William Osler Health System

MEMORANDUM

To: All Osler Physicians, All Staff of Critical Care, Respiratory Therapy and Emergency Department Services

From: Francesca Fiumara, Director of Medicine, Critical Care and Respiratory Therapy
Dr. Brooks Fallis, Interim Medical Director of Critical Care

Cc: Dr. David Borts, Interim Chief of Staff
Dr. Oscar Karbi, Chief of Emergency Services
Tara Coffin-Simpson, Director of Emergency Services
Paula Chidwick, Director of Clinical and Corporate Ethics
Clint Atendido, Associate VP of Clinical Operations and EGH Site Executive

Date: April 14, 2020

Subject: Access to Critical Care Services

The global COVID-19 pandemic brings new challenges to our health care system. While we are preparing for every possible eventuality, we are also preserving our non-COVID critical care capacity.

Currently, the pandemic is putting a strain on our critical care system. We have carefully built a strong expansion plan at both hospital sites. At this time, demands **do not** exceed our physical capacity to care for non-COVID critical illness or COVID-related critical illness:

- **We <u>are not</u> diverting critical care patients to the ward.** While we have been preparing for this as a safe strategy in the event of capacity challenges, we have not arrived at this phase yet. This plan is still in development.
- **We <u>are not</u> in a triage situation.** This requires an Order from Cabinet and direction from the Provincial Critical Care Command Table.

Physicians proposing admission to hospital or proposing critical care to patients/Substitute Decision Makers based on clinical need remains unchanged, regardless of COVID-19 status. In other words, patients consenting to treatment and hospitalization should be admitted, and those who may require critical care should receive consultation from an intensivist (or delegate).

Now more than ever we require the skills, expertise and training of physicians to expertly assess and propose clinically indicated treatment interventions. As pressures increase on our

health care system, we will rely on physicians to propose the right treatment for the right patient at the right time. This is supported by our current laws (HCCA) and ethical principles. In short, this means:

- **A patient who is felt to benefit from critical care should be offered critical care.**
- **If your professional and carefully-considered opinion is that a patient will not benefit from an intervention, it should not be offered.**
- **This is NOT triage, but best medical practice.**

Many patients diagnosed with COVID-19 will survive. Unfortunately patients with ***ARDS*** from COVID-19 have a very poor prognosis. The decision-making around offering invasive mechanical ventilation to this subgroup may be different, but still follows the same guiding ethical and legal principles.

In the coming weeks and months the situation *may* change. We are hopeful that societal behavioral changes and public health initiatives will keep the point prevalence of COVID-19 to a level which can be managed in our system.

If our system becomes overburdened, a decision could be made by the government to lift the health care consent act and enact triage criteria. This will **NEVER** be a local decision. This very serious step to trigger a triage protocol would require an order from Cabinet AND direction from the Provincial Critical Care Command Table.

While we are preparing for this possibility, it is not our current reality.

At this time, everyone who needs critical care and can benefit from critical care, will get treatment.

Please frequently review relevant sections of our website (www.covidcriticalcare.ca), updated daily as required, as a way of ensuring we are referencing the most recent information in a rapidly changing clinical environment.

Thank you for continuing to practice safe, compassionate and best practice medicine.

Please reach out to Francesca or Brooks with any questions.