

Is it morally and ethically right to refuse care to patients who are critical? – Nova Scotia's Health System Triage Protocol for Critical Care.

Nova Scotia's health care system is challenged for resources. A pandemic can further cripple the system leading to chaos. Since the outbreak of SARS in 2003, scarcity of resources and an overwhelmed system have posed a significant challenge for health care decision makers. SARS raised doubts around the effectiveness of our care delivery framework especially during a pandemic and the more recent H1N1 overwhelmed the emergency room visits with influenza-like illnesses. During a pandemic an overcrowded critical care unit of a hospital is forced to redirect patients to hospitals further away for care even if a patient is critically ill. There have been several cases where patients have died en-route to other hospitals because the hospitals closest to them were overcrowded. Currently patients requiring any critical care resources are admitted on a first-come first-served basis without proper protocols for assessment leaving the ones who require these resources for survival, defenseless. It is in times like these that proper planning of critical care resources is critical.

A logical solution one would think would be to allocate scarce resources in areas of great need. The problem however is in categorizing these areas of great need during a pandemic. What is the definition of a legitimate need? How does one decide what is the right legitimate need to allocate these scarce resources? Who should receive care and who should be refused care? Unfortunately there are no existing ethic principles or values that clearly define the answer to these questions.

Due to these critical challenges it became evident and necessary that a triage protocol be developed to ensure all patients received critical care in an equitable and just manner. This is a challenge in itself; like Ontario, Nova Scotia does not have the means currently to ensure such a protocol is incorporated in a fair and consistent manner across the province. The primary challenge is the need for high degree of collaboration and integration among Districts/IWK and the local level providers providing critical care services. Districts would need to establish linkages between and among themselves prior to and during a pandemic event. Districts would also require governance structures to enforce accountability among their local level providers.

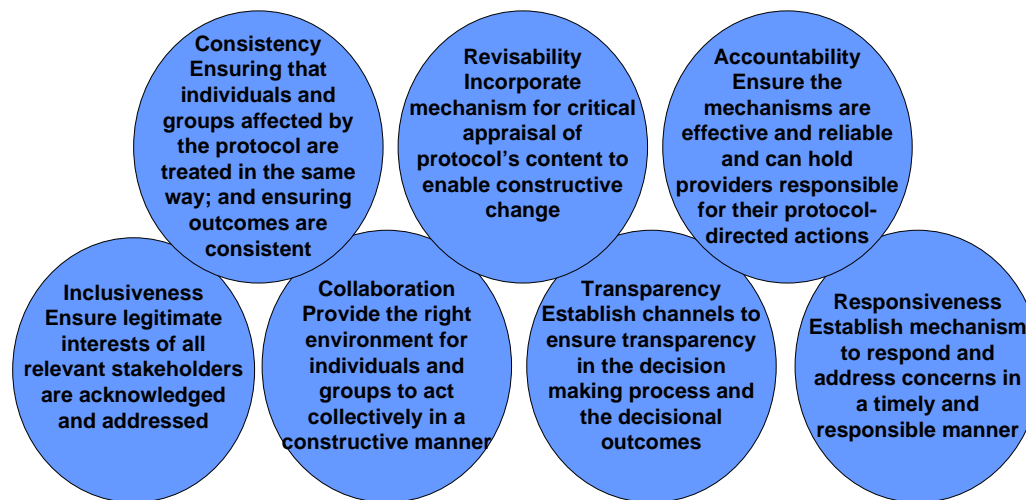
But despite these overwhelming concerns, Nova Scotia has taken the first steps towards creating a healthy critical care system. The protocol in draft form is currently being reviewed by Nova Scotia's health authorities and local level providers. Once approved the draft protocol will be made available to the public for feedback, and after all the updates have been completed the protocol will be incorporated in an open and transparent manner. This complete process should take some time but Nova Scotia is aiming to incorporate the protocol before the onset of another pandemic.

There is however a secondary challenge that is equally important. The success of the critical care protocol depends on its rate of adoption. The triage protocol will have to be congruent with and acceptable to all health care providers at the local levels. This is only possible through common communication channels. Districts/IWK will have to come up with strategies to ensure the messaging is consistent, strategic and transparent. They will also have to identify clinical champions among local providers that will provide the necessary training on the ground to ensure the protocol is adopted consistently across the province.

Nova Scotia's Triage Critical Care Protocol

The creation of the triage protocol went through painstaking and collaborative process where data was collected from expert panels, stakeholder consultations, ethical principles and best evidence applied around the world. Stakeholders included experts from a broad spectrum of health care providers, including public health experts, infectious diseases, and infection control experts; clinicians; and labor unions; professional associations; and health sector regulatory bodies. The data was collected and analyzed to identify the best guiding principles for prioritizing access to critical care resources during a pandemic.

The protocol developed for application in Nova Scotia's critical care system was also adapted from the Final Report of the Ontario Health Plan for Influenza Pandemic (OHPIP), accomplished by the Working Group on Adult Critical Care Admission, Discharge and Triage Criteria (2006). The protocol development working group used the following procedural/process values during the development phase of the Triage Protocol for Critical Care:



The Triage protocol is aimed at providing guidance for making the right and equitable triage decisions during a pandemic and providing the means for health care providers to refuse critical care to patients that have a minimum chance of survival. The protocol offers a measure of evidenced-based support to difficult decisions health providers will be required to make when resources are limited. The protocol equips health care providers to transfer patients who will not benefit from critical care to noncritical care management or palliative care. This will allow other patients who will benefit from critical care services to be admitted more rapidly. It is important to note that those patients who are refused critical care will still receive the best available care at alternate locations.

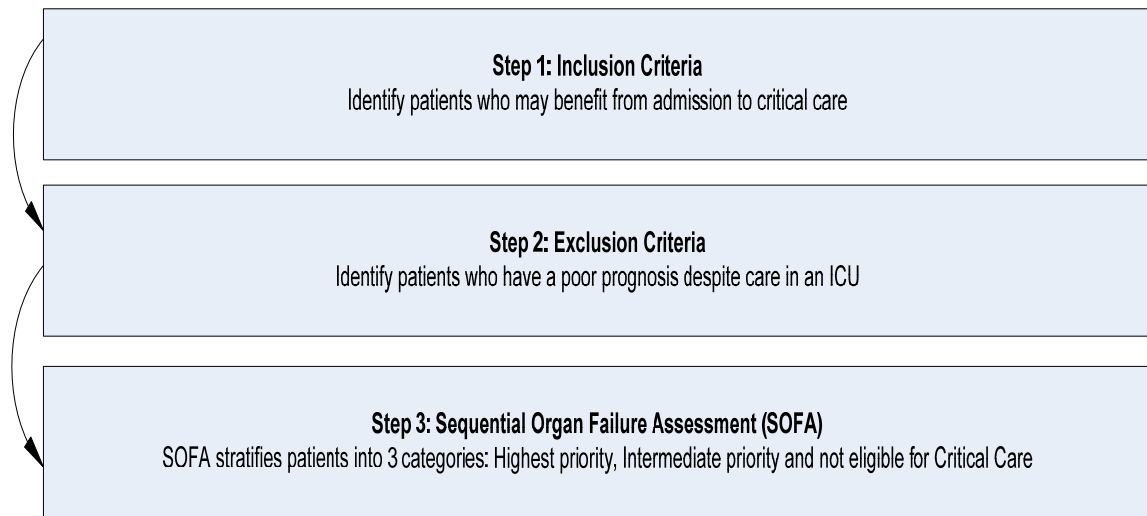
Under normal circumstances, all patients have the right to critical care; however during a pandemic it is impossible to provide the same level of care to all patients. More importantly excessive demand for scarce resources may be experienced in one district more than another. In situations such as these the province is required to provide a systemic and timely response to support all districts/IWK should the need escalate to a mass casualty experience.

Triage Critical Care Protocol Clinical tool-set

Understanding the triage protocol requires an understanding of the clinical tools it utilizes. The clinical tools uses inclusion criteria, exclusion criteria and Sequential Organ Failure Assessment (SOFA) to assess if a patient should be triaged to critical care, put in a queue for ICU bed or transferred to noncritical care management.

When a patient is presented with conditions that require an ICU bed, the treating physician fills a triage form which is a checklist of symptoms with a yes or no box next to it. The criterion for admission to critical care is based on a scoring method that identifies patients who have the best chances of survival. This does not imply that patients who have low chances of survival will not receive care; the fundamental principle of the protocol is founded on the fact that all patients presented during a pandemic will receive care. There is constant monitoring after a patient is admitted to critical care so that every opportunity is taken to move non-ventilated patients (if at all possible) to an area where their care can continue effectively.

The triage protocol has three main components:



SOFA not just assesses patients at the time of admission/transfer but also provides ongoing assessment of patients in critical care. SOFA provides the criteria for organizing patients into those that require critical care and have a better chance of survival, those that can wait for critical care resources, and those that need to be discharged to alternate levels of care.

It may be surprising but a triage protocol gets initiated when there is a military and civilian disaster. For instance, patients are prioritized based on their need for ICU care and their chances of survival. For ease of use, patients depending on their condition are categorized using a color scheme (blue, black, red, yellow or green). The Blue or Black categories are for those who should not receive critical care. Based on their condition those patients are transferred to another medical ward or palliative care. Red is for highest priority for use of critical care resources. In selecting these patients, the aim is to find those that will benefit most from the resources and improve and so on. The basic principle is to optimize the effectiveness of the triage protocol so that patients who have a high possibility of survival are given the

resources. This is also an iterative process where the status of a patient is constantly monitored; patients are again re-assessed and re-categorized according to the color scheme after admission. Based on the change in their medical condition they are transferred out of critical care so that other patients can be admitted who require the resources urgently.

Nova Scotia has also developed other processes to support the triage protocol. These processes look at ongoing re-evaluation processes, exceptions and review mechanisms. In the event of a pandemic and a mass critical care event the implementation of triage protocol would be continuously monitored and assessed by the Central Triage Committee. The committee apart from governing the adoption and implementation of the protocol looks at ways for improving the standards and guidelines of the triage protocol through analysis and dissemination of revisions to local health providers quickly and efficiently.

Another team also known as the support team or District Triage Support team established at local health providers is responsible for offering support to patients/families after they are denied care. This team includes physicians, nurses, allied health professionals and health administrators. The support team is tasked with providing support and advice to patients and their families when they are denied critical care; providing patients and their families with available alternate care options; assuming the role in the case review process; and ensuring documentation is inclusive and consistent across the critical care process.

Conclusion

The triage protocol is a tool when incorporated correctly can make the best use of critical care scarce resources to provide maximum benefits for a larger number of patients presented to an overwhelmed critical care system. It is justified to ask, why Nova Scotia can't increase their current critical care capacity so that they are ready for any pandemic. Unfortunately building critical care capacity is very expensive and not realistic.

With the onset of number of pandemics (H1N1, SARS, influenza) Nova Scotia decision to create the triage protocol and a number of alternatives had to happen sooner rather than later. The protocol is still in the initial stages where the draft is being reviewed by health authorities. The protocol will have to go through a number of updates before it does get incorporated.

However put the protocol does restrict individual rights to critical care but only to the extent where it benefits the entire province. The incorporation of the protocol will ensure optimum utilization of scarce resources. The overall benefit of incorporating the protocol at a provincial level will allow the management of scarce resources for the whole province hence enabling health care providers to transfer patients to other districts where critical care resources may be available.