The Bakersfield Californian

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COVID-19 **PANDEMIC**

PHOTOS BY ALEX HORVATH / THE CALIFORNIAN

Memorial Hospital registered nurses Steve Menchaca and Emily Rentquiano insert a PICC line, a peripherally inserted central catheter, for a patient in the COVID-19 intensive care unit on Tuesday. Hospital administrators have worked feverishly in recent weeks to stretch staff and resources to keep up with an influx of patients brought on by the COVID-19 surge. Meanwhile, they've also made plans for how to distribute treatment in the event of a worst-case scenario, in which demand for care exceeds available medical resources.

'Bad and getting worse'

Sobering plans in place if local hospitals can't handle patient loads

BY STACEY SHEPARD
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Hospital administrators have worked feverishly in recent weeks to stretch staff and resources to accommodate increased patient loads brought on by the COVID-19 surge, but the influx of patients hasn't stopped. To avoid a situation like what happened in Italy, where so many patients converged on hospitals that many were left on gurneys in hallways to die alone, local hospital officials and consultants have quietly planned for months how to allocate scarce medical resources if demand for care eventually exceeds what's available.

Those who developed the plans now anticipate they may soon be activated.

"The community needs to know the situation is bad and getting worse," said Christopher Meyers, professor emeritus and former director of the Kegley Institute of Ethics at Cal State Bakersfield, who has served as a local hospital ethicist for more than three decades. Meyers helped Kern Medical, Adventist Health and Dignity Health earlier this year develop and update their plans for dealing with a crisis care situation at the area's major hospitals.

Under those plans, hospitals would switch modes in an overwhelm scenario from providing care to everyone who comes through the doors to allocating resources in a way that prioritizes treatment for those who would benefit most from it. The protocols for making such determinations touch on highly sensitive moral and ethical scenarios but are largely borrowed from a collective national body of work agreed upon by medical ethicists and care providers.

Memorial Hospital respiratory therapist Jamie Lovelady suctions a patient's endotracheal tube in the COVID-19 intensive care unit on Tuesday.

Still, it's a nightmare situation for any healthcare worker to be put in.

Faced with one ventilator and two patients who need it, who gets the potentially life-saving treatment?

If eight new COVID-19 patients need the drug remdesivir but a hospital has only enough for four patients, how will those doses be allocated? What factors go into that decision?

"We'll have to make decisions on who is going to get care and who is not, and gets sent away to go home," said Dr. Hemmal Kothary, Dignity Health's chief medical officer for several hospitals in Central California, including Bakersfield Memorial, Mercy Downtown and Mercy Southwest. Under an extreme crisis care

Please see **HOSPITALS | A3**

Q&A: Local ethicist Christopher Meyers

BY STACEY SHEPARD
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The Californian spoke in-depth with Christopher Meyers about how local hospitals have prepared to handle an overwhelming number of patients. These excerpts are a combination of written responses provided by Meyers and telephone interviews.

Meyers

Question: Is it drastic to be writing about this topic? Are we really close to seeing our hospitals become overwhelmed and having to allocate scarce resources?

Answer: Hospitals across the country and locally, along with public health departments, are doing incredible work in stretching resources, but the community needs to know the situation is bad and getting worse. The healthcare professionals with whom I regularly talk are worn out — physically and emotionally — and worried about coming weeks. As they should be: The epidemiological models have been strikingly accurate at predicting the surges and the best ones have long said that January will be the worst month. Current numbers bear this out, especially with a predicted major surge after holiday travel and gatherings and, unless something significant changes, a Crisis Standard of Care (CSC) will be almost certainly declared by next month.

Memorial Hospital nurse Delaney Russom and respiratory therapist Jamie Lovelady consult on a patient in the COVID intensive care unit on Tuesday.

I want to be hopeful that healthcare institutions will be able to stretch resources and continue to work collaboratively, and that the citizenry will take the proper steps that would allow us to avoid CSC.

I would be surprised, though, if we do not end up there by next month at the latest. And I'd note that a few days ago the National Academy of Medicine (with other groups) has called upon governors nationwide to make the declaration now, so that

Please see **Q&A | A3**

McCarthy defends absence from veto override

BY JOHN COX
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News reports out of Washington raised a legitimate question this week about Rep. Kevin McCarthy: How is it the Bakersfield Republican missed one of the most politically delicate situations of the last four years — Monday's vote on whether to override President Donald Trump's veto of the National Defense Authorization Act?

McCarthy

The simple answer is that the House minority leader was recovering at his home in Bakersfield from an elbow surgery three days before Christmas. But there's more to it than that.

McCarthy could have voted by proxy, as many members of Congress have done during the pandemic rather than crowd into the U.S. Capitol. But he said by phone Tuesday afternoon that he refrained from doing so out of principle, not because he wanted to duck a sensitive vote.

"I believe it's unconstitutional to vote by proxy," he said. "I believe you have to be there to vote."

His absence from Monday's vote has drawn criticism, including in posts to his Facebook page, where there was a photo of McCarthy recovering on a couch aside his dogs with a Christmas tree in the background. Some say he should have been in Washington to vote despite the pain and recovery process.

If the timing were better, if he had foreseen the previously unscheduled vote and postponed his surgery a second time, would he have supported overriding the president's veto in a vote that ended up passing 322-87 to approve $740 billion in military spending, including 3-percent raises for U.S. troops?

No, he said.

"I would have supported the president," McCarthy told The Californian.

Even though he originally voted in favor of the act, he said he saw room for improvements just as Trump did. And in line with the president's explanation for vetoing the bill, McCarthy said he favors removing a federal law protecting websites from liability for objectionable content their users upload.

McCarthy added that, had he been in Washington, he also would have voted against a separate bill that proposed giving $2,000 stimulus checks to individuals, as called for by Trump. That legislation passed the House but is opposed by Republican leadership in the Senate and is not expected to make it to the president's desk.

Though still tender, McCarthy

Please see **MCCARTHY | A3**

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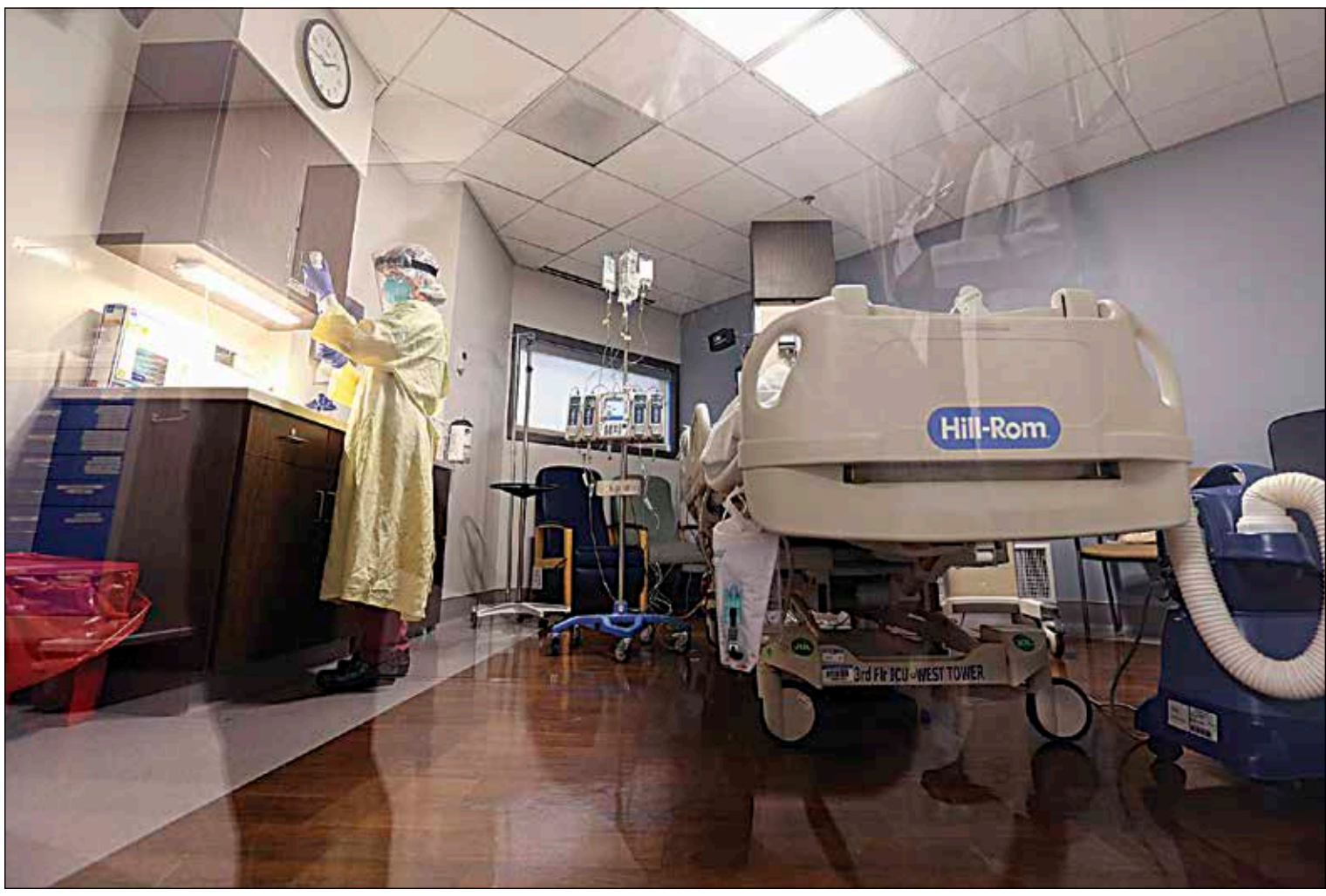
HOSPITALS

Continued from PAGE A1

situation, Kothary would be one of a number of people assembled to make the tough decisions.

He had a plea for the community: "We have to come together. We have to work together no matter where you are, Republican, Democrat, whatever you believe in, whatever you support. Because it's going to destroy a lot of people."



ALEX HORVATH / THE CALIFORNIAN

Memorial Hospital nurse Delaney Russom prepares to administer medicine to a patient in the COVID-19 intensive care unit on Tuesday.

A 'SYSTEM UNDER STRAIN'

Epidemiological models have been strikingly accurate in predicting surges "and the best ones have long said that January will be the worst month," Meyers said.

Local hospitals are currently swamped with a surge set in motion following the Thanksgiving holiday. The fear is in the coming weeks, another swell of patients from the back-to-back Christmas and New Year's holidays will create another surge on top of the current one.

On Monday, there were close to 400 COVID-19 patients in local hospitals, a new high.

It's not just numbers and models foretelling this dark scenario. Meyers said he hears it from the healthcare workers he talks to on a regular basis.

Reports of more people on a ventilator than a hospital has ever seen.

A critical care nurse seeing more deaths in the past month than in the previous several years.

"We are flooded with patients," said Dr. Ronald Reynoso, who is chief medical officer for Adventist Health's Bakersfield and Tehachapi hospitals.

Signs of a mounting crisis are evident elsewhere, as well. Several local hospitals in recent days asked the county public health office to help them find extra staff. One hospital requested more ventilators from the county's stockpile, according to Kern County Public Health Services Director Matt Constantine.

"The system is under strain," Constantine said.

During the summer COVID-19 surge, the state sent in National Guard units to help at several Bakersfield hospitals. This time around, with so many other parts of California facing similar crises, that help isn't available, Constantine said.

Already most local hospitals have received a waiver from the state to go outside of legally-mandated nurse to patient ratios. It is one way hospital administrators can stretch their resources to continue providing traditional care. In addition, many hospitals are asking nurses and hospital staff to work overtime on scheduled days off.

> **"We have to come together. We have to work together no matter where you are, Republican, Democrat, whatever you believe in, whatever you support. Because it's going to destroy a lot of people."**
>
> ***— Dr. Hemmal Kothary***

SOBERING PLANS AND PROTOCOLS

The federal government first asked counties to develop crisis care plans in 2007 and 2008. But in light of the real threat of having to invoke them after seeing how hospitals were inundated in New York and Italy early in the pandemic, local health officials took action earlier this year to update the plans and ensure they're ready to go.

"These are concepts we've always had on the shelf. It's sobering to think we're at a point where they're needed," Constantine said.

Under those plans and protocols, a team at each hospital would be activated, made up of a rotating group of doctors, critical care nurses and hospital administrators. The committee would be called upon to triage cases as they arrive and determine who is most likely to benefit most from treatments that are available, based on specific medical criteria developed by national experts. Those decisions are then communicated to frontline care providers.

Palliative care would be provided to patients for whom care is not provided and information on hospice resources would be given to the family.

There is an appeal process, whereby a doctor treating patients could challenge the committee's decision. However, that appeal — which involves a hospital ethicist, chaplains and other experts — only involves a review of how the patients were initially scored and the appeals group cannot make unilateral decisions about who gets care.

A person's age, race, sex, disability status, religion and ability to pay legally cannot be an explicit factor in making the decisions. However, many of the protocols do assess factors such as an individual's likelihood of survival over the next year, which could bode poorly for the elderly, those with serious underlying medical conditions and people with traumatic injuries, for example a major head injury, or end-stage disease.

Operating in such dire circumstances could last anywhere from six hours to several days or a couple of weeks depending on how intense and sustained the influx of patients remains.

Some local hospitals have already printed fliers to be distributed to families coming into the ER, explaining the crisis situation and the shift in how care is provided. Similar fliers have been made up to hand out to staff.

WHAT YOU CAN DO

- Don't gather with people outside your household
- Wear a mask
- Practice social distancing
- Wash hands frequently
- If you have symptoms of the virus, contact your healthcare provider and avoid contact with others
- Know that some people with COVID-19 do not appear outwardly sick and may not exhibit symptoms
- Those experiencing other medical emergencies such as heart attack or stroke should not delay care. Call 911 and go to the nearest emergency room.
- If you have a medical background that could be useful to area hospitals and medical providers, contact the Kern Medical Reserve Corps at 321-3000.

DECISIONS NO ONE WANTS TO MAKE

Kothary, who has practiced medicine for 20 years and was inspired to become a doctor from watching "Marcus Welby, M.D." as a child, said he believes the community is coming very close — perhaps within two weeks — of hospitals entering a crisis care mode.

Locally, the trajectory of COVID-19 has followed about two weeks behind Los Angeles, said Kothary, who also oversees two hospitals in Stockton and one in Merced. He has noticed what happens in L.A. is seen in Stockton a week later and in Bakersfield about two weeks later.

"It seems to jump Kern and go up north to Stockton and come back down," he said.

The Los Angeles Times has reported in recent days that hospitals there have diverted ambulance traffic and even closed their main entrances to the public.

Kothary

Ambulance diversion is not an option in Kern County under local rules.

Unless things change, Kothary said he will likely activate crisis status at the Mercy and Memorial hospitals next week, which would put hospitals at the ready to call upon its committee if needed.

"We'll call everyone (on the committees) and let them know to be ready if an issue comes up," he said. "We never want to ever go there but we also don't want to be surprised."

In a 2014 interview with Bakersfield Life magazine upon being named chief medical officer for Dignity Health, Kothary said he was drawn to medicine because he "loved the idea of being in a small town taking care of people."

Now, the COVID-19 pandemic threatens to put him and his colleagues in a position no one would envy.

"Someone's going to have to go to the family member and say we don't have the ventilator your family member needs," Kothary said. "That's what keeps me up at night. Worrying about that."

Q&A

Continued from PAGE A1

communities and hospitals can prepare accordingly. They obviously wouldn't make such a call if they didn't think the emergency was very, very real.

There's still some reason for hope. The nationwide numbers are flattening out. California seems to continue to go up. Everything depends on what folks are doing with their lives if we go into surge or not.

Q: What are you hearing when you talk to local healthcare professionals right now?

A: You get reports of more people on a ventilator than an institution has ever seen. You get more deaths in the last month than a critical care nurse had seen in the previous several years. We're at a better place than we were back in March/April/May because we know more about how to treat it. But there's a profound sense of being a step behind the disease. That adds to the fatigue and distress and, really, the moral distress they're feeling.

I was talking with a new physician at one of the regional hospitals last week. He said, "We can't keep up with how many people we need to put on ventilators." They're getting so many sick folks that need ventilators and they're doing everything they can to spread resources. I could hear real torment in his voice as he was describing it.

Q: What is the trigger that sets these crisis care protocols in motion? Does someone at the hospital officially declare a crisis situation and activate these protocols? Is it hitting a certain number of patients, etc.?

A: The declaration of Crisis Standard of Care (CSC) can occur at three levels: 1. The state (governor and California Department of Public Health) can declare it for the entire state. This is less likely, but not out of the question, given how widespread the virus is. 2. Kern County Public Health can declare it for the county, which would trigger it for all the hospitals. 3. Individual hospitals can declare it. Normally the third option is restricted to situations of medical surge caused by a major accident situation or natural disaster; with a virus or other disease, it's easier to plan for impending surges and to transfer patients to nearby facilities where possible. However, if neither the state nor county has declared CSC and an individual hospital has become overwhelmed (with no option to transfer), its leadership can make the declaration.

There are specific defined levels of medical surge: Conventional, Contingent (Phases 1 and 2) and Crisis. The levels are determined by the defined area's (state, county, hospital) ability to accept patients in core service areas (ED, ICU, Telemetry). Restrictions can be caused by either a lack of bed space, lack of equipment (e.g., ventilators), or lack of staff. The specific overload numbers for each level are, I believe, defined by state regulation.

Q: In your 30-plus years as a hospital ethicist, have you seen anything like this?

A: During a bad, bad flu season, it's not at all unusual for individual hospitals to go into a short-term crisis standard just because they're getting so many sick folks coming in they have to implement procedures and open up surge units. In a bad flu season it's not that unusual. It also happens when there's a major accident — back when we had bad fog, and you would get 40 cars piled up on Highway 99.

What's different about this one is it's ongoing and it's widespread. No practicing professional has seen anything of this magnitude during their years of practice. This is new to our generation.

Q: How would the public know if Crisis Standard of Care has been declared and if triage protocols are happening at their local hospital?

A: There's been considerable discussion among hospitals about how to handle that and there was no consensus. If they do declare it, it will be very public in-house. We've already printed up fliers to hand to folks. If someone is coming into the ER, they will be told the information, who they can talk to, where the support systems are for those folks.

Q: If the protocols are activated, what are the instructions that might be given to a doctor or nurse? How different from the normal approach to care would this crisis approach be?

A: This gets at the core of triage protocols. If CSC is declared, a triage committee is activated and composed of a rotating group of critical care physicians, critical care nurses, and a representative from hospital administration. This group will be charged with allocating scarce resources — broadly and in specific cases — when there are not enough for all those who might conceivably benefit from them. These allocation decisions are dictated by specific medical criteria developed by national experts (e.g., The Task Force for Mass Critical Care and the American College of Chest Physicians) and that have clear predictive force in determining which patients are most likely to benefit from critical care interventions. The committee gets activated only if CSC has been declared.

Their decisions can be reviewed, upon request, by an interdisciplinary appeals committee that includes medical, nursing, legal, and ethics.

The goal with having it done as a team is that it takes the attending physician out of the immediate loop. That's good for two reasons. It takes the burden off of them ... it is a hospital decision.

The other is a recognition that we ask doctors and nurses to be patient advocates and do everything for them without knowing what's going on.

Q: What else did you have to consider in drawing up these plans?

A: We spent a lot of time getting palliative care on board and area hospice groups if patients are sent home, to try to connect them with good hospice care.

There are images and direct firsthand accounts from Italy of patients being put on gurneys in hallways. Staff couldn't provide emotional or spiritual support. For us, we've got to do whatever we can to make sure that doesn't happen here.

Q: How long might a hospital be in CSC mode with its committee activated, making decisions about how to allocate resources?

A: You're only in CSC for as long as the numbers warrant it, based on a shortage of bed space, staff available or equipment. It could last six hours at a hospital and never happen again. It could last six days or three weeks.

MCCARTHY

Continued from PAGE A1

has not been entirely idled by the elbow surgery, which he said was an outpatient procedure — originally set for Dec. 15 but postponed amid federal stimulus talks — involving bone perforations and clearing away tendons. He said the condition had been treated previously with steroid shots and platelet injections.

While recovering in Bakersfield, he said, he spent days on the phone with Trump, together with Treasury Secretary Steven Mnuchin, trying to persuade the president to sign a bill extending federal unemployment benefits and offering individuals a $600 stimulus check. After initially coming out against the bill, Trump signed it Sunday.

McCarthy said he didn't argue the case so much as he helped Trump come around.

"The president always makes up his own mind," he said. "Was I able to be a part of explaining things? Yes."

McCarthy said he did not suddenly adopt a position against congressional proxy voting because it helped him out of a tight spot.

He sued in May to halt the practice, alleging the Democrats' use of proxy voting was unconstitutional and amounts to diluting congressional votes because it allows appointed members who vote in person on behalf of others. He said he and other Republicans refuse to participate in the proxy system because it endangers the bills approved in that way.

"I believe if you vote by proxy it'll make the bill unconstitutional," McCarthy said.

His legal counsel, Machalagh Carr, said by phone the nation's founders were aware of proxy voting but they "specifically chose not to allow it" because it undermines face-to-face debate and discussion.

"Even then they realized the importance of people coming together," she said.

McCarthy said the elbow surgery went well but it was serious enough that he didn't get to see his mother for Christmas. A full recovery is expected to take three months, he added, but maybe he'll heal before then.

"I'll do that fast, hopefully," he said.