ETHICAL VACCINE DISTRIBUTION IN JUDAISM
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There is a well-known and often debated story in the Talmud about two men who are stranded in a desert with only enough water to save the life of one of them. The Talmud observes that if both drink from the water they will both surely die, so too if neither drink from the water. BUT if only one drinks the water that person will live.

The situation is further complicated by the fact that we are commanded to preserve human life, including our own at nearly all costs. We are NOT ALLOWED to take another person's life to save our own if that person is not actively trying to kill us.

So, in this terrible but not unimaginable scenario, who drinks the water?

The answer from our tradition is brutal but also straightforward, the person who is holding the water, it belongs to that person and therefore it is required that they drink it to save their own life.

The rabbis propose all sorts of potential exceptions that would allow the one holding the water to give it to the other and thereby save that other person's life; and yes there are ethical calisthenics that could make giving the water the other and sacrificing your own life kosher, but at the end of the day the intent of the mitzvah is clear, if you are holding the water and can only save one person you are obligated to save yourself.

As hard as that is the question is fairly simple in the eyes of Jewish law when you have limited supply of a lifesaving substance that you yourself need and you are in possession of it.

The question is much more complex if there is a limited public supply of a lifesaving substance, in our instance a COVID-19 Vaccine and you are tasked with determining who gets the vaccine first.

It's this more complex scenario that we are blessed to find ourselves in as we finally escape the dark tunnel of 2020 and head toward the light at the end of the tunnel that 2021 proports to represent.

It's both an interesting thought experiment and of course a real-world dilemma being considered by politicians, public health experts, medical ethicists and every human being on the planet. As with the early Talmudic example, Judaism has considered the question if not directly then by analogy for hundreds of years. I want to take some time this morning, following up on my sermon from last shabbat on the question, "Are Jews obligated to get the COVID-19 vaccine?" The answer is yes by the way, and it can be mandated according to Jewish Law.

This morning let's study the Jewish view on, "how to equitably distribute a vaccine that is in short supply?"

First reading from the text of, "Canada's COVID-19 Immunization Plan:
Saving Lives and Livelihoods"

"The goal of Canada's COVID-19 immunization response is to enable as many Canadians as possible to be immunized as quickly as possible against COVID-19, while ensuring that high risk populations are prioritized."

The plan further explains that by "high-risk populations" it means specifically, "the elderly, residents and staff of congregate living arrangements such as long-term care facilities, front-line health care workers, and those in living or working conditions with elevated risk for infection or disproportionate consequences, including Indigenous communities."

These are largely the people we are seeing vaccinated in Canada today and will see in the weeks and months ahead as the vaccine production ramps up.

From both a "purely ethical" and utilitarian perspective, you vaccinate most the vulnerable first – the elderly in nursing homes, and those who are caring for them. Most people seem to agree with this reasoning and have accepted it. But the challenge of who gets the vaccine next is much harder than who gets the vaccine first?

As a former US FDA administrator framed it:

"If your goal is to maximize the preservation of human life, then you would bias the vaccine toward older Americans. If your goal is to reduce the rate of infection, then you would prioritize essential workers. So, it depends what impact you're trying to achieve."

Of course, if you decide to prioritize "essential workers," you're hardly out of the woods.

The Canadian government stated that essential workers are those **"critical to preserving life, health, and basic societal functioning."**

Officially the "Canadian Essential Services and Functions Plan for Canada During the COVID-19 Pandemic" classifies critical infrastructure in Canada according to ten sectors:

1. Energy and Utilities
2. Information and Communication Technologies
3. Finance
4. Health
5. Food
6. Water
7. Transportation

8. Safety
9. Government
10. Manufacturing

Workers in those sectors alone make up perhaps as much as 15 million people a number that swamps the available initial supply of the vaccine. And we haven't begun to address the question of priorities within the "essential workers" category: who is more essential than whom? Do "frontline workers," those whose jobs involve the greater risk of direct contact with the public, take precedence? What about schoolteachers especially those who teach remotely? You might have noticed that education was not on the list provided by the Federal Government. They certainly are "essential" in that they relieve parents of childcare duties, but they don't face as much health risk as other workers. If you add educators, the list that's another 1 million people.

What about groups within the population that are economically disadvantaged or are the targets of discrimination? A strong argument can be made that essential workers or not their members suffer disproportionally from the pandemic and should therefore enjoy a higher priority than others. Perhaps they are closer to the 'most frail' category and should be slotted in after front line health care workers but BEFORE essential workers.

A report of the Hastings Center, an independent, nonpartisan bioethics research institute and think tank in New York argues "Ethical, epidemiological, and economic reasons demand that rationing approaches give priority to groups who have been structurally and historically disadvantaged, even if this means that overall life years gained may be lower."

Does halakhah (Jewish law) have any guidance to offer on these difficult choices?

In a recently published responsa or Jewish legal finding of The Freehof Institute of Progressive Halakhah they took up this very question and I want to walk you through their answers.

To be clear, no ethical tradition, even Judaism, can entirely relieve us of the responsibility to make decisions between competing goods. But halakhah does approach this issue on the basis of some broad principles that, if applied fairly, can help clarify the ethical confusion that confounds us.

The Freehof institute found that Jewish law can be interpreted to support any one of three different criteria for medical resource allocation.

The first criterion is that of the equality of all human life. If every *nefesh* is of equal value in the eyes of God and the Torah, then we are forbidden to make distinctions as to which lives are more worthy of saving than others. While this criterion is morally unimpeachable – are we all not created in the divine image? – it would deny communities the discretion to make thoughtful medical decisions, leading to waste of resources and would ultimately lead to more, rather than fewer, deaths.

The second criterion is that of social value: medical resources are to be allocated in such a way as to improve society. The goal is to act not only to save individuals but to save (or benefit) the right individuals, those who will contribute the most to the general welfare. The obvious problem with this criterion is that the definition of the general welfare – what justice or equity or utility demands in any particular instance – is invariably a matter of controversy. No matter which version of "social benefit" we favor, we will inevitably end up discriminating against some individuals or groups. What then becomes of our commitment to human equality?

The third and final criterion is that of medical efficacy. The practice of medicine (r'fu'ah) is an element of the mitzvah to preserve and protect human life (pikuaḥ nefesh). It follows that we should structure the practice of medicine in such a way as to make it more effective, to save more rather than fewer lives. This is the principle behind medical triage, and it is the best justification for discriminating among individuals. That is, if all lives are of equal worth, the only acceptable warrant for denying or delaying medical treatment for some or many of them is a purely medical one: the goal of *pikuaḥ nefesh* is better served if we prioritize treatment for those who need it the most, as opposed to those who can wait, or for those whom we are more certain that we can save, as opposed to those who are more likely to die even if they receive treatment.

The Freehof Instutute concluded that the best interpretation of the Jewish tradition on these issues is a combination of criteria #3 and #1. The rationing of lifesaving resources should be based as much as possible upon strictly medical criteria. At the same time, we should never lose sight of the fundamental Judaic commitment to the preciousness of each and every human life.

So then how do these principles apply to the distribution of COVID vaccines? Who then shall go first? Should priority be given to those who face the greatest risk of death – older persons, those with underlying medical conditions, and the like – or should the emphasis be placed upon those "essential workers" so as to limit the spread of the disease? And what about considerations of racial and social justice? Groups within the population that are economically disadvantaged or are the targets of discrimination can make a strong argument that their members suffer disproportionally from the pandemic and should therefore enjoy a higher priority than others.

To this last point about those economically disadvantaged and or targets of discrimination, its a laudable position, but it runs counter to the message of Jewish tradition. Medicine's *raison d'etre* is first and foremost to save lives. Allocation decisions must be justified by that rubric, as opposed to other criteria, however worthy those may be.

The Freehof Institute argued that in determining who gets the vaccine and when, communities must practice medicine and not social reform. None of this is to say that considerations of race or economic class are irrelevant to this discussion. Sadly, they figure prominently in matters of public health, and those of us who call ourselves liberals or progressives would hardly think

otherwise. But these demographic realities ought to figure in allocation decisions only to the extent that they are medically significant.

For example, an identified racial or class group may be particularly vulnerable to COVID due to any number of factors (nature of employment; need to use public transportation; lack of adequate healthcare; dense living conditions make it impossible to socially distance; etc.). Members of that group, along with their families, should receive a correspondingly higher priority for vaccination, not specifically because of their racial or class identity and not out of an otherwise laudable desire to rectify past discrimination but simply because the data show that they are relatively more vulnerable to contracting the disease.

By contrast, members of more advantaged racial or class groups may justifiably be ranked lower on the priority scale precisely because they can socially distance and because their work does not expose them to a comparatively high risk of contracting the virus. The point is that medical decisions ought to be based as much as possible upon strictly medical criteria or, at the very least, criteria that can be reasonably defended on legitimate medical grounds.

No thoughtful person would claim that the practice of medicine exists in a vacuum, in splendid isolation from the social and economic realities in which we live. But in a situation of scarcity, when we have to make agonizing, potentially life-and-death decisions of resource allocation, we tread upon shaky ground when we base those decisions on inherently controversial measurements of comparative social worth.

When the Torah, as read by the Rabbis, establishes for us a duty to rescue those who are in danger as in Leviticus 19:16, when we are commanded “not to stand idly by the blood of our neighbor” it does not condition that obligation upon the endangered person's social or financial status, nor does it try to calculate the relative age or life still ahead of them of the people who are in equal peril. The only factor that counts is that she or he is a fellow human being in need of our help.

The greatest mitzvah, the one that outweighs all the others is to save human life. It is to that end, to save lives and, indeed, as many lives as we can. Jewish ethics therefore argue that we should allocate the coronavirus vaccine to save the most lives possible; the sequencing or triage of the distribution of the vaccine should be governed by those most at risk or those most essential to enabling us to continue to save lives and to work backwards from there.