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 webpage with information, prayers and resources from our members and other reliable sources related to COVID-19, available at:

www.chausa.org/coronavirus
Catholic Ethics and the Challenge of COVID-19

Co-sponsored by Georgetown University

April 16, 2020

DNR ORDERS FOR COVID-19 PATIENTS
Myles N. Sheehan, SJ, MD
G. Kevin Donovan, MD, MA

Pellegrino Center for Clinical Bioethics
Georgetown University

NONCONSENSUAL REALLOCATION OF VENTILATORS
Allen Roberts, II, MD, MA
G. Kevin Donovan, MD, MA

Pellegrino Center for Clinical Bioethics
Georgetown University School of Medicine
A Prayer for Persons Suffering From the Coronavirus

Merciful God, hear our fervent prayer for all who suffer from the coronavirus.

May those who are infected receive the proper treatment and the comfort of your healing presence.

May their caregivers, families and neighbors be shielded from the onslaught of the virus.

Give solace to those who grieve the loss of loved ones.

Protect and guide those who strive to find a cure, that their work may conquer the disease and restore communities to wholeness and health.

Help us to rise above fear. We ask all this through the intercession of Our Lady of Lourdes, and in the name of your Son, Jesus, and the Holy Spirit, now and forever.

Amen.
Our Featured Speakers

G. Kevin Donovan, MD, MA  
Director, Pellegrino Center for Clinical Bioethics and Professor of Pediatrics  
Georgetown University

Myles N. Sheehan, SJ, MD  
Lecturer, Pellegrino Center for Clinical Bioethics  
Georgetown University and Provincial Delegate for Senior Jesuits Maryland and USA Northeast Provinces

Allen Roberts, II, MD, MA  
Professor of Clinical Medicine, Associate Medical Director, and Chair of Ethics Committee  
MedStar Georgetown University Hospital
Catholic Ethics and the Challenge of COVID-19

DNR Orders and COVID-19

MYLES N. SHEEHAN, SJ, MD
G. KEVIN DONOVAN, MD, MA

PELLEGRINO CENTER FOR CLINICAL BIOETHICS
GEORGETOWN UNIVERSITY
Objectives

- Review basic principles of ethical decision making in Catholic health care ethics.
- Apply these to the situation of resuscitation decisions in COVID-19 positive patients.
- Review what is known about CPR and in hospital resuscitation prior to the current crisis.
- Consider different potential causes of cardiac arrest in COVID-19 patients and their underlying status to approach resuscitation.
- Understand which patients are candidates for CPR and those for whom it is not indicated.
- Ensure administrative backup and review.
You are an administrator who sits on a Catholic hospital's COVID-19 Response Team. The hospital's ICU director requests that the team issue a policy regarding use of CPR on COVID-19 positive patients.

The ICU director is concerned about ineffectiveness of resuscitation in some patients as well as risk of exposure to the virus to staff involved in resuscitation.

How do you think about this?
In-Hospital Cardiac Arrest and Resuscitation Pre-COVID-19

- Approximately 20% survival rate with in-hospital arrests overall; mechanical ventilation or use of pressors cut this in half.
- Best success is in settings of myocardial ischemia, myocardial infarction, and perioperative events.
- Worse prognosis for those with sepsis, renal failure, multiorgan failure.
- Resuscitation need not be offered to every person, if physicians feel that it would be futile … i.e., it will not restore circulation and breathing and/or chance of survival to discharge is vanishingly small.
- It has remained rare, however, that unilateral “Do Not Attempt Resuscitation” orders are used. The preference is for agreement with patients and surrogates.
COVID-19 Arrest Scenarios

- A previously healthy man in his fifties is receiving oxygen by face mask, with decreased O2 saturations has myocardial ischemia followed by ventricular tachycardia and arrest.
- A woman in her early nineties receiving oxygen by face mask, with underlying metastatic breast cancer, renal insufficiency, and heart failure, suddenly loses consciousness and is found to be in cardiac arrest.
- A 40-year-old woman has widespread organ failure, is maximally ventilated, and has refractory hypotension despite the use of norepinephrine, dopamine, and dobutamine infusions.
- An older patient of unknown age and history suddenly arrests on arrival to the emergency room.
Consider Each Individual

- The man with ischemia in the setting of COVID-19 likely will respond (or not) in a way similar to a patient with myocardial ischemia prior to COVID-19. Resuscitation would be indicated.

- The elderly woman with multiple comorbidities had a poor prognosis of survival prior to COVID-19. She may be resuscitated but discharge out of hospital is questionable.

- The young woman with multiorgan failure and intractable hypotension is dying and receiving maximal treatment possible. When her heart stops, she has died despite trying everything.

- The man in the emergency room is an unknown. We don’t know why he is there or why he has arrested. This man should receive resuscitative efforts.
BUT, consider the safety of health care personnel

- Limit who responds.
- Everyone must use available PPE.
- Keep crash cart outside the room and have a safe method of transferring meds and blood samples into and out of the room of the patient.
AND, think about wishes for treatment prior to disaster

- As possible, inquire about advance directives and durable power of attorney for health care for all admissions.
- Inquire specifically about patient or appropriate surrogate decisions regarding ICU transfer, mechanical ventilation, and resuscitation.
- Have palliative care team assist in discussions as possible and work to ensure excellent care for those who choose to avoid aggressive therapy.
- Document wishes and decisions carefully.
What about Do Not Attempt Resuscitation Orders

- Should not be ad hoc.
- Need for administration and legal to be involved.
- Ideal to have a policy that allows this to be done equitably and in a uniform manner.
- Needs oversight and case review.
- Patients, surrogates, and family need to be informed and conversations carefully planned.
- But a blanket DNR (DNAR) is not acceptable for all COVID-19 patients.
What’s Catholic About This?

- We consider individuals and look to provide the best possible outcome for each person.
- We recognize that simply maintaining a heart beat is not the point of respecting life; we are not vitalists.
- We endeavor to care for all people and not lump them into groups that would not take into account relevant factors and would risk discrimination and marginalization of some.
- We care for our health care workers, and an infectious pandemic means extra care in trying to minimize even unavoidable risks.
- We do not do things ad hoc but consult and work collaboratively to ensure good care, fairness, and learning from what we do.
Catholic Ethics and the Challenge of COVID-19:
Nonconsensual Reallocation of Ventilators

ALLEN ROBERTS, II, MD, MA
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PELLEGRINO CENTER FOR CLINICAL BIOETHICS
GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE
Pandemics create extraordinary circumstances: Medical, Economic, and Social

Some say that extraordinary circumstances require extraordinary responses to conditions that threaten to overwhelm our resources.

We would argue that in challenging times, we must depend on our ethical values, principles, and traditions more than ever.

Circumstances should not change our ethics — our ethics should help us deal rightly with our circumstances.
Unique Aspects of COVID-19

- Extremely contagious
- Extremes of clinical manifestations:
  25% asymptomatic ←----------→ respiratory and multi-system failure
- Extremely high mortality in patients > 65 years old and on the vent
- Death at any age
- Sudden death can follow initial improvement
- Higher incidence, worse outcome in African-Americans
Unique Approach to the COVID-19 Patient in Respiratory Failure

- Care for the Patient ←→ Protect the Caregivers
- We avoid non-invasive modalities (CPAP, BiPAP), as these increase risk of aerosolization
- We intubate patients EARLIER in their trajectory of respiratory failure (avoids a “crisis” situation ←→ more aerosolization)
- Dedicated anesthesia team with PPE and tight protocols
Issues in Resource Allocation

- Personal Protective Equipment
- Medications
- Hospital beds
- Trained professional personnel
- Procedures and equipment, VENTILATORS!
Ventilator Allocation in COVID-19 Pandemic

- Before limiting access, make sure you have maximized supply by limiting elective surgeries, utilizing resources like anesthesia machines, sharing with regional hospitals, inventive techniques of sharing ventilators
- Before the crisis hits, develop a scheme for ethical allocation of ventilators
- Consider exclusion criteria, role of preexisting conditions, physiologic scores of individuals to provide evidence of benefit, avoid any ad hoc decisions, review decisions about allocation
- Consider the removal of individuals from ventilators without consent from patient/surrogate?
Triage Approaches

“Triage”
The assignment of degrees of urgency to decide the order of treatment of a large number of patients

Triage is done everywhere, every day, based solely on clinical criteria

- First come, first served
- Lottery
- Urgency of need — sickest first
- Likelihood of Survival: short-term versus long-term
- Likely Benefit — can be expected lifespan, previous health, benefit to society, etc.
Guidelines and Frameworks for Allocation

Rationing Criteria

- Eligibility
- Disqualifying conditions
- Scoring systems
- Transparency
- REALLOCATION POLICIES
Reallocation Proposals

- May the criteria for rationing include the reallocation of a ventilator from a patient currently on that ventilator to another seriously ill individual who needs one? By what criteria?
  
  - a better chance of survival? Fewer comorbid conditions?
  - is younger? Has a projected lifespan of more years?
  - better neurological status, either at onset, or predicted?
  - pregnant? Already has young children? Is a First Responder?

**Justification**

Triage is intended to save lives. We should not allow patients with a more hopeful prognosis to die when those who are less likely to survive even with ventilator treatment hog the available resources

**Is this ethical? Is it legal?**
Reallocation Can Occur By:

- Voluntarily relinquishing it in advance (patient’s advance directive)
- Family or surrogate agreement
- Mandatory reallocation by medical team
Mandatory Reallocation

- Turns physicians/hospitals into agents of government, with due process requirements and need for liability protection

- Criteria must be narrowly drawn

- Triage procedures must satisfy due process and be transparent

- An appeals process should be made available
A 78-year-old male with COVID-19 has been on the ventilator for nine days. He had no significant comorbidities prior to his illness; he was a jogger, and still working full time. He has not made significant improvement despite state-of-the-art management of COVID-19-related respiratory failure and is developing kidney failure that will require continuous dialysis in the ICU.

A 22-year-old male was admitted four days ago, also with COVID-19, acquired during spring break. He has worsened with high-flow nasal oxygen, and now will require a ventilator in order to survive.
CASES

- 35-year-old African-American male acquired COVID-19 while working as a bus driver. He is obese, hypertensive, and has diabetes mellitus. He is slowly deteriorating on the ventilator for the past eight days, is showing signs of additional organ failure, and may need ECMO to survive.

- A 65-year-old nurse acquired COVID-19 while working 12-hour shifts in the ICU, despite her history of multiple sclerosis. She is developing significant respiratory distress and needs a ventilator.
Reallocating: Arguments Against

- It is impractical. It would require:
  - Time for continual re-evaluations
  - More prognostic precision than medicine can do
  - Open to reallocating the reallocated ventilator

- Unfair to the patient on the vent who may still have a chance
- Destructive to physician-patient trust relationship
- Discriminatory to the disabled, and those on home vents
A pandemic is a crisis but that does not mean ethical standards are dismissed.

The goal of a right healing action for an individual patient needs to be respected even if there may be decreased options.

Rationing schemes need to be cautious because of danger of discrimination against persons with disabilities, increased age, and members of disadvantaged populations.

Rationing protocols should be clear, shared among all practitioners, subject to review of individual cases to ensure conformity, and minimize *ad hoc* decision making.
Register for Upcoming Webinars in This Series

April 23
Part Two: Rationing Criteria and Preferential Treatment

April 30
Part Three: Organizational Ethics and Ethical Issues

www.chausa.org/events/calendar-of-events

Topics for May sessions to be announced.
Thank You for Attending

An email will be sent with a recording of the webinar.

CHA Member Services is here for you!
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