Allocation of scarce resources during the COVID-19 pandemic: a Jewish ethical perspective

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ABSTRACT

The novel COVID-19 pandemic has placed medical triage decision-making in the spotlight. As life-saving ventilators become scarce, clinicians are being forced to allocate scarce resources in even the wealthiest countries. The pervasiveness of air travel and high rate of transmission has caused this pandemic to spread swiftly throughout the world. Ethical triage decisions are commonly based on the utilitarian approach of maximising total benefits and life expectancy. We present triage guidelines from Italy, USA and the UK as well as the Jewish ethical prospective on medical triage. The Jewish tradition also recognises the utilitarian approach but there is disagreement between the rabbis whether human discretion has any role in the allocation of scarce resources and triage decision-making.

INTRODUCTION

The current worldwide pandemic of the novel COVID-19 virus is taxing the global healthcare system including vital life-saving medical supplies and equipment. Healthcare workers are faced with an epic proportion of medical and ethical decisions regarding allocation of these precious resources, especially ventilators. This paper will focus primarily on the Jewish ethical prospective to the allocation of scarce resources during the COVID-19 pandemic.

Physicians in Italy, the first European country plagued by the corona pandemic, were overwhelmed with difficult triage dilemmas as around 10% of those effected with COVID-19 require some form of respiratory assistance.[1] On 7 March 2020, the Italian College of Anesthesia, Analgesia, Resuscitation and Intensive Care published new guidelines regarding the triage of patients due to underavailability of resources. 'It is a scenario where criteria for access to intensive care and discharge may be needed, not only in strictly clinical appropriateness and proportionality of care, but also in distributive justice and appropriate allocation of limited healthcare resources.'[2]

Similar to the battlefield model of triage, privilege is given to those with the 'greatest life expectancy', thus abandoning the traditional 'first come, first served' model. Unfortunately, due to the high number of patients needing respiratory support, these decisions are occurring at greater frequency and at a faster pace. Factors such as age, comorbidities and functional are evaluated in the decision for critical care admission.[2]

In 2009, the Institute of Medicine (IOM) developed a guidance for the establishment of crisis standards of care (CSC) based on the ethical principles of fairness, duty to care, duty to steward resources, transparency, consistency, proportionality and accountability. During a time of disaster there is a paradigm shift from focusing on the individual to providing the best outcome for the population.[3] In March 2020, the National Academy of Medicine, formally known as the IOM, published a discussion paper regarding planning of care during the time of a pandemic with specific focus on the current COVID-19 outbreak. The authors reiterate that the goal of CSC planning is to have processes in place before the crisis to manage the availability of critical resources, thus avoiding the need to make difficult triage decisions. Part of the planning involves 'graceful degradation of services' by making step-down changes to care that is provided.[4] Decision-making should be performed using the principal of proportionality, weighing the compromising of usual standards against optimisation of benefits to the greater society. For example, recycling life-saving respiratory equipment after careful sterilisation, making home continuous positive airway pressure machines, respiratory aide devices, available for hospital use, adjustment of standard criteria for intubation and weaning from ventilators. These measures will provide greater availability of life-saving equipment.[4]

The American Medical Association Code of Medical Ethics delineates that decision-making in times of scarcity of equipment should be based on three factors: 'urgency of (medical) need, the likelihood and anticipated duration of benefit, and the change in quality of life'.[5] Opinion 11.1.3 further calls on healthcare professionals and institutions to: prioritise treatment to those for whom treatment will prevent premature death or extremely poor outcomes. Physicians should use 'an objective, flexible, transparent mechanism to determine which patients will receive recourse when there are not substantial differences among patients and requires that allocation policies be explained both to patients who are denied access to limited resources and to the public'.[5]

On 20 March 2020, in response to the COVID-19 pandemic, the National Institute for Health and Care Excellence in the UK published the Guideline with clinical decision-making. This Guideline provides a clear and detailed algorithm for the allocation of critical care beds and treatment of critical patients during the COVID-19 outbreak. The basis of the Guideline is to maximise patient safety and appropriate use of resources. Admission to an intensive care unit is based on some assessment of frailty, comorbidities and likeliness to recover from the intensive treatment.[6]

In surveying triage protocols, Persad *et al*[7] identified four overarching principles used in treating

people equally: these include lottery and first come, first served models; favouring the worse off based on the rule of recuse; the utilitarian approach of maximising total benefits; and rewarding social usefulness which favours essential professions but is fraught with potential biases. In relation to the novel COVID-19 virus, Emanuel and colleagues[8] delineated the ethical values to guide the rationing of scare resources. In line with the utilitarian approach of maximising benefits, priority of treatment should be given to those with the greatest chance of survival. Healthcare workers should be given preference to promote and reward usefulness. Care should not be based on first come, first served model but rather, random selection should be used, when all patients have a similar prognosis.

AN ANCIENT DISPUTE

Most ethical guidelines relating to triage, as we have seen above, are utilitarian in nature and heavily emphasise the principle of maximising total benefits. The question remains whether Halakha (Jewish law) accepts this approach as well.

In determining Jewish ethics regarding triage, Orthodox Jews look to the Talmud for guidance. The issue of allocation of scarce resources was addressed thousands of years ago in this book of Jewish law.

The Talmud in Baba Mezia (62a) relates:

> Two people were 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 shall live with you'.[9] Your life takes precedence over the life of your brother.

Sokol explains that the basis of the argument between Ben Petura and Rabbi Akiva is whether one takes a deontological or consequential approach to ethics. Deontologists maintain that:

> Actions are in themselves moral ends: that certain features of the action itself make it right or wrong… that an action has good consequences for society, or generally maximizes life, is far less important—according to some views, not inherently important at all—than the moral properties of the action itself.[10]

It follows in the case of the two travellers that it is not relevant if both will die if they share the water; from a moral perspective the question is simply to determine what the right thing to do is now, which is to share the water equally.

Consequentialists, on the other hand, think this approach is foolish. They maintain that:

> The moral rightness or wrongness of an action is determined exclusively by its consequences that is, by the nonmoral good or evil it produces… to put it differently, actions are not moral ends in themselves; they are only means to produce some moral (or immoral end). Actions that increase happiness or maximize life are defined as moral. In the case of the two travelers the water should be given to one traveler because by doing so one maximizes life.[10]

Normative Jewish law follows the utilitarian position of Rabbi Akiva. There are a myriad of explanations of what the precise point on which Ben Petura and Rabbi Akiva disagree on is. Rabbi Avraham Karelitz[11] a leading Israeli Jewish law decider of the last century, 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.

Rabbi Moshe Feinstein, the pre-eminent Jewish decider of 20th century, writes regarding triage: in my opinion if both arrive at the same time [to the hospital], 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.[12]

Another important modern decider, Rabbi Shlomo Zalman Auerbach writes 'that one should primarily take into account the degree of danger and chance for cure'[13] in making triage decisions. This is in fact how many physicians make their triage decisions, they look at the balance between the acuteness of the patient and the reversibility of the disease to decide who should receive scarce resources.

Rav Eliezer Waldenberg, another modern decider, maintains that one can even hold in abeyance life-saving equipment from a patient not expected to live in anticipation of the arrival of a patient with a better prognosis.[14] These approaches are all consistent with a utilitarian approach to triage based on maximising potential life-saving. However, they all agree that once you have initiated treatment with life-saving equipment you cannot remove it to treat another patient.

MODERN APPLICATIONS

Regarding the case of the two travellers discussed above, Rabbi Karelitz maintains if there is a third person who has one bottle of water that can only save one person, according to Rabbi Akiva, he should give it to who he wants, a position that Rabbi Waldenberg agrees with. It appears that the Halakha gives much leeway to the rescuers in deciding who to save. It is not too much of an intellectual leap to say that in this halakhic void, it is society that should decide as opposed to the individual rescuer and thus the decisions of a national ethics committee are in line with halakhic thinking.

Rabbi Emanuel Rackman takes a different approach to the question. He is of the opinion that:

> 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.[15]

Before national guidelines were written, this was traditionally how physicians operated, using their best personal judgements. We are uncertain if this approach is applicable in times of a pandemic, when the healthcare system is in a state of crisis and triage becomes a daily tragic dilemma.

Rabbi Feinstein, as opposed to the deciders above, maintains that if two patients arrive simultaneously, doctors do not have the discretion to choose who should live, because we have no ability to decide whose life is more worthy of being saved, instead one should use a lottery or a first come first system. This is based on the Talmudic principle of (*Sanhedrin* 74) 'what makes you think that your blood is redder than the blood of a fellow human being?' This principle is very broad in Rabbi Feinstein's thinking and applies to the cognitively impaired and even to those in a coma. In his own words 'one must heal or save every individual without any differentiation based upon his intelligence or physical stamina and this applies to triage as well.'[16] The former Chief of Rabbi of Israel, Rabbi Isaac Herzog once asked Rabbi

Feinstein who should receive the limited amount of penicillin available in Israel at the time, and Rabbi Feinstein answered that it should be given to the first patient the physician saw who needed the medication[16] or use a lottery. The distinguished Protestant theologian and ethicist Paul Ramsey also agrees with this approach. Freund writes 'the preference for random selection is not the merit or need or value of the victim but equality of worth as a human being. The governing principle, it might be said, is that man shall not play God with human lives.'[17] Ramsey continues, 'When the ultimate of life is the value at stake, and when not all lives can be saved, it can reasonably be argued that men should stand aside as far as possible from the choice of who shall live and who shall die… random selection is preferable not simply because life is a value incommensurate with all other, and so not negotiable by bartering one man's worth against another's. It is sustained also because we have no way of knowing how really and truly to estimate a man's social worth.'[18]

Rabbi Auerbach also limits the ability of the rescuers to make these hard choices and forbids using age as a determinant in triage decisions. Rabbi Walter Wurtzberger disagrees and maintains that:

> As in lifeboat ethics some rational system of priorities should be devised rather than resorting to random selections of patients. As painful as it may be to play God and determine who shall live as a result of our intervention and who shall die as the consequence of our nonintervention, we cannot abdicate this responsibility. Random choice can hardly qualify as a more humane method to resolve our dilemmas.[20]

He goes further and suggests that social worth should play a role in the decision a position vigorously opposed by Rabbi Feinstein and Professor Ramsey.

CONCLUSION

There is, therefore, a fundamental disagreement between Rabbi Karelitz and Rabbi Waldenberg on one side and Rabbi Feinstein on the other whether there is any human discretion in making these difficult decisions. All are in agreement that utilitarian principles should be the basis for the decision. The difficulty arises when it is impossible to triage based solely on utilitarian considerations. In these circumstances, Rabbi Feinstein maintains that only God can make these life and death decisions and thus leaves the decision to chance (lottery or first come, first served) while Rabbi Karelitz and Rabbi Waldenberg give humans a voice in triage. Once humans are given this responsibility it is reasonable to transfer this responsibility to national or local ethics committees.

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