Triage During the Covid-19 Pandemic: A Halakhic Perspective

By: ALAN JOTKOWITZ

Introduction

During the Covid-19 pandemic, even the richest and most developed countries have faced ethical dilemmas related to triage and allocation of scarce resources that many thought they would never have to face or that would occur only in poorer countries. The concern raised by many healthcare professionals has been that we would reach a point where we would not have enough ventilators or intensive care beds for all the Covid patients who needed them. In fact, this did occur in some European countries. In anticipation of this possibility, ethics committees were formed to develop prioritization schemes. As this is not a new question, halakhic authorities have also addressed the issue and most of their responsa were written decades before the Covid-19 pandemic.[1] The responsa not only address the specific question of triage but touch upon fundamental issues of how to define life, the value of life, and how the halakhic process works and is transmitted. In understanding the halakhic approach to the allocation of scarce resources, rabbinic decisors refer to five Talmudic *sugyot*. Before we enter into the halakhic debate we will briefly summarize these *sugyot*.

The Two Travelers

The Talmud in *Bava Meẓi'a* (62a) relates:

> Two people are traveling on the road and one of them has a bottle of water. If both drink, they will both die; if one drinks, he will arrive at the town. Ben Petura expounded; it is better that they both drink and die and one of them not witness the death of his fellow traveler. Until Rabbi Akiva came and taught "and your brother

[1] For a preliminary discussion of the issue see A Solnica, L Barski, A Jotkowitz, "Allocation of scarce resources during the COVID-19 pandemic: a Jewish ethical perspective," *J Med Ethics*, 2020 Jul;46(7):444-446.

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> shall live with you."[2] Your life takes precedence over the life of your brother.

Normative Jewish law follows Rabbi Akiva. There are a myriad of explanations of what is the precise point on which Ben Petura and Rabbi Akiva disagree. The *Ḥazon Ish*[3] interprets the dispute as revolving around the question of whether saving two lives for a short time is preferable to saving one life for an extended period of time. Ben Petura maintains that saving two lives even for a short time is preferable; therefore they should share the water. Rabbi Akiva feels that it is more important to save the one life. Applying Rabbi Akiva's logic to the allocation of scarce resources, it would follow that resources should preferably be used where lives can be saved as opposed to short-term extension of life.

Who Goes First?

The *mishnah* in *Horayot* 13a states:

> A man takes precedence over a woman when it comes to saving a life and to restoring something lost. A woman takes precedence with regard to provision of clothes and to be redeemed from captivity. When both stand equal chances of being degraded, then the man takes precedence over the woman.
> A *kohen* takes precedence over a *levi*; a *levi* to a *yisrael*; a *yisrael* to a *mamzer*; a *mamzer* to a *natin*; a *natin* to a convert; a convert to a free slave. When? When they are all equal. But if there were a *talmid ḥakham mamzer* and a *kohen gadol am ha-arez*, the *mamzer talmid ḥakham* takes precedence.

The Talmud does not explain why a man takes precedence over a woman, but two reasons are offered by the Rishonim. *Rashba* explains that the preference for saving the life of a man is based on a *derash* of the verse "and your brother shall live with you"[4]—your brother before your sister. No further explanation for this interpretation is offered (and to the best of my knowledge there is no other mention of this *derash* in the Tannaitic literature or other Rishonim). Rambam explains (and most

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2 Lev 25:36.

3 *Ḥoshen Mishpat, Bava Mezi'a, Likutim* 20, 62a. For an enlightened discussion of the philosophical basis for the disagreement between Ben Petura and Rabbi Akiva see Moshe Sokol, "The Allocation of Scarce Medical Resources: A Philosophical Analysis of the Halakhic Sources," *AJS Review*, Vol. 15, No. 1 (Spring, 1990) pp. 63-93.

4 Lev 25:36.

commentators accept his interpretation) that the reason a man is favored is because he is obligated in more *mitzvot*.[5] It is not clear why "obligation in *mitzvot*" would lead to preference in life saving. One can suggest two possible explanations: since the purpose of life in this world is to do *mitzvot*, the fact that a man has the potential to do more *mitzvot* makes his life more valuable; alternatively, the fact that he is obligated in more *mitzvot* denotes a higher level of intrinsic sanctity.

This second explanation is consistent with the explanation of the *gemara* of why a *kohen* takes priority over a *levi* based on the verse "the sons of Amram: Aaron and Moses. Aaron was set apart, to sanctify him as holy of holies."[6] A *Levi* is before a *Yisrael* because of the verse "At that time, God set apart the tribe of *Levi*," and a *yisrael* comes before a *mamzer* because the *yisrael* is genealogically pure and the *mamzer* is not. These explanations are apparently based on stratifying the holiness of a person based on genealogy. However, this prioritization scheme is apparently upended by the conclusion of the *mishnah*, which bases priority on level of Torah knowledge that a person has acquired.

The *gemara in Horayot* 13a adds another element to the equation: "It was taught in a *baraita*: a *kohen gadol* anointed for war takes precedence [in life saving] over the vice *kohen gadol*," because, as Rashi explains, the public needs him in case of a war. Priority given to a *talmid hakham* recognizes past achievements, and the priority given to the *kohen gadol* anointed for war takes into account future communal needs. The priority given to a man can also be viewed from the utilitarian perspective of maximizing potential *mitzvah* observance.

The question that all decisors relate to is the relevance of the Mishnah's prioritization scheme to modern questions of triage.[7]

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5 Rambam, *Perush ha-Mishnah*, *Horayot* 13a.

6 I Chronicles 23:13.

7 For further discussion of the relevance of the Mishnah to modern discussion of triage see Alan Jotkowitz, "'A Man Takes Precedence Over a Woman when it Comes to Saving a Life': The Modern Dilemma of Triage from a Halakhic and Ethical Perspective," *Tradition* 47:1 2014 pp. 48-68. And Chaim Rapoport, "The Halachic Hierarchy for Triage: Rebuttal of a Contemporary Review," *Le'ela,* June 2001, 27-38.

Ḥayyei Sha'ah (Momentary Life)

The *gemara* in *Avodah Zarah* 27b states:

> If a patient will possibly live and possibly die if not treated he may not be treated by a pagan doctor. However, if he will surely die if not treated he can be treated. Can this be? He still has momentary life *(ḥayyei sha'ah*) that is put in danger by receiving treatment form the pagan doctor. We are not concerned about momentary life.

Rashi comments that even if it is definite that the pagan doctor will kill the Jew, one is allowed to take the risk because without going to the doctor one will surely die.[8] The *gemara* brings support for this assertion from the story in II Kings 7 where the army of Aram laid siege to a Jewish town suffering from starvation. Four Jewish lepers decided to surrender to the enemy based on the reasoning that if they stay near the city they will surely die of starvation—so what do they have to lose by giving themselves up?

The decisors conclude from this *gemara* that one may risk momentary life in an attempt at a cure. For example, a patient is allowed to undergo a risky operation if there is a potential for cure. The rabbis debate the parameters of this law (e.g., how much risk is acceptable and who decides), but the concept is accepted. The question they debate is whether this principle of "we are not concerned about momentary life" in risk assessment is relevant to questions of triage.

Treifah

A *treifah* is generally defined as someone who has less than a year to live. There are decisors who relate differently to a *treifah* in life-and-death halakhic decision making. For example, the *Meiri* in *Sanhedrin* 72b suggests that one can hand over a *treifah* in order to save a group of people but one would not be allowed to hand over a healthy person. The *Meiri Sanhedrin* 78a also suggests that the concept of "*ve-ḥizalu ha-edah"* does not apply to a *treifah*. The *Minḥat Ḥinukh* maintains that one is not allowed to kill a *rodef* who is threatening the life of a *treifah* because one is not liable for the death penalty if one kills a *treifah*.

What all these positions have in common is that from a halakhic perspective, a *treifah* does not have the status of a normal, healthy person in certain life-and-death situations. The obvious question is whether this assumption has relevance to triage.

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8 Rashi, *Avodah Zarah* 27b. s.v. *safek ḥai safek met*.

Bezayon Ha-met **(Desecration of the Dead)**

The Jewish legal prohibition on disfigurement of the dead leads to the ethical principle of respect for a corpse and the moral sensitivity that one should develop towards a dead body. The consensus of rabbinic opinion following the landmark ruling of Rav Ezekiel Landau (the *Noda Be-Yehuda*) is that any disfigurement of the dead is strictly prohibited unless there is a reasonable and immediate prospect of saving a human life.[9] This dispensation is known in rabbinic parlance as "at hand"; in other words, there has to be an identifiable person "at hand" who can immediately benefit from the medical knowledge obtained from the autopsy (Rabbi Jakobovits maintains that one had to take into account new circumstances in applying the principle of "at hand." Due to modern communication, patients all over the world can be considered "at hand.")[10] The *Ḥazon Ish* expands the definition and maintains that the second patient does not have to be literally "at hand" but it is enough that there is a high probability that a second patient will appear.[11]

Modern Decisors

Rav Moshe Feinstein. Rav Moshe Feinstein takes a similar position to the *Ḥazon Ish* that scarce resources should be used for the saving of long-term life. He writes regarding two patients who simultaneously come to the emergency room, one who can only live a short time (*ḥayyei sha'ah*) even with medical intervention, and one who can be saved (*ḥayyei olam*) but may not even require treatment, and there is only one bed available—who should be treated? He replied that the physicians should treat the patient that can be saved. He explains:

> "And the reason is obvious that the life of someone who can be saved and live a normal life gets precedence over someone who is dying and the physician is unable to cure, but the dying patient does not have an obligation to save someone else with his life, and if he was treated first he does not have to give up his place."[12]

It is interesting that he does not give a source for this ruling.

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9 *Noda Bi-Yehuda* 2:210.

10 Immanuel Jakobovits, *Jewish Medical Ethics: a comparative and historical study of the Jewish religious attitude to medicine and its practice* (New York: Bloch, 1975) pp. 282-283.

11 *Ḥazon Ish, Ohalot* 22:32.

12 *Iggerot Moshe, Ḥoshen Mishpat*, Part 2 #73:2.

While useful guidance, the categories of Rav Feinstein are not always applicable to modern medicine. When a patient comes to the hospital to be treated it is very difficult to categorize him as either a potential *ḥayyei sha'ah* or a *ḥayyei olam;* the goal of treatment is to make all patients into *ḥayyei olam*. Rav Feinstein was obviously aware of this difficulty and in his responsum defines the *ḥayyei sha'ah* patient as only appropriate for palliation in his words, "to treat the pain." Again this is less useful guidance for physicians, as it is intuitively obvious to most that they would not prioritize the palliative care patient. In a subsequent responsum[13] he clarified his definition of *ḥayyei sha'ah:*

> I was asked to define exactly what is considered a *ḥayyei sha'ah* and what is considered a *ḥayyei olam.* If you have in front of you two patients and you can cure both of them, you should treat the patient who will live more than a year because he has not lost his *ḥezkat ḥayyim* as opposed to the one who, according to the doctor's opinion, won't live for more than a year because he is considered a *treifah.*

One gets the sense that Rav Feinstein recognized the difficulty of his relying on the *ḥayyei sha'ah* paradigm in his original responsum from two years earlier (1984 *vs* 1982) and now uses the *treifah* model in contrast to a *ḥayyei sha'ah* model. Again he brings no proof for this contention and the rationale from a purely halakhic perspective is difficult to understand because there is universal agreement that one is required to save the life of a *treifah* even at the expense of Shabbat desecration. In addition, it is very difficult for physicians to predict who is going to die within a year, and the choice between a *ḥayyei olam* and a *treifah* is rarely the choice the physician faces.

Rav Moshe Sternbach. The modern halakhic conversation on the topic of triage was started when Rav Sternbach was in South Africa and was asked the following question by a Jewish doctor:

> The hospital where I work obtained one new resuscitation machine and with this machine one can extend the lives of patients who can only live for a short time (*ḥ ayyei sha'ah*) because their internal organs are collapsing and they are *treifah*. But on the other hand, every day patients who can be cured are also arriving at the hospital. If you use the machine to save the *treifah* who can only live a short time you will not be able to disconnect the machine and connect to

[13] *Iggerot Moshe, Ḥoshen Mishpat*, Part 2 #75.

> the patient who can be saved because you are actively killing the first person. And even if you decide that one is allowed to disconnect the machine from the *treifah* to connect to a person who can be saved, the *treifah*'s family will shout and raise their voice and will not allow one to take the machine. Therefore, the hospital decided to only use the machine for patients who can be saved because it does not make sense to waste the machine on *treifos* whose life can only be saved for a short time. Every day a Jewish patient whose life can be saved comes to the hospital and because of this rule many Jews have been saved. But the doctor is wondering whether according to the Torah one is not allowed to act this way and one should save the *ḥ ayyei sha'ah* patients.[14]

The doctor is in reality asking two questions. Do we save a *ḥayyei olam* before a *ḥayyei sha'ah*? And can we hold lifesaving equipment in abeyance for a *ḥayyei olam*?

Rav Sternbach gave his answer and due to the gravity and importance of the question asked for the opinions of other senior decisors, whose opinions we will also review.

He concurs with the decision of the hospital on both issues. He bases his position on the halakhic opinions that we have seen above that a *treifah* is not considered a complete person.

He takes the position one step further. He compares a *treifah* to a fetus and, based on the *Minḥat Ḥinuch*, feels one should be stricter with a fetus because the fetus has the potential to live a normal life span while a *treifah* is doomed to die.

In comparing a *treifah* with a fetus, Rav Sternbach is essentially arguing that there is a continuum of what we consider life. Human life is not a binary equation but exists in degrees. Abortion in certain instances is allowed because we are not dealing with a fully developed human life but an entity with potential for life. On the other end of the spectrum, the halakha does not accord the *treifah* the same legal rights as a healthy individual because a *treifah* represents the waning of human life. Rav Soloveitchik in *The Emergence of Ethical Man* strenuously disagrees with this characterization of human life.

> A man in the state of coma possesses all the rights with which the human being is endowed. Whoever inflicts harm is liable for the act. The slaying of a *goses* is synonymous with the murder of a healthy sane person. […] There is not a single opinion in the Tal-

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14 Moshe Sternbach, *Teshuvot Ve-hanhagot, Ḥoshen Mishpat* #858

> mud that tends to deprive the *goses* of his civil rights and juridic qualifications. If Halakhah had identified the idea of man with that of consciousness, logos, intellectual activity, anthropology, then neither the embryo, nor the newborn, nor the man in the comatose state could be considered under the aspect of juridic person. Let us not forget that the embryo or the dying man deprived of all faculties resembles the plant far more than the animal. Instinct, sensation, active response to stimulation, locomotion, and many other neurological processes that characterize animal existence are completely extinct in such persons. And still, man remains man.[15]

Based on the *Ḥazon Ish's* expansive interpretation of what is considered "at hand"—that the second patient does not have to be literally "at hand" but it is enough that there is a high probability that a second patient will appear to allow for an autopsy—he concurs with the decision of the hospital to hold the equipment for a patient with a better prognosis.

Rav Eliezer Waldenberg. Rav Waldenberg rejects the contention of Rav Sternbach that the life of a *treifah* has less halakhic "value" than that of a healthy individual. He nonetheless agrees with the decision of the hospital in Johannesburg because he bases his opinion on the distinction between *ḥayyei sha'ah* and *ḥayyei olam*.[16] The potential for long life overrides momentary life and thus one preferentially saves someone with the potential to live a normal lifespan. Apparently Rav Waldenberg is more concerned with potential life gained than the lack of halakhic protection for a *treifah*. In support for his position he brings the *Pri Megadim* who writes, "If there is one who is definitely ill according to the doctor's estimation and one who is doubtful (*safek*) and medication is only available for one of them, the definite takes precedence over the doubtful."[17]

He agrees with Rav Sternbach that one may hold the equipment in abeyance if there is reasonable certainty that a healthier patient will arrive in need of the equipment.

Rav Shmuel Wosner. Rav Wosner also has great difficulty with the assertion that from a halakhic perspective a *treifah* is less of a life than a healthy person.[18] To my reading, he correctly points out that the *sugya* in *Avodah Zarah* which discusses *ḥayyei olam* is not relevant to our discus-

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15 Joseph Soloveitchik, *The Emergence of Ethical Man* (Ktav: Jersey City, 2005) p. 29.

16 Eliezer Waldenberg, *Ẓitz Eliezer* 17:10.

17 *Pri Megadim, Oraḥ Ḥayyim, Mishbezot Zahav* #328.

18 Shmuel Wosner, *Shevet Ha-levi, Ḥoshen Mishpat* #242.

sion. In *Avodah Zarah* the question being discussed is whether one can risk *ḥayyei sha'ah* for the possibility of *ḥayyei olam* in the same individual; for example, can a sick patient undergo a risky operation which has the potential for cure but also might kill him? In contradistinction, our question relates to two different individuals, one who is a *ḥayyei sha'ah* and the other one who is a *ḥayyei olam*; it is not a question of risk assessment but rather of triage.

He takes another somewhat surprising approach to answering the question and bases his position on the *mishnah* in *Horayot*. He maintains that what the *mishnah* is teaching us is that there are rules in lifesaving. And just as there is a rule that a "man comes before a woman," so too there is a rule that a *ḥayyei olam* comes before a *ḥayyei sha'ah*. What the *mishnah* in *Horayot* teaches is that there are rules in allocation of scarce resources; however, he does not explain the source of the rule that a *ḥayyei olam* comes before a *ḥayyei sha'ah*. Similarly, the story of the two travelers teaches the rule that you come before your friend in lifesaving.

This assumption that there has to be rules regarding lifesaving is not shared by all scholars. For example, Rabbi Emanuel Rackman writes:

> When one must choose between two persons, who will live and who will die, the decision must be that of the person who will act upon it and not that of the state or any of its duly authorized agents… the rich legal literature of Judaism provides him with no imperatives. No court will authorize his action in advance and no functionary of the state will or should be his surrogate to decide for him. The only sanction he may suffer will come from his conscience and public opinion. His problem is exclusively ethical and not legal in character.[19]

Rabbi Rackman's broad assertion that the halakha is neutral regarding moral decisions relating to questions of life and death is difficult to defend. The halakha is unequivocal in stating that non-Jews are deserving of capital punishment for performing an abortion and it is absolutely forbidden for a Jew or non-Jew to kill a terminally ill patient. The fact that in both cases one might not be actually punished either due to the fact that Jewish courts have no jurisdiction over non-Jews or a technical exemption that the court does not carry out a death sentence if one kills a terminally ill patient does not in the least mean that the decision is left

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[19] Emanuel Rackman, "Priorities in the Right to Life," in *Tradition*; and *Transition Essays Presented to Chief Rabbi Sir Rabbi Immanuel Jakobovits to celebrate twenty years in office*, Jonathan Sacks, ed., 235-244 (London: Jews College Publication, 1986).

to the individual. Halakha does not shy away from rendering legal decisions even to the most difficult moral questions. The fact that there has and always will be a difference of opinion does not give the individual the freedom to decide. Halakha does not offer "guidance" in these situations but binding directives.

However, Rav Wosner disagrees with Rav Sternbach and Rav Waldenberg on the extension of the *Ḥazon Ish*'s principle to the case of the hospital in Johannesburg because there is an obligation right now to extend the life of the *ḥayyei sha'ah* which one is not allowed to defer in anticipation that a more viable patient will arrive.

Rav Shlomo Zalman Auerbach. Rav Auerbach also addressed the question from the hospital in Johannesburg and writes

> The decision of the hospital to not use the machine for the *treifah* patient based on the assumption that every day they can save healthy patients is possibly right even though it is not totally clear to me. But in any event the administration decided that this is the policy and because of this I agree with it."[20]

It is interesting that Rav Auerbach places much weight on the decision making of the responsible party, in this case the hospital administration. The reason for this might become clearer in a second responsum he wrote to Dr. Glick on the question of triage.

The text of the question has never been published until now.

> How should one act in situations which occur almost daily in peaceful times and much more during wartime when we do not have enough resources to treat all emergencies who come at the same time? Are there any rules which should guide us on how to prioritize the patient? Should we devote more time to a patient for whom there is a higher probability that the physician can make a difference? Can we make the decision based on age, social standing, disease, who came first? Can we take a ventilator from one patient and give it to another [patient] who is worse off or his chances [for cure] are better? (The translation was approved by Dr Glick.)

Rav Auerbach responds citing the *Pri Megadim* quoted above that "the definite takes precedence over the doubtful" and continues "and thus one first has to take into account [when making triage decisions] the degree of danger and the chance for cure."

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20 Shlomo Zalman Auerbach, *Minḥat Shlomo* #86 second edition.

By adding the criterion of "chance for cure," Rav Auerbach is making an halakhic innovation that we have not seen before. Other decisors have certainly factored into their decision-making the degree of danger the patient is facing or the patient's life expectancy but the utilitarian approach of "chance for cure" is new and consistent with a modern approach which highly values the principle of saving as many lives as possible when faced with limited resources.

Rav Auerbach continues: "Regarding a ventilator it seems to me that this depends on the opinion of the doctor when in the majority [of cases] there will be no further benefit [to the patient] it is better to move it [the ventilator] to a second [patient]."

What is interesting about this statement is that not only does he allow one in certain circumstances to transfer a ventilator from one patient to another but he apparently leaves the decision to the physicians caring for the patients.

It is also important to note that for whatever reason this sentence was deleted from the second edition of *Minḥat Shlomo* even though it appears in the version of the responsum published in *Assia*. Rabbi Auerbach ends his responsum with characteristic humility: "The questions are very difficult and I do not have conclusive proofs [for my positions]."[21]

The Interpreters

With the rapid advances in medical technology and therapeutics in the second half of the twentieth century, complicated medical halakhic questions arose, mostly related to reproduction and end-of-life care. To help answer these questions, decisors turned to physicians and scientists with expertise in medicine, ethics, and halakha for advice and guidance. Not only did these experts help explain the medical facts to the rabbis but they also relayed their opinions to the laity and general public. Many of these interpreters became accepted and respected authorities on their own merits. Most of the decisors wrote their opinions in responsa which are very difficult to read and understand without a sophisticated halakhic background, and these experts translated and explained these crucial halakhic opinions which literally had life-or-death implications for many people. But the question always arises of how faithful are the interpreters to the original meanings of the text and is the line ever crossed between interpretation and offering one's own opinion?

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21 Ibid.

Rabbi Moshe Tendler is not only the son-in-law of Rav Moshe Feinstein but a distinguished halakhic authority in his own right and a professor of biology at Yeshiva University. He advised Rav Feinstein on many medical-halakhic issues and many of Rav Feinstein's responsa are addressed to him. He also translated to English many of the responsa, particularly those related to end-of-life care. In what he maintains is a translation of Rav Moshe's responsum, he writes:

> In my opinion [Rav Moshe], if both arrive at the same time, the decision should be made on the basis of medical suitability. The one who has the best chance of being treated and cured should be given the available bed.[22]

My translation is as follows:

> In my [Rav Moshe] opinion, if both come at the same time and no one has been brought yet [to the intensive care unit], you have to bring first [to the ICU] the one who according to the doctors can be cured.

The original Hebrew is as follows:

> נראה לע"ד שאם באו שניהם בבת אחת, היינו קודם שהכניסו האחד מהם צריך להכניס בתחלה את מי שלדעת הרופאים הנמצאים שם יכולין לרפאותו.

Rabbi Tendler's translation is perhaps not fully precise.

Rabbi Dr. Avraham Steinberg is a rabbi and a pediatric neurologist and recognized as perhaps the leading contemporary scholar of Jewish Medical Ethics. He is the author of the *Encyclopedia of Jewish Medical Ethics* and a close student and interpreter of the medical responsa of Rav Auerbach and Rav Waldenberg. In his usual comprehensive and lucid style he wrote a compendium of laws related to Covid-19 summarizing the various opinions. In this work, he has a section on triage where he writes: "Determinations based on gender, race, religion, nationality, economic status, communal status, vocation, and the like are not factors in determining precedence."[23]

What's surprising about this statement is that there is no reference. All of Rabbi Steinberg's works have extensive references and footnotes and that is part of their greatness. For example, in this brief monograph

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22 Moshe Dovid Tendler, *Responsa of Rav Moshe Feinstein* (Hoboken, NJ: Ktav, 1996) p. 42.

23 Avraham Steinberg, "The Coronavirus Pandemic 2019-20 Historical, Medical and Halakhic Perspectives," p. 37 available at https://7d4ab068-0603-408d-89df-fac4580e17c4.filesusr.com/ugd/8b9b1c_57ceba840c284bb8a3fe96f7d257a90b.pdf.

on Covid-19 of 40 pages there are 225 references. However, there are many authorities who still maintain that we follow the priorities listed in *Horayot* and many decisors would rule that we would save a Jew before a non-Jew. This latter contention is so obvious that there was no need for the *mishnah* in *Horayot* to even mention it. It is also probably true that the majority of contemporary decisors rule that we do not follow the gender preference from *Horayot* but is far from unanimous and it is not clear at all that the majority of decisors would rule that religion is not a factor. I admit that it is difficult for these sentiments to be expressed in many contemporary circles and they go against many of our egalitarian impulses (which I certainly agree with), but I think in service of the truth and academic honesty they should be noted. In fact, on page 34 of the monograph he writes: "As a practical ruling, the greatest of the *poskim* in our generation have written that we are not accustomed to following this Mishnah." This statement is footnoted where he notes that Rabbi Wosner does not agree with this assertion. And thus his unequivocal statement on page 40 is all the more difficult to understand.

Contemporary Decisors

During the Covid-19 pandemic two contemporary decisors, Rav Asher Weiss from Jerusalem and Rav Hershel Schachter from New York, answered hundreds of questions related to Covid-19 in all areas of halakha in areas of ritual, mourning practices, Shabbat and holiday observance, and medical ethics. They consulted with each other and their students collated and published their responsa. They also both wrote on issues related to triage.

Rabbi Weiss accepts almost as a given the triage principles of level of danger and chance for cure. He writes:

> We have to weigh two principles when we come to decide issues of triage, the level of danger and chance for cure. One should treat first the sicker patient who without medical care would be in immediate and grave danger to those patients who are not in immediate danger and we could care for them later if their illness progresses. And we should treat first the patient with the greater chance of cure then someone with a lesser chance. [24] (my translation)

[24] Asher Weiss, *Minḥat Asher* available here https://7d4ab068-0603-408d-89df-fac4580e17c4.filesusr.com/ugd/8b9b1c_93565e70a1fa495d8875452a579d1d06.pdf.

The opinions of Rav Shlomo Zalman Auerbach written with great reservation have become almost obvious to Rav Weiss, so much so that he doesn't feel it necessary to even bring any halakhic sources or proofs for these positions.

Rabbi Schachter penned an important responsum on triage in the time of Covid-19, which was twice revised and updated. He writes (my translation):[25]

> In a case of two patients who arrive simultaneously to the hospital, and there is only one respirator available and we must decide to whom to give it: If one of them has an almost certain chance of being saved, or the other has only a doubtful possibility of being saved, it is obvious that we give preference to the patient with a very good chance of being saved as opposed to the other (see *Nishmat Avraham* to *Yoreh De'ah* 252:2). But if they arrived one after the other, and the first patient has already been connected to the respirator, even if he is an extremely old and ill patient with only a doubtful possibility of survival, and afterwards a young, otherwise healthy patient arrives in need of the respirator—in this case we cannot prefer one life over another [and we do not disconnect the elderly patient from the respirator to give it to the younger patient]. But if when the sick, elderly patient arrives we already know that in one or two hours, more young and otherwise healthy patients [coronavirus aside] will arrive, since this is the daily situation at this time, and it is clear that there are not enough respirators for all patients, thus we consider as if they arrived simultaneously, and we should not connect the sick, elderly patient to the machine [since we know it will imminently be required to save the life of a young person who has a much better prospect of long-term recovery and survival].

Rav Schachter has followed the approach of Rav Feinstein and Rav Auerbach in that the crucial point for prioritization of scarce resources is possibility of cure. However, it is not clear from Rav Schachter's responsum if age is an independent factor in triage decisions or if it is a marker for a worse outcome and is part of the risk-benefit calculation, similar to co-morbid conditions. In an addendum to the *teshuvah*, Rabbi Schachter clarified:

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25 Hershel Schachter available at https://7d4ab068-0603-408d-89df-fac4580e17c4.filesusr.com/ugd/8b9b1c_c43ae9f486e34ee88578fc8004107114.pdf.

> Regarding an elderly patient even if the ventilator was beneficial, he will only be a *ḥayyei sha'ah*.

But this is also difficult to understand for why should the elderly person be considered a *ḥayyei sha'ah* if he or she survives corona unless he was alluding to a case where the elderly patient was dying from the outset. If it's the latter then it's hard to understand why age should matter, the crucial factor seems to be that the patient is going to die anyway. He also does not define what age is considered "elderly" for halakhic triage decision making. He allows physicians to hold a respirator for a brief time for a healthy young patient to arrive, like the opinion of Rav Waldenberg, but does not cite a source for this ruling. He does, however, describe a situation which unfortunately seems to have been likely in New York in these awful times—the near certain arrival of young and otherwise healthy people in need of immediate mechanical ventilation due to the Covid-19 virus.

Rav Schachter continues:

> If the elderly patient was already connected to the respirator and then it became apparent that it was to no avail, [and] because many young people will arrive—then the correct course of action should be for the physicians to designate the patient DNR ["do not resuscitate"]. In a choice between initiating a new therapy for the elderly patient who has "coded," as opposed to treating a younger patient whose arrival is imminent, we should consider this a case of "they arrived at the same time," and we should prioritize the young, otherwise healthy patients. This is not considered a case of "setting aside one life for another." Because starting a new therapy for the old patient as opposed to treating the younger patient is also considered as if they came at the same time and we should prioritize the young healthy patients, and this is not considered as setting aside one life for another.

It is not clear what is the exact clinical response that Rav Schachter is referring to, and it would be hard to believe that one would be allowed to disconnect the elderly patient from the respirator, which most *poskim* consider to be an act of murder (with a possible exception of disconnecting the respirator in order to share it with another patient, which Rav Schachter discusses later in the responsum). A more accepted explanation is that non-continuous therapies would be allowed to be stopped, such as medications to increase the patient's blood pressure, dialysis, possibly administering antibiotics, or transferring the patient from the intensive care unit. It's not clear if Rav Feinstein would agree

with this approach because he felt that once the patient is admitted to the intensive care unit he has "acquired the place" and has rights to continuity of treatment. In the dire circumstance that Rav Schachter describes, in which there is an immediate need for a respirator for a young patient with an excellent chance of survival, the question arises whether one can disconnect the elderly terminal patient from the respirator and use non-invasive ventilation (BiPAP) to sustain the patient in order to give the ventilator to the young patient.[26]

Prognosis

As we have seen, the prognosis of the patient and the likelihood for treatment success plays a major role in the decision making of contemporary decisors. It is important to understand that prognosis as it relates to an individual patient does not only depend on the severity of the current illness but also on the patient's health status and chronic medical conditions. A patient with underlying cardiac or respiratory disease will have a worse prognosis than a healthy patient of the same age and gender. However, in many instances health status is directly related to socioeconomic status. A poor person or a person of color of the same age and gender is more likely to suffer from more chronic health conditions than a rich or white person. There are many known reasons for these disparities and inequalities such as lack of adequate health insurance, access to care, systemic racism, and others that are not defined yet. The implication of this finding is that if we triage solely based on prognosis, people from lower socioeconomic groups and people of color are doubly discriminated against. They have more chronic conditions which lead to increased morbidity and mortality and will have lower priority when it comes to the allocation of scarce resources. The critical question before contemporary rabbinic authorities is whether this understanding of prognosis should play a role in halakhic decision-making relating to triage. Should we deemphasize prognosis as a determining factor, like many decisors do in relation to age, and adopt an approach based on "who says your blood is redder than mine" and human equality?

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[26] It is important to note that both Rav Feinstein, *Iggerot Moshe, Ḥoshen Mishpat* II:75, and Rav Auerbach, *Minḥat Shlomo* #86 second edition maintain that age should not be a criterion in triage decisions.

Conclusions

We have seen how modern and contemporary decisors have generally accepted the utilitarian approach to questions of triage by prioritizing patients with the best prognosis. It is fascinating to see note how this position became the halakhic consensus without much halakhic precedent or prior sources. The role of the "interpreters" also needs to be further studied, not only in the specific case of triage but in other areas of medical halakha as well. In addition, in these sensitive and high-stakes issues, it is imperative that the integrity of the responsum be preserved and faithfully transmitted.

As I write these words, Israel is in the midst of a terrifying second wave and we are in lockdown again. I can only hope and pray that the present discussion remains theoretical in nature and Hashem grants a speedy recovery to all those sick with Covid and a merciful end to the pandemic. ☙