

## Triage

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Traditional wisdom dictates that it is the patient's duty to define what constitutes an emergency- not ours. This may be changing in the climate of managed care as the gatekeeper on the telephone is being called to make that decision for the patient and the health care system. It is true that if patients are allowed to define what constitutes an emergency, mistakes will be made in both the false-positive (anxiety over presumed illness) and false-negative (denial of real illness) patterns. Emergency Medicine is the science that deals with these difficult realities: not all patients are as sick as they think, and not all patients are as well as they presume. Into this already confusing arena, we add the fact that the medically indigent are increasingly using Emergency Departments for their primary care and the medically underserved see the E.D. as their only resort. We can spend our days as the "social police" for society trying to decide which individuals are deserving of care, but we will shortly tire ourselves and become disillusioned and embittered. We will also antagonize our patients and cause resentment in our staff. It is the responsibility of the Emergency Physician to examine every patient who presents for care to the Emergency Department regardless of the type, duration, or severity of the illness, ability to pay or time of the day of presentation. This makes us unique among the medical profession. We are proud of the fact that we remain as the only specialty that, as a whole, will provide care without discrimination and without ability to pay.

Given that, generally speaking, the patient is allowed to define what constitutes an emergency, and given that we will examine each and every patient that presents for care, it is easy to see that the Emergency Department would be sheer chaos if some order were not imposed. That order is called the triage system. Triage is a process where priorities are set and patients are sorted according to critical conditions. Not everyone defines those priorities the same. In the military under battlefield conditions, I am told, those with simple problems that can be rapidly resolved with immediate return to the battlefield are treated first. When I lived and practiced in South Asia, those patients with complicated life-threatening medical problems were sent home or to other hospitals and those with less complicated problems were examined and treated. Triage is thus setting our priorities and matching those priorities with our ability to provide care. Triage is not democratic. Patients are not allowed a vote. It is the medical community that defines the priorities of triage. Emergency Departments in the 1990's have been overcrowded. It is easy to see that if care was democratic, on a first-come-first-serve basis or defined according to ability to pay or social status, patients with relatively minor illnesses would be treated at the expense of those with life or limb-threatening diseases. It would not be hard to imagine our rooms filled with patients with sore throats, sprained ankles, contusions and minor lacerations while heart attacks and G. I. bleeders died in the waiting room.

The system of triage used in Emergency Departments is universally based on severity of illness. With almost no exceptions, it has become a nursing function with written protocols directed by the physician staff. Patients are initially interviewed by the nurse, vital signs taken, and a triage category assigned. That triage category determines the order in which patients will be seen. Most E.D.'s use a three tiered triage system (e.g. emergent, urgent, and non-urgent). Using this system, the patients with the most urgent/emergent illnesses are seen first (patients with the lowest number). All patients in that number category must be seen before patients in a higher number category are seen. As you can see, it is possible for a patient to be assigned a #3 triage category (e.g. upper respiratory tract symptoms) and be next to be seen, yet before he can be seen five other patients arrive and are assigned lower numbers (e.g. higher triage priority). All five of those patients normally would be seen before the patient with an upper respiratory tract infection in a #3 triage category. Those who can wait-do wait. Those who can't wait-don't wait. This is why some patients who come first actually may be seen last.

Contrary to the above, in the last 5 years, it has become common for Emergency Departments to establish "fast tracks" or "prompt care" attended by physician assistants or nurse practitioners. These serve to decrease the backlog of less ill patients and to decrease overcrowding in our E.D.'s, reserving room and time for the more

critically ill patients. However, when run efficiently, it is now possible for patients who are less critically ill to be seen and evaluated before the more critically ill patients.

### **Understanding MCG's triage categories**

#### **CATEGORY 1 LIFE-THREATENING/URGENT**

(Patients seen immediately by physician)

Cardiopulmonary arrest

Severe respiratory distress

Shock

Major trauma

Major burns

Coma

Overdose

Anaphylaxis

Status epilepticus

Uncontrolled hemorrhage

Hypothermia, Hyperthermia (105 F/40 C)

Chest pain of cardiac/pulmonary origin

Multiple fractures

Fractures with vascular/neurological deficit

Severe asthma

Decreased level of consciousness

Eye illness/injury with impairment of vision

Drug overdose

Severe emotional disturbance

Disruptive/violent behavior

Severe headache

Arterial bleeding

Urinary retention

Renal colic

Seizures

Vaginal bleeding/ 1st trimester

Abdominal pain/ R/O ectopic

Nausea, vomiting or diarrhea with dehydration

Immunocompromised patients (sickle cell, AIDS, post transplant, chemo)

#### **CATEGORY 2 SEMIURGENT**

(Patients will need to be seen by physician within three hours)

Cystitis

Pharyngitis

Otitis media

Mild fever

N/V/D without dehydration

Lacerations

Abscess

Hemorrhoids

Simple fractures

Back pain

Foreign body to eye/ \no visual impairment

Vaginal bleeding not associated with pregnancy

Headache, moderate intensity

## Sprains/strains

### CATEGORY 3 NONURGENT/NO NEED FOR EMERGENCY MEDICAL CARE

(Patients need evaluation, but time is not a critical factor. Physician will examine when all other categories have been seen first.)

Attending physician, and only attending, may triage away to appropriate clinic, but only after a medical screening examination.

Simple rash

Chronic headache

Chronic hypertension

Chronic arthritis

Constipation

Rhinitis

"Cold" symptoms

Vaginal/penile discharge without fever

Routine physical exam

Superficial scratches/minor bruises/benign mechanism of injury

Varicose veins