This document is intended to provide a quick reference to ethical principles and core values foundational to the PSJH response to scarce resource management during crisis standards of care and to provide important information about ethics resources available to the response.

The comprehensive response by our health system to any crisis or natural disaster is rooted in our PSJH Mission and Values and in our Promise, “Know me, care for me, ease my way.” Our decision making around preparedness, safety, quality, and care for patients and families affected by the crisis is guided by our Values of Compassion, Dignity, Justice, Excellence, and Integrity. These values are especially important during a crisis. Triage decisions should be made using operational and clinical guidelines according to the best available evidence-based clinical criteria related to condition and survivability in crisis standards of care. This policy seeks to embody compassionate care and our Catholic Identity, which is animated by our *Ethical and Religious Directives for Catholic Health Care Services* 6th ed, specifically Directives 3, 6, 23, 33, 55, 56, 57, and 61.

In addition to other values cited in this document, the ethical bases for Allocation of Scarce Resources during Crisis Standards of Care are grounded in these values: social solidarity, professionalism, justice, equity and excellence.

- **Social solidarity**: principles of respect for persons, the common good, public order, and safety for all, especially those who are most vulnerable, maximizing the number of lives saved when the health care needs overwhelm the available resources within a community.
- **Professionalism**: principles of one’s fiduciary responsibility as a healer, and the institution’s commitment to reciprocity, in this scenario the duty to safeguard caregivers, and integrity regarding evidence based decision-making.
- **Justice, Equity and Excellence**: the equitable distribution of care proportionate to the ability to benefit patients while avoiding and reducing harm where it cannot be avoided and stewardship of available scarce resources. Triage decisions should be grounded in the best available, objective, and evidenced-based information in order to help determine benefit in any given triage situation. Triage officers and teams should be established within local ministries and connect with local and state crisis response networks.

**Issues Pertaining to Stigma, Bias, and Prejudice**

The values of justice and care for the common good compels us to provide care to all in need no matter what race, ethnicity, or nationality they may belong to. The best care for the whole person and justice requires us to foster a welcoming environment with solidarity and inclusivity in all our interactions with patients and family facing the uncertainties inherent in crises. The values of dignity, justice, and autonomy also oblige us to respect privacy and confidentiality as well as to neutralize stigma and defend against discrimination.

**Issues Pertaining to Those Who Are Poor and Underserved**

In fulfillment of the values of dignity and compassion we strive to ensure that those who are poor and underserved receive every effort to keep this population safe and cared for.

**Issues Pertaining to the Ethical Duties to Provide Care and Safeguard Caregivers**

In fulfillment of the values of dignity, compassion, excellence, and integrity, all health care professionals have a moral duty to respond to the needs of the sick and suffering in proportion to their role and professional capacity. In responding to epidemics and pandemics, and in light of safety conditions at work, caregivers should assess their duty to serve together with other obligations such as to family and personal health. The moral duty to provide care under these circumstances may be outweighed by significant burdens and barriers. Discerning these matters is a collaborative effort between caregivers and leadership.
Ethical Dilemmas in Personal Protective Equipment Shortages

Moral distress regarding a shortage of Personal Protective Equipment (PPE) emerges from competing duties in the context of Crisis Standards of Care. Specifically, institutional duties to provide a safe working environment for caregivers within the threshold defined by a particular crisis and caregivers’ professional duty to provide care.

Decisions that would include optimizing, conserving or reusing PPE such as n95 respirators, will benefit by using CDC updated recommendations for appropriate levels of protection, which includes reuse if necessary due to a shortage (see CDC n95 strategy). These recommendations help caregivers and health care institutions provide appropriate care, ensure safety, and preserve the common good in the midst of scarce resources. These recommendations are consistent with the Providence St. Joseph Health Mission and Values, the Ethical and Religious Directives for Catholic Health Care Services, the ethical principles of triage, and professionalism in health care.

Leaders should be attentive and immediately responsive to caregiver concerns about the potential for dramatically unsafe working conditions. All available efforts, under the auspices of the local command center, should be deployed to address the concerns using the tools of Caring Reliably. Leaders also have a responsibility to work with caregivers to ensure the burdens of the additional risk are equitable and do not unfairly burden a given caregiver or family. Individual concerns should be addressed on a case by case basis.

We must acknowledge that these recommendations may change as new information is obtained during the course of any developing or ongoing crisis. What will not change is own commitment to know, care, and ease the way of our patients and our care providers.

Framework for Challenging Questions and Issues in Crisis and Disaster Response

Administrative Triage Teams
During a crisis that requires these guidelines, Triage Teams for the review of hospital admission, ICU admission, and transition to comfort care should be established or activated. If there is conflict or disagreement among the Triage Teams, the Regional Director of Ethics or Clinical Ethicist (where available), Ethics Consult Team, Ethics Committee, and/or Mission Leaders are available to assist as needed.

Bedside and Virtual Care Teams
Caring for the whole person: Established or ad hoc multidisciplinary teams, including chaplaincy, should be called to support any patient and family in need of additional psychosocial and spiritual support, especially in the setting of a triage decision to limit advanced life-supporting treatments or to transition to care focused on comfort.

Ethics Consultation
The professional Ethicists and Ethics Committees of PSJH are ready and able to support the PSJH response to crisis and disasters and to assist with ethical questions and issues. Caregivers and leaders are encouraged to include our Ethicists in decision making as appropriate. Ethicists’ contact information is provided here by region in addition to information for the Theology and Ethics system office.
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Assumptions for use:

1. Health Officer has declared a crisis situation requiring scarce resource management and crisis standards of care, where crisis standards of care is defined as “a substantial change in usual healthcare operations and the level of care it is possible to deliver which is made necessary by a pervasive or catastrophic disaster”.

2. Healthcare systems are overwhelmed despite maximizing all possible surge and mitigation strategies impacting the space and/or staff and/or supplies needed to deliver usual levels of care.

Washington State has adopted and will use the ethical framework developed by the National Academy of Medicine, which stresses the importance of an ethically grounded system to guide decision-making in a crisis standards of care situation. All decisions and communications will be based on the ethical principles below. The National Academy of Medicine defines these ethical principles as:

- **Fairness** – Standards that are, to the highest degree possible, recognized as fair by those affected by them – including the members of affected communities, practitioners, and provider organizations, evidence based and responsive to specific needs of individuals and the population.

- **Duty to care** – Standards are focused on the duty of healthcare professionals to care for patients in need of medical care.

- **Duty to steward resources** – healthcare institutions and public health officials have a duty to steward scarce resources, reflecting the utilitarian goal of saving the greatest possible number of lives.

- **Transparency** – in design decision-making, and information sharing.

- **Consistency** – in application across populations and among individuals regardless of their human condition (e.g. race, age disability, ethnicity, ability to pay, socioeconomic status, preexisting health conditions, social worth, perceived obstacles to treatment, past use of resources).

- **Proportionality** – public and individual requirements must be commensurate with the scale of the emergency and degree of scarce resources.

- **Accountability** – of individual decisions and implementation standards, and of governments for ensuring appropriate protections and just allocation of available resources.

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This Worksheet, along with the corresponding Adult Critical Care Algorithm, are to be used by “Triage Teams” during a declared emergency event whereby an appropriate healthcare official has implemented crisis standards of care. It is recommended that a “Triage Team” be comprised of senior medical personnel, preferably not those primarily taking care of the individual patient under consideration. Please see “Scarce Resource Triage Team Guidelines” for further information.

### STEP 1: Screen adult patients for ICU care during scarce resources

Proceed to following after reviewing patient’s end of life directives/POLST or similar living will documents. For the following conditions consider available staffing and resources. If resources are inadequate, consider transferring the following patients to out-patient or palliative care with appropriate resources and support as can be provided.

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1.</td>
<td>Pre-existing or Persistent coma or vegetative state</td>
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<tr>
<td>2.</td>
<td>Severe acute trauma (e.g. non-survivable head injury)</td>
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<tr>
<td>3.</td>
<td>Severe burns with Low Survival burn scores based on the Triage Decision for Burn Victims table (See Table A below). See Burn Scarce Resource Card for management of critical burn patient outside of a Burn Center.</td>
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<tr>
<td>4.</td>
<td>Significant underlying disease process that predict poor short term survival*</td>
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<tr>
<td></td>
<td>*Examples of underlying diseases that predict poor short-term survival, despite standard treatment, include but are not limited to:</td>
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<tr>
<td></td>
<td>• Severe congestive heart failure</td>
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<td></td>
<td>• Severe chronic lung disease</td>
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<td></td>
<td>• Central nervous system, solid organ or hematopoietic malignancy with poor prognosis for recovery</td>
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<tr>
<td></td>
<td>• Severe cirrhotic liver disease with multi-organ dysfunction</td>
</tr>
<tr>
<td>5.</td>
<td>Baseline functional status (consider loss of reserves in energy, physical ability, cognition and general health)</td>
</tr>
</tbody>
</table>
STEP 2: Determine if patient meets ICU Inclusion Criteria

2A: Patients must have at least one of the following INCLUSION CRITERIA:

1. Requires ventilatory support, either invasive or non-invasive
   - Clinical evidence of impending respiratory failure
     - Refractory hypoxemia (SpO2<90% on FIO2>0.85)
     - Respiratory acidosis (pH<7.2)
   - Inability to protect or maintain airway

2. Hypotension (SBP <90) secondary to either an acute medical or trauma condition, with clinical evidence of shock (altered level of consciousness decreased urine output, or other evidence of end stage organ failure) refractory to volume resuscitation that cannot be managed in a non-ICU setting.

2B: To determine critical care resource allocation the following should be considered:

- Expected duration of need of critical care resource
- Prognosis with consideration to both current epidemiology and underlying illness*
- Response to current treatment
- Degree of Organ Dysfunction as measured by the MSOFA (Modified Sequential Organ Failure Assessment Score) - Please see Step 6 regarding use of scoring system
- Baseline functional status (consider loss of reserves in energy, physical ability, cognition and general health)

*Examples of underlying diseases that predict poor short-term survival, despite standard treatment, include but are not limited to:
- Severe congestive heart failure
- Severe chronic lung disease
- Central nervous system, solid organ or hematopoietic malignancy with poor prognosis for recovery
- Severe cirrhotic liver disease with multi-organ dysfunction

STEP 4: Assess for re-allocation of Critical Care Resource

To determine critical care resource allocation the following should be considered:

- Expected duration of need of critical care resource
- Prognosis with consideration to both current epidemiology and underlying illness*
- Response to current treatment
- Degree of Organ Dysfunction as measured by the MSOFA (Modified Sequential Organ Failure Assessment Score) – Please see Step 6 regarding use of scoring systems
- Baseline functional status (consider loss of reserves in energy, physical ability, cognition and general health)

*Examples of underlying diseases that predict poor short-term survival, despite standard treatment, include but are not limited to:
- Severe congestive heart failure
- Severe chronic lung disease
- Central nervous system, solid organ or hematopoietic malignancy with poor prognosis for recovery
- Severe cirrhotic liver disease with multi-organ dysfunction
**STEP 5: Critical care waiting list**

If a patient meets ICU inclusion criteria and resources are not available, patient will be placed on an ICU waiting list. As resources become available their clinical situation will be re-assessed and they will be re-triaged based on criteria outlined in Step 6. If a clear distinction cannot be made between patients of similar triage priority, the resource will be allocated to the patient who has been waiting the longest.

**STEP 6: Admit to ICU**

Patient data collection outlined on Step 6 of the Algorithm will be continuous and ongoing. It is recommended that every 24 hours of a patient’s ICU stay, their clinical condition will be reviewed and they will be determined to be “Improving”, “Unchanged” or “Worsening”. This determination must not only take into account data points as outlined in Step 6 but must also include updated epidemiology, critical care resource availability and census demands.

Previously, recommendations had been made to use MSOFA score alone to determine triage categories. However, based on more recent data it is current consensus that a specific SOFA or MSOFA score cannot accurately define clinical categories alone, and therefore all criteria outlined in Step 6 including current epidemiology must be taken into account when deciding if patients are “Improving,” “Unchanged,” or “Worsening”.

**Other Adult Considerations**

All patients receiving critical care before the onset of crisis standards will be re-assessed based on the same criteria as all incoming critical care patients. The same data as outlined in Step 6 should be obtained and resources re-allocated if needed dependent on the Triage Team assessment and decisions.

The use of ECMO should be decided on an individual basis by the ICU attending, nursing supervisor and ECMO representative based on prognosis, suspected duration of ECMO, availability of staff and other resources.

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1. Crisis Capacity: Adaptive spaces, staff and supplies are not consistent with usual standards of care, but provide sufficiency of care in the setting of a catastrophic disaster (i.e. provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant adjustment to standards of care. (Hick et al, 2009, IOM)
While much remains unknown about COVID19, particularly in regards to the US population, it is clear the disease is often deadly in elderly patients with co-morbid illness. Care is largely supportive, to include oxygen and respiratory, including ventilator, support. Despite full supportive efforts, many critically ill patients with COVID19 will die, generally of multiorgan failure, sepsis, and/or cardiomyopathy.

All studies and reports regarding COVID19 note an increased mortality associated with both age and the presence of comorbidities including hypertension, diabetes, and coronary artery disease. A retrospective cohort study from Wuhan, China of 191 seriously ill patients with confirmed COVID19 disease reported only a single survivor among 32 patients who received mechanical ventilation.


The survival to hospital discharge for critically ill patients receiving CPR is very low (<15%), with already being on mechanical ventilation, older age, and co-morbidities reducing that likelihood even further.


As such, CPR may be medically inappropriate in a significant portion of elderly, critically ill patients with COVID19 and underlying comorbidities. As per UWMC and HMC policy, clinicians are NOT obligated to offer or provide medically inappropriate treatment, even when requested by patients and/or designated surrogates. (This conclusion is consistent with ERDs.) If treating clinicians, including more than one physician, determine that CPR is not medically appropriate, a Do Not Attempt Resuscitation Order (DNR) may be written without explicit patient or family consent. In all cases, however, the patient and/or appropriate surrogate should be informed of this decision, along with the rationale in support. Patient or family “informed assent” should be sought but is not required. Expert, compassionate communication with patient/family is necessary.


Potential language/points to share with family when CPR is deemed medically inappropriate:

1) Based on our review of your loved one’s clinical status, we are worried that this coronavirus along with their previous medical conditions is leading to an end of life process.

2) We are sorry to share that we believe your loved one is dying.

3) Under these circumstances we do not provide CPR. We want to make sure you understand this decision and have the opportunity to ask any questions that you have.