

## Why we triage

Rhetorical questions, we know, are not questions at all, but statements. Reading Dr Shane Neilson's recent article<sup>1</sup> on disability and coronavirus disease 2019 (COVID-19), I believe that the audience would have been better served had he posed his "thought experiment" as a true experiment, without presupposition of the outcome: "If a 44-year-old physician without a history of addiction, bipolar disorder, and autism appeared alongside one who did in the emergency department, both in respiratory distress, who gets the ventilator preferentially?"<sup>1</sup> Dr Neilson indicates that he has the "lived experience" to know, but clearly this is rhetorical. Frankly, the intensive care unit triage document that I had the opportunity to review as part of my work planning for pandemic response in southwestern Ontario would not have provided any guidance in this scenario, as the medical conditions Dr Neilson lists could not be reliably linked to impaired survival of a serious infectious illness.

I find it problematic that Dr Neilson characterizes the ethos of triage planning as "nonnormative life is less worthy of investment."<sup>1</sup> While a utilitarian approach has its weaknesses, its principal strength is the recognition that outcomes matter to us as human beings. Having 2 people die rather than 1 (because a scarce resource was used to prolong the life of a frail patient who ultimately dies, and a patient with a better chance of survival was denied a life-saving, short-term intervention) will strike most people as an unfortunate and undesirable outcome. Normativity is not the issue here; the reality of being biological creatures means that we all die, but we recognize markers of the imminence of that death. These markers are not perfect, but insisting on perfection is an abdication of our ability and responsibility to exercise moral judgment. Strict application of a "first come, first served" approach, with only a careful documentation of arrival times, might satisfy a desire to highlight the equality of all people, but its passivity violates the desire to create better outcomes for more people.

Without a doubt, those of us working in health care, and particularly those of us without identified disabilities, need to listen to the voices of people such as Dr Neilson regarding protection for vulnerable individuals. However, many triage documents expressly recognize this

need<sup>2,3</sup> and engaging in the planning activity itself does not, contrary to Dr Neilson's assertion, constitute an intrinsic betrayal of these members of our societies.

—Joel R. Wohlgemut MD MA CCFP  
Ingersoll, Ont

### Competing interests

None declared

### References

1. Neilson S. Why I won't see you on the barricades. Disability and COVID-19. *Can Fam Physician* 2020;66:449-50.
2. Upshur REG, Faith K, Gibson JL, Thompson AK, Tracy CS, Wilson K, et al. *Stand on guard for thee. Ethical considerations in preparedness planning for pandemic influenza*. Toronto, ON: University of Toronto Joint Centre for Bioethics; 2005.
3. Centers for Disease Control and Prevention. *Ethical considerations for decision making regarding allocation of mechanical ventilators during a severe influenza pandemic or other public health emergency*. Atlanta, GA: Centers for Disease Control and Prevention; 2011. Available from: [https://www.cdc.gov/os/integrity/phethics/docs/Vent\\_Document\\_Final\\_Version.pdf](https://www.cdc.gov/os/integrity/phethics/docs/Vent_Document_Final_Version.pdf). Accessed 2020 Aug 17.

## Need clear and consistent message about masks

As members of the College of Family Physicians of Canada who are part of Masks4Canada ([www.masks4canada.org](http://www.masks4canada.org)), a community group of Canadian physicians, professionals, and citizens in support of masking in high-risk settings, we are writing to express our concerns with the public-facing article published in the July issue of *Canadian Family Physician*: "PEER simplified tool: mask use by the general public and by health care workers."<sup>1</sup>

We are at a critical time in Canada's fight against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and the surges that are emerging nationwide as economies reopen and interaction increases among the public. Clear and consistent messages are imperative around public masking. Public messaging must clearly articulate that cloth masking is an added layer of protection in addition to physical distancing and hand hygiene.

While we understand that this review of the current available evidence does indeed support the use of public masking in the first infographic, we are concerned that this article provides a confusing and unclear message for the public. We are surprised that such a nuanced evidence base regarding masking would have been made into a public-facing infographic, given the complexities of the emerging evidence base for source control for coronavirus. Many of our colleagues did not realize that these studies were not done with SARS-CoV-2, but with influenza viruses. Those who spoke with members

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2. **Clinical Review:** Medication management and pharmacokinetic changes after bariatric surgery (June 2020)
3. **Geriatric Gems:** Screening tools for virtual assessment of cognition (July 2020)
4. **Research:** Masks for prevention of viral respiratory infections among health care workers and the public. *PEER umbrella systematic review* (July 2020)
5. **FPIN's Clinical Inquiries:** Effect of corticosteroids on pain and function in knee osteoarthritis patients (July 2020)

of the public, family, or friends about the infographic found that a large number of the public concluded that this proved to them that cloth masking in public was not helpful.

The context of this evidence review must not be dismissed. We are in the midst of a pandemic of a novel virus that is showing concerning ongoing morbidity in addition to mortality. We do not have the luxury of waiting for randomized controlled trials to determine the magnitude of benefit that masking could provide for this novel virus. However, there are many other methodological studies with regard to masking during this pandemic that have shown a trend toward benefit. In weighing minimal potential harms against the potential of great benefit of masking while we learn to live with this virus, it is prudent to ensure that there is clear and consistent messaging on how masking should be added to the other public health measures.

We are requesting that the following changes be considered in your infographic to make it much more clear to the public that masking can help during this pandemic:

- Please make clear in your title that the evidence is from studies on influenza viruses and not SARS-CoV-2 (eg, “Masks regarding influenza for the general public”).
- The last point under “What we do not know yet,” which says we do not know if it prevents coronavirus disease 2019 (COVID-19), can be misconstrued as well. It would be prudent to outline how SARS-CoV-2 might behave differently than influenza viruses, that masks in this pandemic are primarily for source control, and the mounting evidence regarding asymptomatic spread further supports the need for public masking.
- Put distancing and hand hygiene in the same (larger) font size as masking. We suggest that this be the recommendation for the public: “Masking is one part of preventing infection. Do this along with 2-metre physical distancing and hand hygiene consistently for your best chance to prevent infection.”

Thank you for your urgent attention to this matter and for your careful consideration of these revision suggestions. This would help to improve on clear public health messaging regarding the relative benefits of masking during this pandemic, so that the public is compelled to improve their 3-pronged efforts to prevent further infections and transmission.

—Edith Hui MD CCFP  
Toronto, Ont

—Amy Tan MD MSc CCFP(PC) FCFP  
Calgary, Alta

—Anh Tran MD CCFP  
Vaughan, Ont

—Jennifer Kwan MD CCFP  
Burlington, Ont

—Christine Gibson MD FCFP MMedEd  
Calgary, Alta  
—Giorgia Tropini MD MSc  
Vancouver, BC  
—Joe Vipond MD CCFP(EM)  
Calgary, Alta  
—Kashif Pirzada MD CCFP(EM)  
Toronto, Ont  
—Cindy Huang MD  
Vancouver, BC

#### Competing interests

None declared

#### Reference

1. Moe S, Dugré N, Allan GM, Korownyk CS, Kolber MR, Lindblad AJ, et al. PEER simplified tool: mask use by the general public and by health care workers. *Can Fam Physician* 2020;66:505-7 (Eng), e187-9 (Fr).

## Response

Thank you for your letter concerning our infographic<sup>1</sup> and the systematic review<sup>2</sup> of randomized controlled trials (RCTs) evidence regarding masks and viral infections. One of the key principles of the PEER (Patients, Experience, Evidence, Research) Group is to promote clear and consistent messaging informed by the best available evidence.

While evidence is important, it is not the only factor that contributes to recommendations. Decisions regarding health include considerations of evidence, clinician experience, and patient preferences and values. This infographic provides clinicians with a synopsis of the current best evidence, and for full transparency we also included the ranges of potential benefit and the gaps in high-level evidence. It was not designed to communicate a specific policy, agenda, or guideline. We state in our last sentence: “This simplified tool is not a guideline; rather, the information is presented to promote application informed by the best available evidence.”<sup>1</sup>

You have asked for a number of changes and also expressed a number of comments and concerns:

**Make it clear that these are studies of influenza.** In each infographic, we mention influenza at least once and also state flulike illness several times (which is likely more than just influenza). We also state there is no mask research in coronavirus disease 2019 (COVID-19). We believe this makes it pretty clear we are not talking about severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection.

**It would be prudent to outline how SARS-CoV-2 might behave differently than influenza viruses, that masks in this pandemic are primarily for source control, and the mounting evidence regarding asymptomatic spread further supports the need for public masking.** As mentioned above, the purpose of this infographic was to present the RCT evidence, not to discuss how the coronavirus behaves or asymptomatic spread. These topics have been covered in a previous Tools for Practice article, summarized in the journal.<sup>3</sup>

**Put distancing and hand hygiene in the same (larger) font size as masking. We suggest that this be the recommendation for the public: “Masking is one part of preventing infection. Do this along with 2-metre physical distancing and hand hygiene consistently for your best chance to prevent infection.”** We already state quite clearly in the middle of each infographic, “Masks are only one part of preventing infection,” and then add in examples of what people should consider.

**Those who spoke with members of the public, family, or friends about the infographic found that a large number of the public concluded that this proved to them that cloth masking in public was not helpful.** We are not sure how, if the infographic was fully reviewed, one would assume cloth masks do not work for community prevention. As stated in the infographic, we focused on RCT evidence and thus do not know yet if cloth masks work in the community. Unfortunately, there is no RCT evidence examining cloth masks for the community prevention of viral respiratory illness.

On the health care worker side, we mention based on 1 trial, cloth mask users had 2% more flulike illness than surgical mask users over 4 weeks. This does not say cloth masks do not work (they might be markedly better than nothing) and the finding is specific to the health care setting. We believed this part of the graphic would help health care professionals make choices around mask type use. Interestingly, the graphic supports the present pattern of use in health care settings: use of surgical masks for most encounters and progression to N95 for high-risk encounters.

There is fair evidence to suggest that the public tends to overestimate the benefits of preventive interventions. For instance, a survey published in the *New England Journal of Medicine* suggested that women overestimated the benefit of mammography by approximately 30 times.<sup>4</sup> A 4% absolute reduction in transmission of influenza-like illness with surgical masks translates to a number needed to “mask” of 25 over 6 weeks. For comparison, the number needed to screen with mammography is approximately 2000 women over 7 years to prevent 1 breast cancer death.<sup>5</sup> Perhaps a closer example is influenza vaccine for reduction of influenzalike illness from 21.5% to 18.1%, giving a number needed to “vaccinate” of 30 over a flu season.<sup>6</sup> It is important to keep the effectiveness of other interventions in context when evaluating benefit.

**We do not have the luxury of waiting for RCTs to determine the magnitude of benefit that masking could provide for this novel virus.** We agree decisions around wearing masks need to be made without waiting for RCTs of masks for the prevention of SARS-CoV-2 infections. However, in the absence of direct evidence for masks for prevention, we believe it is important to consider the best indirect evidence, such as wearing masks