

**YD 339:1.2020b**

**Triage in the Time of a Pandemic:  
The Sanctity of Saving as Many Lives as Possible**

**Elliot N. Dorff**

*Approved on May 13, 2020, by a vote of 21-1-3. Voting in favor: Rabbis Aaron Alexander, Jaymee Alpert, Pamela Barmash, Suzanne Brody, Nate Crane, Elliot Dorff, David Fine, Susan Grossman, Judith Hauptman, David Hoffman, Jeremy Kalmanofsky, Steven Kane, Jan Kaufman, Amy Levin, Daniel Nevins, Micah Peltz, Robert Scheinberg, Deborah Silver, Ariel Stofenmacher, Iscah Waldman, and Ellen Wolintz-Fields. Voting Against: Rabbi David Booth. Abstaining: Rabbis Joshua Heller, Avram Reisner, and David Schuck.<sup>1</sup>*

First things first: we all must recognize that in this time of the COVID-19 pandemic, we are all feeling discombobulated and stressed out. We mourn and grieve our normal lives, their routine, and the meaningful tasks and interactions with people that they include. There is no shame in feeling this way; it is just normal. From Genesis 2:18, “It is not good for a person to be alone,” through many other classical Jewish texts, the Jewish tradition recognized that although we all need some time alone, we also need interactions with other people. One graphic proof of that is that in a prison environment, short of execution or torture, the harshest penalty is solitary confinement, and we unfortunately have ample evidence that people held in isolation for extended periods of time go insane. The Jewish tradition was also keenly aware that how we think and feel about ourselves affects our physical health, and vice versa (consider B. *Sanhedrin* 90a-90b, M. *Avot* 2:2), so in this new normal existence that we have for the time the pandemic lasts, it is really important to reach out and connect with other people, even if we can safely do that only electronically.

If this is a stressful time for us all, it is even more stressful for doctors, nurses, and other health care workers. The vast majority of them are involved in clinical care, where the object is to do the most you can for the welfare of the patient in front of you. American medicine focuses on that to a greater extent than doctors in most other countries and probably to a fault, for American families often insist on doing everything possible to keep loved ones alive even when the medical prognosis is both clear and hopeless (and that is even before we consider quality of life issues, like dementia). For American medical personnel, then, what the pandemic involves is what philosophers call “*a paradigm shift*,” in which they need to shift from a patient-centered focus to a public health perspective. Put more plainly, doctors and nurses now need to think not about whether they can save person X but how can they save as many people as possible, even if that means abandoning the care of person X. As the pandemic gets worse, that may even mean not providing palliative (comfort) care for the dying for lack of human and equipment resources.

---

<sup>1</sup> *The Committee on Jewish Law and Standards of the Rabbinical Assembly provides guidance in matters of halakhah for the Conservative movement. The individual rabbi, however, is the authority for the interpretation and application of all matters of halakhah.*

This is hard for all of us to think about, but most especially for those used to doing all they can for their patients.

The term used for deciding whom to save and whom to ignore is “triage.” It comes from the military environment, where medics had to decide which wounded soldiers on the battlefield they should try to save and which ones they unfortunately had to ignore. The general rule of triage that comes out of that environment is this: without regard to rank or other element of social status, pay attention first to those who need immediate attention in order to survive and, among those, treat first the ones who have the best chance of survival so that they can continue to fight if helped to survive now.

Ancient sources in the Jewish tradition also spoke of triage, but not in a medical context. That is because although ancient and medieval medicine was remarkably good at preventive techniques, its curative capabilities were largely ineffective. Thus Leviticus 13-14 already understands that quarantine should be used to contain contagious diseases, and the Talmud tells us to avoid crowds during epidemics<sup>2</sup> – remarkably astute advice for our time. The Sabbath was a significant Jewish contribution to human understanding of what is necessary for physical as well as emotional and spiritual health. Rabbinic sources warn against eating uncooked meat<sup>3</sup> and advocate eating vegetables.<sup>4</sup>

Curative care, though, was a totally different matter. Until the 20<sup>th</sup> century, the only curative measures that doctors did in an attempt to cure diseases were two things: (1) surgery, but then patients often bled out and died for lack of blood, or they died from infections<sup>5</sup>; or (2) bloodletting because doctors had a sense that many diseases were blood borne. They were right about the blood-borne nature of many diseases but wrong in thinking that taking a pint of blood

---

<sup>2</sup> B. *Bava Kamma* 60b.

<sup>3</sup> B. *Sanhedrin* 9a.

<sup>4</sup> B *Berakhot* 44b.

<sup>5</sup> Herbert Rakatansky, MD, FACP,FACG, Clinical Professor of Medicine emeritus, Warren Alpert Medical School, Brown University, sent me an email in response to an earlier draft of this responsum, in which I mentioned that it was only in 1865 that Dr. Joseph Lister (after whom Listerine was named) recognized that fewer people died if doctors washed their hands between surgical procedures, and I want to thank him for this information:

The effect of handwashing on post delivery mortality was observed independently in Boston by Dr Oliver Wendell Holmes Sr. and in Vienna by Dr Ignace Semmelweiss, both in 1845. Their conclusive findings were ignored in both situations. They were never aware of each other. The then current belief in miasmas triumphed over the objective findings.

The germ theory was developed by Pasteur in the 1850's. Joseph Lister practiced surgery in Scotland...His seminal paper was published in 1867. It demonstrated that spraying carbolic acid on the wounds of compound fractures prevented death (100% mortality previously). He was a friend of Pasteur and believed in the germ theory. He got the idea about carbolic acid from reading a newspaper article from Carlisle, Scotland describing the effect of spraying carbolic acid on fields adjacent to a river contaminated with sewage. Those fields had become poisonous to the cows that grazed there. The carbolic acid restored the fields and the cows thrived. Lister put together all these facts and concluded that microorganisms caused the cows to die and might cause the fatal suppuration of compound fractures. He was correct. But even then it took a number of years for antisepsis to be generally accepted, The first patient to survive an operation on the abdomen without dying of sepsis was operated on in Vienna in 1881 by Theodore Billroth.

would cure the disease; the only disease for which that works is one that my mother had, polycythemia (too many red blood cells), for which the treatment still today is to take a pint of blood every once in a while. It was only in the advent of the sulfa drugs in the early 20<sup>th</sup> century and then antibiotics (Sir Alexander Fleming discovered penicillin in 1928, but it could not be widely produced until the early 1940s) that curative care became effective.

The Jewish sources that deal with triage are therefore not about access to health care, which was ineffective and therefore cheap. The sources instead address two other conditions of scarcity that Jewish communities faced, namely, poverty and redemption from captivity. In Chapter Twelve of my book, *Matters of Life and Death: A Jewish Approach to Modern Medical Ethics*, I review the sources that deal with how to determine who gets the community's limited resources to respond to both poverty and captivity. The following criteria for determining who gets what emerge from the sources (see the book for the sources and a description of how each would be used in context):

- 1) Social hierarchy: save those who are most important in society, defined in the same source (M. *Horayot* 3:7-8) as variously dependent on the number of commandments to which a person was subject, or the person's priestly status, or how much Torah the person knows.
- 2) Concentric circles: yourself first, then your immediate family, then your extended family, then your local Jewish community, then the larger Jewish community, and then people of other faiths (B. *Bava Metzi'a* 62a, 71a; B. *Nedarim* 80b; T. *Pe'ah* 4:9; T. *Gittin* 3:18; B. *Gittin* 61a; S.A. *Yoreh De'ah* 251:3; 252:9).
- 3) A hierarchy of social responsibilities: redeeming captives first, then the sick among the poor, then feeding the poor, then clothing the poor (with women taking precedence over men for both food and clothing), then Jewish education, then building and supporting a synagogue (S.A. *Yoreh De'ah* 249:16; 251:7-8; 252: 1, 3).
- 4) Greatest needs of the individuals at risk: Save those whose lives are most at risk first, followed by those at lesser degrees of risk for their lives, followed by those at risk for harm (e.g., assault, rape) (S.A. *Yoreh De'ah* 252:8).
- 5) Everyone is equal (M. *Sanhedrin* 4:5; B. *Berakhot* 17a; and the difficult case of handing someone over to the enemy in J. *Terumot* 7:20 and *Genesis Rabbah* 94:9).

Although saving people from poverty and captivity may indeed have involved saving lives, the situations our ancestors faced were not usually as overwhelming in the numbers of people in need or in the immediacy of the possibility of death as in the situation that we are now facing in the COVID-19 pandemic. In this context, individual physicians, ethicists, and ethics committees at hospitals, including those who wrote about triage decisions years before the current pandemic and those who are wrestling with formulating hospital policies now, have identified all of the following moral principles that might guide triage decisions:

- 1) Treating people equally, either through "first come, first serve" or through a lottery.
- 2) Favoring the worst-off on the basis of the "rule of rescue."

- 3) Maximizing total benefits (utilitarianism), measured either by the number of lives saved or the number of life-years saved.
- 4) Promoting and rewarding social usefulness, based either on instrumental value for the future of the society or on reciprocity for past contributions, including those on the front lines of fighting COVID-19.<sup>6</sup>

As the many discussions of triage in a medical context demonstrate beyond any doubt, highly intelligent, thoroughly informed, reasonable, and morally sensitive people both can and do disagree with each other on what is the best policy in the morally and psychologically excruciating decisions front-line doctors must make when they lack the resources to do their best for every patient needing their care. Furthermore, I have no doubt that people trying to apply the Jewish tradition to these decisions will also disagree with each other. Indeed, although my good friend, Rabbi Daniel Nevins, and I through two months of a wonderful interaction of critiquing each other's earlier drafts have decided to come to the same conclusion, we disagree on how to get there in reading and applying relevant Jewish sources and in some of the nuances of our shared conclusion, and that is fine: friends can disagree, and one might especially expect that on issues like triage that are both as serious and as morally difficult as can be. After all, we are talking about nothing less than decisions that will determine life and death, and the grounds for making these decisions are also as morally murky as can be, as evidenced by the many different and conflicting criteria for making triage decisions affirmed in both Jewish sources and in secular ethical discussions, as described above. Let me say here, at the outset, that I want to thank him for forcing me to sharpen my own thinking on this issue as he developed his.

First, then, with a deep sense of the gravity of what I am about to write and an even deeper sense of humility in even addressing these triage issues, this is what I would say:<sup>7</sup>

---

<sup>6</sup> There are many discussions of these principles and how to weigh and balance them, but here are three, for example, that come to different conclusions: Gavind Persad, Alan Wertheimer, Ezekiel J. Emanuel, "Principles for Allocation of Scarce Medical Interventions," *Lancet* 2009: 373: 423-31; E. Lee Daughtery Biddison, Ruth Faden, et. al, "Too Many Patients...A Framework to Guide Statewide Allocation of Scarce Mechanical Ventilation During Disasters," *Chest (Contemporary Reviews in Critical Care Medicine)* 155:4 (April 2019): 848-854 (with thanks to Dr. Neil Wenger, Chair of the Ethics Committee of UCLA Medical Center, for alerting me to these and other articles on this topic); and New York State Task Force on Life and the Law, New York State Department of Health, *Ventilator Allocation Guidelines*, 2010, revised 2015 (with thanks to Rabbi Julie Schonfeld for alerting me to this document), [https://www.health.ny.gov/regulations/task\\_force/reports\\_publications/docs/ventilator\\_guidelines.pdf](https://www.health.ny.gov/regulations/task_force/reports_publications/docs/ventilator_guidelines.pdf) (accessed 3/27/20).

<sup>7</sup> I am deeply indebted to discussions this past week of the UCLA Medical Center Ethics Committee, of which I have been a member since the 1980s, for what I write here. Although I am writing here from a Jewish perspective, the UCLA Ethics Committee discussions and the many materials Dr. Neil Wenger, its Chair, had us read in preparation for these discussions, have alerted me to the complications of applying any of the moral principles articulated in Jewish sources and in the general bioethics literature directly, without qualification, and the way in which many of these principles conflict in practice so that painful choices must be made in formulating policy guidelines.

- 1) Patients who have capably indicated, either verbally or in an advanced care document such as the one created by Rabbi Aaron Mackler for the Committee on Jewish Law and Standards, based on the responsa on end-of-life care by Rabbis Reisner and Dorff,<sup>8</sup> that they do not want their life prolonged by medical means or the clinical circumstances are such that life-sustaining treatment cannot attain their goals should have their preference respected and should not be included in the triage pool, provided that their preference clearly is warranted by their current clinical circumstances. In other words, triage decisions to deny care to a given patient out of medical necessity to treat those most likely to survive to hospital discharge are, by definition, those made against the will of the patient and/or his or her family.
- 2) Similarly, what in some circumstances can be life-sustaining treatment (e.g., a ventilator) should not be initiated on patients who have no reasonable prospect of benefiting from it because of their underlying physical condition, for to do so is simply bad practice of medicine. This is true under normal circumstances and, all the more so, during a time necessitating triage of scarce medical resources.
- 3) Because triage will result in patients being denied care that in normal circumstances would be provided and because such denial will possibly lead to adverse medical outcomes for them and maybe even their death, triage protocols should be initiated and maintained only where and when there is evident need to do so because of a shortage of medical personnel and/or materials needed to respond to the demand for them.
- 4) Because clinical care physicians are trained to focus on the patient at hand, they cannot be expected to carry the moral burden of treating some patients at the cost of others. Decisions about whether particular patients meet or fail to meet the triage criteria should therefore be made by a triage officer or team not involved in the clinical care of any of the patients under consideration. This not only recognizes the difficulty of clinical care physicians making the necessary paradigm shift to think of their efforts to heal from a public health perspective rather than a clinical care one; it also is at least a plausible reading of the precedent of the Rabbinic story that proclaims that if the residents of a besieged city can be saved by giving up one of their number chosen by the enemy (in our case, death, and thus those in the process of what the medical community calls “active dying”), that person should be given up but it should not be Rabbi Joshua who hands the person over to the enemy but rather people not involved in the case.<sup>9</sup> Furthermore, it must be a person or group representing the public good that requires and justifies physicians to abandon their Jewish duty to care for all patients who seek their aid<sup>10</sup> in favor of treating some and not others when they cannot treat everyone who needs them.

---

<sup>8</sup> Rabbi Aaron L. Mackler, “Jewish Medical Directives for Health Care,” [http://www.rabbinicalassembly.org/sites/default/files/assets/public/halakhah/teshuvot/19861990/mackler\\_care.pdf](http://www.rabbinicalassembly.org/sites/default/files/assets/public/halakhah/teshuvot/19861990/mackler_care.pdf) (accessed 3/27/20)

<sup>9</sup> J. *Terumot* 8:10; a shorter version of this story appears in T. *Terumot*, end of chapter 7 and in *Genesis Rabbah* 94:9. I discuss this story and the various ways of interpreting its ending in Elliot N. Dorff, *Matters of Life and Death: A Jewish Approach to Modern Medical Ethics* (Philadelphia: Jewish Publication Society, 1998), pp. 291-299.

<sup>10</sup> S.A. Orah Hayyim 339:1.

- 5) As in the military context, in the medical context the primary goal of triage should be to maximize the number of lives saved. More specifically, the goal is to maximize the number of patients who will survive to hospital discharge in a state of health that makes it probable that they will survive beyond that. Nobody knows, of course, how long anyone is going to survive or in what condition, but if the person meets the medical criteria to be stable enough to be discharged from the hospital for further recovery at home, that counts as saving the person's life. This is in accord with the core Jewish value of *pikkuu'ah nefesh*, saving life.<sup>11</sup> It is also in accord with the principle enunciated in the same Rabbinic story noted in #4 above that instructs us to save a group even if it requires giving up a particular person to the enemy for execution -- or, in our case, not treating some dying patients who are unlikely to be saved in order to save others whose lives can be saved.<sup>12</sup>

This is also in line with my 1990 responsum on end-of-life care, in which I used the Jewish legal category of *treifah* – that is, a person with a terminal, incurable disease – to determine what kinds of medical care may be withheld or removed from a patient.<sup>13</sup> A person can be in a state of *treifah*, though, for months and, in the case of some genetic diseases like Familial Autonomia, for years before death, and so the criterion I am invoking here is much narrower than that – namely, that it counts as saving a person's life if he or she can survive to the state of being medically appropriate for discharge from the hospital. Then, of course, we would hope, but never know, that he or she will survive long after being discharged in the state of health that the patient had before contracting COVID-19, or even better.

This is not utilitarianism, for that theory would have us focus on the life years saved, thus favoring young people, and possibly also those who are most useful to society, however that is defined. Saving as many lives as possible, whatever their state of health or ability or age or social or economic status, is rather an articulation of the deep Jewish values of saving life and seeing everyone as of equal worth as created in the image of God as applied to the excruciating decisions required when human and material resources are not sufficient to care for everyone, and so triage is necessary.

- 6) This will mean that some patients who would ordinarily receive and benefit from treatment may either not receive treatment at all, have the initiation of treatment postponed, or have treatment discontinued. All of these cases – including those who do not receive necessary treatment at all -- are situations in which people may die or suffer some other adverse health-related consequence. This is the tragedy of the necessity to triage.
- 7) Triage decisions apply to both withholding and withdrawing limited medical resources. Life-sustaining treatment need not and should not be continued solely because it was

---

<sup>11</sup> B. *Yoma* 85a-85b; B. *Sanhedrin* 74a-74b. For an expanded discussion of this principle, see Dorff, *Matters of Life and Death*. pp. 15-18 and note 3 on pp. 328-329.

<sup>12</sup> See note 4 above.

<sup>13</sup> Rabbi Elliot N. Dorff, "A Jewish Approach to End-Stage Medical Care," [http://www.rabbinicalassembly.org/sites/default/files/assets/public/halakhah/teshuvot/19861990/dorff\\_care.pdf](http://www.rabbinicalassembly.org/sites/default/files/assets/public/halakhah/teshuvot/19861990/dorff_care.pdf) (accessed 3/27/20).

begun. This applies no less to treatment initiated before triage was required. Understanding the considerations justifying withholding or withdrawing medical interventions to be equivalent morally and halakhically is in line with both responsa on end-of-life care approved by the Committee on Jewish Law and Standards, one by Rabbi Avram Reisner and the other by me.<sup>14</sup>

In line with this, in triage conditions the use of scarce medical resources on particular patients must be reevaluated on a timetable supported by the best medical evidence for the patient's condition. This periodic reassessment<sup>15</sup> entails the possibility that a later evaluation will result in the removal of life support from a particular patient for whom continuing care is adjudged by the medical personnel to be futile and transferred to another patient who, if given the treatment, has a reasonable chance of survival to hospital discharge. Such a transfer of medical resources from one person, for whom the use of those resources is now futile, to another who can reasonably be expected to benefit from those resources to the point of hospital discharge should happen even if the patient and/or his or her family wants treatment continued; in fact, hospital futility policies are precisely intended to deal with circumstances when physicians determine that continuing medical interventions cannot achieve the medical goals for which they were initiated and therefore, according to the policy, may and even should be removed despite the patient's or family's opposition to doing so. To remove a medical intervention from one person for whom the intervention is futile to be used by another who may benefit from it is *not* a violation of the Rabbinic principle of *ain dokhin nefesh mipnei nefesh*,<sup>16</sup> that one may not prefer one life over another, because that refers to situations in which it is simply our decision as to whom to save; in triage situations the medical condition of the patients involved is determining which one is more likely to survive, not our voluntary choice.

- 8) All patients who require use of limited medical resources, whatever their disease or their need to utilize limited medical resources, should be equally subject to the triaging process. That is, all patients who need a particular, scarce medical resource such as, but not limited to, a ventilator, are subject to the triage process, not just COVID-19 patients or COVID-19 patients in preference to others. It should go without saying that considerations of gender, race, ethnic background, social-economic status, disability, religion, educational background, and ability to pay for care should play no role in

---

<sup>14</sup> Rabbi Avram Israel Reisner, "A Halakhic Ethic of Care for the Terminally Ill,"

[http://www.rabbinicalassembly.org/sites/default/files/assets/public/halakhah/teshuvot/19861990/reisner\\_care.pdf](http://www.rabbinicalassembly.org/sites/default/files/assets/public/halakhah/teshuvot/19861990/reisner_care.pdf) (accessed 3/27/20); Rabbi Elliot N. Dorff, "A Jewish Approach to End-Stage Medical Care,"

[http://www.rabbinicalassembly.org/sites/default/files/assets/public/halakhah/teshuvot/19861990/dorff\\_care.pdf](http://www.rabbinicalassembly.org/sites/default/files/assets/public/halakhah/teshuvot/19861990/dorff_care.pdf) (accessed 3/27/20). This differs from many authorities in the Orthodox world who permit withholding treatment but not withdrawing it; for very good reason, in my humble opinion, both Rabbi Reisner and I maintain that there is no moral or halakhic difference between withholding or withdrawing treatment, for the appropriate question is whether the treatment is medically appropriate, given the patient's condition, or whether it is instead a prohibited impediment to the patient's natural course of dying.

<sup>15</sup> During a meeting of the Committee on Jewish Law and Standards, Dr. Toby Schonfeld told us that at the Veterans Administration hospitals, the reassessment happens every 48 hours

<sup>16</sup> As Rabbi Nevins notes, this principle is stated in B. *Pesahim* 25b, B. *Yoma* 82b, and especially B. *Sanhedrin* 72b-74a.

deciding who gets what. Age may be considered only insofar as it is clinically relevant to determining a patient's likelihood of survival to hospital discharge. This follows directly from the principle in the Jewish tradition of the equality of every human being.

- 9) Health care personnel on the front lines of caring for people infected by COVID-19 should receive preference in triage decisions over others who are not involved directly in saving lives in, for example, providing protective gear and vaccines, when available, to first responders and those treating patients over those in the general population. This preference is based on the underlying principle of trying to maximize the number of lives saved by protecting those in the thick of the process of doing so. Health care personnel who become infected, however, should be part of the general triage process in obtaining treatment.
- 10) If none of these principles breaks the tie between two or among three or more patients who have not yet been treated, then the ones to get the scarce resource should be chosen by lottery, invoking the principle in Jewish law that we are each equally created in the image of God. A simple flip of a coin will do, however arbitrary that may seem -- but that, of course, is exactly the point: if no medical conditions distinguish potential patients, then fairness requires that everyone have an equal chance to be treated. The alternative egalitarian possibility, "first come first serve," suffers from the injustice that it would prefer those who have ready access to care for socioeconomic reasons to those who do not; it is therefore unjust in these circumstances. Using either method to decide whom to treat will clearly not remedy the rampant inequality in society generally or in the delivery of health care in particular. That inequality is especially evident and problematic in the United States, which lacks universal health care for every resident, but it exists even in countries with socialized medicine whose governments provide a basic level of care for every citizen but permit their wealthier members to augment what the government provides with private insurance. The fact that we cannot provide a full remedy for these inequities does not mean that we should fail to do what we can to treat people as fairly as possible. A lottery will do that in choosing whom to treat when two or more people present themselves to the Emergency Room with more or less equal prognoses and not all of them can be treated for lack of personnel and/or equipment.
- 11) If possible, palliative care for symptom control should be offered to all patients. This is in accord with the responsa of both Rabbis Reisner and Dorff, and stems from our duty to care for others even when we cannot cure, which, in turn is based ultimately on such verses as "Love your neighbor as yourself" (Leviticus 19:18). In the event that there are inadequate resources to meet the palliative needs of all patients, those patients who have been denied priority access to life-sustaining treatment and are expected to die as a consequence of that denial should have priority access to palliative interventions, if these are necessary.

As I understand Rabbi Nevins' position in comparison to mine, the primary place where we disagree is on my assertion that sometimes an intervention should be removed from Patient A in favor of Patient B because Patient B's has a better chance of survival than Patient A does. Several things about this need to be explained. First, as I stated in paragraph #5 above, this is *not*, in my view, a violation of the Talmud's principle that we may not



prefer one life over another because all of those cases are ones in which it is simply a decision based on *the actor's preference to choose one person over another*, for whatever reason the actor has for that choice. In triage situations, in contrast, *it is the underlying medical conditions of the two or more patients before us* that determines who should have access to the machines, medications, and personnel needed.

Second, yes, as Rabbi Nevins says, people involved in making these decisions are going to suffer major stress both psychologically and professionally. Indeed, I would hope that they would be sufficiently attuned to the moral stakes and ambiguities involved to feel such stress and ambivalence. This is exactly why I stated in paragraph #4 above that front-line physicians should not be asked to bear the moral burden of making these decisions, that such decisions should instead be made by a clear policy and applied by a triage officer or team not involved in the care of any of the patients for whom triage decisions must be made. These are excruciating decisions, and the last thing we would want is that the people who are already overwhelmed in treating patients must additionally bear the moral burden of deciding whom to help when they cannot help everyone. Furthermore, from a Jewish point of view, as also stated in paragraph #4 above, it needs to be someone who is not involved in particular patients' care that makes this public health decision so as to relieve the physician from his/her Jewish duty to treat all people who come to them for care and to instead, in line with the Rabbinic story cited in that paragraph, put that burden on someone or some group acting in the name of the public, not Rabbi Joshua who is directly involved in the case.

Third, yes again, as Rabbi Nevins maintains, under normal circumstances we would never remove life support from someone who can benefit from it and who wants to continue to live with whatever its burdens are. But the whole point of this inquiry is to deal with the hopefully very abnormal situation – but the one in which we find ourselves during this COVID-19 pandemic -- in which there are not sufficient resources to provide life support for everyone who needs it. In such situations, first having access to, say, a ventilator does not establish the patient's ownership of that ventilator; it belongs to the hospital, and in triage situations the hospital has the duty to try to save as many lives as possible. This will require periodic reassessments of the medical conditions of people using the hospital's resources and decisions to remove them from patients whose medical interventions have proven to be futile in the effort to save their lives to hospital discharge, despite their own desires to continue using such resources or the wishes of their family.

Fourth, yes, in normal times, if one person is in greater danger than another, and if the second person can simply wait or survive with temporary measures while we attend to the first person, then sure, we should treat the person in greater danger first. Hence the precedent of Pri Megadim that Rabbi Nevins cites, followed by others in the twentieth century. That is exactly what emergency medicine is all about and why, in normal circumstances, people with emergencies will get immediate attention while others will have to wait. That presumes, though, that even though by hypothesis all of the people in the Emergency Room are there for true emergencies, some of them are more urgent than others, and so some people can wait while the most serious emergencies are treated. That, though, is not the situation here, when,

by definition of triage, we are dealing with cases where we cannot save everyone because everyone has effectively arrived at the emergency room at the same time so that it is overwhelmed and cannot accommodate everyone, and everyone must be treated immediately or die. Then some people will inevitably die – not because we want them to die or choose some over others to die, but because some are in worse shape medically than others and their varying medical conditions will determine who shall live and who shall die – and then, I submit, we must do what we can to save the lives of those we can, even if that means that the patients’ varying medical conditions will force us to decide to provide medical support for some patients rather than others or to discontinue life support for those who will die shortly anyway so that we can save others.

Fifth, as stated above, when two or more patients who have not yet been treated have the same diagnosis but not all can be treated because of shortage of medical personnel and/or equipment, then I prefer the lottery system for deciding who will get access to care over “first come, first serve” because the latter privileges those who, for socioeconomic reasons, have greater access to health care and is therefore unjust in triage situations as in life in general, while the lottery system is more egalitarian. It is bad enough that we have that inequality in access to medical care in normal times, especially in the United States; we should not extend it to triage as well if we can do otherwise, as we can with a lottery system.

Finally, sixth, it is precisely the story in the Tosefta, Jerusalem Talmud, and Genesis Rabbah that deals exactly with triage when it is immediately and clearly a question of who should live and who should die. It is, in other words, directly on point, the most relevant source for our question. Furthermore, I would suggest that as reticent as Rambam is to affirm this precedent (and I am too – I would much rather that we never have to face such situations),<sup>17</sup> in the end, it does provide guidance of what we must do in these cases. Specifically, if the enemy – in our case, death – does choose one person over another, then our duty is to save the person whom we have a chance of saving over someone whom we cannot, even if we tried up to this point. To assert that whoever happened to be put on the ventilator first should remain on it even when the chances of saving that person to the point of eligibility for discharge from the hospital are slim to nonexistent and the chances of saving someone else to that point are much better seems to me to be ignoring the medical realities of the cases we are considering, the shortages that are unfortunate but real, and, ultimately, our duty to save lives. Saving lives is what is sacred, so sacred that we are to violate all but three of the other commandments in order to accomplish that.<sup>18</sup>

Again, these criteria of triage are to be instituted only when, in a particular time and place, there is a clear shortage of medical personnel and/or resources, and only for the duration of that condition. Although current conditions portend that at least in some places triage will be necessary for a period of time because of the COVID-19 pandemic, let me

---

<sup>17</sup> M.T. *Yesodei Ha-Torah* 5:5.

<sup>18</sup> B. *Sanhedrin* 74a; see also B. *Yoma* 85a-85b. On this issue generally, see Dorff, *Matters of Life and Death*, pp. 15-18 and, especially, note 3 on pp. 328-329; and, more extensively, Immanuel Jakobovits, *Jewish Medical Ethics* (New York: Ktav, 1959, 1972), pp. 45-98.

express the hope of all of us that it not happen and, if it does, that it be over soon. In the meantime, it is incumbent on all of us to follow the instructions of civil health care authorities to practice social distancing as much as possible in order to stop the spread of the virus. It is also important, in accordance with our tradition's recognition of our need to interact with others, not to reach out and touch someone (!), but to reach out and be there for each other through phone calls and other electronic means of connection.

The Jewish tradition demands that we take care of our own physical and mental health. Thus it is important that we maintain some form of exercise during this pandemic, even if it is not the usual ways we exercise or in the usual places or with the group of people or team we usually are part of. For our own mental health, it is also advisable to engage in new and old ways of learning and social interaction, including reading the books that you intended to read but never got to, learning new things online, playing games online with other people or in person with the members of one's own household, and having conversations with others by phone and online because "it is not good for a person to be alone."

### **P'sak Din: Consensus Halakhic Conclusion by Rabbis Dorff and Nevins**

Our respective responsa addressed many of the medical, logistical, moral and spiritual challenges of medical triage in a crisis such as the Covid-19 pandemic. While our presentations differ in approach and presentation, and we reach some incompatible positions, we agree on the following practical conclusions:

1. Equal access to medical care is a moral and halakhic imperative. Triage decisions must not be based on criteria other than the best chance to save lives.
2. Scarce resources used to prevent infection such as personal protection equipment and vaccines may be assigned on a priority basis to medical professionals and other emergency responders in order to support them in their life-saving efforts.
3. Jewish law differentiates between brief respite (חיי שעה) and recovery (חיי עולם). Scarce medical resources may be directed toward patients who are expected with this therapy to recover over those who are not expected to recover, even with this therapy. Diagnostic tools such as the Sequential Organ Failure Assessment may be used to prioritize allocation of scarce medical resources towards patients who may be rescued, and away from those who are not expected to survive to hospital discharge.
4. If a patient is already receiving medical therapy and is responding, they may not be removed from the equipment prematurely in order to rescue the life of another person based on comparison of the two patients' age, ability, general health, or social status. The only criterion for removing a person from therapy is the determination that they cannot survive to discharge, or their own request to shift to palliative care.
5. If the triage officer determines that a patient cannot be saved, and that their medical resources must be reallocated to another patient in urgent need, the basis for this decision must be explained fully and sensitively to the patient or their representative, and the hospital must continue to support the patient with appropriate palliative and pastoral care, maintaining the respect and dignity of the patient until the end.

