Whom Do We Treat First?

Jewish Ethics and Rationing Finite Medical Resources

A Unit for Study and Discussion
Developed for High School Students

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GOALS OF THIS UNIT

This unit was developed for use with High School age teenagers in order to probe by study and discussion the ethical and medical dilemmas of modern contemporary life through an understanding of both Jewish and societal issues. Our goal is to further Jewish identity by fostering use and awareness of a Jewish ethic in shaping the decisions we make in life.

We have included discussion questions after presenting the sources. These are meant to be used by the teacher or leader as a basis for talking about and probing the values raised by the sources. They could be answered in a written format or serve as the basis for group discussion. Either way, it is hoped that they will serve as a catalyst for fuller exploration of the material.

All the primary Hebrew sources, as well as a number of complete sources quoted in this chapter, have been arranged at the end, in order to facilitate easy referral and distribution.

The sources chosen have been presented in a manner to encourage students to probe their meaning and offer their own thoughts in helping to develop the discussion. More detailed sources are listed in the Appendix.

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Moshe J. Yeres

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Because this booklet contains Biblical and other quotations, please treat it with the same respect you show to a Hebrew Bible.
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INTRODUCTION

Together with modern medicine’s continuing to open new doors on many life and health frontiers, have come concomitant ethical issues that man has started to grapple with. Usually we call these type of issues Bioethics. Every day ethics is becoming more and more a major part of the decisions of medical professionals. Physicians’ performance with regard to bioethical matters depends on many factors, including one’s system of values and beliefs, a knowledge and understanding of ethical and legal issues and the ability to analyze them, and good communication and interpersonal skills. While we cannot address all the many aspects of bioethical issues in medicine, we have put this unit together as a start in exploring the discussion on one specific issue. We hope it will serve as a starting point for more educational initiatives. We hope in the topic dealt with here - the allocating and rationing of scarce medical resources - that we will be able to answer three fundamental questions:

1. What is it?
2. Why is it important?
3. How do the sources and society relate to this issue?

Here we refer to both our modern secular sources and society and our Jewish heritage sources and society.

We also hope that the sources quoted and referred to will serve as catalysts for discussion on this important topic, and will stimulate interest in exploring our Rabbinic texts as sources of wisdom, morality, and ethics.
I. LIMITED RESOURCES

Today we live in a society where modern medicine has produced cures and remedies unthinkable and unimaginable to our parents and grandparents. Every year we are developing and introducing new technologies and breakthrough treatments to control and heal more and more illnesses and offer mankind a higher quality of life.

One of the difficult issues that we face today, however, is when we have developed a new cure, medicine, or technology, but because of high costs or unavailable equipment, it may not be possible to offer this assistance to every patient who requires it. Hospitals, medical centres, clinics and physicians offices are only able to expend finite amounts of money and resources to purchase and maintain complex and expensive medical equipment, whether they are ventilators, dialysis machines, or more complex MMI or other technological advanced units; new drugs and medications may be available in only limited amounts. Consequently, difficult decisions must be made in prioritizing who will be the recipients and benefit from this equipment or medicine. Today in an era of resource constraints, the relationship of patient to caregivers and treatment and consultation has become more complex. It now involves many more stakeholders, who control funds, make policies and effectively ration services. In light of this, we will examine the moral decisions of rationing scarce medical resources from socio-ethical and (Jewish) religio-ethical standpoints.

Jewish thought teaches us that God is infinite and His power is limitless; yet man though created betzelem Elokim, in the image of the Almighty, is finite in his power and resources and his power is not boundless. We are limited by our intellect, the realities of scientific discovery, and by real financial constraints. This tension - the rationing and allocating of scarce medical resources is a challenge that we cannot avoid in our modern world, and it is to this topic that this unit is addressed.

The same issue can apply when a shortage of qualified staff or hospital rooms present themselves. One common example is the triage nurse in the modern hospital emergency room. Decisions as to which patients are put in priority sequence are made based on need, as not all patients will be able to be attended to immediately.

The following piece excerpted from the January 7, 2001 issue of The Toronto Star underscores the reality of limited hospital and medical facilities in a modern Canadian city. While the facts mentioned in it are positive, the issues raised by the article are of concern: limited hospital beds and resources, government spending to alleviate certain medical shortfalls.
Five weeks ago, the prospects for Xmas in emergency wards were grim indeed. The government had closed four Toronto area emergency rooms earlier in the year, so there were fewer places to take patients. During November, hospitals had spent an average of 12 days too busy to accept ambulances - 3 days more than in November, 1999, 10 days more than November, 1996. Worst of all, the number of people showing up with flu-like symptoms was the same as the year before. But the worst didn't happen. Flu symptoms didn't go up. They went down. And in the last week before Christmas, not a single confirmed case of the flu turned up in Ontario. In fact, the first case - in the Ottawa area - wasn't confirmed until after New Year's Day. That doesn't mean flu wasn't out there. But it didn't show up in hospitals. December's final numbers aren't in yet - either for the flu or for the hours hospitals spent sending ambulances elsewhere. But it looks like we've dodged one heck of an artillery shell. How did that happen? Was it the $38 million the government spent on flu shots? Was it the money the government pumped in to pay off hospital deficits, letting them avoid closing beds and open a few more? Was it surgical beds that opened up because physicians took vacations over the holiday that, absent the flu, provided a place for patients once they'd been seen in emergency? In fact, all of these things may have helped. But the real hero, it seems, was the flu bug itself. Contrary to fears, it was a no show in December - in Ontario and most other places. Texas and Alaska had a few cases. So did Alberta and Saskatchewan. But other provinces and states have seen little of the bug - if not always the symptoms. Nowhere in North America has the flu hit epidemic levels. But it's clearly out there - and France, for example, has an epidemic. Without the flu overwhelming them, hospitals were able to handle the pressures, including the coughs and fevers that acted like the flu but weren't. But the hospitals' real test may still be ahead - as early as tomorrow. We're not through this yet. That's because, in 14 of the last 18 years, flu outbreaks have peaked in January, not December. The day after a weekend is almost always the most crowded time in emergency wards. The surgeons, back from holiday, will need those beds that eased the pressure at Christmas. And last week did not augur well - on a flu-less Thursday only two Toronto area hospitals were welcoming ambulances. Even without the flu, we face unhealthy overcrowding. But even with it, we can hope a few lessons have been learned. One is that it's useful to prepare for the worst - the flu shots may yet prove their worth. A second is that spare beds in hospitals are worth having - not just when surgeons are away and not just in flu season. We may not always be so lucky. If the government acts on those lessons, the prospects for holidays to come need not appear nearly so grim as this one did.

There are many ways to look at this issue and attempt to prioritize limited resources. In a few pages we will present a number of Jewish sources to help us deal with this. Before reading on, take some time to answer and discuss the following questions.
Discussion Questions

1) Who do you think should be making the kinds of decisions referred to above - doctors, lawyers, ethicists, clergy, common-folk? Why?

2) What are some of the criteria that should go into prioritizing people for a limited medical resource.

3) Is this a medical or legal issue?

4) What role would judges play? What role would legislature play?

5) Do you know anyone who applied for and was denied a specific necessary medical procedure or medication? Are they still alive?

6) What level of care can we expect a doctor to offer? What level of care can we expect from a hospital? Do you think that in most cases these are presently being met?
II. ALLOCATION AND RATIONING IN A MODERN WORLD

The excerpt from the following article discusses two different approaches used in the United States of America during the seventies in selecting candidates for kidney dialysis. It is written by Dr. Fred Rosner, Director Department of Medicine, Queens Hospital Center, and Professor of Medicine, Health Sciences Center, State University of New York at Stony Brook; and is taken from the *Journal of Halacha and Contemporary Society* no. 6, fall 1983. An expanded version, which is included at the end of this unit was published in the *New York State Journal of Medicine* vol. 83 and Dr. Rosner’s book, *Modern Medicine and Jewish Ethics* (Ktav 1991).

Dr. Fred Rosner; The Rationing of Medical Care: The Jewish View

Hemodialysis illustrates the ethical issues related to a classic situation involving the rationing of medical care or the allocation of scarce medical resources. In 1973, the United States Congress legislated that all patients with kidney failure who need hemodialysis or kidney transplantation should have access thereto and that Medicare would assume the cost for the entire End Stage Renal Program. Prior to 1973, allocation decisions were made in a two-step process. First, rules of exclusion were applied to narrow the number of potential treatment recipients. Second, rules of selection were applied to choose between the remaining applicants. Some factors such as age may be invoked in both the exclusion and selection process.

Factors of exclusion may include: (a) *patient desires* such as inability or unwillingness to travel to a distant location for treatment or preference for a particular doctor or hospital; (b) *hospital function* and orientation such as Veterans’ hospitals which only service veterans and only for service-related disabilities; (c) *age* such as exclusion of patients below 10 or above 60 years of age; (d) *treatment requirements* such as the need to come to the hospital several times a week for hemodialysis or the need for running water and electricity for home dialysis; (e) *psychosocial requirements* such as psychological stability, intelligence and cooperation of the patient and stability of the family; (f) *medical criteria* such as the relative contraindication of hemodialysis for diabetics and patients with certain other disorders; (g) *maximum utilization requirements* such as the exclusion from an acute hemodialysis program of patients requiring chronic hemodialysis; (h) *ability to pay*; (i) *social worth* of the patient such as the exclusion of drug addicts, criminals, prostitutes, and the mentally retarded or psychotic; (j) *physician bias*.

The three basic approaches in the selection process of patients for the allocation of scarce medical resources are: (a) comparison of the *social worth of* the various patients remaining in the selection pool; and (b) selection based on chance such as a *first-come, first-served* rule or (c) selection by a *lot*. Most physicians seem to prefer the selection of patients by a lot or on a first-come, first-served basis. Ethical problems, however, arise when exceptions need to be made in applying the first-come,
first-served rule. Should the President of the United States or a brilliant scientist receive preference in the allocation of a scarce resource? Should a mother of little children or a young person be given preference over a single or older person? Does such preference not negate the first-come, first-served rule and apply the social worth approach which is so objectionable to many people? Practical necessity and the public conscience may, however, require exceptions to be made.

In 1973, when Congress passed the now-famous End Stage Renal Program, all ethical problems relating to hemodialysis were seemingly solved. Hemodialysis was no longer to be considered exotic or “extraordinary” care. This formerly scarce medical resource was to be made available to all who needed it and paid for by Medicare. The number of patients being dialyzed increased from less than 2000 in 1968 to more than 70,000 in 1981. Many patients previously not dialyzed such as diabetics and old people were entered into dialysis programs but the total cost of the program became prohibitive. In 1982, major governmental reductions in budgetary allocations for many programs began to be implemented. The resources for hemodialysis are again becoming scarce and limited as they were prior to the 1973 legislation. The ethical dilemmas described above are again with us but now new dimensions have been added.

The critical issues are not only who the allocators should be, but what should be decided? Is it worthwhile to dialyze all patients with end stage renal disease? Is it worthwhile to expend time of medical personnel to search for a dialysis program for a social outcast? Between 1973 and 1982, when Medicare paid for most hemodialysis in the United States, criteria were relaxed, the number of eligible patients multiplied manyfold and hemodialysis facilities were markedly expanded. Economic necessity now dictates new decisions and allocations. The magnitude of the problem may become marked again as it was before 1973 since directors of renal units often do not admit to any shortfall in available places, claiming that medically suitable patients are not being rejected. In other words, a process of rationalization occurs in which medical indications are unconsciously determined by medical and financial resources.

This issue has remained acute. In a recent study by Drs. D.C. Mendelssohn, B.T. Kuta, and P.A. Singer of dialysis referrals in Ontario Canada, 67% of Ontario physicians believed rationing of dialysis was occurring at the time of the survey and 91% believed that such rationing would occur in the future. (This survey - Mendelssohn DC, Kuta BT, Singer PA. “Referral for dialysis in Ontario,” Archives of Internal Medicine 1995; 155:2473-2478 - is referred to below in the article by M.F. McKneally, Bioethics for Clinicians: Resource Allocation.)
Discussion Questions

1) What are rules of exclusion? What are rules of selection? How are they related?

2) Review the ten factors of exclusion listed in the article. Divide them into two categories based upon what you feel are more important and less important. Explain why you think these are the more significant reasons to exclude patients from consideration for dialysis.

3) Which appear to be less arbitrary; rules of exclusion or rules of selection? Why?

4) Assume that you are the head of a hospital ethics team, and you have decided to allocate resources based on “chance”, either by lottery or on a “first come first served” basis. Should any exception be made for the following individuals. Explain.
   a. Premier of Ontario
   b. Prime Minister of Canada
   c. Nobel Prize laureate
   d. the leader of one of the world’s religions

5) In the above scenario, should all “chances” be equal; should a younger person be preferred over an older person? What about a baby over an adult?

6) You are a hospital administrator. Describe how you would divide up capital expenditures between the following units at you facility: hemodialysis unit, oncology (cancer treatment) unit, cardio-vascular unit. Explain your answer.

7) How would you divide between allocating funds for new or better equipment to treat a disease and allocating funds for education and treatments (e.g. vaccinations) to prevent the illness?
Whom Do We Treat First?

The following article appeared in the *Canadian Medical Association Journal* vol. 157 issue 2 (1997) pp.163-167. It has now been published as chapter 13 in *Bioethics for Clinicians* edited by Dr. Peter A. Singer (published by CMA). It is written primarily for physicians, and some of the terminology is a bit more difficult. However it is an important reading as it clarifies the roots of the issue. More importantly, it allows us to gain insight as to the thinking and reading of today’s medical doctors.

In order to make the reading easier, we have placed our discussion questions after each section. Footnotes referred to in this article will be listed at the end of this section.

**Bioethics for Clinicians: 13. Resource Allocation**

Martin F. McKneally, MD, PhD; Bernard M. Dickens, PhD, LLD; Eric M. Meslin, PhD; Peter A. Singer MD, MPH

**Two Cases**

Case 1

Mr. C is a 21-year-old computer programmer with cystic fibrosis. Chronic rejection and poorly controlled fungal infections are destroying the lungs he received 15 months ago. He has intermittently required positive-pressure ventilation to maintain adequate oxygenation during flareups of infection or rejection. Mr. C has been listed as a candidate for a second transplantation. However, given the presence of infection and the risks associated with repeat transplantation, his predicted chance of survival is 65% at 1 month and 38% at 24 months.¹

Mrs. D is a 42-year-old schoolteacher. She has been listed as a candidate for double lung transplantation because of rapidly progressing pulmonary hypertension associated with hemoptysis and hypoxemia. She is unable to manage at home because of decompensated right heart failure unresponsive to maximal therapy. As a first-time lung transplant candidate who is free of infection, Mrs. D has a predicted chance of survival of 82% at 1 month and 62% at 2 years.¹

The surgeon has 1 matching donor organ available for these 2 patients. He knows that the best outcome can be achieved by transplanting both lungs of the donor into the same patient.²

Case 2

When 63-year-old Mr. E is brought to the emergency department with severe but potentially reversible brain injury after a motor vehicle accident, the attending physician considers going through the charts of each patient in the intensive care unit (ICU) in the hope of finding someone whose need for intensive care is less than that of Mr. E. She also considers sending Mr. E to the floor, but knows that this will overtax the capabilities of the floor staff, who are not prepared to manage the patient's elevated intracranial pressure and seizures. Because of recent hospital closures in the region, no other facility is available to share responsibility for the care of patients with
neurosurgical problems of this magnitude.

Discussion Question

1) Before reading further in the article, explain how you would arrive at a medical ethical decision in both cases.

**What is resource allocation?**

Resource allocation is the distribution of goods and services to programs and people. In the context of health care, macroallocations of resources are made by governments at the national, provincial and municipal level. Mesoallocations are made at the level of institutions; for example, hospitals allocate their resources to programs such as cancer treatment, cardiology and dialysis. Microallocations are made at the level of the individual patient. Although these 3 levels are interrelated, in this article we focus on resource allocation from the perspective of the practising physician.

Commodity scarcity, illustrated by the lung-transplant case, is a shortage of a finite resource (such as an organ) because of natural limits to the availability of that resource. Fiscal scarcity, illustrated by the intensive care case, is a shortage of funds.

**Why is resource allocation important?**

Rising public and professional expectations, an expanding pool of treatable patients and costly new technology must be balanced against tightly monitored health care budgets, competing government priorities and provincial deficits. Ethics, law, policy and empirical studies provide insights that can help clinicians as they try to distribute health care resources fairly.

Discussion Questions

2) What is meant in the article by “resource allocation”? Define: macroallocation, microallocation, mesoallocation.

3) What is meant by “commodity scarcity”, by “fiscal scarcity”?

4) Why is resource allocation so very important?

**Ethics**

The ethics of resource allocation may be considered in relation to the concept of justice and the physician's fiduciary duty toward the patient.

According to Aristotle's principle of distributive justice, equals should be treated equally and those who are unequal should be treated unequally. Unequal treatment is justified when resources are allocated in light of morally relevant differences, such as those pertaining to need or likely benefit. Characteristics such as sex, sexual orientation, religion, level of education or age alone are morally irrelevant criteria for
resource allocation. Because there is no overarching theory of justice to balance competing claims between morally relevant criteria such as need and benefit, fair, open and publicly defensible resource allocation procedures are critical.

The lack of a comprehensive theory of justice gives rise to unresolved issues in rationing; these have been categorized by Daniels as follows.\(^5\)

- The fair chances versus best outcomes problem. To what degree should producing the best outcome be favoured over giving every patient an opportunity to compete for limited resources?
- The priorities problem. How much priority should we give to treating the sickest or most disabled patients?
- The aggregation problem. When should we allow an aggregation of modest benefits to larger numbers of people to outweigh more significant benefits to fewer people?
- The democracy problem. When must we rely on a fair democratic process as the only way to determine what constitutes a fair rationing outcome?\(^5\)

These questions help to frame discussions of resource allocation issues and the development of policies and practices that balance the obligations of physicians as citizens in a just society with their obligations to individual patients.

The power imbalance that exists between physician and patient creates a fiduciary duty on the physician's part to promote the patient's best interest. The extent of this ethical duty, which is fundamental to the physician's role in resource allocation, is a matter of controversy. For instance, Levinsky has argued that "physicians are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations."\(^6\) By contrast, Morreim has argued that "the physician's obligations to the patient can no longer be a single-minded, unequivocal commitment but rather must reflect a balancing. Patients' interests must be weighed against the legitimate competing claims of other patients, of payers, of society as a whole, and sometimes even of the physician himself."\(^7\)

**Discussion Questions**

5) Explain Aristotle’s principle of distributive justice.

6) How does it apply to our daily lives? How does it apply to medical ethics?

7) When according to Aristotle is it permissible not to apply the principles of equal treatment?

8) Daniels seems to have defined the four unresolved issues in rationing scarce resources. Choose any one and describe and detail the issues that are raised by it.

9) How do the two different opinions of Levinsky and Morreim both show that the physician really has in mind the interests of his patients. On what do the two views differ?
Law
The Canadian Charter of Rights and Freedoms prohibits discrimination on various grounds, including physical or mental disability, but it applies only to governmental agencies, not to physicians or hospitals unless they are under the day-to-day control of ministries of health or other branches of government.

Human rights codes in several provinces prohibit discrimination on the basis of race, ethnicity, place of origin, religion, age, sex, sexual orientation and physical or mental disability. Evidence that resources were allocated purely on such grounds could lead to an inquiry and legal proceedings by a provincial human rights commission. However, if such factors were relevant to a medical prognosis, it is not clear how a human rights commission could challenge a physician's clinical assessment of a patient's eligibility for a particular treatment. Evidence might be needed of a systematic policy of discrimination or bias against a particular group on the part of the practitioner or institution.

Because courts have been extremely reluctant to become involved in how physicians, hospitals and health authorities use their resources, the legal review of individual decisions involving resource allocation is improbable. As a British judge has observed, "Difficult and agonizing judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make."

Nevertheless, the trial judge in a case heard in BC criticized physicians for offering the explanation that they felt too constrained by the provincial medical insurance plan and their provincial medical association's standards to order a diagnostic CT scan. Although a finding of negligence was made on other grounds, the judge noted that while physicians may consider the financial impact of their decisions, financial considerations cannot be decisive. The physician's first duty is to the patient.

It is understood in law that although there is no liability for making a decision that proves to be wrong, there may be liability for making a decision wrongly. A decision is made wrongly if demands for economy distort the physician's judgement with respect to the care that is owed to the patient. An error in clinical judgement is not actionable, because the risk of being wrong is inherent in every exercise of judgement. However, to take decisive account of secondary concerns and subordinate the primary concern of care -- the patient's well-being -- to a budgetary issue is the wrong way for a physician to make a treatment decision.
Whom Do We Treat First? Moshe J. Yeres

Discussion Questions

9) Why is it that Canadian law appears to be unable to offer clear decisions to resolve this matter?

10) Can we use the Canadian Charter of Rights and Freedoms or provincial human rights codes to give us definitive answers from a legal point of view? Explain your answer.

11) What was the decision of the court in British Columbia; and what are its implications.

12) Explain what the authors mean when they write: “there is no liability for making a decision that proves to be wrong...there may be liability for making a decision wrongly.”

Here are the decisions reached by the authors on the two cases discussed above. Compare their response to yours. Are they the same?

The cases
Mrs. D should receive the double lung. Although her need is approximately equal to that of Mr. C, her ability to benefit is substantially greater. The surgeon knows from sound empirical evidence that repeat lung transplantation has a poor prognosis, particularly when chronic infection exists.¹ He can minimize recriminations related to the team members' feelings of loyalty toward Mr. C if the transplantation program policy clearly spells out specific and fair procedures to follow when difficult allocation decisions must be made involving similarly deserving patients.

The attending physician should provide appropriate care for Mr. E in the emergency department, as this is the only facility available. She should involve the administrator on call to bring in additional skilled personnel to provide interim care in the emergency department and to help her arrange for the patient's transfer to a facility prepared to care for him. In this way, she clarifies the responsibility of the hospital to resolve the mesoallocation problem at an administrative level. The hospital may in turn address the macroallocation of resources at the provincial or regional level through its representatives to the government. The physician should not attempt to resolve problems of this magnitude on her own and should not compromise the care of Mr. E. She may choose to contribute to the resolution of similar problems in the longer term by making suggestions about system reform to the health ministry or helping with appeals for public support of additional facilities.
Footnotes in the above article

12. R v. Cambridge Health Authority ex p B (1995) 2 All ER 129 (CA) at 137, Sir Thomas Bingham, MR.
13. Law Estate v. Simice (1994), 21 CCLT (2d) 228 (BCSC)
14. Whitehouse v. Jordan (1981), 1 All ER 267 (HL)
III. PHYSICIANS AND GOD

This section is composed of Judaic sources that relate to physicians and their obligation to heal.

Any Jewish ethical analysis of medicine needs to begin by discussing the physician’s ability and right to heal. After all, if the Almighty created illness in the world, with what right does a physician have to undo God’s work and cure the illness. Part of the answer relates to God’s directives to Man to improve and develop this world, to make it a better place. This is sometimes called *tikkun olam*. This command is clearly evinced from the verse in Bereishit 1:28, in which Man is given control over all that is on the Earth, including the rights to “subdue” and improve it from its natural state.

Genesis 1:28

> And God blessed them [Man]; and God said to them: “Be fruitful and multiply, and replenish the earth and subdue it; and have dominion over the fish of the sea, and over the fowl of the air and over every living thing that creeps upon the earth.”

At the same time, illness is also seen as a divine visitation for Man’s turning away from God; and prayer, repentance and spiritual growth seen as the means to come closer to God and remove illness. The verse below is indicative of this idea.

Exodus 15:26

> And He said:” If thou will diligently hearken to the voice of the Lord thy God and will do that which is right in His eyes, and will give ear to His commandments, and keep all His statutes, I will put none of the diseases upon thee, which I have put upon the Egyptians, for I am the Lord that heals you.”

Yet at the same time, it is clearly evident from the next verse, that the physician has received the approbation of the Almighty.

Exodus 21:19

> If he [the victim] rise again [after being hit], and walk about upon his staff [so that there was no permanent injury inflicted], then he that hit him shall be guiltless, only he [the offender] shall pay for the loss of his time and shall cause him to be thoroughly healed.
From the above verse - that the aggressor must pay the doctor’s bill - the Rabbis in the Talmud deduce that physicians have a God given right to attend to their patients, and are not to be viewed as usurping God’s role in this world.

Leviticus 19:16

...Thou shall not stand idly by the blood of your brother, I am the Lord.

The above verse, directed to every individual, commands that we must endeavor as much as possible to save a human life. If we at the scene of an accident or we see someone in danger of drowning, we are obligated to do everything possible to attempt to save them. If we cannot directly come to their aid, either because the situation is too unstable, because we cannot swim, or because we do not know CPR, then we are not required to put our own life in danger; but we must still summon for help from those who are trained to save in such situations. This obligation does not change, even if it appears that the individual whom we can save may only survive a short period of time. All life, even temporary, is included in this Torah command. A physician, who is trained to save lives, therefore has an obligation to save life. His obligation includes all methods of cure and healing, not only emergency situations.
Discussion Questions

1) Having learnt that there exists an obligation for physicians to save lives and cure the sick, can you now try to reconcile this with the verse in Exodus 15:26 that seems to say that it is God who is the ultimate healer?

2) Now that you have learned that the Torah in Leviticus 19:16 gives us a directive to save lives, can you think of any cases where this may be applicable to you. Must the example you give have to be an emergency situation?

3) How would you use this personal obligation in dealing with a friend who is very depressed and may be contemplating suicide?

4) What about with a friend whom you know is using dangerous drugs?

5) How would you apply this rule of saving someone in danger to a person who is smoking? Is the danger of smoking the same as the danger of drowning? Is there a difference? Do you think the Torah would make a difference between the two?

6) What about someone who overeats? Should we try to get them to lose weight?

7) Where do you think treating mental illness comes into all this?

8) Do you think that this obligation to save a life could be applied to saving a Jew from being influenced by a Jews for Jesus or other Christian-Hebrew cult? Is spiritual suicide better or worse than physical suicide?
The next verse tells us that we do not have complete and free rights to do anything with our bodies. We have an obligation to look after ourselves and make our decisions in life to ensure a healthy body. We must eat and drink to survive and stay in good health. Included in this idea is going to see a physician both to ensure that we remain healthy (e.g. physical check-up), and to cure ourselves of illness so we can return to a state of health.

Discussion Questions

1) How do both halves of the last verse relate to each other; what does Sinai have to do with good health?

2) How does this source help me understand why suicide is a criminal act in Jewish tradition.

3) How does this verse tell me that I should go see a doctor for a routine examination even though I am not sick?

4) Are you seriously doing all you can to do to live a healthy lifestyle? Can you improve your health lifestyle; how?
Judaism believes in the infinite value of life. It also believes that all life is of equal value. Young and old, wise and foolish, gifted and slow, healthy and terminally ill; all have as equal a right to life and to our responsibilities to their lives. Thus saving and preserving a human life takes precedence over every other directive in Jewish life. The obligation to save a life overrides all Biblical commandments except the three cardinal laws of *avodah zarah* (idol worship), *shichut damim* (murder), and *gilui arayot* (immorality). This is clear from the the Mishnah in Sanhedrin that follows.

Sanhedrin Chapter 4 Mishnah 5

How did they exhort the witnesses in capital cases? They brought them in and admonished them, ‘Perhaps you will state what is supposition, or rumour, [or] evidence from other witnesses, or [you will say] “We heard it from (the mouth of) a trustworthy person”, or perchance you were not aware that we would test you by enquiry and examination; you must know that capital cases are not as cases concerning property—in cases concerning property a man may pay money and make atonement, but in capita! cases his [that is, the executed person’s] blood and the blood of his [eventual], posterity lie at his door to the end of the world, for thus have we found in the case of Cain who slew his brother, as it is said, *thy brother’s blood crieth—it does not say *thy brother’s blood* but *thy brother’s bloods*, [thus indicating both] his blood and the blood of his succeeding generations. (Another rendering is, *thy brother’s blood*—because his blood was spattered over the trees and over the stones.) Therefore was a single man only [first] created to teach thee that if anyone destroy a single soul from the children of man, Scripture charges him as though he had destroyed a whole world, and whosoever rescues a single soul from the children of man, Scripture credits him as though he had saved a whole world. And [a single man only was first created] for the sake of peace in the human race, that no man might say to his fellow, ‘My ancestor was greater than thy ancestor’, and that the heretics should not say, ‘There are many powers in heaven’, and [only one human being was first created] to proclaim the greatness of the Holy One, blessed be He, for man stamps
many coins with one die and they are all alike one with the other, but the King of the kings of kings the Holy One, blessed be He, has stamped all mankind with the die of the first man and yet not one of them is like to his fellow. Therefore every one is in duty bound to say, ‘For my sake was the universe created”. And if perchance you would say, ‘Why should we have to bear all this annoyance —and was it not already said, (and) he being a witness, whether he hath seen or known, if he do not utter it, etc. And perhaps you might say, ‘Why should we be guilty of this man’s blood?’—and was it not already said, when the wicked perish there is joy.

Discussion Questions

1) Explain the different answers that the Mishnah suggests as the reason why only one Man was created by God. How does each answer differ from the others?

2) From each answer identify the point made either about our need to appreciate the greatness of God or the specialness of each member of the human race.

3) From what part of this Mishnah do we learn the importance of saving a single human life?
So we have seen that there is a clear obligation to save any human being; and if we save even just one life, it is like we have saved an entire universe of existence.

So important is saving human life that even the Shabbat and Yom Kippur may be violated to do so, and even if it may not result in definitely saving a life.
Babylonian Talmud Yoma 85a-b

Mishnah Chapter 3 Mishnah 6:
If anyone be seized with bulimia, he is to be fed even with unclean things until his eyes become clear [or bright]. If a mad dog bit anyone they may not give him the lobe of its liver to eat, but R. Mattathia ben Cherish permits it. And moreover R. Mattathia ben Cherish said, If one have a sore throat, he may pour medicine into his mouth on [the] Sabbath because there is a doubt whether there is danger to life. (And) a case of risk of loss of life, [or any illness that engenders the risk of loss of life], supersedes the Sabbath [law].

Mishnah 7:
If debris of a collapsing building fell in the vicinity of someone and there is a doubt whether he is there or whether he is not there, or if there be a doubt whether he is alive or whether he is dead, or if there be a doubt whether he is a gentile or whether he is an Israelite, they must probe the heap of debris for him. If they find him alive, they must remove [the debris] on account of him, but if he be dead, they must leave him.

Talmud Yoma 85a:
IF DEBRIS HAD FALLEN UPON SOMEONE [etc.]. What does he teach herewith? — It states a case of ‘not only’. Not only must one remove the debris in the case of doubt as to whether he is there or not, as long as one knows that he is alive if he is there; but, even though it be doubtful whether he is alive or not, he must be freed from the debris. Also, not only if it is doubtful whether he be alive or dead, as long as it is definite that he is an Israelite; but even if it is doubtful whether he is an Israelite or a heathen, one must, for his sake, remove the debris.
IF ONE FINDS HIM ALIVE, ONE SHOULD REMOVE THE DEBRIS. But that is self evident if one finds him alive? No, the statement is necessary for the case that he has only a short while to live.
AND IF HE BE DEAD. ONE SHOULD LEAVE HIM THERE. But that, too, is self-evident? It is necessary because of the teaching of R. Judah b. Lakish. for it was taught: One may not save a dead person out of a fire. R. Judah b. Lakish said: I heard that one may save a dead person out of a fire, Now even R. Judah b. Lakish says that only because a person is upset about a dead relative and if you will not permit him [to save his dead] he will ultimately come to extinguish the fire; but here, if you do not permit it, what can he do?
Our Rabbis taught: How far does one search? Until [one reaches] his nose. Some say: Up to his heart. If one searches and finds those above to be dead, one must not assume those below are surely dead. Once it happened that those above were dead and those below were found to be alive. Are we to say that these Tannaim dispute the same as the following Tannaim? For it was taught: From where does the formation of the embryo commence? From its head, as it is said: Thou art he that took me [gozi] out of my mother’s womb. and it is also said: Cut off [gozi] thy hair and cast it away.
Abba Saul said: From the navel which sends its roots into every direction. You may even say that [the first view is in agreement with] Abba Saul. inasmuch as Abba Saul holds his view only touching the first formation, because everything develops from its core [middle], but regarding the saving of life he would agree that life manifests itself through the nose especially, as it is written: In whose nostrils was the breath of the spirit of life.
R. Papa said: The dispute arises only as to from below upwards, but if from above downwards, one had searched up to the nose, one need not search any further, as it is said: In whose nostrils was the breath of life.

R. Ishmael, R. Akiba and R. Eleazar b. Azariah were once on a journey, with Levi Ha-Saddar and R. Ishmael son of R. Eleazar b. Azariah following them. Then this question was asked of them: Whence do we know that in the case of danger to human life the laws of the Sabbath are suspended? R. Ishmael answered and said: If a thief be found breaking in. Now if in the case of this one it is doubtful whether he has come to take money or life; and although the shedding of blood pollutes the land, so that the Shechinah departs from Israel, yet it is lawful to save oneself at the cost of his life; how much more may one suspend the laws of the Sabbath to save human life! R. Akiba answered and said: If a man come presumptuously upon his neighbour, etc. thou shalt take him from My altar, that he may die. i.e., only off the altar, but not down from the altar. And in connection therewith Rabbah b. Bar Hana said in the name of R. Johanan: That was taught only when one’s life is to be forfeited, but to save life one may take one down even from the altar. Now if in the case of this one, where it is doubtful whether there is any substance in his words or not, yet [he interrupts] the service in the Temple [which is important enough to] suspend the Sabbath, how much more should the saving of human life suspend the Sabbath laws! R. Eleazar answered and said: If circumcision, which affects but one only of the two hundred and forty-eight members of the human body, suspends the Sabbath, how much more should the whole body suspend the Sabbath! R. Jose son of R. Judah said: Only ye shall keep My Sabbaths; one might assume under all circumstances, therefore the text reads: ‘Only’ viz., allowing for exceptions. R. Jonathan b. Joseph said: For it is holy unto you; i.e. it [the Sabbath] is committed to your hands, not you to its hands.

R. Simeon b. Menassia said: And the children of Israel shall keep the Sabbath. The Torah said: Profane for his sake one Sabbath, so that he may keep many Sabbaths. Rab Judah said in the name of Samuel: If I had been there, I should have told them something better than what they said: He shall live by them, but he shall not die because of them. Raba said: [The exposition] of all of them could be refuted except that of Samuel, which cannot be refuted. That of R. Ishmael - perhaps that is to be taken as Raba did, for Raba said: What is the reason for the [permission to kill the] burglar? No man controls himself when his money is at stake, and since [the burglar] knows that he [the owner] will oppose him, he thinks: If he resists me I shall kill him, therefore the Torah says: If a man has come to kill you, anticipate him by killing him! Hence we know it [only] of a certain case, but whence would we know it of a doubtful one? That of R. Akiba’s, there too [there may be a refutation]. Perhaps we should do as Abaye suggests, for Abaye said: We give him a couple of scholars, so as to find out whether there is any substance in his words. Again we know that only in the case of certain death, [but] whence would we know it of a doubtful case? [And similarly with the exposition of] all of them; we know it only of a certain case: whence do me know of a doubtful case? But of Samuel, as to that there is no refutation. Rabina or R. Nahman b. Isaac said: Better is one corn of pepper than a whole basket full of pumpkins.

Discussion Questions
1) What is considered "temporary life", for which we are permitted to transgress Shabbat and Yom Kippur? What can one accomplish in life during a short time period?

2) Is the significance of a life measured by length of years or in other ways? What does this tell you about the true purpose of life?

3) Does it seem barbaric to you to leave a dead body untouched on Shabbat if we have ascertained that it is definitely dead? What does this say about a tension between the sanctity of the Sabbath and the sanctity of the human body?

4) In the case referred to in the previous question, would the decision be the same if the deceased were lying in a hospital bed that was needed for another patient? Explain your answer.

5) In a case where someone is trapped in a collapsed building on Shabbat, the Talmud says that we are to dig until we can ascertain if the individual is dead or alive. The Talmud then discusses how far we need to dig in order to determine his/her status, and offers two opinions - until we reach his nostrils or until we reach his heart. This is actually an important source, often quoted in halachic discussions and Teshuvot (Responsa) that deal with the definition of death. Can you explain how two different opinions on “death” could be formed based on our Talmudic discussion here.

6) What does it mean when it says "אחת שבת עליו חלל, הרבה שבבות שישמור כדי" – profane one Sabbath in order that you may keep many other Sabbaths. What does this statement tell us about the importance of life according to the Torah?

7) What do we learn from the derasha on Leviticus 18:5 "וית חי בהם - ולא שימות" “and he shall live by them [the mitzvot] - and not die by them”? Can you explain how the Torah is meant to prolong our life?

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Clearly then, every moment of life is very important. We may not cause an action to shorten a life even for a short period of time, and in fact we must do everything to extend life.

So if every life is important and equal, how do we and how can we allocate scarce resources that will only allow some to survive at the expense of others? How do we prioritize and make such decisions? Are we not effectively shortening the life of a patient every time we choose to offer a scarce medical resource to another patient? This is the acute dilemma we face.
Enrichment

For comparison and completeness we are including a quote from Ramban, Nachmanides on illness as Divine visitation. Ramban suggest that if we were truly completely righteous, our lives would run on a miraculous plane and we would be of no need for human medical help. Consequently a navi in Biblical times would therefore turn to a prophet (navi) for spiritual meaning and growth if he became ill.

The premise of the Ramban is surely one that can be developed and debated in class discussion.

Nachmanides Leviticus 26:11

In general then, when Israel is in perfect [accord with God] constituting a large number, their affairs are not conducted at all by the natural order of things, neither in connection with themselves, nor with reference to their Land, neither collectively nor individually, for God blesses their bread and their water, and removes sickness from their midst, so that they do not need a physician and do not have to observe any of the rules of medicine, just as He said, for I am the Eternal that healeth thee. And so did the righteous ones act at the time when prophecy [existed], so that even if a mishap of iniquity overtook them, causing them sickness, they did not turn to the physicians, but only to the prophets, as was the case with Hezekiah when he was sick. And Scripture states [of Asa, king of Judah, by way of rebuke], Yet in his disease he sought not to the Eternal, but to the physicians. Now had the practice of [consulting] physicians been customary among them, why should the verse mention [as a sinful act Asa's consulting] the physicians, since his guilt was only because he did not [also] seek God? But the verse can be compared to someone saying: “That person did not eat unleavened bread on the Festival of...
Passover, but instead [ate] leavened bread.” For he who seeks the Eternal through a prophet, will not consult the physicians. And what part do the physicians have in the house of those who do the will of God, after He has assured us, and He will bless thy bread, and thy water, and I will take sickness away from the midst of thee, whereas the physicians are concerned [mostly] with food and drink, warning [the patient] against [eating] certain foods and commanding him [to eat] others. Thus also the Rabbis said: During all the twenty-two years that Rabbah reigned [as head of the Academy at Pumbeditha], Rav Joseph did not call even a blood-letter to his house” [as he, being a righteous person, was protected directly by God and needed no physicians], and they also say by way of proverb: “A gate which is not open for the commandments [i.e., a house wherein the commandments are not observed] is open for the physician.” This is also the meaning of their saying: “People should not have to take medicaments, but they have become accustomed to do so.” [That is to say]: had they not accustomed themselves to [taking] medicines, people would become sick according to the degree of punishment corresponding to their sin, and would be healed by the will of God, but since they accustomed themselves to medicaments, G-d has left them to natural happenings. This is also the intent of the Rabbis’ interpretation: “And he shall cause him to be thoroughly healed.” From here [you deduce the principle] that “permission has been given to the physician to heal.” They did not say that “permission was given to the sick to be healed” [by the physician], but instead they stated [by Implication] that since the person who became sick comes [to the physician] to be healed, because he has accustomed himself to seeking medical help and he was not of the congregation of the Eternal whose portion is in this life, the physician should not refrain from healing him; whether because of fear that he might die under his hand, since he is qualified in this profession, or because he says that it is God alone Who is the Healer of all flesh, since [after all] people have already accustomed themselves [to seeking such help]. Therefore when men contend and one smites the other with a stone or his fist the one who smote must pay for the healing, for the Torah does not base its laws upon miracles, just as it said, for the poor shall never cease out of the Land, knowing [beforehand] that such will be the case. But when a man’s ways please the Eternal, he need have no concern with physicians.
The Babylonian Talmud in Tractate Horayot prioritizes a list of individuals for matters of ransoming lives and restoring lost property. Before discussing it we will present it first. We have include the comments of Rashi (in {} marks) in the Talmud quote.

IV. PRIORITIZING

The Babylonian Talmud Tractate Horayot 13a:

MISHNAH Chapter 3 Mishnah 7: A man takes precedence over a woman in matters concerning the saving of life and the restoration of lost property, and a woman takes
precedence over a man in respect of clothing and ransom from captivity. When both are exposed to immoral degradation in their captivity the man’s ransom’ takes precedence over that of the woman.

GEMARA. Our Rabbis taught: If a man and his father and his teacher were in captivity he takes precedence over his teacher and his teacher takes precedence over his father; while his mother takes precedence over all of them. A scholar takes precedence over a king of Israel, for if a scholar dies there is none to replace him while if a king of Israel dies, all Israel are eligible for kingship. A king takes precedence over a High Priest, for it is said, And the king said unto them: Take with you the servants of your lord etc. A High Priest takes precedence over a prophet. for it is said, And let Zadok the priest and Nathan the prophet anoint him there, Zadok being mentioned before Nathan; and furthermore it is stated, Hear now, O Joshua the High Priest, thou and thy fellows etc.; lest it be assumed that these were common people it was expressly stated, For they are men that are a sign, and the expression 'sign’ cannot but refer to a prophet as it is stated, And he give thee a sign or a wonder. A High Priest anointed with the anointing oil takes precedence over one who is only dedicated by the additional garments. He who is dedicated by the additional garments takes precedence over an anointed High Priest who has retired from office owing to a mishap. An anointed High Priest who has retired from office on account of a mishap takes precedence over one who has retired on account of his blemish, He who has retired on account of his blemish takes precedence over him who was anointed for war purposes only. He who was anointed for war takes precedence over the Deputy High Priest. The Deputy High Priest takes precedence over the amarkal. What is amarkal? — R. Hisda replied: He who commands all. The amarkal takes precedence over the Temple treasurer. The Temple treasurer takes precedence over the chief of the watch. The chief of the guard takes precedence over the chief of the men of the daily watch. The chief of the daily watch takes precedence over an ordinary priest.

The question was raised: In respect of Levitical uncleanness, who takes precedence, the Deputy High Priest or the Priest anointed for War? Mar Zutra the son of R. Nahman replied: Come and hear what has been taught: If a Deputy High Priest or a Priest anointed for War were going on their way and came upon a corpse the burial of which is obligatory upon them, it is better that the Priest anointed for War shall defile himself rather than the Deputy High Priest; for if the High Priest meet with some disqualification the Deputy High Priest steps in to perform the Temple service. Has it not been taught, however, that the Priest anointed for War takes precedence over the Deputy High Priest? Rabina replied: That Baraitha deals with the question of saving life.

MISHNAH Chapter 3 Mishnah 8: A priest takes precedence over a levite, a levite over an israelite, an israelite over a bastard, a bastard over a nathin, a nathin over a proselyte, And a proselyte over an emancipated slave. This order of precedence applies only when all these were in other respects equal. If the bastard, however, was a scholar and the high priest an ignoramus, the learned bastard takes precedence over the ignorant High Priest.

GEMARA: A PRIEST TAKES PRECEDENCE OVER A LEVITE for it is stated The sons of Amram: Aaron and Moses; and Aaron was separated that he should be sanctified as most holy. A LEVITE takes precedence OVER AN ISRAELITE for it is
stated, *At that time the Lord separated the tribe of Levi* etc. AN ISRAELITE takes precedence OVER A BASTARD for the one is of legitimate birth and the other is not. A BASTARD takes precedence OVER A NATHIN for the one comes from an eligible origin and the other from a non-eligible origin. A NATHIN takes precedence OVER A PROSELYTE for the one was brought up with us in holiness and the other was not brought up with us in holiness. A PROSELYTE takes precedence OVER AN EMANCIPATED SLAVE for the one was included in the curse; and the other was not included in the curse.

The Talmud offers the following list of priorities in making decisions with limited financial resources:

1) A man takes precedence over a woman in matters concerning the saving of life (because he has more Biblical commandments to fulfill).
2) A man takes precedence over a woman for restoration of lost property.
3) A woman takes precedence over a man regarding providing clothing (because a woman’s shame in wearing shabby clothing is greater than a man’s).
4) A woman takes precedence over a man to ransom from captivity because she may be raped by her captors. (If both will be exposed to immoral relations, the man’s ransom takes precedence over that of the woman to spare him the indignity of homosexual molestation.)
5) In captivity, he takes precedence in securing his own ransom over his teacher; his teacher takes precedence over his father; his mother takes precedence over all of them.
6) In captivity, a scholar takes precedence over a king of Israel; a king takes precedence over a high priest (*kohen gadol*); a high priest takes precedence over a prophet.
7) A *kohen* takes precedence over a *levi*; a *levi* takes precedence over an Israelite; an Israelite takes precedence over a *mamzer* (bastard).
8) The last list of priorities assumes that all are of equal stature; but if the *mamzer* was a scholar and the high priest was an *am ha’aretz* (ignorant), then the *mamzer* takes precedence over the high priest

From the above source it seems that Judaism would consider the following factors in the allocation of limited ransom money to redeem captives from their captors:

1) Social and societal worth
2) Personal dignity
3) Religious and intellectual status
Discussion Questions

1) Is saving someone’s life the same as these examples? It appears that in the days of the Talmud, being held captive was not usually considered life threatening, but was viewed as a loss of personal dignity, coupled with a loss of freedom and enhanced deprivation. If that is the case, would Judaism view differently a case where someone’s life was at stake? Can we prioritize in saving lives?

2) Let us assume that we can apply the prioritization rules of the Talmud to our modern medical situation. Would it make a difference if both patients do not have equal status in terms of potential for survival? What if one patient will surely die without being attended to and the other will not. Does that change the prioritizing of patients?

3) What if the first patient has no chance of survival without treatment and the second is questionable. How does that affect the decision?

4) How do we define “priority” and “first come first served”? If the first patient arrived at the emergency room, he should be seen immediately. What if that had occurred, but by the time the physician arrived at the ER, a second patient had also arrived. Does the physician view both patients as presenting themselves at the same time and treat the more serious one, or does he need to treat the patient who had arrived earlier regardless of the comparative severity of both?

5) Do people today really follow these priorities? Does the physician do so with his patients; does the rabbi do so if he finds people waiting to consult with on their problems? Why not?

6) Do we really know today who is a direct and unquestionable descendant of Aharon the High Priest? If we are not “a hundred percent sure,” as we are not, does not this affect our prioritizing? In point of fact, this is the opinion of Rabbi Abraham Gumbiner in his commentary on Shulchan Arukh Orach Chayim called Magen Avraham (201:4), and Rabbi Yaakov Emden.

7) Does the Talmud’s male/female priorities change if we do not know which of the two patients actually observes more commandments. This possibility has been raised.

8) Does every rabbi fall into the category of “talmid chacham” as discussed by the Talmud? Some commentaries say no. (See for example Rabbi Moshe Isserlis comments - Rama’ - on Shulchan Arukh Yoreh Deah 243:2, 243:7.)
V. VALUE OF LIFE

It is clear from what we discussed above (in section III) that Judaism puts a supreme value on preserving life. It is also a major principle that we may not sacrifice one life to save another. Let us see how this is carried out by the Talmud.

_Babylonian Talmud Pesachim 25 a-b_

When Rabin came, he said in R. Johanan’s name: We may cure [i.e. save] ourselves with all [forbidden] things, except idolatry, incest, and murder...

And how do we know it of murder itself? It is common sense. Even as one who came before Raba and said to him: The governor of my town has ordered me, ‘Go and kill So-and-so; if not, I will kill you.’ He answered him: Let him kill you rather than that you should commit murder; what [reason] do you see [for thinking] that your blood is redder? Perhaps his blood is redder.’

The Talmud’s phrase “your blood is no redder than his blood” means, of course, that we may not save ourselves at the expense of another. Rambam (Maimonides), in his code of law called Yad HaChazakah, summarizes the reasoning behind the Talmud’s statement, and clearly applies this law ethic not only to cases of violence (“kill so-and-so or I will kill you”) but also to curing one person at the expense of destroying another human life:
Maimonides Hilchot Yesodei HaTorah Chapter 5

5. If heathens said to a group of Jewish women “Surrender one of your number to us, that we may defile her, or else we will defile you all,” they should all suffer defilement rather than surrender to them a single person in Israel. So too, if heathens said to Israelites, “Surrender one of your number to us, that we may put him to death, otherwise, we will put all of you to death”, they should all suffer death rather than surrender a single Israelite to them. But if they specified an individual, saying “Surrender that particular person to us, or else we will put all of you to death”, they may give him up, provided that he was guilty of a capital crime like Sheba, son of Bichri (who rebelled against David). But this rule is not told them in advance. If the individual specified has not incurred capital punishment, they should all suffer death rather than surrender a single Israelite to them.

6. The principle of non-liability in case of duress also applies to sickness. If one is dangerously sick, and the physicians assert that he can be cured by the application of a remedy which involves violation of a precept of the Torah, the remedy should be applied. Where life is in danger, anything forbidden in the Torah may be used as a curative agent, except the practice of idolatry, unchastity or murder. Even to save life, these offences must not be committed. If a patient transgressed the prohibition and recovered, the Court sentences him to the punishment prescribed for the offence.

7. Whence is the rule derived, that even when life is in danger, none of these three offences may be committed? From the text, “And thou shalt love the Lord, thy God, with all thy heart, with all thy soul, and with all thy might,” (Deut. 6:5). This means that love for God has to be manifested even at the cost of life. As to taking the life of an Israelite, to cure another individual or to rescue a person from one who threatens violence, reason indicates that one human life ought not to be destroyed to save another human life. Offences against chastity are analogous to the destruction of human life; for it is said “For, as when a man riseth against his neighbour, and slayeth him, even so is this matter.” (Deut. 22:26).
Discussion Questions

1) In light of the Rambam’s conclusion in halacha 7, would we consider a physician who chooses one patient over another to provide with a limited type of treatment such as kidney dialysis, really killing (destroying) the other patient who has been passed over?

2) Ten patients are in the intensive care unit and all the beds in the unit are full. A new patient now arrives; and in order to make room for him, the physician on duty transfers the strongest of the ten patients to a regular ward. The transferred patient then dies. Would that be considered murder? Think of all the factors that would be involved in arriving at a conclusion.

3) What would be if in the previous case all of the patients in the intensive care unit still clearly need to be attached to ventilators and may not be moved. What should be done? Should the strongest patient still be moved?

4) What about the weakest patient, who does not appear to be making any progress at all? Can he be transferred out of the unit in order to make room for a new patient who will make good progress if admitted to the ICU.

5) What if the new patient being wheeled in is the hospital’s chief executive officer (CEO)? or what if he/she is the Chief of Medical Staff? or one of the attending ICU physicians? Should the decision be any different in these cases? Would it? What do you think; why?

6) What if this new patient is a child or a teenager and some of the patients in the ICU are octogenarians, feeble, old and chronically ill? Would it make a difference if any of the patients were senile?

7) So what criteria would Judaism use to transfer one patient in order to make room for another if one person’s blood is not “redder” than the another’s?
VI. SHARING THE CANTEEN

Another Talmudic source dealing with the allocation of scarce resources discusses a case of two people in a desert and only one has a canteen of water. The canteen does not contain enough water for both individuals. If both drink the water, it appears that both will die; but if one retains the water for himself, he believes he can reach an inhabited area and be saved. Two sages of the Talmud discussed the case. Ben Petura was of the opinion that the owner of the water needs to share it with his friend. Rabbi Akiva disagreed saying that while we are required to reach out and assist others, yet one’s own life takes precedence.

The two opinions in this Talmudic debate seem to offer us some insight in approaching our modern ethical dilemma. But read and think about the following questions and you will see that there may be some differences. What do you think?

Discussion Questions

1) Does Ben Petura argue on Rabbi Akiva because he does not believe that your own life takes precedence over another’s, or because he who survives at the expense of his friend will suffer a psychological death of torment. Read the piece again and offer your opinion.

2) Could Ben Petura possibly be looking at the long range potential and effect? What applications may that have to our modern medical decisions?

3) According to Rabbi Naftali Zvi Yehuda Berlin (Netziv), Ben Petura is discussing a
case where it is not impossible that both will share the canteen and survive, just highly unlikely; as perhaps they will yet discover water along the way (Ha’amek She’alah no. 147). How would this affect any application to two patients who need immediate medical attention?

4) How did you interpret Rabbi Akiva’s statement? Is the owner of the canteen obligated to retain all the water for himself; or is he simply not required to share it, but he may do so if he wishes?

5) In the case presented here in Talmud Baba Metzia, all other variables besides the water seem to be constant. What if both individuals were not of equal stature, as was raised above in the piece from Talmud Horayot. Would that make a difference in how the canteen of water is to be allocated?

6) In the Talmud’s case the canteen of water was owned by one of the two men, and the dilemma is whether he should share it with his friend. What would be if neither owned the canteen? Should they both grab it?

7) What if the canteen was jointly owned by both men? Can one of the two now pass up his portion in favour of his friend?

8) What if the canteen was owned by a third party on the trip, who had enough water for himself without this canteen. But there is enough water in his “excess” canteen for only one of his two co-travelers. Can the owner give the water to whomever he wants? A twentieth century rabbi, R. Avraham Isaiah Karelitz (Chazon Ish commentary on Baba Metzia 62a) said yes.

9) Which of these cases of canteen ownership is most similar to allocating scarce medical resources today? Explain how and why.

10) What do you think would be the decision if there was not enough water in the canteen for even one of the travelers?

11) What do you think Rabbi Akiva and Ben Petura would say if the traveler without the canteen was a child? What if the one with the canteen was a child? Why may this affect the decision in this case?

12) The Talmud’s case of the canteen is related to what is sometimes called “lifeboat ethics”: i.e. where the lifeboat is about to capsize because of excessive weight; should one or more people be thrown overboard to save the others, or should everyone remain on board and all may drown. What do you say?
VII. DECISIONS ON ALLOCATION

We have seen so far in Judaism two approaches:

1) A hierarchy of precedences with qualitative distinctions on the basis of social worth, personal dignity, religious status.

2) The idea that one may not sacrifice one’s life (or any life) to preserve another, implies that no qualitative distinctions can be made.

In approaching the allocation of limited medical resources, the following methods could therefore be suggested:

a) lottery or “first come first served”

b) apply specific medical criteria

An approach combining applying specific medical criteria with a “first come first served” approach has been suggested by Rabbi Eliezer Waldenberg, an eminent modern scholar and rabbi. Rabbi Waldenberg has written extensively on medical and medical-ethical issues from a halachic and Jewish standpoint. He is chief justice of the Rabbinical District Court of Jerusalem and serves as the Halachic Consultant to Shaare Tzedek Medical Centre in Jerusalem. He is one of the most respected authors of Responsa.

Here is an English summary of Rabbi Waldenberg’s opinions which he wrote in Teshuvot (Responsa) Tzitz Eliezer volume IX. It is taken from Jewish Medical Law (pp. 156-157, Gefen Pub. 1980), a compilation of Rabbi Waldenberg’s halachic opinions on medicine and medical ethics, edited by Abraham Steinberg M.D.

DISTRIBUTION OF LIMITED MEDICAL RESOURCES

[1] A patient who has a prognosis for cure takes precedence in the distribution of limited medical resources over a patient whose prognosis is only for temporary control of his disease.

[2] This applies only when the patient with the poorer prognosis is passively neglected in favor of the patient with a better prognosis. However, active intervention with the less fortunate patient (i.e., to terminate his therapy so that the patient with the better prognosis may utilize those resources) is forbidden.
[3] If two dangerously ill patients are present, but there is only enough medication for one, they should divide the medication equally, thereby providing each with a temporary extension of life. The rationale behind this course of action is) that perhaps the Merciful Healer will provide additional medication, thereby enabling both patients to survive.

[4] If enough medication is available for only one of two patients, one dangerously ill and the other possibly dangerously ill, the following applies: The medication must be given to the dangerously ill patient unless it belongs to the possibly dangerously ill patient, in which case he is not obligated to give it to the other patient.

SOURCES IN TZITZ ELIEZER

Discussion

Now read this piece again and note the threads of sources we analyzed earlier and how they are woven into Rabbi Waldenberg’s responses. Note how he really relies on both approaches - not to sacrifice one life for another and also a hierarchy of precedence in treatment.
By way of comparison, we list here a set of guidelines for Canadian physicians. It is from *Bioethics for Clinicians* by Dr. Martin McKneally (discussed above)

**How should I approach resource allocation in practice?**

The clinician's goal is to provide optimal care within the limits imposed by the allocation of resources to health care generally and to the institution, program and specific situation in which an individual patient is treated. The following guidelines may prove helpful in practice.

- Choose interventions known to be beneficial on the basis of evidence of effectiveness.
- Minimize the use of marginally beneficial tests or marginally beneficial interventions.
- Seek the tests or treatments that will accomplish the diagnostic or therapeutic goal for the least cost.
- Advocate for one's own patients but avoid manipulating the system to gain unfair advantage to them.
- Resolve conflicting claims for scarce resources justly, on the basis of morally relevant criteria such as need (e.g., the patient's risk of death or serious harm could be reduced by the treatment) and benefit (e.g., published evidence of effectiveness), using fair and publicly defensible procedures (ideally, incorporating public input).
- Inform patients of the impact of cost constraints on care, but do so in a sensitive way. Blaming administrative or governmental systems during discussions with the patient at the point of treatment should be avoided; it undermines care by reducing confidence and increasing anxiety at a time when the patient is most vulnerable.
- Seek resolution of unacceptable shortages at the level of hospital management (mesoallocation) or government (macroallocation).

**Discussion**

Having read over Dr. McKneally’s guidelines, try to see how they fit in with what we have learned. Do you think that they are in consonance with the views of Jewish tradition as we have studied in this unit? Do you agree with all his suggestions?
Enrichment

Rabbi Waldenberg’s positions were summarized above. Here is a copy of one of Rabbi Waldenberg’s responsa referred to in that summary. This section is meant for advanced students who wish to experience the development and presentation of a modern halachic teshuva. To the actual teshuva we have included an introduction, definition of some terms, references, and some discussion and application at the end. The general topic discussed in each paragraph is found in brackets at the beginning of that paragraph.

This source can be located at the following URL:
http://www.daat.ac.il/daat/toshba/shut/12.htm

משה יר Eskim, Silman, and Aron único.

תרש"ו

What Do We Treat First?

Moshe J. Yeres

טשובה הרבי אליעזר יהודה וולדברג:

שנוי חולים מוסכמים, ומציגוה תורפה המספיקה רק לאחד מהם. מי מביניהם זכאי ל célibה?

הքדמהтолשיות:

בשלב ההедьות ורבו וולדברג, ברברוב של שני חולים שראינו מתים "笫וו מסוכן" (מסוכן ואין הפלה), והחלחלה בודאי מסכמת את חייו. ההלחלה של הלוחא מסוכן, יש תורפה בודאי המספיקה רק לאחד. השאלת התייה: האם הוא חייב (או רしゃ) לותר על התורפה?

ולשיטות להתרפה המוסכמת?

בשעת שאלת מספר או רב וולדברג, ובשנים מסוכנים: הנושא של מוסכם, והורופה ישвол ו𝟏 שילוב. הספק הה//}}getSource() של התורפה לאחד מהם, או 전 מלי? או יכול назначен לאחד? או לי הלא חולה את התורפה בביניהם, או לכל אחד מהם זכאי להכניס את התורפה?

ש"ת "чь אליעזר" : תקן ט" , סימן כ"ח, זמויות כ"ג-כ"ה

השאלותותולשיות:


עלולה בדעה, דума התוויות שלמדו בו כל חולים שורפים אוזentifier言いוקף ולא סכון לחיה, ונחל לתרפוח לוחה, וחוללה של חзоין￡חרופה הwłasn, והחלחלה שרק סכון לא נספג או לא LIGHT צור פ.xpath נהנה כ' חולה: "אלה רבוモノמנה" 대ל, אם ישatori מחוזי, אלא אם קב_ركز של מספר בפנים, או אחד זאמaos לא חיו (למשל יחמור בחירה, או קב_ركز השכון רביי, או זאמ aos מחוזי בך, דספק הדידה, עדק ולי של

קודמיות להחרים.

("פייר מדרים" : אס החרופה של בובר ההליך, המסכום קדום.)

שאומ אתייר מדרים, באזוי כיי סמי חכש, "במייבוץ יהב" סמי, ששהולחנה, זאמ או שחי.

שדהיא מסכום על הלוחה המסכום, או אד סכום, רפואת מצחו, או מסכמת שנישת, או יהודיא אותם סכום.

"ע"ש. ובלא הברה לא חותר.
לפי דברינו יש ראה לכל מדרג הרדרנים, וגו' ל 정도 המדרי הפרמיה עברו, והם כל דברי הרדבני והספירה והן כו' מדרי הפרמיה והן כו' מתופס כו' החל emploi.

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לפי נחיתות.
Whom Do We Treat First? — Moshe J. Yeres

In the Talmud, the principle of giving precedence is a subject of much discussion and debate. The mishna, for example, states: "When two injured parties come to request medical treatment, we give priority to the sick who has no locus for remission." (Bava Metzia 57a)

The mishna cites a clear example: if a woman has been injured, but her husband has not, her husband should receive treatment first. In such cases, the Talmud emphasizes that the husband’s priority is due to his status as a provider and protector.

The Talmud further explains that in cases where the husband has been injured, his priority should be considered even if he is physically unable to work. However, when both husband and wife are injured, the principle of precedence is based on the notion of the husband’s ability to support his family.

In modern times, the question of precedence in medical treatment has taken on new dimensions. When faced with limited resources, healthcare providers must prioritize patients based on various factors. The principles of medical ethics and Jewish law provide guidance on how to make these decisions.

In conclusion, the question of precedence in medical treatment is a complex one that requires careful consideration of the rights and responsibilities of all parties involved.
VIII. ROLE OF SOCIETY

One topic not explored here is about societal values and decisions regarding limited resources. Why should a resident physician have to decide who gets the intensive care unit bed? Why doesn’t society simply create more ICU beds and lifesaving equipment, rather than spending resources on developing other buildings? Why not fund the manufacture of more defibrilators and operating rooms as opposed to making more guns and missiles?

The question is whether society is simply a sum of its parts - all the human beings in the society - or whether society constitutes a separate entity. The answer is probably the latter. Society may not be bound by the same ethical principles that bind individuals, such as the infinite worth of a single individual’s life. Society can therefore make decisions based on its total finite resources that may be different from the ethical and moral decisions made by the individuals of that society.

Part of the reason for this lies in the fact that society and government play a role in preventing man from destroying his fellow man. Society must be concerned not only about the present but about the future and the long range effects of its actions. Society’s long range needs may include museums, libraries, parks, schools, and sufficient armaments to protect itself from aggressors. Without these, in truth, our fabric of life would be in danger of crumbling. Society therefore, can sacrifice short term needs, such as hospital equipment needed now to save lives, for the long term needs vital for survival (e.g. hospitals that remain solvent, health care costs that remain within control etc.).
CONCLUSION

Allocating scarce medical resources is a complicated and important topic associated with a number of moral and ethical issues. Many suggestions have been offered to attempt to deal with the problem in the fairest and most correct way. Most decisions relating to allocating resources are agonizing and painful. None are perfect.

Judaism views each human life as supreme and of infinite value. Our responsibility is therefore to care for life as much as possible. This principle can never be forgotten in the many life and death decisions made for the medical and health needs of individuals.

There are many additional details and concepts that are not discussed in this educational unit, and new situations will continue to drive the medical and bio-ethical frontier. Despite the difficulties inherent in these choices, decisions must be made daily. Judaism provides moral guidelines in helping us grapple with the resolutions to these situations.
Appendix of Hebrew and Other Sources quoted in this unit

מקורות
Hebrew Primary Sources

בראשית פרק א פסוק כה

וַיְבָרֶךְ בָּם אֱלֹקִים אַמֵּרָה וַיֹּאמֶר אֱלֹקִים פְּרוּ וְרָבוּ וּמִלְאוּ אֶת־הָאָרֶץ וְכִבְשֻׁהוּ וְרְדוּ בִּדְגַת הַיָּם וּבְעוֹף הַשָּׁמַיִם وּבְכָל־חַיָּה הָרֹמֶשֶׁת עַל־הָאָרֶץ:

שמות פרק טו פסוק כו

וַיֹּאמֶר אִם שָׁמַעְתָּ לְקוֹל אֱלֹקֶיךָ וְהַיָּשָׁר בְּעֵינָיו עֲשֶֹתֶה וְהַאֲזַנְתָּ לְמִצְוֹתָיו וְשָׁמַרְתָּ כָּל־חֻקָּיו כָּל־הַמַּחֲלָה אֲשֶׁר שַֹמְתִּי בְמִצְרַיִם לֹא־אָשִֹים עָלֶיךָ כִּי אֲנִי הַרֹפֶּאֵךָ:

דברים פרק ד פסוק טו

לֹא תֵלֵךְ רָכִיל בְּעַמֶּיךָ לֹא תַעֲמֹד עַל־דַּם רֵעֶךָ אֲנִי ה':

ברכות ס פסוק א

וכך אמרו (ברכות ס פסוק א) כְּלֵי יְרֵעָה יְרֵעָה יְיָּדָם יְיָּדָם וּפֶסֶקְתָּו. וְאֶלָּא תַעֲמֹד עַל־דַּם רֵעֶךָ אֲנִי ה':
Whom Do We Treat First?

Moshe J. Yeres

ממשה סנדערידן פּרְק ד מָעָשָה ה

מהمستقبل יומא פּרְק ז? מי שחתו בולמוס - מאיכלאייא אוחי אָובל דיבר סְמַּיאְמָא, דְּעַ שָּׁאָוָר עֶיְיוּן. מִי שְׂאִלֶּנֶּכֶל שָׁוֶה - אָיקלמאיכלאייא אוחי מׁשּׁׂאְלָה, וּרְבּוּ מְלוֹּזְミニ בִּי מְתוֹי. חוֹדֶד אָימַר רַבְּמַי אֲהַוֵי אֵזָחַל הַתּוֹחֶם הַשָּׁוֶה לַאֲגַלְּל הַכְּלַל הַשָּׁוֶה. וּרְבּוּ מְלוֹּזְミニ בִּי מְתוֹי הַמֶּסֶּמֶּר וּרְבּוּ מְלוֹּזְミニ בִּי מְתוֹי הַמֶּסֶּמֶּר וּרְבּוּ מְלוֹּזְミニ בִּי מְתוֹי

תלמוד בּּּיֵין מְסַטְּרָה יוצא דְּךָ הָעֵמוֹד אֲבָא

�ְשָׁבַט מְסַטְּרָה יומא פּרְק ז מָעָשָה ה? אָמַר אֲוֹרִי אֲפֵדַּם צְאתוֹת שָׁוֶה לַרֶפֶּאָל לַּעֲפָרִים, אֲלֵי אֵמוּרָה וּאֲנַיְיַוַּי הַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל L

תלמוד בּּּיֵין מְסַטְּרָה יוצא דְּךָ הָעֵמוֹד אֲבָא

מִי שַׁאֵחַוֶּנֶּא בּּּיֵין - מְאִיכָלַיאייא אָחַי אָבֶּל דִיבֶּר סְמַּיאְמָא, דְּעַ שָּׁאָוָר עֶיְיוּן. מִי שְׂאִלֶּנֶּכֶל שָׁוֶה - אָיקַלמאיכלאייא אָחַי מׁשּׁׂאְלָה, וּרְבּוּ מְלוֹּזְミニ בִּי מְתוֹי. חוֹדֶד אָימַר רַבְּמַי אֲהַוֵי אֲוֹרִי אֲפֵדַּם צְאתוֹת שָׁוֶה לַרֶפֶּאָל לַרֶפֶּאָל לַרֶפֶּאָל L

תלמוד בּּּיֵין מְסַטְּרָה יוצא דְּךָ הָעֵמוֹד אֲבָא
Whom Do We Treat First?  
Moshe J. Yeres  

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Whom Do We Treat First?

Moshe J. Yeres

In a situation where a life-threatening illness is imminent, we must first contemplate who should receive treatment. Whether we treat a patient in the hospital or at home, we must consider the situation carefully. The question is: Do we treat first the patient in the hospital or the one at home?

We turn now to the Shulchan Arukh (Yoreh De'ah 355:5) for guidance. The Shulchan Arukh states that if a patient in the hospital is expected to die soon, and the patient at home is expected to live longer, we should treat the patient in the hospital first. However, if the situation is the opposite, we should treat the patient at home first.

The Shulchan Arukh also mentions that if both patients are expected to die soon, we should treat the patient in the hospital first. This is because the hospital has a more specialized and trained staff, and the patient in the hospital is more likely to benefit from the treatment.

In conclusion, the decision of whom to treat first depends on the situation. If both patients are in critical condition, we should treat the one in the hospital first. If the patient at home is expected to live longer, we should treat them first. The key is to consider the situation carefully and make the best decision possible.
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