Testimony

A Pamphlet from Pax Christi Texas

Anticipating May 10, 2020

Communications with the editor should be sent to j6anthonyblasi@yahoo.com.

Pax Christi International was founded in 1945 with the encouragement of Bishop Pierre Marie Théas of Montauban, France, by Marthe Dortel Claudot, as a Christian lay organization dedicated to preventing a repetition of the savagery of the twentieth century's world wars.

Editorial

After the calendar, the Sunday Liturgical Reading reflections are based on readings for the Fifth Sunday of Easter. Tom Keene's poem is *The Bastard Messiah.* For more of Tom's poems, see http://www.tomkeeneandthemuse.com/index.php.

After the poem is a report issued by the Hastings Center, a highly regarded bioethics institute, under the title, *Ethical Framework for Health Care Institutions & Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic: Managing Uncertainty, Safeguarding Communities, Guiding Practice*. The importance of the topic at the present time is evident. The report provides a framework, i.e. a series of connected topics, not a list of "answers." Something of its nature is necessary for coherent thinking on a complex issue. Some may want to skip the major opening section and look at the "Guidelines" section that follows. There is also a list of resources, including the online address for a video for ethics committees.

This item comes from the Pax Christi El Paso online newsletter: **CENTRO SANTA CATALINA**: **From Sr. Terri Rodela OSF:** Come do your face mask shopping with us, **Centro Santa Catalina,** and support the "Women's Cooperative of Faith and Hope" in Juarez, MX. They have been busy making masks as they respond to the needs of our time. Bishop Mark Seitz commissioned the women to make masks for him and the seminarians, as well as a couple of medical gowns for himself, for visiting the sick.
Mask Description: hand washable and reusable, pocket on top for inserting filter (eg. coffee), elastic over ears,
Cost: $6.00 each or 4 for $20.00. Large quantity rates are negotiated by contacting me at, 915-227-5113 or centrosantacatalina@icloud.com
Click on the link below to order your masks!
https://app.elevatedfundraising.com/enroll/product/ZemGZ

Calendar

Events in Texas cities involving a gathering of ten or more people have been canceled because of the global pandemic.

El Paso

Sunday April 26-Monday May 11, Mondays-Sundays, 7:00am-3:00pm, Isaiah House annual fundraiser. Order a red cheese enchilada plate take-out (915) 593-8490, pickup Lunch Box, 667 N. Carolina Dr. Tickets previously purchased can be redeemed. Isaiah House offers men leaving prison a temporary place to reside.

Alternatives

Any time: Conversation, "Re-Opening the Nation: What Values Should Guide Us?" Danielle Allen (Ethics, Harvard University), Zeke Emanuel (Medical Ethics & Health Policy, University of Pennsylvania), moderator Mildred Z. Solomon (Hastings Center & Global Health, Harvard University).
https://www.youtube.com/watch?v=ahjo9oQ4lk8&feature=emb_title

Monday May 4, 6:30pm (7:30 ET)-7:30pm (8:30 ET), Rabbi Michael Lerner and Cat Zavis, Zoom discussion of Lerner's recent article, "Don't Waste an Economic Meltdown."
https://zoom.us/j/97540108123?pwd=OUhjSjdyTHVqMm1IUkRSbDF5UlFvdz09
Meeting ID: 975 4010 8123
Password: 133011

Friday May 8, 1:00pm (2:00 ET)-2:00pm (3:00ET), Zoom Webinar: "Defend the Sacred. A Conversation with Michael McNally." In this conversation Michael McNally, author of *Defend the Sacred*, will join Shawn Casey to discuss how Native nations draw on the rhetorical power of religious freedom to gain legislative and regulatory successes." RSVP at
https://berkleycenter.georgetown.edu/events/defend-the-sacred.
Detailed information by email to berkleycenter@georgetown.edu.

Friday June 5, 9:30am-3:00pm, online conference: "How Science Can Strengthen the Faith of Your Church." 9:30 Elaine Howard Ecklund (Rice U.); 10:25, Mark Labbarton (Fuller Seminary); 11:15 Praven Sethopathy (Cornell U.), 12:30 Greg Cootsona (Cal. State, Chico) & Gus Reyes (Texas Baptists) on engaging youth and emerging adults in science; 1:20 Nichole Phillips (Emory U) & Harvey Clemons

(Pleasant Hill Bapt. Church) on race, social justice, science; 2:10 Jonathan Hill (Calvin U) & Lee Hsia (First Bapt. Church, Houston) on human origins; 2:50 Closing remarks. The conference will be preceded by the release of Elaine Howard Ecklund's book, *Why Science and Faith Need Each Other*. The first 250 people to register will receive a free copy; include your mailing address when registering. Register here:
https://riceuniversity.zoom.us/webinar/register/WN_w1ouOgz2R0etvzPbnHD4Zg
Instructions to join the webinar will be sent to you after registering.

Second Reading (First Peter 2:4-9)

Occasionally in the Bible one comes across a strange reference to a rejected stone. For example, Psalm 118:22-23 reads, "The stone which the builders rejected has become the head of the corner. This is the Lord's doing…." (See also Isaiah 28:16.) The author of *First Peter* takes up this image. After calling for a conversion with other metaphors, he writes, "Coming to him—a living stone, rejected by society but a valuable chosen by God—let yourselves as living stones, a spiritual house, be built into a holy priesthood, offering through Jesus, Messiah, spiritual sacrifices acceptable to God." Seldom do we call to mind that taking the divine into account calls for a turning away from what is held to be valuable in this world, as well as the inevitable rejection by "the world" of whoever dares to take the divine to heart. After all, the Messiah was crucified.

Third Reading (John 14:1-12)

"Do not trouble your heart; believe in God, and believe in me." The scene is one of the *Johannine Gospel's* versions of the farewell address of Jesus, set in the context of a Passover meal. By custom, the disciples of a rabbi ask questions. As Jesus spoke of going to the Father, Peter asked, "Why is it not possible for me to follow now?" Indeed! Why can't we all just be swept up in a rapture and not be troubled with living in the world? Don't worry: "There are many abodes in my Father's house." "And you know the way…." Then Thomas asked, "Sir, we do not know where you are going. How can we know the way?"

As union with the Father became imminent, the way to Him became less evident. There was a good reason for this: One of the ways we depict God is as

the Creator. Our depictions are unavoidably inadequate. As suggested by the Trinitarian nature of God, even *number* as a category cannot be used to describe God in any adequate manner. To speak of *the* Creator suffers in this respect. Similarly inadequate is what we mean by *Creator*—someone who has a plan and sets about realizing it. But God is not the big clock-maker in the sky; philosophers for centuries have spoken instead of Pure Act rather than an ultimate planner modality set apart from an ultimate construction modality.

In one sense God knows what is to be in the future; however, there can be no before, during, and after in God. Consequently, in another sense unknowing, rather than knowing, is characteristic of deity. The more Peter, Thomas, and we seek to know the way to the Father, the less we actually know. The more we are ready to accept open-endedness, the closer we are to knowing the way. And the indeterminateness inherent in open-endedness is precisely the feature of everyday life that could trouble us. So we need to bother with life in this world—out of control as that is—but we should not "trouble our hearts" over that.

Poem

The Bastard Messiah

In the minds of his Nazarene neighbors
he was a conceived-out-of-wedlock bastard.
He was not the son of Joseph,
they called him son of Mary.

In the minds of his friends and followers,
he was a messiah, a gift of God to the people,
to Israel, to the world.

Two mindsets.
How to reconcile, bring them together?

A story! A virgin, an angel, a decision, a yes, a birth.

Handed down from one generation to the next

and the next to this our day,
a story of how rejected rocks become cornerstones.

It is the story of ourselves.

Tom Keene

Ethical Framework for Health Care Institutions & Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic:
Managing Uncertainty, Safeguarding Communities, Guiding Practice

Nancy Berlinger, PhD; Matthew Wynia, MD, MPH; Tia Powell, MD; D. Micah Hester, PhD; Aimee Milliken, RN, PhD, HEC-C; Rachel Fabi, PhD; Felicia Cohn, PhD, HEC-C; Laura K. Guidry-Grimes, PhD; Jamie Carlin Watson, PhD; Lori Bruce, MA, MBE; Elizabeth J. Chuang, MD, MPH; Grace Oei, MD, HEC-C; Jean Abbott, MD, HEC-C; Nancy Piper Jenks, MS, CFNP, FAANP

The Hastings Center, March 16, 2020

CONTENTS

Summary

An ethically sound framework for health care during public health emergencies must balance the patient-centered duty of care—the focus of clinical ethics under normal conditions—with public-focused duties to promote equality of persons and equity in distribution of risks and benefits in society—the focus of public health ethics. Because physicians, nurses, and other clinicians are trained to care for individuals, the shift from patient-centered practice to patient care guided by public health considerations creates great tension, especially for clinicians unaccustomed to working under emergency conditions with scarce resources.

This document is designed for use within a health care institution's preparedness work, supplementing public health and clinical practice guidance on COVID-19. It aims to help structure ongoing discussion of significant, foreseeable ethical concerns arising under contingency levels of care and potentially crisis standards of care. Its method is to

- pose practical questions that administrators and clinicians may not yet have considered and support real-time reflection and review of policy and processes;
- explain three duties of health care leaders during a public health emergency: to plan, to safeguard, and to guide; and
- offer detailed guidelines to help hospital ethics committees and clinical ethics consultation (CEC) services quickly prepare to support clinicians who are caring for patients under contingency levels of care and, potentially, crisis standards of care.

This document is not intended to be, and should not be considered, a substitute for clinical ethics consultation or other medical, legal, or other professional advice on individual cases or for particular institutions. It reflects an evolving public health emergency; references are current as of March 16, 2020.

Foreseeing Ethical Challenges in the Care of Patients with COVID-19

Ethical challenges in health care are common even under normal conditions because health care responds to human suffering. To act ethically should be integral to professionalism in health care. However, professionals often experience uncertainty or distress about how to proceed. Cases involving patients with life-threatening illness, including those who lack capacity to make decisions concerning life-sustaining interventions and other medical treatment, often give rise to uncertainty. Institutional ethics services, such as clinical ethics consultant

teams and ethics committees, respond to this practical reality by helping professionals, patients (as able), and family members to reflect on choices and make informed decisions, with reference to the rights and preferences of patients and the duties of professionals to avoid harm, benefit patients, and act fairly while maintaining professional integrity.

A public health emergency, such as a surge of persons seeking health care as well as critically ill patients with COVID-19 or another severe respiratory illness, disrupts normal processes for supporting ethically sound patient care. Clinical care is patient-centered, with the ethical course of action aligned, as far as possible, with the preferences and values of the individual patient.

Public health practice aims to promote the health of the population by minimizing morbidity and mortality through the prudent use of resources and strategies. Ensuring the health of the population, especially in an emergency, can require limitations on individual rights and preferences. Public health ethics guides us in balancing this tension between the needs of the individual and those of the group.

While all health care resources are limited, public health emergencies may feature tragically limited resources that are insufficient to save lives that under normal conditions could be saved. There is a basic tension between the patient-centered approach of clinical care under normal conditions and the public-centered approach of clinical care under emergency conditions.

In a public health emergency, first responders need clear rules to follow. Triage protocols, for example, help first responders to swiftly prioritize patients for different levels of care based on their needs and their ability to respond to treatment given resource constraints. If these rules seem unfair or cause greater suffering and distress to patients, then the burden on first responders will be excruciating. Significant moral distress is likely to arise for providers who must adhere to disaster-based protocols that require giving or withholding treatment, especially life-sustaining treatment, over the objections of patients or families.

Three Ethical Duties of Health Care Leaders Responding to COVID-19: *Plan, Safeguard, Guide*

An ethically sound framework for health care organizations during public health emergencies acknowledges two competing sources of moral authority that must be held in balance:

- *The duty of care that is foundational to health care.* This duty requires fidelity to the patient (non-abandonment as an ethical and legal

obligation), the relief of suffering, and respect for the rights and preferences of patients. The duty of care and its ramifications are the primary focus of clinical ethics, through bedside clinical ethics consultation services, institutional policy development, and ethics education and training for clinicians.

- *Duties to promote moral equality of persons and equity (fairness relative to need) in the distribution of risks and benefits in society.* These duties generate subsidiary duties to promote public safety, protect community health, and fairly allocate limited resources, among other activities. These duties and their ramifications are the primary focus of public health ethics.

Clinicians, such as physicians and nurses, are trained to care for individuals. Public health emergencies require clinicians to change their practice, including, in some situations, acting to prioritize the community above the individual in fairly allocating scarce resources. The shift from patient-centered practice supported by clinical ethics to patient care guided by public health ethics creates great tension for clinicians. Some clinicians frequently make care decisions across large populations. Some clinicians have training in emergency triage, and some regularly train to prepare for a range of public health emergencies. Other clinicians are less familiar with patient care in the context of a large-scale, perhaps prolonged, public health emergency.

In responding to COVID-19, an ethical framework for health care institutions should acknowledge the tension between sources of authority for health care and public health in the contexts in which these tensions are most likely to arise in clinical practice. The duties of health care leaders to clinicians and community during a public health emergency can be expressed as follows: to plan, to safeguard, to guide.

The Duty to Plan:

Managing Uncertainty

Health care leaders have a duty to plan for the management of foreseeable ethical challenges during a public health emergency. Ethical challenges arise when there is uncertainty about how to "do the right thing" in clinical practice when duties or values conflict. These challenges affect the health care workforce and how a health care institution serves the public and collaborates with public officials.

Planning for foreseeable ethical challenges includes the identification of potential triage decisions, tools, and processes. In a public health emergency featuring severe respiratory illness, triage decisions may have to be made about level of care (ICU vs. medical ward); initiation of life-sustaining treatment (including CPR and ventilation support); withdrawal of life-sustaining treatment; and referral to palliative (comfort-focused) care if life-sustaining treatment will not be initiated or is withdrawn. Triage decisions may also need to be made concerning shortages of staff, space, and supplies.

The Duty to Safeguard:

Supporting Workers and Protecting Vulnerable Populations

Health care organizations are major employers. Responding to public health emergencies includes safeguarding the health care workforce. During a surge of infectious illness amid deteriorating environmental conditions, clinicians and nonclinicians, such as maintenance staff, may be at heightened risk of occupational harms. Vulnerable populations during a public health emergency include those at higher risk of COVID-19, due to factors such as age or underlying health conditions, and those with preexisting barriers to health care access, due to factors such as insurance status or immigration status. Health care institutions that employ trainees, such as medical students and nursing students, should recognize these workers as a vulnerable population.

The Duty to Guide:

Contingency Levels of Care and Crisis Standards of Care

The tension between the equality and equity orientation of public health ethics, expressed through fair allocation of limited resources and a focus on public safety, and the patient-centered orientation of clinical ethics, expressed through respect for the rights and preferences of individual patients, is stark when life-sustaining interventions are not available to all patients who could benefit from these interventions and would likely choose them. A severe respiratory illness such as COVID-19 can require ventilator or ECMO support for critically ill patients in an intensive care unit, with ongoing monitoring by respiratory technicians and critical-care nurses. But ICU beds and staffing are scarce resources, and a surge of critically ill patients could quickly fill available beds. Shortages of many other types of staff, space, and supplies are also to be expected. First come, first served is an unsatisfactory approach to allocating critical resources: a critically ill patient

waiting for an ICU bed might be better able to benefit from this resource than a patient already in the ICU whose condition is not improving.

A public health emergency requires planning for and potentially implementing a range of contingencies to manage the increased demand for care and the resource scarcity. Contingency levels of care under emergency conditions unavoidably and gradually reduce quality of care due to limits on staff, space, and supplies. Infection control protocols reduce quality of care in other ways, such as by restricting visitors.

A hospital or health system's institutional ethics services, including clinical ethics consultation (CEC), should function as resources for clinicians experiencing uncertainty and distress under normal conditions. The foreseeable uncertainty and distress that clinicians and teams will face under contingency or crisis conditions call for focused preparation by institutional ethics services; see **Guidelines for Institutional Ethics Services Responding to COVID-19** below.

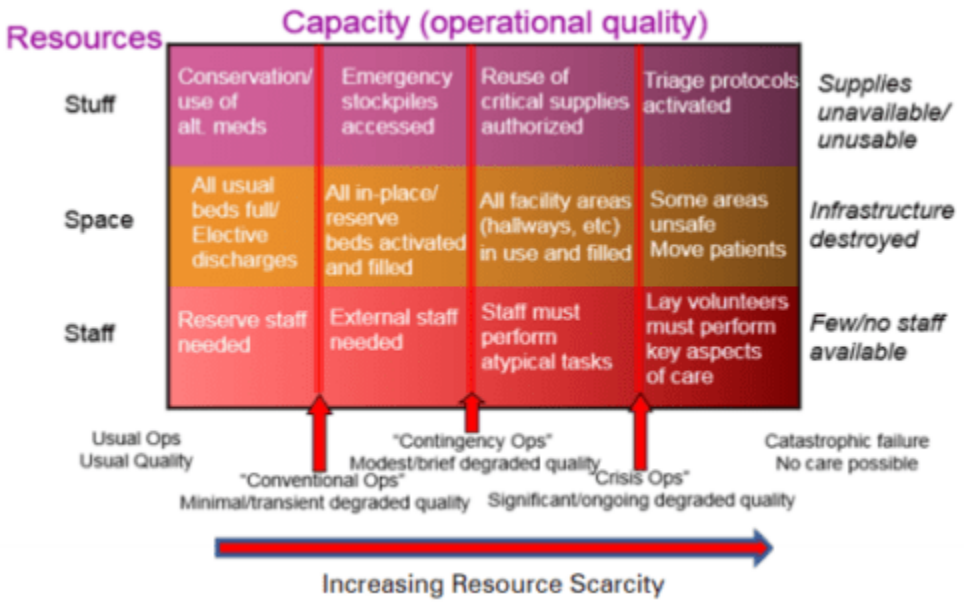

Figure 1: The Gradual Degradation of Quality as Resource Scarcity Worsens
This figure illustrates the granular nature of care quality as it gradually degrades from usual care through contingency and then crisis operations, with illustrative examples of strategies used by organizations to maintain optimal quality of care at each stage despite increasingly severe shortages of staff, space, and supplies. Note that resource categories are interrelated, so shortages in one category affect other categories. For example, there may be adequate numbers of ventilators but not enough trained respiratory technicians and critical care personnel to use them. There may be a need to use crisis standards of care for some resources but not others.

Health care institutions are crucial to our society's ability to withstand and recover from public health emergencies. Support for ethical practice is crucial to health care integrity and the well-being of the health care workforce. Recognizing and addressing the special challenges health care workers face in responding to COVID-19 is part of health care leadership and civic duty.

Examples of Institutional Policies and Processes to Review or Update Using This Framework

This document is designed to help hospitals, health systems that include hospitals, and community health centers conduct preliminary and ongoing discussion, review, and updating of institutional and organizational policies and processes concerning the care of patients during the outbreak of COVID-19 or another infectious disease. Relevant policies and processes include the following:

- institutional and health system policies concerning coordination with public health authorities responsible for surveillance, reporting, quarantine, and resource allocation from federal and state stockpiles (see **Quick Reference** below);
- processes and practices in response to public health emergency mitigation efforts (e.g., school closings and changes to public transportation) as these efforts affect the health care workforce;
- frameworks for allocation of scarce resources, including staff, space, and supplies as well as ventilators and other technologies, within hospitals, systems, and regions;
- policies and processes concerning the transport and acceptance of critically ill patients to tertiary care centers;
- policies and processes concerning discharge, transfer, and leaving against medical advice during an infectious disease outbreak, including limits on the right to transfer during an infectious disease outbreak and emergency conditions;
- policies and processes concerning advance notification of patients and community about care limitations, including through a website, email, and social media and at presentation in the emergency department;

- policies, processes, and practices concerning the use of personal protective equipment, including allocation processes and training requirements for staff, visitors (if allowed), and others, such as guards accompanying patients in custody;
- policies and processes concerning patient registration and screening in the ambulatory setting;
- policies and processes concerning patient privacy and confidentiality of medical information, including notations of infection status in publicly viewable areas;
- policies, processes, and practices concerning documentation and the use of the electronic medical record (EMR);
- practices for managing care of actively laboring patients with exposure risk, policies regarding infant isolation, and breastfeeding guidelines during an infectious disease outbreak;
- policies supporting informed decision-making (in consent for and refusal of treatment), including processes for appropriate use of advance care planning documents during a public health emergency;
- decision-making processes concerning "patients alone" (patients who lack decision-making capacity, advance directives, and surrogate decision-makers), including the potential need to adapt these processes for triage or isolation conditions;
- decision-making processes concerning patients with court-appointed surrogates (guardians or conservators), including communications with judges about rapid responses in such cases;
- policies and processes concerning providing and withholding treatment over the objections of patients or surrogates (including parents/guardians) due to severe resource limitations during a public health emergency;
- processes concerning access to palliative care for symptom relief and comfort-focused care during a public health emergency and potential limitations on life-sustaining treatment, including oversight of palliative care safety under these conditions;
- policies and processes concerning accommodations under the Americans with Disabilities Act for health care workers with underlying health conditions as these accommodations conflict with patient care staffing during an infectious disease outbreak, with attention to management of accommodations of staff in clinical and nonclinical roles, e.g., transport, security, food, laundry, and environmental services.

- policies and processes concerning refusal by health care workers to participate in patient care or nonclinical roles during an infectious disease outbreak, including appropriate and inappropriate uses of conscientious objection processes;
- policies and processes concerning regulated or contractual maximum number of hours and concerning rest periods between shifts;
- processes for employees to report unsafe working conditions;
- processes for employees to obtain support in response to increased workplace and personal stress during a public health emergency, including communications about availability of institutional services and remote services available via local public health departments and social service organizations;
- policies and processes regarding interaction with immigration authorities and supporting health care access for populations fearful of immigration law enforcement or stigma associated with perceived nationality, ethnicity, or infection risk;
- processes and practices for palliative care services in hospitals; and
- processes and practices for institutional services; see Guidelines below.

Other existing policies and processes not listed here will also require thorough review in light of emergency management conditions and local challenges.

Guidelines for Institutional Ethics Services Responding to COVID-19

Clinical ethics consultation (CEC) services, clinical ethics consultants, and ethics committees should recognize duties to promote equality of persons and equity in distribution of risks and benefits in society and consider how best to support clinical practice during a public health emergency.

A hospital's institutional ethics services should prepare for service during a public health emergency.

- Leaders of institutional ethics services, such as ethics committee chairs or clinical ethics consultants, should determine the availability of committee members and consultation providers for service during a public health emergency, mindful that clinicians may have patient care roles and that many members will be limited to remote access.

- Preparation to provide ethics services during a public health emergency should focus on the consequences of contingency levels of care for patient-centered care, the consequences of crisis standards of care for patient preferences, and how ethics services will support clinicians in managing foreseeable ethical challenges in the care of patients with COVID-19. Training in or working knowledge of key principles of public health ethics and disaster response is integral to preparation.
- Ethics leadership should support and contribute to discussion, review, and updating of relevant policies and processes with reference to the ethical duties outlined in this document.
- Ethics services should collaborate with interdisciplinary palliative care services concerning practice under contingency and crisis conditions, in view of their frequent collaboration under normal conditions and the likelihood that these services will be short-staffed.
- Ethics services should prepare to respond to staff moral distress under crisis conditions, with attention to different clinical areas, such as the emergency department, medical ward, and ICU, and to support across shifts. Training in or working knowledge of key principles of public health ethics and disaster response is integral to preparation.
- Clinical ethics consultants should review and update consultation processes and practices to accommodate resource limitations, infection control restrictions, and visitor restrictions.

For our webinar for Hospital Ethics Committees and Clinical Ethics Consultation: https://www.thehastingscenter.org/guidancetoolsresourcescovid19/

Selected Resources
COVID-19

COVID-19: Crisis Standards of Care
J. L. Hick et al. "Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS-CoV-2." *NAM Perspectives.*Discussion paper. Washington, DC: National Academy of Medicine, 2020. https://doi.org/10.31478/202003b.

Italian Society for Anesthesia, Analgesia, Resuscitation, and Intensive Care. "Clinical Ethics Recommendations for Admission to Intensive Care and for Withdrawing Treatment in Exceptional Conditions of Imbalance between Needs and Available Resources." English

translation. March 13, 2020.
https://www.academia.edu/42213831/English_translation_of_the_Italian_SIAARTI_COVID-19_Clinical_Ethics_Recommendations_for_Resource_Allocation_3_6_20.

COVID-19: Obstetrics Care
Centers for Disease Prevention and Control. "Interim Considerations for Infection Prevention and Control of Coronavirus Disease 2019 (COVID-19) in Inpatient Obstetric Healthcare Settings." February 18, 2020. https://www.cdc.gov/coronavirus/2019-ncov/hcp/inpatient-obstetric-healthcare-guidance.html.

COVID-19: Health Care Workforce and Medical Students
J.G. Adams and R. M. Walls. "Supporting the Health Care Workforce during the COVID-19 Global Epidemic." *JAMA*. March 12, 2020.
https://jamanetwork.com/journals/jama/fullarticle/2763136.

Whelan, G. Young, and V. M. Catanese. "Medical Students and Patients with COVID-19: Education and Safety Considerations." American Association of Medical Colleges. March 5, 2020. https://www.aamc.org/system/files/2020-03/Role%20of%20medical%20students%20and%20COVID-19-FINAL.pdf.

Crisis Standards of Care, Resource Allocation, Ventilator Allocation
National Academy of Medicine (formerly Institute of Medicine)

Institute of Medicine. *Crisis Standards of Care: Lessons from Communities Building Their Plans: Workshop in Brief*. Washington, DC: National Academies Press, 2014.
http://www.nationalacademies.org/hmd/Activities/PublicHealth/MedPrep/2014-APR-02/Workshop-in-Brief.aspx.
Institute of Medicine. *Crisis Standards of Care: A Toolkit for Indicators and Triggers*. Report brief. Washington, DC: National Academies Press, 2013.
http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2013/CSC-Triggers/CSC-Triggers-RB.pdf.

Institute of Medicine. *Engaging the Public in Critical Disaster Planning and Decision Making*. Workshop summary. Washington, DC: National Academies Press, 2013.
http://www.nationalacademies.org/HMD/Reports/2013/Engaging-the-Public-in-Critical-Disaster-Planning-and-Decision-Making.aspx.

Institute of Medicine. *Crisis Standards of Care: Systems Framework for Catastrophic Disaster Response*. Report brief. Washington, DC: National Academies Press, 2012.
http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2012/Crisis-Standards-of-Care/CSC_rb.pdf.

Institute of Medicine. *Guidance for Establishing Standards of Care for Use in Disaster Situations: A Letter Report*. Report brief.
Washington, DC: National Academies Press, 2009.
http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2009/DisasterCareStandards/Standards%20of%20Care%20report%20brief%20FINAL.pdf.

B. M. Altevogt et al. *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations*. Emergency Books, 2. Institute of Medicine of the National Academies, 2009.
http://www.inovaideas.org/emergency_books/2.

State-Level and System-Level Guidance

Michigan Department of Community Health, Office of Public Health Preparedness. *Guidelines for Ethical Allocation of Scarce Medical Resources and Services during Public Health Emergencies in Michigan*. Vol. 2. November 2012.
http://www.mimedicalethics.org/Documentation/Michigan%20DCH%20Ethical%20Scarce%20Resources%20Guidelines%20v2%20rev%20Nov%202012.0.pdf.

Minnesota Department of Health. *Minnesota Crisis Standards of Care Framework: Ethical Guidance*. January 10, 2020.
https://www.health.state.mn.us/communities/ep/surge/crisis/framework.pdf.

Minnesota Department of Health. *Minnesota Crisis Standards of Care Framework: Health Care Facility Surge Operations and Crisis Care*. March 1, 2020.
https://www.health.state.mn.us/communities/ep/surge/crisis/framework_healthcare.pdf.

Minnesota Department of Health. *Patient Care: Strategies for Scarce Resource Situations*. May 2019. https://www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf.

New York State Department of Health, New York State Task Force on Life and the Law. *Ventilator Allocation Guidelines*. November 2015.
https://www.health.ny.gov/regulations/task_force/reports_publications/docs/ventilator_guidelines.pdf.

Veterans Health Administration's National Center for Ethics in Health Care, Pandemic Influenza Ethics Initiative Work Group. *Meeting the Challenge of Pandemic Influenza: Ethical Guidance for Leaders and Health Care Professionals in the Veterans Health Administration*. July 2010.
https://www.ethics.va.gov/docs/pandemicflu/Meeting_the_Challenge_of_Pan_Flu-Ethical_Guidance_VHA_20100701.pdf.

United States Department of Health and Human Services, Assistant Secretary of Preparedness and Response (ASPR), Technical Resources, Assistance Center, and Information Exchange (TRACIE)

U.S. Department of Health and Human Services. "ASPR TRACIE Resources." https://asprtracie.hhs.gov/.

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, TRACIE. "Healthcare Coalition Influenza Pandemic Checklist." 2019. https://asprtracie.hhs.gov/technical-resources/resource/4536/health-care-coalition-influenza-pandemic-checklist.

See also:

Centers for Disease Control and Prevention. *Ethical Considerations for Decision Making regarding Allocation of Mechanical Ventilators during a Severe Influenza Pandemic or Other Public Health Emergency*. July 1, 2011. https://www.cdc.gov/about/advisory/pdf/VentDocument_Release.pdf.

Additional Guidance on Resource Allocation and Disaster Response

A. H. Matheny Antommaria et al. "Ethical Issues in Pediatric Emergency Mass Critical Care." *Pediatric Critical Care Medicine* 12, no. 6, supplement (2011): S163-S168. https://journals.lww.com/pccmjournal/Fulltext/2011/11001/Ethical_issues_in_pediatric_emergency_mass.9.aspx.

M.D. Christian et al. "Development of a Triage Protocol for Critical Care during an Influenza Pandemic." *Canadian Medical Association Journal* 175, no. 11 (2006): 1377-81. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1635763/pdf/20061121s00015p1377.pdf.

S.K. Cinti et al. "Pandemic Influenza: The Ethics of Scarce Resource Allocation and the Need for a Hospital Scarce Resource Allocation Committee." *Journal of Emergency Management* 8, no. 4 (2010). https://wmpllc.org/ojs/index.php/jem/article/view/1337.

E. L. D. Biddison et al. "Too Many Patients . . . a Framework to Guide Statewide Allocation of Scarce Mechanical Ventilation during Disasters." *CHEST* 155, no. 4 (2019): 848-54. https://doi.org/10.1016/j.chest.2018.09.025.

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Sisters of Charity of the Incarnate Word, International JPIC Committee
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San Antonio Peace Center
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Texas Catholic Campaign to End the Death Penalty
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