Lessons learnt from a close encounter with triage

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Analysis

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KEY MESSAGES

- **There was a lack of detailed practical national decision-support guidance during the first wave of the COVID-19 pandemic in the UK**
- **ICU bed capacity was not exceeded but resources were stretched and the authors suggest fear- driven anticipatory triage impacted on admission and escalation of treatment thresholds**
- **Explicit guidance and open dialogue could have facilitated ordinary decision-making in extraordinary times and a renewed emphasis on the fundamentals of such decision-making is required**
- **Transparent ethical guidance and good quality information sharing of hospital bed states with primary care and ambulance services could help**

reduce unnecessary pre-hospital triage in a second wave of the pandemic

Contributors and sources

This article is written by a COVID-19 ethics working group made up of consultants from ICU, renal medicine, emergency medicine, palliative care, liaison psychiatry and two lawyers. The group worked in a large London hospital to develop decision-support guidance at speed during the height of the pandemic in the UK in Spring 2020. The paper reflects on the experiences of the multi-expert group, as well as presenting the group's central hypothesis that having explicit national triage criteria could have prevented some of the worst fear-driven anticipatory triage seen at this time. We offer some recommendations for minimising these consequences for a potential second wave.

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Patient involvement

Due to the nature of this article, the authors did not seek patient involvement.

Conflicts of Interest

We have read and understood the BMJ policy on declaration of interests and declare the following interests: no competing interests.

Licence

Lessons learnt from a close encounter with triage

There was very little detailed, practical guidance available to support complex decision-making around escalation of treatment and resource allocation during the first wave of the COVID-19 pandemic in the UK. This paper is written from the viewpoint of a COVID-19 ethics working group in a large London hospital in the middle of the pandemic. Our central ethical claim is that a lack of detail in national decision-support guidelines, together with a lack of good quality and visible information sharing between clinical decision-makers in hospitals and communities, led to fear-driven anticipatory triage with serious consequences for patients and NHS staff. We offer some recommendations for minimising these consequences for a potential second wave.

Introduction

Ethical guidance has been produced by professional and regulatory bodies in the UK, as well as within NHS Trusts and networks, during the COVID-19 pandemic (1, 2). The possibility of needing to ration health care resource, and particularly access to critical care, has undoubtedly been a driver for this. Despite this, there has been very little detailed, *practical* guidance available to support complex decision-making around escalation of treatment and decisions about who might benefit most from resources in the eventuality of demand exceeding availability. Fortunately, the NHS did not run out of Intensive Care Unit (ICU) beds during the first wave, so formal triage mechanisms did not need to be invoked. However, as a COVID-19 Ethics Working Group at a large teaching hospital, we believe that the lack of practical national guidance with some concrete degree of detail has had other unforeseen consequences that require consideration. In this paper we identify those consequences and suggest ways in which to prepare for a potential second wave of COVID-19 and also for subsequent public health emergencies that could place NHS resources under strain.

The pandemic arrives

The current pandemic has led to unprecedented uncertainty for governments and healthcare bodies across the world, bringing with it the very real threat of overwhelmed systems. The perennial question for ethicists about if and how to plan on a utilitarian basis to save the maximum number of lives has been brought into stark focus. In March 2020, it became an

urgent operational question in the UK needing the attention of policy makers, health care providers and clinicians in a way we have not previously encountered (3). Clearly in such a situation it was not going to be possible to get everything right. In the UK, steps were quickly taken to massively increase ICU bed capacity and also to protect existing secondary care health structures by cancelling all elective and outpatient work. There was also a recommendation to GPs that high-risk groups should have advance care plans in place for decisions around hospitalisation and ventilation with COVID-19, as well as around resuscitation status (4).

However, all of these steps were taking place in the context of a dearth of national guidance. Clinicians were able to look to countries affected by the pandemic ahead of the UK (5, 6) to see what might lie ahead. Guidance, most notably that produced by SIAARTI in the Italian context suggesting that there might need to be a simple age cut-off for admission to ICU, appeared to many to be too simplistic. An early – and very high-level – attempt was made in the UK to provide critical care guidance for the pandemic (the NICE 'rapid response' guideline NG159) (7). However, within days of publication, this was the subject of threatened judicial review proceedings due to concern that its reliance on the Critical Frailty Score would discriminate against individuals with learning disability or other 'stable' cognitive impairments (8). NICE and NHS England issued no further detailed guidance as to 1) under what circumstances triage might have to be considered; and 2) how it should be undertaken.

Not publishing national guidance seems likely to have been influenced by political (including health service political) concerns as to the public reactions that would be engendered by media portrayals of ICU doctors 'playing God' as well as by the ICU expansion policy. It is striking that the first guidance seeking to guide triage decisions in an 'operational' fashion was not published by NICE, NHS England or the Department of Health and Social Care, but rather by the Intensive Care Society – and was also not published until after the peak of the first wave in London (9).

Riding the first wave

As the first wave passes through, we have seen the NHS to stand up to many of the demands of the pandemic without being completely overwhelmed, at least in terms of ICU beds and ventilators. However, it is important to acknowledge that it has been affected and stretched at other points in the system, and also that the expansion in ICU beds and ventilators stretched the quality of intensive care such that normal GPICS standards have been harder to meet, and that clinical decision-making changed in the process (10). We

think it is important to reflect on the impact this has had on patient and NHS staff outcomes and to learn from this before a second wave of the pandemic.

An unexpected consequence of the pandemic has been a reduction in Emergency Department (ED) attendances - at its peak, a fall of 57% in April 2020 (11) - and reduced bed occupancy in general hospitals resulting from this, together with a reduction in elective and GP admissions. 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. Some of the explanation was undoubtedly down to people choosing, themselves, not to 'burden' their local hospitals, even in the presence of non-COVID related serious conditions such as myocardial infarction and stroke presentations (12, 13) and/or being fearful that going into hospital would infect them. This poses complex and challenging questions as to the messaging that was used in relation to healthcare – the simple message of 'stay home, save the NHS' tragically did not, in all cases, equate to 'save lives'.

But another part of the explanation, we suggest, is because anticipatory triage was taking place in the community, driven by fear of an overwhelmed health system. 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 (14, 15), 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. In short, demand suppression resulting from anticipatory triage limited access to hospital care. One hypothesis is that failure to communicate a clear decision-making and triage policy resulted in professionals making the policies up in their own minds - without consistency and under conditions of fear - where the worst eventualities were expected with unchecked biases.

Despite not needing to ration ICU beds, the sheer volume of service re-arrangement, staff sickness and self-isolation, re-deployments and complex clinical decision-making, particularly at the height of the first wave, proved extremely burdensome for doctors facing new challenges and managing an illness about which we still have a lot to learn. These factors may have contributed to increased levels of stress and reduced confidence in decision-making. Additionally, pressures both to get patients out of hospital to create bed capacity and the anticipation of needing to make triage decisions, in preparation for what was feared ahead, may have also been a factor in altered decision-making. We think the lack of clarity about the tipping point between normal treatment escalation and triage may have played a part in systems imposing higher than usual thresholds for accessing medical

treatment. It seems likely that raised thresholds of transfer to hospital had unanticipated consequences for patients in high-risk groups. Put bluntly: what proportion of the "excess" 18,000 care home residents who have died in the UK during the pandemic (16) might have gone to hospital for medical care and survived in non-COVID times? And – even more bluntly – what proportion of those residents themselves chose not to go to hospital, and what proportion had the choice made for them?

The core of the challenge

We know from existing evidence that difficult decisions around levels of and access to treatment are psychologically challenging and associated with moral distress in health professionals (17, 18). Many hospitals, including our own, have introduced decision-making guidance and support, to aid the process and share its burden. Work is still required to embed supported decision-making within the hospital culture, in order to enable doctors to see it as an important tool and move away from the often self-imposed, expectation of needing to be self-sufficient in all decision-making. On reflection, it may be that the main challenge for doctors during the first wave was adjusting to ordinary decision-making (i.e. decision-making not based on triage) in extraordinary times (when an encounter with triage loomed) and that this compounded the high volume of decisions and lack of time to make them, as well as any psychological distress that arose in the process. If this is an accurate analysis of the situation, it may be that having more decision-making support in place for the second wave will allow decision-making that is better adjusted and confident. In doing so, this may in turn allow a change in the psychological language away from 'distress' to 'adjustment' and 'resilience' instead.

How to do it better

We now have time to pause and reflect on the UK's first experience of the pandemic and think about what else needs to change in preparation for a second wave, which may be upon us later this year. With ICU expansion, we did not run out of ICU beds, but frontline staff were placed under significant strain and other resources, including some drugs, syringe drivers and renal replacement therapy, were stretched across the community and hospital. We suggest that political reluctance to address the possibility of ICU and ventilator triage has had a damaging effect on more widespread decisions around access to health care. The worst did not come to pass but the vacuum of open dialogue about carefully considered and detailed ethical guidance around ICU triage is likely to have contributed towards implicit triage in the community, on the wards and by patients themselves. This pre-hospital and pre-

ICU decision-making was in many cases influenced by fear rather than the reality of the situation. We suggest that patient and staff experiences and outcomes could be improved during a second wave of the pandemic by introducing 1) transparent ethical guidance and decision-making support at all access points to health care which has some detail and 2) good quality information sharing between hospital and community which is visible to individuals and teams when making clinical decisions, for example of hospital bed states between primary care and ambulance services to prevent unnecessary pre-hospital triage. The pandemic may last for another year and we need to think longer term about how to ensure that a fatigued system is supported.

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