Triage

Distribution of scarce resources is a problem that pervades modern medicine. Almost every medical action involves an element of prioritising: treatment given to one patient very often means less given to another; less time and attention or less availability of a scarce technology.

The problem has a wide reach: triage is practised not only at the immediate clinical level in the emergency room or at the roadside scene of an accident, but throughout the system – when a hospital administrator apportions a budget, triage decisions must be made. Is it appropriate to fund a clinic that practises pediatric preventive medicine in the face of a lack of intensive care beds? Should broad screening programs be funded while there are immediate acute needs that are unserved? It is axiomatic in medicine that "prevention is better than cure" – but is it acceptable to channel resources to the prevention of future disease in the face of present suffering that demands alleviation?

Indeed, at the broadest political level similar questions arise: may a society fund its parks and museums in the face of competing national defence or health needs? How are immediate lifesaving needs at the societal level to be balanced against broad economic needs that in the long run also affect life in a real way?

The Talmud[1] discusses the situation of a town with a water source that is sufficient for the town and others beyond, but only if the locals drink and do not wash laundry. If the locals drink and wash, there will be insufficient water for the more distant population. May the locals wash or are they constrained by halacha to drink only so that there will be water for the distant population to drink too? Although at first glance it may seem obvious that they should drink only, the Talmud records an opinion that holds that they may in fact wash as well. The reason is that if they do not maintain adequate hygiene there will be spread of disease among them that will present danger, and although that danger may not be quite as acute as the danger presented by immediate thirst, it may be taken into account. Although there are dissenting opinions in this scenario, it is apparent that broader considerations than the immediate and most obvious may be relevant to a community facing life and health risks.[2]

Some years ago, a couple suffering from long-standing infertility was assisted in conceiving and giving birth to a child by a hospital in Israel. The grateful father made a substantial donation to the hospital, stipulating that his money should be used by the hospital's fertility unit to assist other couples in similar circumstances. The hospital's director, however, declined the gift on the grounds that saving life ought to take priority over fertility treatment – surely, he argued, it cannot be right to spend limited funds in bringing children into the world when there are people already in existence whose lives are threatened by disease; those already-extant individuals should be treated first. The donor stood his ground and refused to make his contribution unless it were to be used for fertility treatment, and Rabbi Eliashiv was asked to adjudicate.

Rabbi Eliashiv ruled that the man was entitled to have his funds used for fertility purposes. When asked why that should take priority over lifesaving needs, Rabbi Eliashiv stated that a country needs a normal spread of facilities; if one allows only emergency needs, one risks developing an embattled mentality that may lower morale in a real way, and that too is a threat to a community. One cannot require this individual to contribute to a particular cause against his will; he may fund the service of his choice.[3]

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[1] Nedarim 80b.

[2] Issues of priority setting on the societal level are discussed at length in A. Steinberg, Encyclopedia of Jewish Medical Ethics, Vol. III, pp. 848-860.

[3] Related by Rabbi Y. Zilberstein.

Triage in the Acute Setting

Who takes priority in saving life when choices must be made among individuals?[4] Various selection criteria are relevant in halacha; the following are the main ones (where there is dissension, the majority view is presented; references are provided for minority views and further discussion).

There are two levels that require study here, namely, the criteria themselves and their organization in a hierarchy – each triage criterion assigns priorities, but beyond that, the criteria need to be ordered. Which criteria are to be applied first, or put differently, which priorities take priority? Building a hierarchy of priorities is a complex exercise; in the list that follows it will be pointed out where an element is decisive and where it may be equal or secondary to another, but it must be remembered that nuances of each scenario can affect the decision and mature halachic judgment is needed.

Unless indicated otherwise, each of the following criteria applies where it is the only consideration (each is subject to circumstances that may require it to be overridden).

Proximity *(ein ma'avirin)*

One of the most basic criteria in halachic triage is given by the principle of *ein ma'avirin al hamitzvot* – one may not bypass a mitzva, or put another way, when all else is equal, obligations are to be discharged in their order of proximity.[5] This principle can be superseded by a number of others (see below for examples), but it is a basic starting point. The principle states that when more than one mitzva require fulfilment, the one that is closer takes priority: if two patients need attention, the doctor must treat the patient who is physically closer to him – he may not bypass that obligation for an equal but more distant one. All else being equal, one does not bypass a mitzva.

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[4] See below, Appendix VI: Current Selection Criteria for Renal Dialysis and Transplantation for comparison with secular criteria.

[5] Igr. Moshe Ch. M. 2:75 as applied to seeing patients – the patient who calls first (or the patient closest to the doctor when there is no prior call) should be seen first.

In Hadassa hospital around 60 years ago, at the start of the modern antibiotic era, eight children with meningitis required treatment. There was unfortunately only enough penicillin for two children, and the doctors approached Chief Rabbi Herzog for his opinion on how to decide which two children should be treated. Bacterial meningitis has a high mortality and at that time penicillin offered a very good chance of cure; this was certainly a life-and-death question. Rabbi Herzog called Rabbi Moshe Feinstein in New York and they discussed the dilemma. Rabbi Feinstein indicated that the doctors should enter the children's ward and give the medication to the first two children they encountered. The first child should receive treatment – that child may not be bypassed; thereafter a similar consideration would apply to the second (the next closest) child; thereafter there would unfortunately be no medication left.[6]

Relatives

One is obligated to treat one's own family members before others (this is not specifically a medical obligation – one should also give charity and other assistance to one's relatives first).[7]

This criterion may be inappropriate in the usual hospital setting where applying a personal priority such as this may in fact constitute an infraction of the rules – in such circumstances a doctor would not be entitled to give priority to his own relatives.

Where this obligation does apply however, it will take precedence over the previously listed prohibition of not bypassing a duty; that is, all else being equal, one would have to bypass a stranger to treat one's own close relative.[8]

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[6] Rabbi Feinstein was of the opinion that the Mishna (Horiyos 13a) concerning a particular set of selection criteria was not relevant in this case. Rabbi Feinstein (Igr. Moshe Ch. M. 2:75) states that even where those criteria are relevant, proximity (or a prior call to see a patient) takes priority. Tzitz Eliezer (18:1) too relegates those criteria to limited circumstances.

[7] Deuteronomy 15:7 and Isaiah 58:7. For discussion of further priority criteria, see Ch. Sofer Ch. M. 127. For extensive discussion in English, see R. S. Taub, The Laws of Tzedaka and Maaser (ArtScroll, 2001) pp. 49-57 and note 1, pp. 50-51 for original sources.

[8] The halachic derivation of this point is beyond the scope of this work (the student of halacha will find it an instructive exercise).

Definite vs doubtful danger

A definite danger takes priority over a doubtful danger; treatment must be given to the patient who is in certain danger before one who is only possibly in danger.[9] As a corollary to this, if both are in equal danger but an available medication will certainly help one and only doubtfully help the other, it must be given to the one who will certainly benefit.[10]

This criterion may be set aside when the definite danger to a few is offset by a doubtful danger to many – depending on the degree of doubt and the numbers of people involved; see the next item.

Many vs. few

When many are in danger efforts to save them must take priority over efforts to save fewer; resources must be applied such that they benefit as many as possible.

Several subcategories can be distinguished here:

(i) Saving many with possible harm to few:

When saving many depends on *possible harm* to a few (that is, where there is a chance that attempts to save the many will actively harm others) more caution is needed although in principle such action may be undertaken with extreme attempts to avoid such harm. In the collapse of a building where emergency excavation is undertaken to save many who are buried in the rubble, but necessarily at the cost of the chance of injuring some in the process, it may be acceptable to proceed. Here, the decision must be based on the relative likelihood of saving many and the chance of actively injuring the few; work should proceed as far as possible in layers to give the maximum chance of rescuing those in more superficial layers before going deeper to reach others with the attendant risk of harming those still undiscovered in the upper layers.

(ii) Many doubtful vs few certain:

When a choice must be made between saving a few who are in definite need or many who may only possibly be in need, the relative probabilities become relevant, and the relative proximities will also modify the decision.

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[9] Pri Megadim 328; 7:1.

[10] R. M. Hershler, Halacha and Medicine Vol 4, p. 84.

A few examples will clarify this. A terrorist shot the guard at the entrance to a settlement and ran on into the settlement. A bystander was faced with the choice of stopping to help the guard who was seriously wounded or pursuing the attacker in an attempt to prevent many residents from becoming victims of a suicide attack. Rabbi Eliashiv was later asked what the correct choice would have been; his opinion was that under the circumstances described, pursuing the attacker would be the preferred option. Where there is almost certain to be an attack on many that could very possibly be thwarted, one should make that attempt.

However, a similar situation that occurred at around the same time elicited a different response. On that occasion, a terrorist injured an individual on the outskirts of Jerusalem and proceeded in the direction of the city. A doctor who arrived on the scene was placed in the dilemma of having to choose between helping the victim or pursuing the perpetrator who had disappeared by the time the doctor arrived. In this case, Rabbi Eliashiv's opinion was that the immediately threatened victim should be treated. Here there are many elements of doubt regarding subsequent events: there is no certainty that the terrorist will reach the city and achieve his aim – he may be stopped by others or fail to detonate his explosives; and in addition there is no assurance that the pursuers will find him or in fact be able to stop him. In such a scenario treating the definitely endangered victim who is here now takes precedence.

The general approach is that these scenarios need individual assessment: in each case the risks and benefits on both sides of the equation need to be weighed in order to reach an appropriate decision. The default position is that the definite takes precedence over the doubtful in halacha, even when the definite are few in number and the doubtful are many. However, when the odds are clearly in favor of benefit to the many the default must be altered; and the numbers of people in danger on both sides of the question are also relevant – the balance will shift if very many people are endangered.

Another example to illustrate this point: the victim of a road traffic accident needs attention, but there is an obstruction in the road threatening to cause further serious accidents. The rescuer must choose between attending to the injured victim or removing the obstruction. The correct choice here depends on the relative probabilities as assessed by the rescuer at the scene – if it is close to certain that further serious accidents are imminent, it would be proper to remove the obstruction

first. If it is not clear that this is the case, the victim must be stabilized first and only then the danger averted.[11] The default rule in halacha is to prioritise the definite and the immediate; where overwhelming danger exists to many however, even when that danger is not as immediate, this default may shift.

Where treatment has already begun

A patient who is being treated acquires a certain "right" to continued treatment;[12] where a patient has already begun receiving treatment one may not abandon that patient to treat another. Even where abandoning the patient involves adding no active element of harm this would not be allowed; it is certainly forbidden where the act of abandoning the patient would cause harm – where, for example, the patient will react to being abandoned with a sense of panic or hopelessness (such emotions are halachically considered real elements of danger to a seriously ill patient).[13]

This stricture applies even to abandoning a patient whose chance of salvage is doubtful for another who can certainly be saved, abandoning one who is terminal for another who could be salvaged in the long term, and abandoning one patient to treat many.[14] In all these situations, the patient who has already been admitted to an ICU (intensive care unit) or other treatment facility may not be moved out due to his poor prognosis in order to admit a patient with a better prognosis; once treatment has begun the patient has a right to its continuation.[15]

Where treatment has not yet begun, one may bypass a non-salvageable patient to treat a salvageable one, and bypass one to save many (the

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[11] Rabbi Y. Zilberstein.

[12] Igr. Moshe Ch.M. 2:73.

[13] Igr. Moshe Ch.M. 2:73 and 2:75.

[14] At a mass disaster scene, one may not leave one patient who needs lifesaving attention once treatment has begun to move on to assess others (this may conflict with some current triage protocols; see below, p. 184).

[15] This applies even where the first patient was improperly admitted, whether deliberately or in error. In addition, the first patient, once admitted, has no obligation to make way for the second even where the first patient's prognosis is poor and the second's is good; indeed, he may be forbidden to do so (Igr. Moshe Ch.M. 2:73). See Salvageable vs non-Salvageable Patients, p. 178.

principle of *ein ma'avirin* is set aside in these circumstances), provided that the act of bypassing causes no active harm.[16]

However, it is permissible to move one patient from an ICU to a lower care ward if that would facilitate the treatment of many, but only where the lower care ward offers a *fully adequate* level of care. One does not always have to provide the highest level of care as long as the care offered always meets rigorous objective standards.[17]

Healthy vs ill

Where two are in danger and only one can be saved, the healthier patient should be saved;[18] for example, when only one can be saved from a fire or other danger.[19]

However, if saving the sicker patient will enable *both* to survive, of course that must be done. In an emergency evacuation situation, where evacuating the sickest first will result in saving maximum lives (because the healthier will survive while the more fragile are being evacuated) that is what should be done. But when it is apparent that moving the sicker patients out first will leave the healthier ones to die, the priority becomes to save the healthier (this has been termed "reverse triage.")[20]

Salvageable vs non-salvageable patients

Salvageable patients *(chayei olam)* are given priority over the non-salvageable *(chayei sha'a)*.[21] One may bypass the non-salvageable to

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[16] For example, where the patient being bypassed will become anguished or panic-stricken at the realization that he is being abandoned due to the hopeless nature of his condition (Igr. Moshe Ch.M. 2:73). See p. 180 for details.

[17] This is not necessarily in conflict with the statement of the Birchei Yosef (336) who says that a patient must request the services of the most expert physician available – as the Tzitz Eliezer explains (Ramat Rachel 5:22), that condition is probably mandatory only in situations where no objective standard of medical practitioners' qualifications exists; however, where all available physicians are stringently required to meet certain minimum standards (as with modern accreditation requirements), this would not be necessary.

[18] Yaavetz, Migdal Oz; Otzar Hatov 91.

[19] M. Berurah 334:68.

[20] See Anatomy of a Disaster, p. 271.

[21] See Clinical Case 21, p. 191 for derivation of this priority.

reach the salvageable[22] (provided no harm, physical or emotional, is done to the non-salvageable in the process; see below).

Rabbi Moshe Feinstein was asked about the following situation. Two patients require treatment; one is a *chayei sha'a*, terminally ill, and the other is a *chayei olam*, salvageable in the long term. Both need immediate ICU care: the former to prolong his temporary situation, the latter for observation and prevention of a sudden dangerous event (for example, a life-threatening cardiac arrhythmia), and although he may survive without ICU monitoring (he may not experience the event), if he does there will not be adequate time to get him into the ICU and he will die. (This can be summarised as a "certain *chayei sha'a*" against a "doubtful *chayei olam.*") Who takes precedence?

Rabbi Feinstein writes that if both cannot be admitted to the ICU, the long-term salvageable patient should be given priority. However, if the one who is expected to survive only for the short term *has already been admitted* to the ICU, it is forbidden to move him.[23] Once he has begun to receive treatment, that treatment is now being appropriately given; since the hospital's mandate is to treat all those in their care, each patient in his own right, he may not be set aside for another. This applies even if the first patient was wrongly admitted, whether in error or deliberately; once he is there, the place is "his." In addition, this applies whether the patient already receiving treatment is paying or not; if that particular healthcare system delivers therapy to all patients equally, irrespective of payment (that is, if the system is ordinarily obliged to treat such a patient where no more salvageable patient happens to be present), even if that patient is indigent he is fully entitled to the therapy he is now receiving and financial considerations may not be used to "sideline" him in favor of another.

Furthermore, the patient who is now receiving priority has no obligation to sacrifice his place for another patient even when that other patient has a better chance of long-term survival. Indeed, such sacrifice may be forbidden.

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[22] The principle of prioritising *chayei olam* over *chayei sha'a* takes precedence over the principle of not bypassing a mitzva. The derivation of this precedence is beyond the present scope; see also p. 174 and note 8 there.

[23] Igr. Moshe Ch.M. 2:73.

Rabbi Feinstein points out that all this applies only if the less salvageable patient has *already been admitted* and his treatment commenced. If however treatment has not begun; for example where the patient has not yet been admitted to the ICU, and the more salvageable patient arrives subsequently, the second should be given priority. Although the less salvageable patient arrived first (so long as he has not yet been admitted to the unit), he is set aside in order to save the one who can be saved in the long term.

But this has an important exception: if the first patient is *conscious and aware that he is being set aside*, that may not be done – Rabbi Feinstein states that in such a case the first patient is likely to perceive his situation as hopeless ("I am being abandoned; I am probably incurable...") and that anguish and despair constitute real additive lethal effects in situations of desperate illness. (In halacha, since pain, anguish, depression and hopelessness are regarded as material factors affecting survival, the physician who ignores the significance of such factors may be guilty of adding to his patient's lethal burden.)[24]

What is the default assumption in such situations? Rabbi Feinstein is of the opinion that one should generally assume that a patient who perceives that he is being set aside for another patient who arrived later will panic or experience a dangerous feeling of hopelessness; therefore unless it is clear that the second patient can be advanced ahead of the first with no compromise of the emotional condition of the first, the default handling of such situations is to treat patients in order of arrival – "first come, first served." This avoids the possibility of causing dangerous anguish to an abandoned patient.

Note that in selecting a *chayei olam* over a *chayei sha'a*, nothing may be done that actively shortens the life of the *chayei sha'a.*

One salvageable vs. two non-salvageable patients

The Chazon Ish was of the opinion that one person's *chayei olam* should take precedence over two people who have only *chayei sha'a*. He demonstrates this based on the Talmudic discussion[25] of two people

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[24] One may not inform a terminal patient of the gravity of his situation where that knowledge may cause anguish or despair (Igr. Moshe Ch. M. 2:73).

[25] B. Metzia 62.

threatened by thirst where one is in possession of enough water for only one to survive. There the question is whether the owner of the water should drink it and survive or share it with the other person to give both an extended but only temporary prolongation of life. The definitive conclusion is that the owner of the water should use it to save his own life. The Chazon Ish points out that in effect this ruling is teaching that a person is obliged to save one (himself, in this case) for *chayei olam* rather than enable two to survive for only a short while; based on this the Chazon Ish rules that if the water is in the hands of an outside third party, that third party should likewise give it to only one of the two to enable one to survive in the long term (ownership of the water, in the opinion of the Chazon Ish, is not the deciding factor in the original scenario). In other words, one *chayei olam* takes precedence over two *chayei sha'a*.[26]

First come, first served

Patients should be seen in the order in which they arrive when other factors (such as urgency) are equal.[27] The source for this is the general Torah obligation of fairness and decency.[28] [29] Since a physician is obliged to respond to a patient when called, a patient who calls first should be seen first (unless a subsequent call is to attend to a more urgent case).[30]

Men or women first

Although lifesaving priorities are given in the Code of Jewish Law (in the context of redeeming hostages)[31] among one's mother, father, Torah teacher and others, much of this is not relevant in medical triage.[32]

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[26] Chazon Ish, Ch. Mishpat, Likutim 20.

[27] See Nishm. Avraham Vol. II, p. 181-185 for details and numerous exceptions.

[28] "And you shall do the straight and the good..." (Deut. 6:18).

[29] R. Y. Zilberstein.

[30] Igr. Moshe Ch. M. 2:74.

[31] Sh. Aruch YD 252:8:9.

[32] Igr. Moshe Ch. M. 2:74 and 2:75 indicates that those criteria are subservient to others and hard to apply. See also Minch. Shlomo Tinyana 86:1 and Tzitz Eliezer 18:1.

With regard to gender, Yaavetz discusses the question of whether a boy or a girl takes priority; he quotes Maharam Katz and disagrees with him.[33] This debate does not have major medical application;[34] however in certain circumstances such as assigning priority in the case of a cosmetic procedure, there may be a gender preference.[35]

In the case of fetal reduction[36] too, no priority is given to either gender (even if priorities were established according to the criteria discussed in Horiyos 13, these are not relevant to fetuses).[37]

Age

Old age is not a valid criterion for assigning a patient lower triage priority.[38] (Even extremely old patients must be treated fully and aggressively, and even where a patient himself claims advanced age as a reason to be allowed to die, such a claim is not valid.)

Other factors – marital status

Other issues may raise triage questions too: during the 1948 war in Israel, a volunteer was needed for an extremely dangerous mission. The commander responsible for selecting the volunteer sent an urgent question to the Chazon Ish: who should be sent – a married or an unmarried man? The Chazon Ish indicated that it is preferable to send a man who has children – one who has already fulfilled the mitzva of procreation rather than a single man who has no progeny.

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[33] Sh. Yaavetz 68 and 69. See Yaavetz Migdal Oz; Otzar Hatov 91 for a list of triage priorities, including the issues of younger or older, adult or child, old or ill, and various others.

[34] See note 32 above.

[35] Rabbi Zilberstein gives priority to a girl over a boy in the case of cosmetic surgery for a facial deformity.

[36] See Fetal Reduction, p. 93.

[37] Rabbi Eliashiv states that the criteria of Horiyos 13 are not applicable to fetuses because (among other reasons) they are not yet obligated in mitzvot (and the hierarchy of precedence in Horiyos is based on relative levels of mitzva obligation).

[38] Igr. Moshe Ch.M. 2:75. But see note 33 above.

Military triage

Military situations are predicated on a different calculus with respect to a number of the criteria listed here.[39] In terms of the two principles of definite vs doubtful danger and many vs few, the following example provides an illustration.

A senior military medical officer was sent into Lebanon with a group of soldiers during the conflict there. He was the only doctor accompanying the group, although he was assisted by a military medic trained in basic medical skills. Soon after crossing the border one of the soldiers in the group was injured, and the doctor assessed his condition as so serious that if he arranged a helicopter evacuation to hospital in Haifa the man would probably survive, but only if he accompanied him personally; sending him with the medic would mean almost certain death for the injured man. But in order to accompany the soldier he would have to leave the rest of the soldiers in the field without a doctor, and he found himself in an acute dilemma. What was his primary duty – to the injured man, or to provide the medical cover for the group that was necessary to facilitate their mission?

(In the event, the decision was taken out of his hands: a large helicopter arrived and evacuated the entire group.) The doctor subsequently sought halachic insight into his dilemma, however, and Rabbi Eliashiv was consulted. Rabbi Eliashiv stated that in the equivalent civilian situation, there is no question that the proper course of action for the doctor would be to accompany the injured man personally. The reason is clear: a definite danger takes priority over a doubtful one – this man is *certainly* in danger now, while there is only the *possibility* that others may be injured later. However, said Rabbi Eliashiv, in the military situation, that consideration does not apply: the doctor must stay with his men.[40]

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[39] See also p. 59.

[40] This case also raises the issue of the *certain few* vs the *doubtful many* discussed above: one man was definitely in danger, but there existed the possibility of many being injured later. (Although that is certainly relevant in military situations, it may not be the overriding deciding factor.) Detailed analysis of the halacha in wartime is beyond our present scope; see Preemptive War in Jewish Law in R. JD Bleich, Contemporary Halachic Problems Vol. III, especially pp. 275-278.

Conflict with Secular Protocols

Some established principles of modern triage may not accord with halacha.[41] For example, where a triage protocol calls for assessment of all the injured at a disaster scene before definitive treatment is given to any particular patient,[42] this may mean passing over a seriously injured patient who needs immediate treatment in favor of assessing the remaining victims. The logic for this system is to facilitate finding as many of the seriously injured as possible; this would be hindered by stopping the triage effort to treat an individual definitively. However, in halacha this may not be correct: if, during a triage effort, an individual is encountered who needs immediate care and will die if the triage doctor moves on, the doctor may not leave that patient, not even in the effort to find others who may be equally in need. This definite patient takes priority over the other possible ones. Generally, the patient who is clearly in immediate need of lifesaving treatment may not be abandoned to continue the triage assessment; this is certainly true where the patient in immediate need has already begun receiving at least some form of treatment so that moving on would constitute an act of abandonment with lethal consequences.

[41] See below, Appendix VI: Current Selection Criteria for Renal Dialysis and Transplantation.

[42] See for example: Hogan, DE, Burstein JL. Disaster Medicine, 2nd ed. (Lippincott, Williams and Wilkins, 2007); chapter 2. In mass disaster triage, rapid initial assessment of each victim typically takes 15 to 60 seconds.

Clinical Cases – Triage

Clinical Case 19: Triage: Many vs Few and Definite vs Doubtful

An ambulance is despatched to attend to an injured child. En route the ambulance crew receives a call to proceed to the scene of an accident in which five adults have been injured; the extent and severity of their injuries is unknown.

Should the ambulance continue to the child or divert to the injured group?

Analysis:

The answer to this type of question depends on the relative likelihood of the various options in the best judgment of the personnel involved. Factors to use in deciding should include: (1) relative numbers of injured – all else being equal the greater number should be given priority; (2) relative severity of injuries as far as can be determined; (3) where these are doubtful: proximity – whichever need is the closer. In this case, where the severity of injuries is unknown, the ambulance should probably continue its journey to the child if that is the closer destination.

See "Many doubtful vs few certain" (page 175) for comparison with other cases with differing relative variables.

Clinical Case 20: Disaster Scene Triage

A young lady doctor found herself applying lifesaving pressure to a severed artery in the neck of a child at the scene of a terrorist attack. It was clear to her that if she abandoned the child she would almost certainly be able to save others. Should she abandon this single individual in order to save many, or is she forbidden to abandon him since that would directly bring about (or at the very least, allow) his death?

Analysis:

A question that must be answered here is whether desisting from applying pressure to a bleeding vessel is to be considered actively causing death or passively allowing it to occur – is the removal of a finger in that situation an act of killing or merely the discontinuation of saving? If it is the former it is clearly forbidden in halacha; if the latter, would it perhaps be proper where there are multiple other lives to be saved?

And further, even if the removal of a finger from a bleeding artery is sufficiently homicidal to render it forbidden when it is an isolated act, is that true where the finger is being removed in the very act of saving another life? The Chazon Ish was asked about the case of a car careening down a mountain road with failed brakes, heading towards a group of people. The driver had the option of steering the car to one side, but unfortunately only to a place where an individual was standing. Should he passively allow his car to continue into the group or actively turn and run down the individual?

In the course of discussing this case[43] the Chazon Ish makes the point that while one may not hand over an (innocent) individual to murderers to be killed[44] even in order to save many, it is possible that one may be permitted to deflect an arrow that is about to kill many away from them towards a single individual. The difference is that in the former case one is committing an intrinsically cruel act with a murderous result (of course only in order to save the many, but such an act nonetheless), while in the latter one is primarily performing an act of salvation – the primary act is that of deflecting the arrow away from its imminent victims, and that is an act of saving. Perhaps turning a car away from a group of people in its path is likewise an act of salvation (even when the consequence is that an individual will now be in the vehicle's path). Against this consideration, however, is the fact that deflecting an arrow (or turning a car) towards an individual is an act that will kill; handing an individual over to murderers is not a direct act of killing. The Chazon Ish does not come to a definitive conclusion on this aspect of the question. It seems however, that the Chazon Ish would agree to an act that saves a group while endangering a lone individual where that act of salvation is not one that *directly* kills the individual.[45]

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[43] Chazon Ish, Sanhedrin 25.

[44] See p. 189 and note 4 there.

[45] Perhaps changing the points on a railway line to deflect a train away from a track on which a number of people are standing onto a track where only one is standing may be an example – deflecting the train is an act of salvation, but it is questionable whether that act ought to be considered also the direct killing of the single individual. It would seem that deflecting an arrow directly towards a person is a more direct action than setting points that lead to a train's changing course.

In our case, where the intention is likewise to save the many, how should the action be construed? Should we see the primary act as the removal of the hand from the child's neck and therefore necessarily a forbidden act of abandonment (or worse), or should we see the primary act as the movement of the hand *towards* the many it will save and its withdrawal from the child no worse (and possibly better) than the act of deflecting the arrow towards the individual, and therefore ought to be allowed because its primary nature is an act of saving the many?

It seems that the former view is definitive here: releasing the pressure that is preventing catastrophic hemorrhage is forbidden, even when that act is also the beginning of a movement to save others.

There is another aspect to this question too. Rabbi Moshe Feinstein rules that a patient who has begun to receive treatment has a right to continue receiving that treatment, even where another patient would have taken priority were a choice to have been made before treatment began.[46] If two patients who both need intensive care arrive simultaneously at a unit that has only one available bed, the patient who is salvageable (*chayei olam*) should be treated rather than the one who is unsalvageable (*chayei sha'a*). However if the unsalvageable patient has *already been admitted*, he must not be removed – once his treatment has begun he has acquired the right to that treatment, even if he were improperly selected in the first place.

In light of this, it seems that the doctor would not be allowed to release the hemostatic pressure that is saving the child's life because since that treatment has begun the child has "acquired a right" to its continuation, quite apart from the fact that such an act may be considered homicidal in itself in the eyes of halacha. The presence of many others who could be saved (who should ordinarily be given priority) does not break that right; the doctor must not move. The doctor is therefore forbidden to abandon the patient who is currently receiving lifesaving treatment, even in the attempt to save others.

[46] See above, p. 179.