The Covid19 pandemic presents unprecedented challenges for hospitals, healthcare providers and patients. Necessity demands a reexamination of previously accepted norms, including the decision regarding cardiac resuscitation. (See #3 and 4 below for summary) This document presents the critical issues—prognosis, level of resource scarcity, and risk to health workers—that factor into clinical decision making:

- The possibility that CPR may not offer benefit for some patients, particularly those with comorbidities, multiple organ failure, and/or with progressive respiratory failure despite maximal levels of invasive mechanical ventilation.
- Performing CPR and advanced airway management on patients with COVID and judged to have a poor prognosis must also account for increase transmission to healthcare workers, threatening staff well-being and reducing their availability to treat future patients.
- Due to lack of testing and expectation that COVID is prevalent in the community, we should presume that every patient in cardiac arrest may be infected with SARS-CoV-2 and appropriate precautions should be taken before starting resuscitation on all patients.
- If extreme scarcity, even patients without known COVID will compete for ventilators and ICU beds and will be considered in the same allocation guidelines.
- Treatment decisions on each case should be based on similar factors, rather than automatic withholding of certain treatments from certain groups.

RECOMMENDATIONS

1. Attending physicians are not obligated to offer or to provide CPR if resuscitative treatment would be medically inappropriate, even at the request of a patient or legally authorized representative. Several conditions should be met before this applies:
   a. The attending has had a discussion with the patient or healthcare agent about the minimal benefits of resuscitative measures. Direct conversations about code status should take place at the earliest feasible time between the attending/clinical team and patients and/or surrogates.
   b. Due to the limited availability, capacity and capability of other facilities determined at that time, it is impractical to transfer the patient to facility who can honor the advanced directive.

2. For patients with or without COVID, a determination that CPR would be medically inappropriate may be made on the grounds that CPR would not serve a medical purpose because of the patient’s prognosis with or without CPR. In addition, for patients with COVID, the risks to healthcare providers of performing CPR may influence a determination that CPR is not medically appropriate, if coupled with considerations of individual patients’ prognoses. Finally, if personal protective equipment (PPE) is
already being rationed, the need for substantial PPE use to perform high-quality CPR may inform
determinations of medical appropriateness, if coupled with considerations of patients’ prognoses.

a. In the event that the institution has implemented the Crisis Standards for Triage it may also be
appropriate not to offer CPR for certain patients with or without COVID on the grounds that if
the patient had a cardiac arrest and return of spontaneous circulation were achieved, the patient
would not receive a high enough priority for subsequent critical care. When possible, this
determination should be made in coordination with the triage team.

3. If an attending physician, in conjunction with other clinicians involved in a patient’s care, determines
that CPR is not medically appropriate for any of the above reasons, s/he should solicit the independent
review of a second attending physician who is not involved in the patient’s care, whenever possible.

a. If the second attending is available and concurs that CPR is medically inappropriate, then the
primary attending should enter a Do Not Resuscitate order in the medical record and document
how this decision was made.

b. If the second attending is not immediately available and the urgency of the situation and the
decision requires immediate action, the primary attending should document the decision and the
reasoning in the medical record as above.

4. Physicians who decide not to offer CPR should inform the patient or representative of this decision and
its rationale, and assure the patient that all other forms of indicated care will continue. Patient or
representative assent should be sought, but is not required.