Triage: Going full circle? Hopefully

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Some 30 years ago, as a medical student in Bombay, I questioned one of life's secrets: we had hundreds of poor, illiterate people attend our outpatient clinics daily. How did these patients know which queue to join? The answer came in the form of a head porter, a gentleman clad in khaki who carried out "enquiries" at the front door. Conversations were brief:

"So you've had a cough for 2 weeks. Any fever?"

"Yes sir, every night."

"Well, I think you should go to the TB clinic which is situated over there," the man in khaki would say, noting that the patient looked a little emaciated.

And of course if someone arrived in distress or just appeared sick, "Casualty" was round the corner.

Considering my hospital currently employs more than 25 nurses for the purposes of triage, this porter did a great job. Blessed only with common sense, knowledge of the system and a willingness to make decisions, he was able to help hundreds of patients each day. I cannot recollect a resident ever speaking critically of his "triage" skills, though that dreaded word wasn't then in common use.

Throughout the '80s and the early '90s, in British "accident and emergency" departments, efficient receptionists, with similar qualities to my khaki-clad friend, triaged thousands of patients, asking some to sit down and others to go "straight in, and I will call the doctor." Promoting children was commonplace. These receptionists were supported by a nurse, and performed a not-too-difficult task with class and efficiency and no blood pressure cuff in sight! They kept an eye on the waiting area, constantly re-evaluating patients. "Would you like something for the pain?" was a standard question, one far more reasonable than the drivel overheard nowadays:

"That pain in your big toe, what does it feel like?"

"Feel like? Um, it just hurts."

"Does it throb or is it like a knife?"

"A bit of both, really."

"We'll say it throbs, then. How much does it throb? No, I need a number between 1 and 10. Can't accept words such as 'a lot' ... let's choose a 7 shall we ... no, make it a 5."

If we spent as much time relieving symptoms as we do documenting them, the patients would be a lot happier. What comes next? A 10-point nausea scale, a 12-point fatigue scale and a 20-point, 3-colour aggravation range? All this, despite the fact that visual analog scales have not been shown to be useful in acute pain, let alone in emergency department waiting rooms where patient encounters may lack privacy, are emotionally charged, stressful and often present major language barriers.[1,2]

In some undefined moment that was ultimately to revolutionize the meaning of science and sensibility, some persons decided that triage had to be formalized and structured. Their motives were good, but they did not foresee the monster they would create.

Manchester in the UK developed a system that extolled the virtue of doing an ABCD check (airway, breathing, circulation, disability) on everyone, in-grown toenails included.[3] It was not universally well-received.[4]

But observation-driven triage systems such as the Canadian Emergency Department Triage and Acuity Scale (CTAS) took matters to a new extreme.[5] From one of the most stressed-out health care systems in the developed world[6,7] came an expensive paradigm: nothing is "minor" unless the accompanying observations (blood pressure, pulse, oxygen saturation and coma scale) are normal. Never mind that such observations are often not reproducible![8] Take that logic further and things get worrisome; for example, no brain is uninjured until a computed tomography

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Submitted June 22, 2008; Accepted Aug. 7, 2008

This article has not been peer reviewed.

CJEM 2009;11(1):120;119

https://doi.org/10.1017/S1481803500011015 Published online by Cambridge University Press

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scan is normal. And why does triage carry on ceaselessly during those rare times when beds are available in the department?

Clean and dry dressings applied to wounds were to be (painfully) removed and infection invited because everything had to be "inspected," anuses included. And all in the name of "triage." Observation-driven triage had invented a new "science," namely, the sideshow. Sadly, it is a sideshow that harms patients by wasting time and resources. But play a game long enough and it becomes reality: many nurses now subliminally believe that triage is the sole reason patients attend the emergency department! Witness the response to a busy shop floor: triage must go on, unfettered! More staff is dispatched to the farce at the front door even though the bottleneck that requires release is invariably at the point of definitive care, wherefrom resources are diverted! Try telling a CTAS-disciple at such times that triage needs only 1 experienced nurse or doctor, and everyone else should be at the front line (a point that is never triage), and they will seek to confine you.

A recent short stint back at the Department of Emergency Medicine, Sandwell Hospital, in Birmingham, UK, was refreshing. Observation-driven triage had been penetrated by intelligence and was exposed for the sham it really was. As a result, a glass screen was interposed between the nurse and the patient. A good history and an active eyeball (with attached brain) were the only tools allowed. No fanciful examinations permitted in triage. Pain was alleviated if the patient wanted it to be. Children were sped through regardless. Importantly, 1 nurse did it all, and did it well.

So, should we have triage? Of course we should. But what we must resist is the tendency to lend the process a shroud of science when it is no more than a blend of experience, decision-making and broad guidelines. Sick or seriously injured patients should be eyeballed and taken directly to "Resuscitation." (Call them category 1 or 2 depending on their responsiveness). Patients with minor injuries should be eyeballed and seen by a fast-track practitioner as quickly as possible (assisted by staff who might otherwise be wasting their time in triage). Call such patients category 4. That leaves a core group of conversant and orientated patients (stable) inside the department who will require further assessment. Call them category 3's. That's it in a nutshell. There's no more science to it than that.

Sadly, I still encounter the negative outcomes of observation-driven triage regularly. I remember seeing a man with an ankle sprain who enjoyed a coma scale of 15. Just what I needed to know! And I had to call him into my consulting room and take his bandage down myself because — you got it — the nurses were all in triage. Now all I need to see is a cement burn in the eye that I will commence irrigating urgently. I do hope he hasn't been kept waiting, even though his vital signs are normal.

Competing interests: None declared.

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https://doi.org/10.1017/S1481803500011015 Published online by Cambridge University Press