nefesh*. Rather, his status as a "marked man" could perhaps remove his shield of *pikuah nefesh* protection.

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 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. Even the "lenient" authorities such as Rabbi Yehudah permit the sacrifice of a specified group member only if the entire group, including this person, would otherwise be killed. This is far removed from our current triage scenario in which the person using the ventilator can be sustained and even healed, even if their long-term prognosis is worse than those of a younger or otherwise healthier patient.

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

[15] See B. *Pesahim* 25b, *Yoma* 82b, and especially, *Sanhedrin* 72b-74a.

[16] **תוספתא מסכת תרומות (ליברמן) פרק ז.** סיעה של בני אדם שאמרו להם גוים תנו לנו אחד מכם ונהרגהו ואם לאו הרי אנו הורגין את כולכם יהרגו כולן ואל ימסרו להן נפש אחת מישראל אבל אם ייחדוהו להם כגון שייחדו לשבע בן בכרי יתנו להן ואל יהרגו כולן אמ' ר' יהודה במי דברים אמו' בזמן שהוא מבפנים והן מבחוץ אבל בזמן שהוא מבפנים והן מבפנים הואיל והוא נהרג והן נהרגין יתנוהו להן ואל יהרגו כולן. **תלמוד ירושלמי (ונציה) מסכת תרומות פרק ח דף מו טור ב /ה"ד.** תני סיעות בני אדם שהיו מהלכין בדרך ופגעו להן גוים ואמרו תנו לנו אחד מכם ונהרוג אותו ואם לאו הרי אנו הורגין את כולכ' אפילו כולן נהרגין לא ימסרו נפש אחת מישראל ייחדו להן אחד כגון שבע בן בכרי ימסרו אותו ולא ייהרגו אמר רבי שמעון בן לקיש והוא שיהא חייב מיתה כשבע בן בכרי ורבי יוחנן אמר אף על פי שאינו חייב מיתה כשבע בן בכרי. **בראשית רבה (תיאודור-אלבק) פרשת ויגש פרשה צד.** תני סיעה של בני אדם שאמרו להם גוים, תנו לנו אחד מכם ונהרגנו, ואם לאו אנו הורגים אתכם, יהרגו כולם ואל ימסרו נפש אחת מישראל, ואם יחדוהו להן כשבע בן בכרי נותנין ואל יהרגו כולם, אמר רבי יהודה בד"א בזמן שהוא מבפנים והן מבחוץ, אבל הוא מבפנים והן מבפנים, הואיל והוא נהרג והן נהרגים, יתנו להם ואל יהרגו כולם, כגון שהוא אומר ותבוא האשה אל כל העם, [אמרה להם] הואיל והוא נהרג ואתם נהרגים תנוהו להם ואל תהרגו כולכם.

Maimonides limits the possibility of sacrificing one to spare the many to a person who is already condemned to death, and he hesitates to share this information, even in such a case.[17] In the responsa literature, this passage is used to confirm the prohibition on killing one to save the many, and a refusal to quantify the value of life. Rabbi Jehiel Jacob Weinberg, who survived the *Shoah* and understood the terrible moral calculus forced on communal leaders in crisis, writes in *Seridei Aish* of the supreme value of each individual life:

> אלא הפירוש הוא, שהחיים הם הערך העליון והמוחלט שלא ניתן לשיעורין ולהערכה, ואפילו חיי רבים לא ניתנו להצלה ע"י שפיכת דמים של נפש אחת. שפיכת דמים הוא איסור מוחלט בלא שום הגבלה ותנאי.[18]
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> Rather the interpretation [of the Sheva b. Bikhri story] is that [saving] life is the highest value, and it is not given to quantification or assessment [of value], even if many lives can be saved only by the killing of one person. Murder is absolutely forbidden with no limit or condition.

Rabbi Dorff offers the story of Sheva b. Bikhri in its rabbinic retellings as a basis for instituting a policy in the extreme situation of a pandemic in which one viable patient could be denied scarce medical resources or even removed from them in order to treat several other patients. I would need to see 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."[19] This principle is cited and applied to bioethics scenarios by twentieth century Orthodox *poskim* Rabbi Moshe Feinstein, Rabbi Shlomo Zalman Auerbach, and Rabbi Menashe Klein.

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 (טריפה) 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

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[17] **רמב"ם יסודי התורה פרק ה, הלכה ה.** וכן אם אמרו להם עובדי כוכבים תנו לנו אחד מכם ונהרגנו ואם לאו נהרוג כולכם, יהרגו כולם ואל ימסרו להם נפש אחת מישראל, ואם יחדוהו להם ואמרו תנו לנו פלוני או נהרוג את כולכם, אם היה מחוייב מיתה כשבע בן בכרי יתנו אותו להם, ואין מורין להם כן לכתחלה, ואם אינו חייב מיתה יהרגו כולן ואל ימסרו להם נפש אחת מישראל.

[18] **שו"ת שרידי אש חלק ב סימן לח.**

[19] **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.

required resource. If it is not known which patient has made prior claim, then he suggests that the conflict be settled by lottery.[20]

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 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].[21]

Rabbi Menashe Klein responds to a question from an observant physician serving in a hospital with only one ventilator. If the first patient in need is terminally ill, may they be treated, even to preserve brief life of less than a year (חיי שעה)? And what if an otherwise healthy patient with better chances to survive (אדם שלם) later arrives—may the ventilator now be removed from the dying patient to save the life of the newcomer? In contrast to Rabbi Auerbach, Rabbi Klein responds with unambiguous permission:

> עכ"פ מה שעולה לפענ"ד הדרך הנכון אליבא דכ"ע ואליבא דהלכתא ע"פ התורה והנימוס שיתקנו תקנה כזו דכל זמן שאין כאן אדם השלם ישתמשו עם המכונה הזו למי שצריך אפי' הוא טריפה ובאם יבא אדם השלם אז יעבירו אותה המכונה ויתנוה להאדם השלם.[22]
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> Nevertheless, what emerges in my humble option is that the proper path according to all, and according to the halakhah and practice that have been established is that as long as there is no viable patient they may use this machine [i.e., the ventilator] for whoever needs it, even for a terminal patient, but if a

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[20] **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.

[21] **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.

[22] **שו"ת משנה הלכות חלק יז סימן קעה.**

viable patient (אדם השלם) comes, then they should transfer this machine and given it to the viable patient.

The basis of Rabbi Klein's analysis is not that saving multiple lives has greater priority than saving one, but simply that a dying patient has a limited claim to equipment that can be used to save the life of a person who is not otherwise dying. This is not a one-versus-many analysis, but a one against one determination. All lives are of equal value, but not all courses of therapy are equally effective. While every breath of life has value, Jewish law has long established that a person who is dying may be treated differently from a person whose life can be saved. Rabbi Klein takes this principle to its logical conclusion—one may remove the ventilator from a dying patient in order to save a stable patient, sacrificing the already departing life of one to save the other. This is not the same as taking the resource from one viable patient to transfer to another, as it seems that Rabbi Dorff is suggesting.

These sages write with trepidation and doubt, and I share the same emotions. Nevertheless, I would make the following general statements with reference to medical triage in halakhah:

1) 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."[23]
2) 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).
3) If an action does not endanger one's own life, then they are obligated to save the lives of others, even at a financial 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 to survive, even if this does not leave enough for the second village. However, the upstream village cannot use all the water for their animals but should rather 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).[24]

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[23] M. *Sanhedrin* 4:5; Avot DR"N A 31. We must admit the ugly fact that classical halakhic literature differentiates between saving Jewish and gentile lives. Both are ultimately to be saved, but the latter is "for the sake of peace" (מפני דרכי שלום). A redemptive (or wishful) reading of this expression sees it not as a form a Jewish diplomacy but of *imitatio Dei*, since God is known as Shalom/Peace, and has mercy over all God's creatures. In any event, we apply *pikuah nefesh* to all human lives.

[24] 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.

4) 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 (and extend their abilities to continue life-saving work).
5) **Pre-Treatment triage**: 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. Who has claimed the resource first? (R' Auerbach)
    c. 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 would not start a terminal patient on the ventilator if a viable patient also required it).
6) **Post-treatment triage:** Current possession implies that it is forbidden to take away a life-sustaining resource from one person in order to give it to another. However:
    a. If the current 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).
    b. If Patient A is determined by the physician to be terminally ill (טריפה) then their ventilator may be reassigned to Patient B who is not terminally ill (this permission is not universally held, as shown by Rabbi Auerbach. However, it has support from Rabbi Klein, and accords with rabbinic sources going back to Tosefta that remove the shield of *pikuah nefesh* from people who are deemed terminally ill and beyond rescue with or without this resource).
    c. We may not remove a vital medical resource from one person in favor of another on the ground that the latter is younger, generally healthier, expected to live a greater number of years, or somehow more valuable to society, including their occupation as a medical professional. Such criteria would betray our foundational belief that all people are created in the divine image, and that life has infinite worth. It would run counter to the cardinal rule of halakhah, "we do not take one life to save another." Only if the current user of the ventilator is

determined to be terminally ill, or requests termination of the therapy because of suffering may the scarce resource be reallocated to save another life.

These arguments apply to the allocation of ventilators, and to other scarce medical resources such as donated organs. It seems to me that Jewish law does not permit the removal of lifesaving equipment 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, or in the event that Patient A is determined to be terminally ill (expected to die within a year), with or without use of the ventilator. In this regard I respectfully disagree with the conclusions of Drs. Emanuel, et al., White and Lo, and with my senior colleague and friend Rabbi Elliot Dorff (who calls such a case tragic).

P'sak Din: Halakhic Conclusion[25]

In the throes of a pandemic or other health emergency in which clinicians must choose among patients (or have a triage officer 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 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 above criteria. Likewise, if a ventilator dependent patient is deemed terminal, the scarce resource may be reallocated to a viable patient. However, it is forbidden to remove a patient from a ventilator, causing their death, based only on the utilitarian assessment that another patient has a better prognosis, or meets some other socially valued criterion. 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 such orders and focus instead on healing and saving all viable patients equally with all available resources.

כנלע"ד

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