A Jewish Ethical Approach to Resource Allocation in Medicine

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Abstract

The allocation of medical resources is an essential part of medical decision making. Though many recognize the need for a universal approach to resource allocation, none currently exists. In order to develop an ethical framework, physicians and ethicists must first agree which values should guide allocation decisions. There is much debate over what criteria should be included and what weight should be accorded to each of them. The goal of this paper is to identify the values currently being proposed and to compare them with the values that underlie Jewish approaches to resource allocation. I focus on principles highlighted by Persad et al and Brock. Persad identifies "ethical principles for allocation [that] can be classified into four categories, according to their core ethical values: treating people equally, favoring the worst-off, maximizing total benefits, and promoting and rewarding social usefulness" (2009, p. 423). Brock includes the responsibility of the physician and the rule of rescue. Through an examination of the Jewish views on these secular approaches to rationing and the values that underlie them, I highlight the need for research and agreement on core values in secular ethics before the development of protocol.

Introduction

While it is often declared that medical services should be made available to all who need it, the unfortunate fact is that this is not yet possible. Some may argue that this would be easily fixed by a redistribution of funds. However, medical experts have all experienced forms of rationing that were based not just on fiscal decisions, but the shortage of resources, clinical space and availability of medical personnel. Consequently, many ethicists and medical professionals proclaim the need for a "just distribution of medical resources", but there are no agreed upon guiding principles (Luce & White 2009, p. 221; Christian et al., 2006). Within the protocols for allocation and triage that do exist, Dr. Sobol and Wunsch note that none of the "sets of criteria… offers guidance as to how to triage patients of similar acuity." (2011, p.217) This lacuna calls for a set of guiding principles to help with resource allocation at all levels of medical decision making. In order to develop an ethical system, all of the stakeholders need to achieve a consensus on which values should guide allocation decisions. Without an agreement on an underlying value system for resource allocation, there will continue to be much debate over which criteria should be included and what weight should be accorded to each of them. In this manuscript, I analyze the values employed by secular Western ethicists and compare and contrast them with those from the Jewish law code known as Halacha.

Background

It is helpful to understand the difference in the origins of these two systems of decision making. Jewish medical ethics are based on an analysis of Jewish law, which according to those who follow Orthodox Judaism, are the set of rules and moral code given to the Jewish people at Mount Sinai. Many issues have arisen over the centuries from disagreements over the interpretation of this law code and from disagreements on how to apply existing rules to new situations. Nevertheless, Halacha provides its followers with an uncontestable starting point. Secular ethics are philosophical concepts constructed from man's reason. So while an ethicist can create what he considers just rules and regulations, without a consensus on guiding principles each ethicist is liable to come up with his or her own conclusions which can contradict one another.

Philosophers have articulated multiple principles to help guide difficult decisions about resource allocation. Persad, Wetheimer, and Emanuel identify "ethical principles for allocation [that] can be classified into four categories, according to their core ethical values: treating people equally, favoring the worst-off, maximizing total benefits, and promoting and rewarding social usefulness" (2009, p. 423). Dan Brock illustrates the rationing decisions that need to take place at various levels of health care.

Role

One of the issues Brock notes is the transformation of the role of a physician. Previously the physician was to "be a single-minded advocate" for the patient, ignoring all factors besides the best way to treat the patient (Brock, 2007, p. 134). Brock maintains that this role is complicated by insurance companies, which require physicians to be "cost conscious in their use of health care resources" by trying to do as few procedures as necessary (Brock, 2007, p. 135). This, in turn, leads to bedside rationing (Brock, 2007). Brock believes that this rationing is not only necessary, but preferable. He maintains that even when the necessary guidelines are established, it is important that physicians are able to use their "discretion to depart from those guidelines when the specific circumstances of a particular patient are different enough from what the guidelines assume." (Brock, 2007, p. 136) While many ethicists and practicing physicians would agree that some amount of individualized decision making must be left to the physician, it is extremely difficult to quantify such autonomy. Furthermore, the insurance companies Brock praises for encouraging rationing would never approve of such broadly given power.

Not only is this evolution of the physician's role at odds with insurance companies, there are also debates within the medical community about the role of the physician. As Dr. Fred Rosner notes, the 1980s American Medical Association Principles of Medical Ethics "bases the patient-physician relationship on the model of a contract" (Rosner, 1993, p. 24). While this was updated in the 2001 revision to "regard responsibility to the patient paramount", the AMA principles still maintain that a physician can decide in the first place if he or she wishes to treat a patient outside of emergencies (Veatch & Haddad, 2010, p. 422).

In contrast to these debates, the Jewish perspective is generally more unified. While Halacha acknowledges the physician's role to be the patient's advocate, it does so as a covenant, not a contract, and without the possibility of exemption from duty. The doctor has an obligation to "*always* extend help to those in need of medical services" because she "is God's messenger in healing people in need." (Rosner, 1993, p. 24) This means that a

physician cannot refuse to treat a patient, and once he or she has taken them on, they must do everything in his or her power to heal that person. Furthermore, this prohibits physicians from participating in the bedside rationing which Brock praises, and instead requires them to use every last resource.

Rule of Rescue

Brock also highlights the rule of rescue, defined as "the psychological disposition not to let an identified person in imminent peril die or suffer very serious harm when we have the ability to save them or to prevent that harm" (Brock, 2007, p. 137). Brock does not provide his opinion as to whether the rule of rescue should be instituted, nor is he able to present a consensus of what most secular ethicists would say on the issue. Jewish Law on the other hand seems to have a clear position on the rule of rescue. First, the abovementioned covenant between physicians and God requires a doctor to treat any patient. Furthermore, the rule of rescue in Judaism applies even to non-physicians. In the Tractate of Baba Metzia in the Talmud, there arises a question concerning two people lost in the desert with enough water to save one of them. One personality in the Talmudic discussion, Ben Patura, says the two should share the water even if both will die. Another, Rabbi Akiva, says the owner of the water should take it all for himself based on a passage in Leviticus 25:36, which states "that thy brother may live with thee". Rabbi Akiva interprets "with" as the important part of God's statement, indicating that a person first must save himself for there to be someone for the saved brother to live "with". The passage concludes that the law is in accordance with Rabbi Akiva, and that the preservation of one's own life takes priority. However, the Chazon Ish says if there is a *third* party who owns the water and does not need it for himself the rulings of Patura and Akiva can be extended. Akiva's ruling would allow the third party to choose which of the other two to give the water to, and then that person would own the flask and would be obligated to preserve his own life ("Insights to the Daf" n.d; Rosner 1993). Rabbi Eliezer Waldenberg explains how this scenario is to be applied to medical Halacha. He sides with Patura rather than Akiva and says those in a position to provide care are likened to a third party who is choosing how to donate their water and must ration equally between two dangerously ill patients in the hope that God will intervene after the temporary extension of life (Steinberg & Simons, 1980). Here we see again that while there is disagreement for both secular and Jewish ethicists regarding the rule of rescue, Halacha has a greater chance of coming to an agreed upon conclusion. Since there is an agreed upon origin, the debate in Jewish law revolves around the specific question of interpretation of the rule of rescue rather than whether it applies at all.

Worst Off

Many secular theories and most religions include some preference for treating the "worst off" first in their approach to triage. There is a multitude of conflicting opinions proposed by secular ethicists, and I will treat each of these in turn while highlighting the unified view of Halacha. Typically, the term worst off means "the poorest and the sickest" which are often one and the same (Brock, 2007, p. 143). Brock notes that even "if we decide to sacrifice some aggregate health benefits to ensure that the worst off are treated, we are still left with the unresolved problem of how much aggregate health benefits we should be prepared to sacrifice to do so." (Brock, 2007, p. 143)

Persad et al. believe that used by itself, a sickest-first allocation is flawed as it "ignores post-treatment prognosis: it applies even when only minor gains at high cost can be achieved." (Persad, Wertheimer, & Emanuel, 2009, p. 424) In addition "it myopically bases allocation on how sick someone is at the current time—a morally

arbitrary factor in genuine scarcity." (Persad, Wertheimer, & Emanuel, 2009, p. 425) They conclude that this method is "inherently flawed" and should be excluded from allocation systems (Persad, Wertheimer, & Emanuel, 2009, p. 427).

This conclusion is directly at odds with the Jewish perspective. Dr. Abraham S. Abraham, writes that "if one patient would certainly die if left untreated and the other only questionably, then the physician should treat first the patient who would otherwise certainly die" (Rosner, 1993, p. 90). However, he qualifies his stance on sickest first with respect to prognosis. If one has a good chance of surviving while the other will likely die even with treatment, we should treat the former. Additionally, he adds that a physician cannot interrupt a treatment in progress, even to save a patient who would benefit, if it would "hasten the death of a person" (Rosner, 1993, p. 95). The Tzitz Eliezer limits the idea that medication be provided to a dangerously ill patient over a possibly dangerously ill patient with the aforementioned qualification of ownership. If the medication belongs to the possibly ill patient, he can choose whether to give it to a sicker patient (Steinberg & Simons, 1980). The Jewish view is thus in uniform agreement that sickest first is an important principle in ethical resource allocation even though it requires some qualifications in practice.

Persad et al propose that the other form of favoring the worst off is to show preference to the youngest first. The authors argue that this is a just form of allocation since it "directs resources to those who have had less of something supremely valuable—life-years." (Persad, Wertheimer, & Emanuel, 2009, p. 425) They note that while some will view this as biased towards a certain group, it is in fact fair because everyone ages. However, they qualify their approval of youngest first by stating that they do not believe infants have the same claim as others to life years since they have not developed. The authors state that it is "intuitively worse" for a twenty-year-old to die than an infant (Persad, Wertheimer, & Emanuel, 2009, p. 425). They conclude their analysis of youngest first by saying it "ignores prognosis, and categorically excludes older people", so it should "be combined with prognosis and lottery principles in a multiprinciple allocation system." (Persad, Wertheimer, & Emanuel, 2009, p. 425)

This is another area where the opinion of Persad et al seems to be directly at odds with the Halachic perspective. As Rabbi Moshe Feinstein notes, age should not be a "factor in triage considerations". Instead, he argues that the "only acceptable criterion is medical suitability, not the length of survival, for survival is in the hands of Hashem [God] and has to do with the individual's [ordained] lifespan." (Feinstein & Tendler, 1996, pp. 66-67) According to this viewpoint, a physician must do all he can at the present moment, but cannot presume to know what will happen in a patient's future. Though a patient may be cured today and be given apositive prognosis, God may still cause him to die prematurely. Rabbi Feinstein goes so far as to assert that age "be discounted completely in all medical decisions" (Feinstein & Tendler, 1996, p. 67).

Social Usefulness

Another pair of concepts proposed by Persad et al. is promoting and rewarding social usefulness. Unlike the other values listed which the authors believe could in theory be used independently to allocate resources, they believe that social value cannot be used independently since it first requires a consensus on what societal values are useful. The first form of social usefulness they examine is the instrumental value, which "prioritises specific individuals to enable or encourage future usefulness"

(Persad, Wertheimer, & Emanuel, 2009, p. 426). The authors acknowledge that the approach is insufficient "because it derives its appeal from promoting other values," and because people disagree about how to define usefulness. Despite its shortcomings, they believe it can be appropriate "where a specific person is genuinely indispensable in promoting morally relevant principles" (Persad, Wertheimer, & Emanuel, 2009, p. 426). Their second proposal is reciprocity, or allocation based on previous usefulness. Again, the authors believe there are shortcomings to this idea, such as "time-consuming, intrusive, and demeaning inquiries", but nonetheless conclude it could be used in conjunction with other allocation principles (Persad, Wertheimer, & Emanuel, 2009, p. 426).

The idea of social usefulness perhaps comes the closest to the Jewish view on allocation. Like the secular view, Halacha proposes a combination of allocation principles. However, as we have seen, Jewish law has an easier time ascribing weights to these principles. As such, it ranks rewarding social usefulness right behind sickest first. In addition, Jewish law prescribes specifically in the Mishnah in Horayot 3:7-8 that the order of treatment for patients *of equal chance for survival* is male before the female, Priest before Levite, Levite before Israelite, and sage before commoner. Though the Mishnah is not explicit in the reason, the commentators easily parse it out, noting that orders of preference are based on holiness (Rosner, 1993).

While it is clear that Halacha advocated a hierarchical system of some kind it was almost always circumvented in practice. To begin, this ranking only applies when two people are present simultaneously with the same condition. In addition, it is extremely time-consuming if not impossible to deliberate which category a person fits today. The tribal lineages are no longer clear and few are ready to pronounce one man a sage and another an ignoramus. In the case of men being prioritized before women, the Magen Avraham questions whether we can assume that just because men are required to fulfill more commandments then women, that a specific man does indeed fulfill more than a specific woman (Rosner, 1993). Despite this practice of circumvention, the codification of these ideas provides groundwork for Halachic ethicists to delineate modern day rules.

Equality

Persad et al propose that lotteries are a very useful tool for decreasing bias in rationing, but they are insufficient on their own as they are blind to all the other principles mentioned (2009). Jewish law would have no issue with using lottery as long as it was subservient to the ideas of sickest first and the hierarchical rules mentioned above. The second method Persad et. al. mention for rationing equitably is first-come, first-served. They note that The American Thoracic Society describes this system as "a natural lottery—an egalitarian approach for fair [intensive care unit] resource allocation" (Persad, Wertheimer, & Emanuel, 2009, p. 424). However, the ATS and Persad et al. believe it "allows morally irrelevant qualities—such as wealth, power, and connections" an unfair advantage in receiving care and therefore do not advocate for its use in rationing (Persad, Wertheimer, & Emanuel, 2009, p. 424). Thus, of the two options proposed to reduce bias, only a part of one is viewed as legitimate.

The Halachic position on first-come, first-served is quite different from the position of Persad et al. Whereas Persad et al. recommend excluding this principle from an allocation system, Jewish law supports its inclusion. It is unclear, however, what weight to give the principle of first-come, first served. When two patients arrive at different times for treatment, first-come first-served is used. If they are waiting for the

physician, then regardless of who was earlier to wait in line, the hierarchical rules take precedence (Rosner, 1993). There is some debate whether this principle is only customary or truly a Halachic rule. Regardless, this principle highlights the idea that Jewish law is, in general, against cessation of treatment. Even if first-come, first-served is only a custom, and *not* a binding obligation, it is clear that someone who is in the midst of being treated may not be put in a life threatening situation to attend to a later arrival (Rosner, 1993). In this sense, first-come, first-served is even more concrete in Jewish law.

Maximizing Total Benefit

The last principle proposed by Persad et al is the idea of maximizing total benefit. The first method of doing so is maximizing the number of lives saved. The authors conclude that this idea is "insufficient on its own" (Persad, Wertheimer, & Emanuel, 2009, p. 425). The other methods to maximize total benefits are life years of patients and prognosis of patients. The authors realize that prognosis or life-years saved are also insufficient alone. Again, we see Persad investigating multiple principles for rationing without being able to fully advocate any one of them.

Jewish law would seem to disagree with the authors of *Principles* regarding maximizing total lives saved. The whole basis for life-saving in Jewish law is from Leviticus 19:16 "Do not stand idly by as your friend's blood is shed". If it is bad for us to allow one person's blood to be shed, how much more so we should be concerned when many are dying. This would indicate that as many lives as possible *should* be saved. In addition, since the saving of a life is also based on fulfillment of more commandments in the future, it would make sense that prognosis should be a factor as well. That said, Jewish law would probably have more restrictions on the inclusion of these other principles. Firstly, maximizing total benefits could lead to ignoring the treatment of the sickest first. In addition, the aforementioned views on how to weigh the age of a patient indicate that prognosis cannot be used too much for allocation, as the physician should consider God's control of a patient's survival.

Conclusion

Jewish medical ethics are based on analysis of Jewish law which, although it is "dynamic" and subject to different interpretation, provides a solid foundation. For almost all of the principles of rationing healthcare resources that were examined, there was disagreement amongst secular sources. While some debate exists among Jewish medical ethicists, there appears to be greater consensus to favor the principles of sickest first, a hierarchy of holiness and first-come, first-served. When questions of resource allocation and medical ethics arise, the Jewish approach has a point of origin to refer back to in order to parse out the particular applications of Halacha. This difference highlights the need for research and agreement on a set of core concepts in secular ethics before the development of specific regulations for resource allocation.

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