Thank you for joining us for today’s webinar

*The program will begin at 1 p.m. ET.*

Catholic health care is on the front lines responding to the coronavirus outbreak in the United States. During this time, we pray for all those affected by the virus. CHA has created a web page with information, prayers and resources from our members and other reliable sources related to COVID-19, available at:

www.chausa.org/coronavirus
Making Ethical Choices With Limited Resources: Lessons From Catholic Health Care

April 1, 2020

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A Blessing for Caregivers

May you see with tender eyes the wounds of those before you.
May you hear with well-tuned ears, the unspoken needs of those whose voices are muted.
May you hold with gentle hands the bodies and the spirits of those you care for.

May the beauty of soul,
The strength of spirit,
The wholeness of being
Lead you, inspire you
And let you know your own
Beauty of soul,
Strength of spirit,
Wholeness of being.

May you know that as you care for others,
God cares for you, sees you,
Holds you tenderly.

Amen.
Today’s Moderator

Brian Kane, Ph.D.
Senior Director, Ethics
Catholic Health Association
St. Louis
Our Featured Presenters

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“First Order” Principles of Catholic Social Teaching

- Human Dignity
- Common Good
- Justice
What Does Human Dignity Mean?

• “Non-instrumentality”
• Persons as ends, not means
• A person’s innate value that is not diminished by age, race, social or economic status
• A defining boundary that cannot be violated by others
• The Great Equalizer: Human dignity as the most basic human quality that is shared by every single person
Human Dignity as Relational

“The human person, made in God’s image, is born into a *community of relationships* and is social by nature.

**Rights and responsibilities** are seen as the demands of upholding and defending human dignity in social, economic and political spheres.”
The Common Good

**Definition:** The sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfillment (Gaudium et Spes)

- Not the greatest good for the greatest number or the collective good
- Always takes precedence over private goods
- Family, loved as a shareable good, its good is my good
- God is the common good par excellence (Augustine)
- In Him alone, private and common good are one
Justice: A Many-splendored Thing

• A state ("a just society") and a virtue ("a just person")
• A web of interdependent relationships within a social unit, big or small
• Concerns relationships of
  – Individuals to the whole (contributive)
  – The whole to the parts (distributive)
  – The parts to one another (contracts)
Mutual Reinforcement

Justice → Common Good → Human Dignity → Justice
Operational Principles of Catholic Social Teaching
Meaningful Work

• Work has two dimensions: What it produces, and what it does to the worker.

• It is a primary means of achieving purpose and meaning in life.

• In the midst of challenges that we face in this pandemic, it is essential to keep in mind not only how we treat our patients, but also how we support our staff.
The Dignity of Work and the Rights of Workers

The economy is to serve people, not people for the economy

Work is a form of continuing participation in God's creation, not just a way to make a living

The basic rights of workers must be respected
Solidarity

• “We are all in this together.”

• It is a virtue. Persons in solidarity have a habitual view of their real relationships with one another, and act as if those relationships are real.

• Solidarity leads to a preference for the poor and vulnerable.
Subsidiarity

• Authority and decision making should be located at the appropriate (usually lowest possible) level of organization.

• Subsidiarity involves empowerment and participation.

• While we need to create larger structures in order to accomplish our goals, we need to keep delegating power to the lowest possible level.
Stewardship

• Rooted in the fact of creation and the “universal destination of human goods.”

• I don’t radically “own” anything.

• Extends to spiritual and non-material goods (e.g., tradition, mission) as well as physical goods.
Ethics Guidelines Regarding COVID-19

Kevin Murphy, Ph.D.
Senior Vice President
Mission Innovation, Ethics and Theology
CommonSpirit Health

April 1, 2020
COVID-19 | Common Ground in Guidelines

There are common source documents that a majority of many crisis guidelines utilize:

3. Utah Pandemic Influenza Hospital and ICU Triage Guidelines for Adults and Pediatrics (January 2010)
Decision Criteria | Common Assessment Tools

The types of criteria tools included in the Guideline Template are:

1. Exclusion Criteria for Hospital Admission
2. Sequential Organ Failure Assessment / Modified SOFA / APACHE Score
3. Inclusion Criteria for ICU/Ventilator
4. Glasgow Coma Score
5. Revised Trauma Score
6. Triage Decision for Burn Victims
7. New York Heart Association (NYHA) Functional Classification
8. PUGH Score
COVID-19 | Clinical Ethics Standard Work

1. Striving for strong regional collaboration.
2. A statement on patients treated with dignity and respect regardless of race, ethnicity, national origin, age, sexual orientation, gender identity, etc.
3. Recognizing need to attend to the vulnerable (Directive 3).
5. Separation for objectivity between Triage Team and Care Team.
7. Transition care plan when resources not allocated (ventilator). Emphasis on the care plan we can and will offer.
8. Transparency in communicating with patients and family members about decision making approach.
9. Universal DNR orders for all COVID-19 patients vs Unilateral DNR orders for individual patients.
COVID - 19 | Clinical Ethics Questions Arising

1. **Utilitarian Approaches**: (Greatest Good for the greatest number vs saving as many lives as possible with the resources you have.)

2. **Unilateral DNR**: Not as a policy for all patients (Risk for Caregivers) vs assessed within individual patient situations.

3. **SOFA**: Whether to use SOFA scores, Modified SOFA, or APACHEIII

4. **Age**: Not a categorical exclusion; one to consider among other factors.

5. **Disability**: Not a categorical exclusion.
COVID - 19 | Clinical Ethics Questions Arising…Continued

6. **Visitors**: Not permitted, exceptions possible in certain circumstances.

7. **Duty to Care**: Cases raised with clinicians’ refusals.

8. **All Things Being Equal**: a) First come, first served; b) some show a preference for health care professionals who can re-engage in health care delivery; c) years of life; d) lottery

9. **Appeal Mechanisms**: Many have something.
   A) Request to change approved triage process,
   B) Retrospective deviation from approved triage process,
   C) Reevaluation of patient because of incorrect/incomplete information, change in clinical state, or new information available.
Second Level Ethics | Frontier Territory

We will face complexity and tragedy in frontier territory.

We will attempt to “tame” it.

And...we will confront limits.
When we experience betrayal...

because some of our best attempts will be inadequate...

can we respond without blame or distance?
Second Level Ethics | Path of Blame

- Not a good patient!
- Am I a good clinician?
- Am I a good leader?
- Am I a good person?
COVID - 19 | Second Level Ethics

• Encounter Vs Technique
• Hope vs Despair
“Hope is not the expectation that things will turn out well; it is the belief that there is meaning no matter how things turn out.”

Vaclav Havel
Setting the Stage

Becket Gremmels, Ph.D.
System Director, Ethics
CHRISTUS Health

April 1, 2020
Second Order Principles

• Equity
  • All persons have an equal claim to receive the health care they need under normal circumstances
  • Triage and allocation decisions must be grounded in evidence-based, objective, clinical criteria on how to best meet those needs

• Transparency
  • The process for making decisions should be readily accessible and understandable by those affected by the decision

• Consistency
  • Triage decisions should be consistent between triage teams at the same facility
  • Consistency in practice between facilities in the same community engenders trust
Triage Team Structure and Responsibilities

System Triage Team
1. Review requests from Transfer Center
2. If transfer is approved, determine site — facility and unit — of treatment for patients
3. Provide consultation and support as requested by Regional Triage Teams

Regional Triage Team
1. Triage patients in the region
2. Whether to test a patient for COVID-19
3. Transfers between facilities in the region
4. Whether to contact Transfer Center
5. When to request review by System Team
6. How to allocate other scarce resources
Exclusion/Inclusion Criteria

• Hospital Admission Exclusion Criteria
  • Acute severe neurological injury
  • End-stage organ failure
  • Patient wishes
  • Volunteers?
  • Others

  Do not admit to hospital
  Send to alternate care site

• ICU Admission Inclusion Criteria
  • Requires invasive ventilatory support
  • Hypotension with evidence of shock

  Only admit these patients to ICU
Triage Algorithm

• Patient Categories
  • BLUE – alternate care site
  • YELLOW – intermediate priority
  • RED – highest priority
  • GREEN – alternate care site

• Sequential SOFA scores every 48 hours in ICU
Other Factors to Consider

• Patients too sick to receive a scarce resource should still receive other appropriate care, including curative treatments that are not scarce
  • Stems from human dignity

• Triage team members should not be caring for the patients in question
  • Mitigates conflict of interest

• Liability protections for triage team
  1. Governor’s order (e.g., Michigan)
  2. By statute if following state-endorsed triage guidelines (e.g., Virginia)
  3. Make triage team a peer review committee under the Medical Executive Committee
## Case Scenarios

<table>
<thead>
<tr>
<th>Status</th>
<th>Patient A</th>
<th>Patient B</th>
<th>Patient C</th>
<th>Patient D</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>48</td>
<td>82</td>
<td>18</td>
<td>68</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td><strong>Need for ICU</strong></td>
<td>Needs ventilator, on high-dose norepinephrine</td>
<td>Needs ventilator</td>
<td>Septic shock, 3μg/kg/min dopamine</td>
<td>Needs ventilator</td>
</tr>
<tr>
<td><strong>Comorbidities</strong></td>
<td>None</td>
<td>Severe emphysema, on home O₂</td>
<td>Hx of IV drug use</td>
<td>Class IV CHF, active MI</td>
</tr>
<tr>
<td><strong>Organ Failure Status</strong></td>
<td>Respiratory failure, ARDS, septic shock, and oliguric renal failure</td>
<td>Respiratory failure only</td>
<td>Septic shock only</td>
<td>Respiratory failure, heart failure</td>
</tr>
<tr>
<td><strong>SOFA Score</strong></td>
<td>13</td>
<td>3</td>
<td>4</td>
<td>8</td>
</tr>
</tbody>
</table>
Applying Policies and Principles Within Regions and Facilities

Leslie Kuhnel, DBe, MPA, HEC-C
Division Vice President
Theology and Ethics
CHI Health

April 1, 2020
Regional Approaches to Triage: Planning and Implementation
Local Responses/Local Responders
Network Triage Committee Approach
Remaining Questions
Thank you for attending

For additional information, prayers and resources related to COVID-19, visit: www.chausa.org/coronavirus

CHA Member Services is here for you!
(800) 230-7823 (M-F 8 a.m. to 5 p.m. CT)
servicecenter@chausa.org