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Triage



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Decision making is one of the most crucial and painstaking elements of our positions as healthcare providers. While choices made in the personal realm of our lives can influence our paths and those of our friends and families; those decisions made inside the doors of our institutions leave an indelible mark on the lives of our patients, their families, and to a greater extent, our colleagues and the culture of our workplace. Certainly, decisive diagnostic and treatment determinations are imperative to achieving positive outcomes of patients under our care, but more monumental is the decision that brings them into our care in the ICU in the first place: TRIAGE.

The questions surrounding which patients should be admitted and when they should be discharged have existed since the inception of intensive care units. A debate as to whether critically ill patients, who have little chance of survival should be admitted and further, as to whether the ICU is the place where patients should die, has raged on over the past decades and is still a matter of discussion amongst intensivists internationally.

In this current climate of fiscal responsibility, much of our focus is on the cost effectiveness of care, with regards to staffing ratios, technology-laden treatment options and the limited availability (and even scarcity, in some cases) of ICU beds. This environment places an increased stress on the proper allocation of resources and as a result, there exists a undeniable need to define a clear policy for determining the most expedient and befitting place for each patient upon arrival at, and throughout their duration of stay at hospital.

While there are numerous scores utilised to predict mortality in the ED / ER and the intensive care unit; a definitive scoring system to determine which patients are most likely to benefit from admittance to the ICU is still lacking in most institutions. Empirical data from ICUs in seven countries is being compiled from the ELDICUS Study – (Triage decision making for the elderly in European intensive care units) and the forthcoming analysis and valorisation process should yield a Europe-wide ICU triage system for one of the largest patient populations. In this edition of ICU Management, Prof. Khorram-Manesh and his colleagues from the Prehospital and Disaster Medicine Centre in Gothenburg, Sweden offer an expert overview on disaster triage while Dr. Rehn and team from Norway focus on the importance of effective and efficient triage of trauma patients- both in the pre-hospital environment and upon arrival at hospital. From her post-H1N1 stance in Canada, Dr. Hawryluck expands the discussion to include the ethical considerations of triage, within the realm of a disaster or pandemic as well as within a routine critical care scenario.

Matrix features in this issue include the second of Prof. Pelosi's two-part review of conventional and non conventional interfaces for non invasive respiratory support, and Prof. Pova and his expert colleagues from Portugal and Brazil revisit the always intriguing topic of the usefulness of biomarkers within the clinical decision making process in sepsis.

In our Country Focus, we look at the history of healthcare in Turkey, current reforms and the unique challenges of administering intensive care within the country. In part two of the interview with Prof. Julian Bion in the Viewpoints section of the journal, he chronicles the trials and tribulations and ultimately, the advantages of working in one of the largest ICUs in the world.

Finally, the updated 2010 ERC Guidelines on Resuscitation were recently released, and we have included a short excerpt featuring the most important changes to the guidelines on Adult Advanced Life Support.

As we await an objective, standardised triage admission and discharge instrument developed from the ELDICUS Study data (or another harmonisation of standards to be utilised in our triaging of our patient populations), we must, meanwhile, continue to deeply consider the ramifications of each decision we make – both with one stern eye on the costs involved in admitting each patient, and the other equally focused on the ethical quandary that will inevitably follow each decision.

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