
03-Aug-2020
BMJ-2020-060204 Lessons learnt from a close encounter with triage

Dear Dr. Cairns,

Thank you for giving us the opportunity to consider this paper, which we discussed at our editorial meeting (present: Paul Simpson, Peter Doshi, Emma Rourke, Sophie Cook).

We are pleased to make a provisional offer of publication if you are able to revise it to address the points made by the referees and the editors. The referees' and editors' comments are available at the end of this letter.

We hope that you will be able to revise the paper and send it back to us soon. When you resubmit, could you kindly ensure that you provide:

(a) A covering letter outlining how you have responded, or not responded and why, to both the referees comments and those of the editors.
(b) A word count (excluding the references and words in boxes and tables). You should aim to keep this count below or very close to 2000 words.
(c) Please check that all the information required in the manuscript (see note below) is included in the revised manuscript.

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I hope you will find the comments useful.

Best wishes,

Paul J. Simpson, PhD
International Editor, The BMJ
psimpson@bmj.com

INFORMATION TO INCLUDE IN REVISION
Please would you also check that you have provided the following information

* Competing interest statement (in the style explained at http://www.bmj.com/about-bmj/resources-authors/forms-policies-and-checklists/declaration-competing-interests)

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Editors' Comments:

:: Can you reconsider your title. The editorial team wondered whether something along the lines this from the key messages - making ordinary decisions in extraordinary times - may be more engaging.

:: Can you recraft your standfirst. It may be worth looking at other Analysis articles as a model but these are usually a single sentence.

:: Could you specify "in London" here - I know this is obvious from your affiliations but these are often not read by readers (or hard to find). "as a COVID-19 Ethics Working Group at a large teaching hospital"

:: Rather than referring to "The paper…" could you continue to engage the reader in the last sentence of the introduction. It could read something like this:

"What we've learned from the first wave of covid-19 has implications for a potential second wave and subsequent public health emergencies that could place NHS resources under strain."

:: Your article is very well written but the title, standfirst, and introduction all have a slightly stilted feel that many academic articles suffer from. It would be fine to change your title and standfirst' and adjust the final sentence of your introduction paragraph. However, I think your article would be better if you went even further and deleted the first paragraph. The article would then start at a much more interesting hook "The current pandemic has led to unprecedented uncertainty…" rather than "Ethical guidance has been produced…" You could then move your nutshell paragraph to the end of the "pandemic arrives" section (which would now be your intro):

"As a COVID-19 Ethics Working Group at a large teaching hospital in London, we believe that the lack of practical national guidance with some concrete degree of detail has had other unforeseen consequences that require consideration. What we've learned from the first wave of covid-19 has implications for a potential second wave and subsequent public health emergencies that could place NHS resources under strain."

:: Can you take a careful look at acronyms and jargon and explain them if they are not going to be universally obvious. For example:
> Who is SIAARTI? (The Italian Society for Anesthesia, Analgesia and Intensive Care).

> Readers will probably find it more useful to know the NICE guideline was for critical care in adults rather than its code (NG159), especially given that there is a reference to the guideline itself (which appears to be broken).
> The acronym ED is defined but not used.

:: "Especially in the face of high numbers of UK deaths and the spotlight on care home deaths, a very real question must be as to why this has been so." Could read: "In the face of a high number of UK deaths and the spotlight on care home deaths, the question must be asked: how did this happen?"

:: Your manuscript is really nicely written but there's a couple of places where you write very long sentences. Readers will struggle with these unless you break them up into shorter sentences.

There's a nice article on gov.uk about sentence length:
https://insidegovuk.blog.gov.uk/2014/08/04/sentence-length-why-25-words-is-our-limit/

Here's a sentence that is 68 words long: "There is increasing concern that GPs were put in the unenviable position of being asked to contact their elderly and frail patients to hastily discuss decisions about ICU admission and resuscitation, and that together with altered ambulance service thresholds for transfer to hospital, this led to barriers to accessing hospital for some who may have benefitted from medical treatment, irrespective of whether ICU admission would have been appropriate."

:: We felt that you could elaborate a little further on the two final points you've made. Who is responsible for this and what mechanisms are needed to make sure this happens?

:: "The pandemic may last for another year…" It may last much longer than a year without a vaccine.

Reviewers' Comments to Author:

Reviewer: 1

Recommendation:

Comments:
few minor points
Inconsistency whether acronyms have been spelt out: ED is but SIAARTI, NICE, GPICS are not.
I would remove emotive terms such as 'tragically [line 172].

I loved this piece
It is well written and resonates with my early experience of the Pandemic and its response (I am a GP).
If anything - the paper does not quite capture the fear GPs had of referring any one to hospital at all - and how they had to sit with their decision - which was at times wrong and in some cases as the paper makes out led to the unnecessary death of a patient.
It does however capture the early chaos - too many guidelines (often competing), not enough reliance on performing what we do already in the new environment.
I agree with their view that we need to learn from the first phase but I wonder whether the authors need to be more forthright in their conclusions. if as they are arguing that the NHS did cope (as it had extra ITU capacity), why then did we not try and restore normal services earlier - and not as now, have a massive back log and fear built up. I also think the authors - who are an impressive group might make more recommendations as too how we should do things differently if (and when) we get the second spike

Additional Questions:
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Please enter your name: Dr Clare Gerada

Job Title: Medical Director

Institution: NHS Practitioner Health

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If you have any competing interests (please see BMJ policy) please declare them here:

Reviewer: 2

Recommendation:

Comments:
Thank you for asking me to review this article. As an Analysis article I think it meets the aim of stimulating debate. In line with my stated competing interests, I am generally in support of the points made by the authors, however I do disagree in parts with their emphasis in places so offer the following comments for consideration.

It would be valuable to acknowledge the lack of data available about Covid outcomes at the beginning of the pandemic and how this required a much more generic approach than perhaps might be the case at the start of a second wave. What we have learnt from the data now does influence not just decisions and discussions of treatments offered but also the duration of treatment on intensive care at least.
I think the biggest concern I have in general (including in this article) is the way people have confused the need for decision support guidance with that for triage guidance. I see the former as encouraging and supporting normal decision making eg use of RESPECT, advance care planning, identifying the balance of benefit vs burden of ICM treatment when resource isn't severely limited whereas triage guidance is outside of those parameters and focussed on identifying who will get treatment in resource limitation.
I agree with the authors' view that there is growing evidence of inconsistent and illogical decision making where individuals thought they were acting to triage at a time when that was not required or indicated. However I do take issue with their comment that there was a lack of detailed national guidance. I feel that there was more guidance in place during the pandemic to support ICU decision making than before it, and that it is behaviour that had a bigger impact: people didn't use their normal decision making processes in the face of information telling them to do so.
Moreover other guidance eg the ICS guidance came too late and as the clinical evidence base is now showing, was not suffiiciently evidence based to be robust and therefore useful.
I also feel it fair to reflect a view that it wasn’t just a situation of raising the threshold for admission to hospital and ICU but an associated genuine change in the balance of risk and benefit for some individuals in coming to hospital.
One final point and very minor- I doubt the BMJ readership would be familiar with GPICS as an abbreviation or a document so will need outlining.

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Please enter your name: Daniele Bryden

Job Title: Consultant in Intensive Care Medicine

Institution: Sheffield Teaching Hospitals NHS FT

Reimbursement for attending a symposium?: No

A fee for speaking?: No

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Funds for research?: No

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If you have any competing interests (please see BMJ policy) please declare them here: I wrote the NICE rapid clinical guidance NG 159 that the authors refer to in this paper. I was also part of the NHS England national critical care clinical reference group and reviewed the guidance document produced by the Intensive Care Society on behalf of the Royal College of Physicians.
I sit as part of the Faculty of Intensive Care Medicine Legal and Ethical Policy Unit with one of the authors of this paper (ARK).

Date Sent: 03-Aug-2020