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CANADA

Ontario developing 'last resort' guidelines on which patients to prioritize if hospitals are overwhelmed by critical COVID-19 cases

By **Jennifer Yang** Staff Reporter
Sun., March 29, 2020 | 7 min. read

The provincial government has developed a "triage protocol" for doctors who may soon be forced to make ethically fraught decisions over how to ration critical care beds and ventilators — a policy document that will shape life-or-death choices over which patients to prioritize if hospitals become overwhelmed by the COVID-19 outbreak.

The document, dated Saturday and obtained by the Star, suggests the province is taking steps to prepare for worst-case scenarios already playing out in hard-hit regions such as Italy and New York, where COVID-19 wards are overflowing and doctors are being forced to ration life-saving interventions like ventilators.

It acknowledges that intensive care units (ICUs) in Ontario are already operating near — or even above — capacity and that "even the lowest estimates of (COVID-19) incidence would exceed our capacity at an early stage."

"There is a compelling need to prepare a triage system to allocate critical care resources in the event of a severe surge in demand, to be used only as a last resort," states the document, which was published by Ontario Health, the newly created "super-agency" for overseeing health-care delivery in the province. "The consequences of failing to prepare for this eventuality are potentially serious, as has been seen in Italy, a country with similar ICU resource levels to Canada."

The protocol document was developed by Dr. James Downar, secretary of the Canadian Critical Care Society and a critical care specialist at the Ottawa Hospital, who was working "under the auspices" of the province's COVID-19 command structure. When reached by email, Downar said he was referring all media requests to Ontario Health, which was unable to respond by deadline.

The province did not respond to questions about whether the document represents the finalized protocol or a working version. But its existence is sure to provide some measure of relief to anxious ICU physicians across Ontario, who have been following the harrowing stories streaming out of COVID-19 epicentres such as Italy and New York while also watching the coronavirus outbreak become increasingly urgent at home.

Last week, Ontario saw the number of COVID-19 patients being treated in ICUs jump from 17 on Wednesday to 63 on Saturday. The Ministry of Health told reporters that the province's current ICU capacity is at 68 per cent, with efforts underway to clear more ICU beds and procure more ventilators — including 300 already purchased and newly secured contracts to provide as many as 10,000 more.

But as of Friday, the most specialized ICU beds — known as Level 3 beds, needed by the sickest COVID-19 patients — were already at 85 per cent capacity.

"From a critical care physician's perspective, this (triage) document is crucial," said Dr. Bram Rochwerg, an associate professor at McMaster University and critical care physician, researcher and site lead with the Juravinski Hospital in Hamilton. "I don't think any critical care doctors in Canada anticipated a situation where we might have to start triaging based on resources that

we had. It’s scary … (but) having a policy provides protection and pathways and protocols to enact if, God forbid, we ever get to that point.”

The protocol document states that the purpose of a triage system is to minimize death and illness for the population overall and ensure consistent and predictable guidelines.

The system will be triggered only if local resources have been depleted and every attempt has been made to relocate patients to other facilities that still have capacity. The document acknowledges, however, that “transportation resources will become stretched in a pandemic and this will not always be possible.”

The document states that the health-care system can adjust to “mild” or “moderate” surges by adapting existing resources, such as using operating room ventilators or enlisting non-ICU staff.

But if the system enters a state of “major surge” — defined in the protocol as a system operating at 130 per cent capacity or more — regional hospitals are informed that triage will be “imminent.” When the system hits a breaking point (theoretically defined in the protocol document as 200 per cent of normal capacity), triage protocols are activated and begin to escalate in a stepwise fashion, where the more overwhelmed the system becomes, the stricter the criteria for which patients will be prioritized for critical care.

Under the triage protocol, patients will be assessed according to both inclusion and exclusion criteria. Those who are excluded from treatment will be patients “who are very likely to die from their critical illness, and people who are very likely to die in the near future even if they recovered from their critical illness.”

At level 1 triage, for example, doctors are advised to exclude patients who have greater than 80 per cent predicted mortality. At level 3, patients with greater than 30 per cent predicted mortality will be excluded. Under the triage protocol, long-term-care patients who meet specific criteria will also no longer be transferred to hospitals.

Decisions on which patients are excluded will be based on “good data to show who is unlikely to survive a long critical care stay when they have COVID” or any other critical care issue, said Dr. Alison Fox-Robichaud, past president and spokesperson for the Critical Care Society of Canada, which consulted on the triage protocols.

The decision to activate the triage system will also be made regionally and treatment decisions for specific patients will be made by a team of people — thus relieving individual doctors from having to shoulder these burdens alone, she said. “I think the most important thing from a critical care perspective is this isn’t going to be an individual critical care physician’s decision, if we have to invoke this.”

Patients who no longer meet the criteria for care under the triage system will be removed from life-saving interventions like ventilation or not have them offered, according to the protocol. But this does not mean these patients will stop receiving medical treatment or care. They will also receive “the highest priority for palliative care.”

“(This protocol is) coupled with a clear palliative care plan so that if we have to, heaven help us, get into this situation, we are going to be providing good care, kind and compassionate care, to the best we can in the middle of a pandemic,” Fox-Robichaud said.

The protocol outlines three guiding principles for the triage protocol, the first being “utility,” meaning physicians should allocate resources to patients who stand to benefit the most.

The second is “proportionality” — in other words, the number of patients who will be negatively affected by this last-resort triage system should not exceed the number of people who stand to benefit.

The third principle is fairness, meaning only clinical information should be used to decide which patients are treated over others. “Priority should not be given to anyone on the basis of socioeconomic privilege, or political rank.”

Trudo Lemmens, a bioethicist and professor of health law and policy with the University of Toronto, said he feels this last principle has been given short shrift in the protocol and he would like to see more explicit language guaranteeing that all patients — particularly those from vulnerable populations — will be considered equally. He is especially worried about patients who may be more easily assessed as having a poorer chance of survival — for example, people with disabilities or homeless people. “It suggests too easily that these clinical assessments are value-neutral,” he said.

Lemmens also finds the notion of removing patients from life support to be ethically problematic. “If it comes to a situation where somebody’s on a ventilator and we already committed to this person who is receiving the necessary care, I think it may be more problematic to withdraw that from a person with significant chance of survival than to say to somebody who now enters the hospital system, ‘Well, we currently don’t have anything available,’” he said.

For critical care physician Dr. Robert Fowler, the province’s triage protocol is the kind of document “you prepare but hope to never use,” but he is glad that it now exists and is generating an important conversation.

“This is the first time that Ontario has really had to grapple with this in a concrete way,” said Fowler, who works at Sunnybrook Health Sciences Centre.

He believes it's too soon to say whether Ontario or Canada will see a COVID-19 crisis of Italy or New York proportions and he believes it's still possible social distancing measures have made a difference in flattening the curve. He notes that critical care units across the province have also become very well integrated since the SARS crisis, so that even if one hospital or region reaches capacity, there is still the option of relocating patients to other regions or even provinces before activating the triage system as a last resort.

In the meantime, he says, the general public can do its part in preparing themselves for their own worst-case scenarios. People should be having difficult conversations now about whether they would even want ventilation or other invasive interventions should they ever find themselves in an ICU ward — if the answer is no, then that would mean freeing up a bed or ventilator for another patient who would want it.

"These are always the sort of conversations that you think, 'Oh gosh, I don't want to talk about that,'" Fowler said. "But it's a conversation that's as relevant now as it ever was."

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