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WHITE PAPER:

The ERDs and the Maryland Framework for the Allocation of Scarce Life-Sustaining Medical Resources in the COVID-19 Pandemic

Pandemic infections present a multiplicity of challenges for our society, our healthcare systems, and for Catholic hospitals in particular. By their very nature they strain our resources and our social and professional obligations to each other. When faced with a surging number of cases that threaten to overwhelm our ability to respond in a normal fashion, it is prudent to anticipate the burdens and challenges and to prepare plans for meeting them, even in the worst case scenarios. One such plan is the *Maryland Framework for the Allocation of Scarce Life-Sustaining Medical Resources in a Catastrophic Public Health Emergency*. It is likely that this plan, or some variation of it, will be put into place in our region when the time comes. It may be mandated for hospitals in the state of Maryland, and recommended for those in the District of Columbia, including MedSTAR Georgetown University Hospital. Although much in this plan may be seen as reasonable and even commendable, some aspects may be a poor fit for the principles and values in Catholic healthcare as characterized in the *Ethical and Religious Directives for Catholic Healthcare Services* This paper will focus on those limited aspects that might prove problematic. (ERD #6)

Hospitals and healthcare professionals acknowledge a moral obligation to care for the sick and vulnerable. In Catholic healthcare, this is seen as an embodiment of a ministry of healing representing the Lord's concern for the sick. (ERD p.3) Normally this focuses on the dignity and the good for an individual patient. In a public health crisis, it must include the dignity and the good for all those affected and competing for scarce resources. In such a situation, it is imperative that we maintain our own values in regard to both individuals and the population as a whole, not forgetting that populations themselves are aggregates of individuals who all deserve the same degree of respect for their lives and welfare. It is under these strained circumstances that hospitals and healthcare professionals must struggle to maintain their commitment to the good of all their patients, with special attention to the most vulnerable "sensitive to their vulnerability at a time of special need" (ERD #2) while striving to promote the health and the very survival of those who will most likely benefit from life-sustaining resources.

With these principles delineated in the Ethical and Religious Directives for Catholic Healthcare Services (ERDs) in mind, we can now turn to issues suggested by the Maryland Framework. The framework is intended "to assist Maryland hospitals and public health agencies in their response to a declared catastrophic health emergency in which there has been an order implement scarce resource allocation procedures." It employs a scoring system based primarily on two considerations: 1) likelihood of short-term survival with intensive care services, and 2) likelihood of long-term survival, based on the presence of comorbid conditions. Age is a secondary consideration for helping to differentiate between those patients with equal scores. The triage framework is to be applied to all scarce resources such as ventilators and dialysis, with variations in judgment and allocation depending on clinical circumstances. The implementation of the scoring system will be overseen by a Disaster Triage Team at each hospital which may need to make adjustments in critical care resource management as experience accumulates

over time. This should have the advantage of taking allocation decision-making away from individual physicians, thus decreasing subjectivity and unjustified variation.

Potential Problems in the Allocation Framework:

1) The strategy for ventilator allocation relies heavily on the SOFA score. Clinicians must determine if this is an appropriate use for SOFA.
2) The prognosis for long-term survival is to be scored according to comorbid conditions. Great caution must be taken to avoid the appearance, and the fact, of devaluing individuals simply on the basis of disability or societal contribution (ERD #3), rather than an immediate and verifiable limitation of their life expectancy.
3) The stratification of age categories does not depend solely on an apparent higher risk of mortality for the aged. It includes different strata for younger age patients calculated on their "opportunity for a full lifespan" and social utility. A morally justifiable age-related restriction should depend solely on the individual patient prognosis and inability to benefit.
4) The framework envisions potentially withdrawing scarce resources like the ventilator from one patient and reallocating it to another because of the second patient's assumed better chance for survival. This is highly problematic, entailing both ethical and legal jeopardy. It would be a rare situation in which sufficient justification could be found.
5) An immediate appeal of triage decisions must be made available the patient's families prior to their implementation.
6) The question of CPR for ventilated COVID patients must not result in an automatic denial/DNR order, despite the acknowledged hazard to the team that responds. It should be individualized and discussed with appropriate surrogates in advance. If a sufficient evidence base accumulates, it may be seen as futile care (and non-obligatory) in specific clinical situations.
7) Such a plan should not be implemented on the basis of an individual physician or administrator initiative. It should only occur in the setting of a recognized, verified, widespread catastrophe after all strategies to avert the need for implementation of the framework had failed.

This review only identifies specific problematic issues that would arise in conflict Catholic healthcare values. It acknowledges that there are many issues in the emergency response that are not addressed here, but are being aggressively and satisfactorily addressed by MGUH physicians and administrators. With those above issues identified, we should be able to work together to find a common and satisfactory solution to them all.

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