Thanks all for your participation in the 4/16/20 version of COVID in 20. Thanks especially to our colleagues from VA National Center for Ethics in Health Care for sharing their experience and wisdom with us.

We value your time, so we want to make sure to keep to the 20-minute timeframe. This will limit our ability to answer all questions on the call, so here are answers to questions posed during the COVID in 20. A special thanks to Drs. David Alfandre and Ken Berkowitz for answering these.

Can we write DNR orders without consent in certain situations?

A unilateral DNR order placed either without the consent or over the objection of a patient or family is not ethically justifiable as it violates existing ethical standards and VHA Handbook 1004.03: Life-Sustaining Treatment (LST) Decisions: Eliciting, Documenting, and Honoring Patients' Values, Goals, and Preferences.

However, at the time of a cardiopulmonary arrest of a patient with presumptive or confirmed COVID-19, the responsible code leader (who must be fully donned with personal protective equipment (PPE)) must make an initial rapid assessment of whether CPR will achieve its goal of restoration of spontaneous circulation (ROSC). This clinical judgment should be based on existing clinical standards for CPR including the patient's co-morbidities, clinical state prior to the code, and initial rhythm, etc. The same clinical reasoning process continues until ROSC or the code leader decides to terminate CPR when unable to establish ROSC. At any time after the initial assessment of the patient, the code leader has both the clinical authority and ethical responsibility to terminate CPR if s/he determines that CPR will not achieve its intended physiologic goal (i.e., ROSC). This is ethically justifiable because it promotes care in accord with accepted standards of medical practice as well as promotes the patient's best interest by not providing ineffective or non-beneficial treatment.

Under crisis standards of care and the implementation of the triage protocol as described in VA's authoritative guidance, patients who are excluded from scarce life-saving resources based on established criteria or who have been triaged to the blue category will, of necessity, be excluded from access to scarce resources that may be needed for cardiopulmonary resuscitation. Under these conditions DNR/DNAR orders will be entered into a patient's record with patient notification but without the need for consent.

Question: How are clinicians handling the issue of the difficult airway patient in whom your normal airway team has been unable to intubate and you do not have in-house surgical backup to establish an emergency surgical airway?

This question is outside the purview of our office. We direct you to the appropriate clinical subject matter experts in VHA.

A question regarding the tiebreaker: how do we decide which is the best methodology for this (i.e. first come, first served versus lottery)?

First-come, first-served and random lotteries are both ethically justifiable approaches if both approaches are objective, transparent, fair, and applied consistently. The Scarce Resource Allocation Team makes the determination about which approach should be used at the facility depending on the feasibility of implementation. A suggested strategy that respects these important values for first-come, first-served is to use the date and time that the attending requests initial SRA

assessment rather than the time the patient is triaged in the emergency department or admitted to acute care. If the SRA Team prefers, it could establish that the Triage Team use a random selection or lottery process as the basis for assigning order within a priority (color) category. Please see VA's authoritative guidance for more information

Ken or Dave - has any facility had to activate their Scarce Resource Allocation Triage Team yet? I worry in EM that we might find ourselves in a scenario where we won't have all the data back to calculate a SOFA score - and qSOFA is not detailed enough.

To our knowledge, no VA facility has yet implemented crisis standards of care as described in the April 8th Executive in Charge Memorandum (attached at the bottom of this document). Our office has been working with facilities around the country to stand up their Scarce Resource Allocation Teams to prepare for this possibility and to assist their local leadership in that decision-making process.

Facilities may use the mSOFA score in place of the SOFA. The SOFA measures were chosen based on their existing evidence-base for predicting short-term survivability, practicality, and ease of collection.

Speaking of Ethics...How often have you heard of the engagement of Chaplains in end of life or other care for the portion of patients receiving care... has it been sufficient, waning, satisfactory? Are there any other noticeable ethical issue where Chaplains have assisted or been a go to?

We have not received any specific information related to this question. We recommend you reach out to the national Chaplain leadership for more information.

MEMO-Standard of Care.pdf