Triage in the Time of a Pandemic

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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. 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 to save those who have the best chance of survival and 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 Rabbinic sources, for example, warn against eating too much meat and advocate eating fruits and vegetables.

Curative care, though, was a totally different matter. Until the 20th 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 (it was only after the war, in 1865, that Dr. Joseph Lister discovered that fewer patients died of infections if medical personnel washed their hands between procedures and kept the surgical environment clean, and yes, Listerine was named after him); or (2) blood letting 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 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. It was only in the advent of the sulfa drugs in the early 20th 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 their lives, it was not usually as overwhelming in numbers of the people in need nor 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 and 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.[1]

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. Furthermore, I have no doubt that people trying to apply the Jewish tradition to these decisions will also disagree with each other. That said, this is how I, 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, would say:[2]

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[1] 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 (accessed 3/27/20).

[2] 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) Because triage will result in patients being denied care that in normal circumstances would be provided, possibly leading to 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 or materials needed to respond to the demand for them.
2) 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 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.[3]
3) 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 in whatever state of health and ability they had before being infected by the COVID-19 virus. This is in accord with the core Jewish value of *pikkuu'ah nefesh,* saving life.[4] It is also in accord with the principle enunciated in the same Rabbinic story noted in #2 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 in order to save others whose lives can be saved.[5] 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.
4) 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.

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[3] 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.

[4] 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.

[5] See note 3 above.

5) 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 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.[6] 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, with the possibility that a later evaluation will result in the removal of life support from a particular patient for its use for another patient.
6) 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 deciding who gets what. Age may be considered only insofar as it is clinically relevant to determining a patient's likelihood of survival. This follows directly from the principle in the Jewish tradition of the equality of every human being.
7) 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,[7] 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.
8) 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 ("futile care"). This is true under normal circumstances and, all the more so, during a time necessitating triage of scarce medical resources.

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[6] 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 (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 (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..

[7] 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 (accessed 3/27/20)

9) Health care personnel on the front lines of caring for people infected by COVID-19 and who, if infected, have a good chance of recovering and being able to rejoin the people caring for those infected should be given preference over all others, based on the underlying principle of trying to maximize the number of lives saved.
10) On the same principle, it is reasonable to prefer pregnant women in the last month or two of pregnancy, when the fetus is viable outside the womb and probably within the range of normal over others on the grounds that they present society with the probability of saving two lives rather than one.
11) If none of these principles breaks the tie between two or among three or more patients, 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. This requires, as noted in paragraph 5 above, periodic evaluations of the prognosis of those already using the scarce resources to determine whether they should continue using them or taken off them in favor of someone else with a better prognosis to survive to hospital discharge. 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.
12) 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 should have priority access to palliative interventions, if these are necessary.

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, let me 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 or 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."