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Silent Triage: Public Health decision-making beyond prioritisation

Eva Kuhn ,[1] Oliver Henke ,[1] Esther Evang,[1] Timo Falkenberg ,[2] Walter Bruchhausen,[1] Andreas Schultz [1]

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[1]Section Global Health, Institute for Hygiene and Public Health, University Hospital Bonn, Bonn, Germany
[2]Institute for Hygiene and Public Health, University Hospital Bonn, Bonn, Germany

Correspondence to
Dr Andreas Schultz;
andreas.schultz@ukbonn.de

Summary box

- ⇒ The large-scale disruption of (public) health services during the COVID-19 pandemic can be considered to be a Silent Triage.
- ⇒ Silent Triage is an unintended, prospectively oriented, passive and unspoken process.
- ⇒ Silent Triage needs to be recognised and named as a phenomenon when subordination or a one-sided focus on particular interests appears in health policies.
- ⇒ Defining the term Silent Triage can serve as the starting point of a new normative debate on weighing up individuals' and groups' interests as well as different (health) needs and human rights.

INTRODUCTION

The COVID-19 pandemic has influenced clinical care and health service provision in low-income and middle-income countries. Besides having no timely access to routine vaccination,[1] services for non-SARS-CoV-2-related health conditions faced major restraints due to pandemic countermeasures. Serving as an example, outpatient visits, HIV tests conducted and the administration of the Diphtheria-Tetanus-Pertussis (DTP3) vaccine decreased significantly in Kenya.[2] In Ethiopia, Nigeria and Burkina Faso over half of the essential health services have been affected by limitations in access, referrals, prevention and health promotion activities.[1] Schools were closed, and Kenyan girls were twice as likely to become pregnant before graduation than before SARS-CoV-2.[3]

Even though it was already stressed in early 2020 that maintaining services for, for example, reproductive health is 'not a luxury',[4] avoiding contagion with SARS-CoV-2 became de facto the primary consideration in many areas of care. Health and health-related needs were assigned certain importance, according to their felt urgency or because of the availability of resources in time, space or personnel. Many individuals' non-SARS-CoV-2-related medical interests were subordinated to this one public (health) interest. Hence, we argue that the widely visible disruption of health services, and obstructed access to clinical care and Public Health programmes, as well as the suspension of other health-related measures such as WASH and nutrition programmes, could be considered a form of 'triage'. However, while conventional triage is a conscious decision with an immediate impact mainly on already known individuals, we introduce the term 'Silent Triage', pointing out the unconsciousness and passiveness with regard to most persons concerned. Whereas conventional triage is highly needed to optimise overall health outcomes for a given group of individuals, Silent Triage may create collateral damage such as malnutrition among school children[5] or more late-stage diagnosis of cancer in the future.[6]

CONVENTIONAL TRIAGE, PRIORITISATION IN HEALTH POLICIES AND SILENT TRIAGE

In emergency medicine, triage is a procedure for prioritising assistance in the event of insufficient resources. Its characteristics are the selection and categorisation of individual patients that are affected by an emergency, resulting from one joint event for all cases under decision. Guided by expert (physician) opinion, patients are categorised in light of their injury or disease, according to their prognosis, and the resources available for their appropriate treatment.[7] An explicit, overt medical decision is taken and realised within a few hours. With a sudden, great number of people in need and the inability to help everyone, conventional triage bears little risk of a politically or ideologically motivated selection of beneficiaries. Starting from a similar setting of urgent need, Silent Triage, however, passively and inadvertently, means creating long-term exclusion from certain health benefits for the persons concerned

Table 1 Schematic differences between conventional triage, Silent Triage and prioritisation in health policies

	Conventional triage	Silent Triage	Prioritisation
Underlying reason	One event	One event and/or routine	Routine
Target individuals	Clearly identifiable individuals	Not yet known individuals	Particularly categorised groups
Institutional setting	Clinical and preclinical	Health facilities and authorities	Health and other public authorities
Urgency	High		Medium to low
Time horizon for impact	Present	Present and future	Future
Mode of selection	Rather active	Largely passive (letting it happen)	Rather active
Criteria	Explicit	Explicit and implicit	Explicit
Effects	Mainly clinical	Clinical and Public Health	

which could increase health inequity, particularly when institutionalised (see table 1).

The missing long term and overall perspective distinguishes conventional triage from the concept of prioritisation common in health policies (see table 1). Triage has a clear focus on the overarching situation of a single event and the possible withdrawal of an already-started treatment. In contrast, prioritisation still provides patients 'with healthcare services in due course'[8] and does not imply that medically necessary treatment, sometimes even life-saving treatment, may not be provided.

Like conventional triage in clinical settings, prioritisation in health policies is an active process driven by objectively verifiable indicators like cost-effectiveness and the probability of years of healthy lives lost. In contrast, Silent Triage appears as a rather passive phenomenon driven by subordination due to a (felt) urgency and sudden shift of attention towards certain new health threats. Prioritisation is a long-term, conscious and retrospectively backed up decision-making. Silent Triage though may result from a sudden and unspoken process, resulting in a devastating, often immediate and lasting impact of regular health service disruption. Here is, where the overarching and well-established Public Health principle of equal attention to equal health threats is profoundly shaken.[9]

CHARACTERISTICS OF SILENT TRIAGE IN THE COVID-19 PANDEMIC

In contrast to conventional triage decisions concerning acute care, Silent Triage may also concern chronic medical care, medical supply and Public Health services like vaccination or mass treatment schemes. In the first months of the pandemic, cancer prevention and screening programmes were suspended completely or downscaled to avoid SARS-CoV-2 infections,[6] leading to more late-stage diagnoses.

Decisions that may evoke Silent Triage such as a lock-down could be made urgently considering the scarcity of resources, for example, a shortage or unavailability of personal protective equipment. Having said that, we are aware that lock-downs—a decision designed to limit overall virus spread—also involve multiple other decisions, implicit and explicit, which determine an individual's or subpopulation's ability to access essential services such as vaccination or screening.

However, we assume that policy makers will have been aware—to varying degrees according to context—of some of these indirect impacts and in some cases, measures were introduced to counter them. For example, as routine childhood vaccinations in the UK remained accessible, we postulate that—nevertheless—fear and trade-offs between competing interests were reasons why many groups then decreased their uptake of those offers. As this also happened unconsciously, unintended, sometimes unexpectedly, we consider it a Silent Triage.

We argue that, unlike conventional medical triage, the term Silent Triage should also be used including non-medical, preventive interventions and other services as school meal provision or provision of scarce blood products. Selection may occur by starting, halting or omitting health interventions. For example, the closure of schools has increased malnutrition among school children as more than 370 million children globally missed out on daily school meals. Often, school meal programmes provided the only meal many children consumed in a day.[10] Closures were brought forward, even though a direct causality regarding the transmission route was scientifically difficult to support.

We suggest that Silent Triage mainly concerns competing interests between groups with certain future health needs (like with prioritisation in health policies) rather than individuals with immediate medical requirements (as in conventional triage). Most of these groups share characteristic needs not related to the incident that initiated the decision, as in school children, pregnant women and patients with cancer. The impact of apparently short-term decisions like a restriction of health services or a lock-down accumulates over time, even after the intervention stops or the lock-down has been lifted. For example, next to the long-term increase of cardiovascular diseases caused by a shortage of essential

medicines, disruption of food systems and routine health services, a worsening of hypertension, diabetes and obesity will also lead to increased risk of severe implications of SARS-CoV-2.[11]

A WORKING DEFINITION

The discussed characteristics lead us to propose the following working definition: Silent Triage is the repeated or continued, primarily unintended neglect of health needs that results from focusing on the benefit of a chosen intervention without regard to the possible side effects on the health of other groups. Its primary root cause may be scarce resources, a lack of current knowledge or ideological distortions. Silent Triage does not necessarily manifest when and where an action is taken; it can manifest with a time or spatial shift.

The consequences of the decision, leading to certain groups not receiving necessary (public) health services, remain unidentified and undocumented, hence 'silent' at first. They are not reflected or not able to be reflected on, not considered or neglected in the decision-making process.

CONCLUSION

Defining the term Silent Triage can serve as the starting point of a new normative debate on weighing up individuals' and groups' interests, different (health) needs and human rights. However, this will not solve the problem of decisional uncertainty in 'volatile, complex and ambiguous environments'.[12] As Haier *et al* have elaborated in their 'pyramid model', shifts in decision-making (procedures) and normative conflicts will continue to exist, but their anticipation may improve crisis management.[12]

Notwithstanding this limitation, we consider the concept of Silent Triage as a tool to recognise an insufficient practice, a descriptive term for what has happened in silence throughout the SARS-CoV-2 pandemic. Silent Triage needs to be recognised and named as a phenomenon when subordination or a one-sided focus on particular interests appears in health policies. An elaborated concept for a so far Silent Triage, situated between conventional triage and prioritisation (as table 1 shows), can provide professionals with 'an easy-to-use, scalable and durable information collection infrastructure'.[8]

This categorisation will help raise awareness of the complexity and context-sensitivity of such far-reaching Public Health decisions beyond the SARS-CoV-2 pandemic. By unveiling the underlying principles and potentially conflicting interests affected, lessons can be learnt for subsequent decisions of similar scope. Initiatives such as establishing learning systems with the structures of the Nigeria Centre for Disease Control[13] point into a promising direction. Yet, the examples and outlined characteristics underline the importance of considering local and regional circumstances. These may result in divergent decisions and actions in epidemiologically similar circumstances. This makes Silent Triage a worldwide applicable heuristic tool when tackling global health issues.

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ORCID iDs
Eva Kuhn http://orcid.org/0000-0002-8337-9639
Oliver Henke http://orcid.org/0000-0002-9838-9805
Timo Falkenberg http://orcid.org/0000-0001-6778-4178
Andreas Schultz http://orcid.org/0000-0002-7774-8784

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