Code Status and COVID-19 Patients

The Catholic Health Association and the Supportive Care Coalition offer this document with gratitude to our colleagues at the University of Washington recognizing that the clinical indicia for decision-making about any medical intervention are the same as they have always been. Although this decision-making model is put forth as a response to COVID-19, it is merely an application and implementation of best-practices applied to the current setting.

Catholic health care is committed to the healing ministry of Jesus recognizing the inherent dignity of all who seek care. For those patients who are facing life-threatening illness, we will remain true to our value of accompaniment. Even though critical care services may no longer be administered, we recognize the sacredness of these moments, and God's loving presence with us in them, and will continue to care even though we cannot cure.

While much remains unknown about COVID-19, particularly in regards to the U.S. 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 COVID-19 will die, generally of multiorgan failure, sepsis, and/or cardiomyopathy.

All studies and reports regarding COVID-19 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 COVID-19 disease reported only a single survivor among 32 patients who received mechanical ventilation. https://www.thelancet.com/pb-assets/Lancet/pdfs/S014067362305663.pdf

The survival to hospital discharge for critically ill patients receiving cardiopulmonary resuscitation (CPR) is very low (<15%), with use of mechanical ventilation, older age, and co-morbidities reducing that likelihood even further. https://www.atsjournals.org/doi/full/10.1164/rccm.200910-1639OC

Beyond the clinical statistics of benefit, hospitals need to take into consideration the health and safety of their staff. Resuscitative measures often involve many members of the care team, use a large amount of personal protective equipment, and most importantly, have a high risk of aerosolizing bodily liquids. In light of COVID-19, it is advised that these procedures be examined and modified, if possible, to reduce staff exposure to the virus. Catholic health care's duty to care exists not only for the patient but also for the care team.

CPR may be medically inappropriate in a significant portion of elderly, critically ill patients with COVID-19 and underlying comorbidities. As per Parts 3 and 5 of the *Ethical and Religious Directives for*

Catholic Health Care Services, if it is shown that the burdens exceed the benefits, it is morally acceptable to withhold such procedure. The clinical indicia for decision-making about any intervention are the same that they always are. This decision-making model was not developed in response to COVID-19; it's merely being applied and implemented in the current settings.

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. This will need to be in line with any state specific regulations or laws. 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 the patient and their family is necessary. We should also continue, or start, all comfort and palliative measures. Pastoral care should be consulted to provide spiritual support to the patient and the family. As during all patient encounters, we are committed to providing compassionate care.

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. Under these circumstances, CPR will most likely not be successful and will cause harm.

3) This does not change our current approach. We are continuing to provide care and any clinically indicated treatments.

4) We want to make sure you understand this decision and have the opportunity to ask any questions that you have.

Taken from guidelines written by Mark Tonelli, MD, MA; Denise Dudzinski, Ph.D., J. Randall Curtis, MD, MPH, James Fausto, MD.