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EDITORIAL

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It is generally accepted that the concept of triage began in the military context. It was used in the battlefield to focus limited medical resources on the injured soldiers who were most likely to benefit, ignoring those casualties close to death or with untreatable injuries. It was an early (and possibly the first) example of large scale clinical risk management.

From its military origins it evolved to become a key component of modern clinical practice in both the emergency department and the mass casualty setting. Patients are prioritised into different categories using simple criteria based on clinical presentation, symptoms and vital signs. As the processes became more systematic so triage evolved further, with definitions around ideal waiting times for different triage categories. These waiting times can be used as crude markers of system quality and infrastructure – for example, 100% patients in triage category one should be seen by a doctor immediately. Such markers have been a key part of the Australasian Triage Scale for many years. The UK has tended to follow the model based on the Manchester Triage Scale. The differences between the two systems are in the detail, not the philosophy.

The recent UK government driven changes in emergency care, based around the four hour target, have led to triage being done differently in most departments, and abandonment of traditional triage practice in some. Patients are placed into broader categories, such as 'resus', 'majors', 'minors', and 'see and treat'. Some people even advocate dropping the term triage and replacing it with terms such as 'first assessment' or 'initial assessment'. Why use words with several syllables when one word with two syllables is already in use and describes the same thing?

Aside from semantics, supporters of the proposal that the traditional triage model is no longer relevant argue that this is because the patient is seen by a doctor (or nurse practitioner) more quickly than they used to be. This may be true but it does not eliminate clinical

risk. Triage not only allows staff to allocate a patient to the right clinical area of an emergency department, it also acts as a risk management tool. Applied properly by suitably skilled and trained staff, triage reduces clinical risk, or put another way, improves patient safety. Patients still need to be placed in order of priority within their allocated clinical area. Although a case can be better made for not applying it to the 'see and treat' group, it does not hold up for patients in the 'resus' and 'majors' groups. Apart from clinical priorities patients in 'majors' may be hidden from view by a curtain, a pillar or human oversight. Despite the recent NHS reforms patients can still wait a long time for medical assessment. A long time cannot be clearly defined, as in the new time conscious world we inhabit sixty minutes may be considered an eternity, but while they wait to be seen patient prioritisation is still an imperative.

The disciplines of emergency medicine and NHS emergency departments have both responded magnificently to the recent government reforms. Let's not lose the rigour and safety net for patients and staff that triage offers. Let's not throw the baby out with the bath water.

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