Re-Envisioning Mass Critical Care Triage as a Systemic Multitiered Process

To the Editor:

The article by Devereaux et al has made a valuable contribution through the provision of detailed guidelines for mass critical care practice. However, it is important to further contextualize critical care triage as a core component of a broader triage system. Envisioning triage as systemic process emphasizes the crucial interrelationships among patient care, the process of central decision making, and triage implementation itself.

Large-scale catastrophic events require a crucial shift from individually based care to population-based care through the adoption of an operational process that influences critical decision making at all points of contact. This can be viewed as a multitiered process that incrementally addresses mass critical care decision making under significant resource constraints. When necessary, decisions at each point of contact must ensure that only appropriate patients are directed to a critical care site for final disposition critical care site. This systemic process relies on first-order triage practices to interface with the community to reduce risk exposures and define appropriate standards of care for the affected population; second-order triage at the prehospital/staging facility level to sort casualties for treatment and transport; third-order triage at the hospital level to optimize patients’ opportunities for survival within the constraints of available resources and procedures; and lastly, fourth-order triage at the regional level to provide system-wide oversight and resource support of the public health response. Such a process is inherently dynamic, with casualty prioritization remaining subject to change based on timely implementation of a central command structure, the availability of accessible resources, the accuracy and timeliness of situational awareness, and the efficacy of risk communications. The seamless integration of this systems-based model, coordinated through the incident command system and a deployed Health Emergency Operations Center will ensure that treatment prioritizations are undertaken in a manner that is effective and equitable.

Ultimately, critical care decision making and outcomes are only as good as the underlying triage-management system. The incorporation of a systemic triage protocol will alleviate the patient care burden at each subsequent tier and reduce the overall need to ration care. Accordingly, triage management can no longer be thought of as an isolated department- or hospital-level process.

Italo Subbarao, DO, MBA
Nathan A. Bostick, MA, MPP
American Medical Association Public Health Readiness Office
Chicago, IL

Frederick M. Burkle, Jr, MD, MPH, DTM
Harvard Humanitarian Initiative
Cambridge, MA
Edbert B. Hsu, MD, MPH
Johns Hopkins University Office of Critical Event Preparedness and Response
Baltimore, MD
John H. Armstrong, MD
University of Florida College of Medicine
Jacksonville, FL
James J. James, MD, DrPH, MHA
American Medical Association Center for Public Health Preparedness and Disaster Response
Chicago, IL

The authors have no conflicts of interest to disclose.

Reproduction of this article is prohibited without written permission from the American College of Chest Physicians (www.chestjournal.org/misc/reprints.shtml).
Correspondence to: Italo Subbarao, DO, MBA, American Medical Association Public Health Readiness Office, 515 N State St, Chicago, IL 60657; e-mail: Italo.subbarao@ama-assn.org
DOI: 10.1378/chest.08-1891

REFERENCES


Response

To the Editor:

We appreciate and agree with the triage concepts put forth by Subbarao and his distinguished coauthors. Prior to the framework proposed by the Task Force for Mass Critical Care, regional coordination of individual ICUs in the United States had undergone limited conceptual development. Much detailed guidance was needed for critical care professionals to enhance surge capability and optimally allocate scarce life-saving interventions during disasters. This was the focus of the framework of the task force, but, for clarification, we agree that critical care triage should not happen in isolation. Instead, the framework was intended to be integrated into a broader triage system.

Given the experience with severe acute respiratory syndrome (or SARS) a few years ago and the burgeoning concern about a