greater tolerance of triage errors as they are caught and corrected at successive levels of care.

Is this kind of modeling study helpful? Yes. Despite some obvious limitations, the article generates a fruitful discussion surrounding a core question in disaster medicine: how does overtriage influence critical mortality? It also emphasizes more broadly the critical role that triage plays in determining outcomes than does the relative proportion of critical casualties to treatment capability, with the corollary that focusing on the rate of overtriage (ie, getting triage “wrong” in the direction of overcrowding) may obscure other drivers of critical outcomes.

In analyzing its flaws, we are reminded that “planning should take into consideration how people and organizations are likely to act, rather than expecting them to change their behavior to conform to the plan.”5 In essence, the article becomes a call rather than expecting them to change their behavior to conform to the plan. In essence, the article becomes a call rather than expecting them to change their behavior to conform to the plan. In essence, the article becomes a call rather than expecting them to change their behavior to conform to the plan.

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REFERENCES


Response to Armstrong et al

Nathaniel Hupert, MD, MPH, Eric Hollingsworth, BS, and Wei Xiong, PhD

We are pleased that the thought leaders and originators of this line of research consider our article1 to be a useful contribution to ongoing discussions about improving mass casualty trauma care. Our approach focused on the tripartite, dynamic relationship among patient selection resulting from triage decisions, trauma system treatment capability, and time-dependent mortality. Our main finding is that, for most mass casualty incidents, triage accuracy has less impact on outcomes than does the relative proportion of critical casualties to treatment capability, with the corollary that focusing on the rate of overtriage (ie, getting triage “wrong” in the direction of overcrowding) may obscure other drivers of critical outcomes.

As noted by Armstrong et al2 in this issue, our model did produce “a positive correlation between overtriage and critical mortality when the number of noncritical casualties increases” but this relationship is both nonlinear and dependent on the ratio of critical casualties to treatment bays. For all of its limitations, this model represents a conceptual framework that begins to reflect the complex relationships among actions, resources, and patient outcomes, and we will continue our efforts to improve its fidelity to the realities of trauma care in both the field and hospital settings.

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Commentary on “Is Overtriage Associated With Increased Mortality?”

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