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Considerations for a Resource Allocation Framework for Intensive Care Units and Acute Care: A Qualitative Study Exploring the Experiences of Equity-Deserving Groups During the COVID-19 Demand Surge and Triage-Avoidant Strategies

Taylor Shorting, Jaya Rastogi, Cécile M. Bensimon, Alice Virani, Maxwell J. Smith, Simon Oczkowski, Dianne Godkin, Marika Warren, Sabira Valiani, Judy King, James Downar and Sarina R. Isenberg

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See table of contents

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Article abstract

During COVID-19, most intensive care units (ICUs) in Canada implemented strategies to manage a surge in demand for critical care to avoid turning people away, termed “triage-avoidant strategies.” These strategies, including redeploying non-ICU staff to the ICU to increase patient capacity, and transferring people over long distances to available beds, may have caused negative consequences for patients, healthcare staff, and equity-deserving groups. This study explores the perspectives of equity-deserving groups and organizations on triage-avoidant strategies during COVID-19, examined organization-specific responses, and identified system-level recommendations to improve equity, access, and preparedness. A qualitative descriptive study was conducted between July and December 2023 across five provinces in Canada. Participants, including staff from organizations serving equity-deserving groups, as well as government and healthcare representatives, were recruited through professional networks and snowball sampling. A semi-structured interview guide was used to elicit perspectives, which were then analyzed inductively using thematic analysis. 23 individuals from Ontario (n=12), British Columbia (n=4), Saskatchewan (n=4), Nova Scotia (n=2) and New Brunswick (n=1) participated. 15 participants (65%) identified as persons of colour or among equity-deserving groups; 13 (57%) participants worked within organizations representing decision-makers, clinicians, and/or equity-deserving groups. We identified three themes: 1) Triage-avoidant strategies were perceived to have disproportionately harmful effects on equity-deserving groups and healthcare providers; 2) organizations acted to mitigate effects of triage-avoidant strategies; and 3) various system-level actions could help mitigate the perceived effects of these strategies in future surges in demand. This study contributes to the literature by incorporating perspectives of representatives from diverse organizations and equity-deserving groups on how triage-avoidant strategies disproportionately harmed the populations they serve. Our findings can inform the development/implementation of triage-avoidant strategies that mitigate the perceived harmful effects on decision-makers, clinicians, and equity-deserving groups, while promoting equitable care.

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Considerations for a Resource Allocation Framework for Intensive Care Units and Acute Care: A Qualitative Study Exploring the Experiences of Equity-Deserving Groups During the COVID-19 Demand Surge and Triage-Avoidant Strategies

Taylor Shorting[a], Jaya Rastogi[a], Cécile M. Bensimon[a,b], Alice Virani[c], Maxwell J. Smith[d], Simon Oczkowski[e,f], Dianne Godkin[g], Marika Warren[h], Sabira Valiani[i], Judy King[j], James Downar[a,j,k,l,m], Sarina R. Isenberg[a,j,o]

Résumé

Pendant la COVID-19, la plupart des unités de soins intensifs (USI) au Canada ont mis en place des stratégies pour gérer une hausse de la demande en soins critiques afin d'éviter de refuser des patients, appelées stratégies d'évitement du triage. Ces stratégies, notamment la réaffectation de personnel non spécialisé en soins intensifs vers les USI pour augmenter la capacité d'accueil, ainsi que le transfert de patients sur de longues distances vers des lits disponibles, ont pu entraîner des conséquences négatives pour les patients, le personnel de santé et les groupes en quête d'équité. Cette étude explore les perspectives de ces groupes et des organisations qui les représentent concernant les stratégies d'évitement du triage durant la COVID-19, examine les réponses propres aux organisations et identifie des recommandations à l'échelle du système pour améliorer l'équité, l'accès et la préparation. Une étude qualitative descriptive a été menée entre juillet et décembre 2023 dans cinq provinces canadiennes. Les participants, incluant du personnel d'organisations au service des groupes en quête d'équité ainsi que des représentants gouvernementaux et du secteur de la santé, ont été recrutés par le biais de réseaux professionnels et d'un échantillonnage boule de neige. Un guide d'entretien semi-structuré a été utilisé pour recueillir les points de vue, qui ont ensuite été analysés de manière inductive à l'aide d'une analyse thématique. Au total, 23 personnes provenant de l'Ontario (n=12), de la Colombie-Britannique (n=4), de la Saskatchewan (n=4), de la Nouvelle-Écosse (n=2) et du Nouveau-Brunswick (n=1) ont participé. Quinze participants (65 %) se sont identifiés comme personnes racisées ou appartenant à des groupes en quête d'équité; 13 (57 %) travaillaient au sein d'organisations représentant des décideurs, des cliniciens et/ou des groupes en quête d'équité. Trois thèmes ont été identifiés : 1) les stratégies d'évitement du triage ont été perçues comme ayant des effets disproportionnellement néfastes sur les groupes en quête d'équité et les professionnels de la santé; 2) les organisations ont agi pour atténuer les effets de ces stratégies; et 3) diverses actions à l'échelle du système pourraient contribuer à atténuer les effets perçus de ces stratégies lors de futures hausses de la demande. Cette étude apporte une contribution originale à la littérature en intégrant les perspectives de représentants d'organisations diverses et de groupes en quête d'équité sur la manière dont les stratégies d'évitement du triage ont causé des préjudices disproportionnés aux populations qu'ils desservent. Nos résultats peuvent éclairer l'élaboration et la mise en œuvre de stratégies d'évitement du triage qui atténuent les effets néfastes perçus sur les décideurs, les cliniciens et les groupes en quête d'équité, tout en favorisant des soins équitables.

Mots-clés

COVID-19, équité en santé, unités de soins intensifs, pandémie, éthique en santé publique, urgence de santé publique, allocation des ressources, triage

Abstract

During COVID-19, most intensive care units (ICUs) in Canada implemented strategies to manage a surge in demand for critical care to avoid turning people away, termed "triage-avoidant strategies." These strategies, including redeploying non-ICU staff to the ICU to increase patient capacity, and transferring people over long distances to available beds, may have caused negative consequences for patients, healthcare staff, and equity-deserving groups. This study explores the perspectives of equity-deserving groups and organizations on triage-avoidant strategies during COVID-19, examined organization-specific responses, and identified system-level recommendations to improve equity, access, and preparedness. A qualitative descriptive study was conducted between July and December 2023 across five provinces in Canada. Participants, including staff from organizations serving equity-deserving groups, as well as government and healthcare representatives, were recruited through professional networks and snowball sampling. A semi-structured interview guide was used to elicit perspectives, which were then analyzed inductively using thematic analysis. 23 individuals from Ontario (n=12), British Columbia (n=4), Saskatchewan (n=4), Nova Scotia (n=2) and New Brunswick (n=1) participated. 15 participants (65%) identified as persons of colour or among equity-deserving groups; 13 (57%) participants worked within organizations representing decision-makers, clinicians, and/or equity-deserving groups. We identified three themes: 1) Triage-avoidant strategies were perceived to have disproportionately harmful effects on equity-deserving groups and healthcare providers; 2) organizations acted to mitigate effects of triage-avoidant strategies; and 3) various system-level actions could help mitigate the perceived effects of these strategies in future surges in demand. This study contributes to the literature by incorporating perspectives of representatives from diverse organizations and equity-deserving groups on how triage-avoidant strategies disproportionately harmed the populations they serve. Our findings can inform the development/implementation of triage-avoidant strategies that mitigate the perceived harmful effects on decision-makers, clinicians, and equity-deserving groups, while promoting equitable care.

Keywords

COVID-19, health equity, intensive care units, pandemic, public health ethics, public health emergency, resource allocation, triage

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INTRODUCTION

During the global COVID-19 public health emergency, healthcare systems struggled to meet the overwhelming surge in demand for critical care resources (1). In Canada, where many intensive care units (ICUs) operated near capacity even prior to COVID-19 (2), decision-makers sought to develop strategies to optimize critical care resource use. Addressing increased demand for limited critical care resources took two broad approaches: 1) prioritizing certain patients for critical care over others ("triage") or 2) to avoid triage, surging above normal capacity by redeploying non-ICU staff to the ICU, and transferring ICU patients over large distances to available beds. Many jurisdictions developed resource allocation frameworks (3-8) or applied existing triage tools to the COVID-19 context to manage the unprecedented surge in demand for ICU resources (9,10). Ontario, Canada's most populous province, developed the "Critical Care Clinical Emergency Standard of Care for Major Surge" framework (8), which included three system-wide triage levels to maximize the number of lives saved while avoiding or mitigating potential discrimination and bias (8). Quebec (11) and Israel (12) both adopted similar frameworks, although they were never deployed.

To avoid deploying triage frameworks, hospitals and healthcare jurisdictions adopted a series of triage-avoidant strategies such as cancelling non-emergent procedures, redeploying non-ICU staff to the ICU, and moving patients from overwhelmed hospitals to hospitals with available resources. While triage-avoidant strategies likely saved lives by allowing acutely ill patients to receive ICU care for COVID-19 and avoid adverse outcomes including death, these strategies may also have led to negative consequences for patients, family members, staff, and healthcare organizations, particularly for individuals among equity-deserving groups. Consequences may have been clinical (e.g., delayed care) (13), organizational (e.g., healthcare provider moral distress) (14), and/or equity-related (e.g., reduced trust in healthcare) (15). Equity-deserving groups, as defined by the Government of Canada, are "A group of people who, because of systemic discrimination, face barriers that prevent them from having the same access to the resources and opportunities that are available to other members of society, and that are necessary for them to attain just outcomes" (16). Examples of equity-deserving groups include women, Indigenous peoples, racialized/visible minority persons, persons with disabilities, and LGBTQ2S+ individuals (16), who experience sexism and gender discrimination, racism, and ableism, among other often co-occurring and mutually reinforcing forms of discrimination and oppression in healthcare and community settings.

Previous studies have suggested that individuals among equity-deserving groups may be more susceptible to harm from triage-avoidant strategies because they already face structural barriers to equitable care (i.e., care delivery adjusted to meet the unique needs of individuals and communities with the aim to support similar health outcomes across groups with different social circumstances) (17) including racism, poverty, gender bias, and geographic isolation (18,19). In addition, mistrust of the healthcare system may lead to avoidance of formal care, contributing to delayed diagnoses and reduced opportunities for early intervention (18,19). However, these studies focused on general healthcare use (not specific to triage-avoidant strategies) (18,19), were conducted prior to the pandemic (18,19), and primarily explored the association between racial discrimination and delayed or forgone care, and experiences of racial discrimination and beliefs about coronavirus-related racial bias (20).

Future surges in demand for critical care will likely lead to the use of triage-avoidant strategies like those used during COVID-19. However, the potential negative effects of these strategies are not well understood, especially as they concern equity-deserving groups. Limited research reports directly on the views of these groups themselves (5), yet inclusion of perspectives among those equity-deserving groups is critical to develop relevant and inclusive approaches (5). These groups have largely been excluded from discussions about how triage-avoidant strategies disproportionately harmed them compared to the general population; from insights on organization-specific actions that were implemented to mitigate these effects; and from recommendations at the system level for future strategies to reduce harm. Incorporating these perspectives is essential for developing resource allocation frameworks that are more equitable and responsive to the needs of all populations.

OBJECTIVE

Our study had three objectives:

1. *Understand* perspectives and experiences among equity-deserving groups of the disproportionate effects of triage-avoidant strategies on communities with whom they work, relative to the general population.
2. *Explore* organization-specific actions implemented during COVID-19 from the perspectives of individuals representing equity-deserving groups — such as Black, Indigenous, and People of Colour (BIPOC), persons with disabilities, and disease-specific organizations — as well as staff from healthcare organizations and government agencies.
3. *Identify* system-level recommendations for future pandemic strategies that can minimize harm, improve equitable access to care, and enhance organizational preparedness.

METHODS

Study Design

Between July and December 2023, we conducted a qualitative descriptive study (21), using semi-structured interviews and focus groups via videoconferencing platforms (e.g., Zoom and Microsoft Teams), with individuals from across Canada about experiences related to their specific organizations. Guided by a post-positivist epistemological stance, interviews and focus groups were conducted with decision-makers, clinicians, and individuals among equity-deserving groups. Post-positivism focuses on the experiences of the majority and asserts that there is no universal truth and that multidimensional evidence can be inferred by perceived data (e.g., data obtained in focus groups/interviews) (22,23). The Bruyère Health Research Ethics Board approved this study on July 17, 2023 [Study #M16-23-007].

Participant Recruitment

Maximum variation (24) sampling was used to understand a wide range of perspectives and experiences, including participants who represent a variety of equity-deserving groups, such as BIPOC, persons with disabilities, and disease-specific organizations. We also included participants from healthcare organizations and government agencies. The aim was to engage participants who could describe how COVID-19 was managed in hospitals and how these strategies affected the individuals and communities served by their organizations.

To identify potential participants, we leveraged community-, provincial-, and national-level contacts from among our broader study team's existing networks (i.e., project principal investigators, co-investigators, knowledge users, and collaborators). A Google spreadsheet was circulated to the broader study team, who were asked to provide the name of persons at the organization, the respective organization, the type of organization (e.g., BIPOC, persons with disabilities, disease-specific organizations, healthcare organizations, and government agencies) contact information for the individuals, and whether the research coordinator (JR) could mention the study team member's name in the initial recruitment email. JR contacted the individuals listed in the spreadsheet via an email invitation that included an overview of the study purpose, inclusion criteria, and procedures. The email asked the recipient to share the recruitment email and poster with other representatives within their organization. After each interview/focus group, participants were asked to circulate the study poster to their colleagues who met participant criteria (i.e., snowball sampling) (25).

Prior to inviting representatives among Indigenous organizations to participate in the study, we invited representatives to engage in a preliminary conversation to ensure our research vision and goals were both sensitive to and respectful of the organization, and more broadly, to Indigenous communities. Then, we asked for letters of support (drafted by the organization) that expressed approval for the research coordinator to invite representatives from the organization to participate in the study. Eligible participants were 19 years of age or older, fluent in English, and represented decision-makers, clinicians, healthcare organizations, and/or equity-deserving groups.

Data Collection

The research team collaboratively created a single interview/focus group guide (see Appendix 1: Supplementary File A). The core research team drafted the questions, then circulated them to the broader team for feedback. We refined the guide after the first few focus groups/interviews. Prior to study commencement, participants completed a written consent form via email, then an online demographic questionnaire using Microsoft Forms. All focus groups and interviews were conducted and audio-recorded using Microsoft Teams and Zoom, and recordings de-identified and transcribed by the company, PlayWrite. Data collection ended when no new themes or insights emerged, i.e., we achieved data saturation, and recruitment was therefore concluded (21,26).

Analysis

Thematic analysis (27,28) was used to analyze focus group and interview data. We first engaged in close readings of transcripts to thoroughly understand the dataset, and then developed a preliminary codebook using inductively derived codes. Code saturation was reached once no new codes were developed based on review of the transcripts (28). The finalized

codebook and interview transcripts analyzed with the aid of MAXQDA qualitative analysis software (29). JR and TS consensus-coded the first two transcripts to establish intercoder reliability and finalize the codebook, independently coding and then comparing their work to ensure alignment. The remaining 10 transcripts were double-coded: each coder worked independently on a subset of transcripts, after which they reviewed each other's coding through discussion to ensure consistency and agreement. We reviewed the coded segments and explored preliminary patterns, and then identified core themes and exemplary quotations.

RESULTS

Eight focus groups and four interviews were conducted. Nineteen participants took part in the focus groups, and four participated in the interviews, for a total of 23 participants from Ontario (n=12), British Columbia (n=4), Saskatchewan (n=4), Nova Scotia (n=2) and New Brunswick (n=1). Seven participants (31%) identified as persons of colour or as from an equity-deserving group; 13 (57%) participants worked within organizations representing decision-makers, clinicians, and/or groups that represent people from equity-deserving groups (see Table 1 for participant demographic characteristics).

Table 1: Participant Characteristics

Characteristics	No. (%) of participants
Gender	
Woman	15 (65)
Man	7 (31)
Prefer not to answer	1 (4)
Age	
35-44	8 (35)
45-54	7 (31)
55-64	5 (22)
65-74	1 (4)
75-84	1 (4)
Prefer not to answer	1 (4)
Province or territory occupation resides in	
Ontario	12 (53)
British Columbia	4 (17)
Saskatchewan	4 (17)
Nova Scotia	2 (9)
New Brunswick	1 (4)
Organization type	
Governmental	7 (31)
Not-for-profit	5 (22)
Education	3 (13)
Healthcare	2 (9)
Hospital	2 (9)
Non-governmental	1 (4)
Not-for-profit; charity	1 (4)
Not-for-profit; governmental	1 (4)
Not-for-profit; non-governmental	1 (4)
Years in current role	
Less than 1	1 (4)
1-3	3 (13)
4-6	6 (26)
7+	13 (57)
Identification as a person of colour or an equity-deserving group	
No	15 (65)
Yes	7 (31)
Prefer not to answer	1 (4)
Please identify which group[1]	
South Asian	3
Afghan	1
African Canadian/Black	2
West Asian	1
Organization represents decision-makers, clinicians, and/or equity-deserving groups	
Yes	13 (57)
No	10 (43)

[1] This item was presented in an open textbox format in Microsoft Forms

We identified three major themes related to participants' perspectives of, and experiences with, triage-avoidant strategies implemented during COVID-19: 1) triage-avoidant strategies had disproportionately harmful impacts on equity-deserving groups and healthcare providers; 2) organizations attempted to mitigate negative effects of triage-avoidant strategies; and 3) system-level actions could help mitigate the negative effects of these strategies in the future (see Table 2).

Table 2: Exemplary Quotations

Theme; subtheme	Illustrative quotation
Theme 1: The use of triage-avoidant strategies had disproportionately harmful effects on equity-deserving groups and healthcare providers, compared to the general population	
Adjusting the standard of care	*One of the main challenges we found is that the lack of support provided in the hospital setting was due to the focus of the healthcare teams on medical needs, and not on disability needs. For example, interpreters not being admitted to support people who are deaf, or personal care attendants not being able to meet with people with physical disabilities, to make sure that their daily care needs were met. This often led to people avoiding the hospital out of fear that they would only be treated for a medical condition and not their essential daily needs.* [FG1-2]
Cancelling/postponing non-emergency procedures	*Often, for families with young children who have complex or compromised or complicated needs, it's a precious window of time in terms of their early years. Delays have a potential impact on child development.* [FG3-3]
Cancelling/postponing specialist treatments	*The big impact that we saw was the impact on delayed treatment and management for several conditions. These conditions then needed to be aggressively over-managed.* [FG10-1]
Patient relocation	*It was more vulnerable, marginalized patients who were being transferred versus the ones who had more privilege and empowerment, who were able to stay closer to home because they knew how to advocate for their loved one to stay closer to home.* [FG8-1]
Staffing ratios/staff redeployment	*The COVID public health emergency was incredibly stressful for everybody personally and professionally. Some of these strategies, some of the difficult moral decisions people had to make …The overload and work, the being redeployed to new patient areas and populations that people wouldn't have elected to go to necessarily or didn't feel adequately trained for.* [FG8-1]
Theme 2: Organization-specific actions used to mitigate effects of triage-avoidant strategies	
External-facing strategies	*Our organization was also part of a bigger provincial advocacy group where there was service providers, provincial advocate organization, some individuals that would meet very regularly to hear what was happening, coordinate communication, coordinate advocacy strategies, just make sure that there was also that piece happening during COVID-19 for our sector.* [FG3-3]
Internal-facing strategies	*We would urge people to be vaccinated. We would work diligently in trying to convince people about the need for a vaccine. And we had, and still have, a good number of people who mistrust the health system. The only way that they would have been vaccinated is because we had culturally specific vaccine clinics that we fought for.* [FG6-1]
Theme 3: System-level actions suggested for the future to mitigate the effects of triage-avoidant strategies	
Increased collaboration and consultation when developing/implementing protocols	*You need people engaged who can advocate for these patients who are vulnerable, and that includes both their own family, whoever they define family as, as well as the engagement of community partners and community-based advocates who can help us to hear the voice of equity-seeking members of our community, and make sure that our policies and procedures bring that equity lens, and that they feel empowered and engaged in decisions about their own health.* [FG8-1]
Increased healthcare provider-oriented training	*Health care providers would need robust human rights training—to support all health system service provision, but especially with triage, that there would need to be a good grasp of what accommodation means in health care, and what are the human rights dimensions of making these decisions.* [FG7-2]
Increased patient/family education and support	*Education for these marginalized communities, specifically, in ways that resonate with those individuals will be key. Having knowledge is power. It empowers patients and caregivers to manage their disease effectively, but [also] know the decisions that they will need to make in the future, if there are these certain outcomes.* [FG5-1]
Increased public education	*A very frank conversation with the public about what the health care system is trying to do, and how we're limited in Canada. We saw quite a lot of distrust in the medical system because of inadequate resources or previous terrible stories of what had happened…there's no easy fix. If we're transparent about what we can and can't do, that might help.* [FG9-3]

Triage-Avoidant Strategies had Disproportionate Harmful Effects on Equity-Deserving Groups and Healthcare Providers

Participants discussed the effects of triage-avoidant strategies, including adjusting the standard of care, patient relocation, postponing/cancelling non-emergency procedures and specialist treatments, decreasing staffing ratios and staff redeployment. Though effects may not have been directly related to any one triage-avoidant strategy and may have occurred with triage as well (e.g., visitor restrictions), these are nonetheless important to acknowledge for any future surge in critical care demand.

Adjusting the Standard of Care

When experiencing an overwhelming surge in demand, participants noted that healthcare facilities adjusted their standard of care to meet patient needs by cancelling rehabilitation services, implementing visitor restrictions, and using unconventional

hospital spaces to accommodate patients receiving emergency care. However, adjusting the standard of care corresponded with decreased quality of care. For example, individuals requiring rehabilitation services (e.g., physiotherapy, occupational therapy), did not receive the services required to support their activities of daily living. Moreover, visitor restrictions affected services and accommodations (e.g., interpreters, personal care attendants, family networks) required for people with diverse needs to receive adequate care in hospital spaces. Hospital spaces, such as non-ICU wards or floors, were adapted to meet the overwhelming surge in demand, but often fell below the traditional standard of care. As a result, participants felt as though persons with diverse needs might have avoided healthcare facilities out of fear that healthcare providers would focus on their acute needs, and neglect their functional needs, leading to inadequate care.

Cancelling/Postponing Non-Emergency Procedures and Specialist Treatments

Non-emergency procedures were postponed and/or cancelled to reallocate resources to ICUs and to redeploy staff (e.g., nurses, therapists, physicians) to provide acute frontline care. However, conditions previously deemed non-urgent often then evolved into more complex, urgent conditions. For example, one participant highlighted that delayed diagnostic imaging could result in patients being more ill in the long term (FG9-1). Further, seniors who did not receive non-urgent care for their conditions experienced challenges in their daily living activities. Similarly, children who missed non-urgent care experienced negative effects on their overall development. Participants also noted that cancelling some specialist treatments led to delayed diagnosis and treatment trajectories, and that more patients subsequently presented with increased illness severity that then required more aggressive treatment.

Patient Relocation

Patients were often relocated to different hospitals in various regions or across provinces to receive adequate care. Participants reported that relocating patients posed barriers for families, including transportation logistics and relocation costs, and resulted in patients being separated from family members who provide essential, daily support. Families were often not consulted during these decisions. The process for selecting patients for relocation was not standardized or transparent, and the rationale for relocating patients was not conveyed to receiving physicians. Participants also noted that people from equity-deserving groups were overrepresented in patient relocations, potentially because non-marginalized individuals had more health literacy and privilege to better advocate for themselves or their family members to receive care closer to home.

Staffing Ratios/Staff Redeployment

Participants also expressed that staffing ratios were altered, and healthcare providers were redeployed into new roles in hospital settings to meet patient needs. Increased provider-patient ratios resulted in decreased quality of care, particularly for patients requiring accommodation (e.g., meal support, mobility support). Participants also noted that families felt patients were discharged from the hospital too quickly due to staffing shortages.

Participants discussed how healthcare provider shortages in hospital and a lack of primary care providers in community settings resulted in overworked, burnt-out healthcare professionals being more likely to express unconscious biases and discrimination in their care delivery toward equity-deserving groups. Participants also noted that healthcare providers often experienced moral distress when redeployed to ICU environments. For example, some healthcare providers felt motivated to assist in the ICU but did not feel adequately trained with ICU-specific skillsets.

Organizations Attempted to Mitigate Effects of Triage-Avoidant Strategies

External-Facing Strategies

To mitigate negative effects of triage-avoidant strategies, participants described various external-facing strategies that their organizations employed during COVID-19. For example, some organizations consulted with government officials to discuss recommendations surrounding triage protocol. Other organizations leveraged media outlets to disseminate knowledge and advocate for their community members. Several participants noted that their organizations facilitated conversations among community members to share their lived experiences and enabled collaboration with other organizations. Some participants representing healthcare organizations noted that healthcare providers, both within their institutions and across regions, built capacity by engaging in consistent communication, coordinating advocacy strategies, and providing consultative services to ensure high-quality care delivery.

Internal-Facing Strategies

Organizations also employed internal-facing strategies to mitigate the effects of triage-avoidant strategies. For example, some healthcare organizations employed healthcare provider resources, such as response teams and system navigators, to support patients and families navigating the healthcare system during COVID-19 in both hospital and community settings. Other organizations employed culturally focused strategies, including culturally specific healthcare spaces and vaccine clinics within community settings, and community-based interpreter services to mitigate feelings of community distrust in healthcare systems and spaces, and reduce structural barriers to healthcare services.

System-Level Actions Could Help Mitigate the Effects of These Strategies in the Future

Participants suggested several system-level actions to be implemented to mitigate the effects of triage-avoidant strategies.

Increased Collaboration and Consultation When Developing/Implementing Protocols

When developing a triage protocol, further consultation is needed between medical professionals (e.g., healthcare providers, academics), healthcare system users (i.e., patients) and healthcare system user advocates (e.g., family members, friends, community-based advocates). Participants explained that increasing consultation and collaboration can help to ensure that policies are developed using an equity-based lens, and account for diverse populations' needs.

Increased Healthcare Provider-Oriented Training

Participants also expressed that further training in hospital environments, particularly within ICUs, is required for high-quality care delivery and system user satisfaction. Moving forward, increased human rights, cultural safety, and trauma-informed care training for healthcare providers was deemed necessary to support healthcare system service provision. Participants stated that increased training in ICU environments may increase high-quality care delivery, as well as healthcare systems and user satisfaction.

Increased Patient/Family Education and Support

To ensure that patients and families are educated about the patient's condition and healthcare trajectory, participants reported that healthcare providers need to collaborate with patients and families to ensure they have the necessary information to inform and empower them in subsequent decision-making. In addition, visitor restrictions during COVID-19 negatively affected patients' ability to carry out activities of daily living and resulted in dissatisfaction with care delivery as their support systems (e.g., family members, friends) were unable to assist them while receiving care in hospital. Moving forward, participants suggested patients require in-hospital social support while receiving healthcare to alleviate communication barriers and ensure care needs are being met.

Increased Public Education

Lastly, participants noted that during COVID-19, members of the public felt uninformed about the mechanisms and current constraints of the healthcare landscape. Moving forward, they suggested that further public education about these constraints and transparent engagement between healthcare providers and healthcare system users could alleviate distrust in the healthcare system.

DISCUSSION

Our study gathered experiences and perspectives of decision-makers, clinicians, and equity-deserving groups from across Canada regarding the effects of triage-avoidant strategies used during COVID-19. Participants perceived that triage-avoidant strategies had disproportionately harmful effects on equity-deserving groups and healthcare providers; shared how organizations attempted to mitigate negative effects of triage-avoidant strategies; and suggested system-level actions that could help mitigate the negative effects of these strategies in the future.

The Unintended Yet Harmful Effects of Triage-Avoidant Strategies on Equity-deserving Groups

Equity-deserving groups experienced several unintended yet harmful effects from the use of triage-avoidant strategies. For example, they faced exacerbated barriers to access and availability of healthcare services, including delayed or cancelled procedures and specialist treatments, as well as logistical and financial challenges related to patient relocation. They perceived that quality of care, and consequently health outcomes, were also negatively affected. Participants noted that adjustments to the standard of care contributed to reduced rehabilitation services, decreased attention to diverse patient needs, and increased illness severity due to postponed interventions. Social support was similarly compromised, with participants highlighting separation from support networks due to isolation or relocation, and reduced access to essential services such as personal support workers or interpreters. Participants perceived that systemic inequities were further amplified by the overrepresentation of equity-deserving groups in patient relocations and the exacerbation of unconscious bias or discrimination stemming from staffing shortages and redeployment.

COVID-19 Amplified the Effects of Existing Inequities in Access to Emergency Care

Respondents felt that COVID-19 heightened the effects of existing inequities on people's abilities to access emergency care. For instance, participants highlighted that equity-deserving groups often avoided seeking care in formalized healthcare spaces due to previous experiences of racism and discrimination. Some patients felt that their conditions were dismissed (e.g., were not admitted to emergency care, symptoms were unrecognized) resulting in exacerbated underlying conditions and, in some cases, participants reported resulting fatalities. Financial factors further affected healthcare users' ability to access supplementary private care outside of the publicly funded healthcare system. Additionally, geographical location, transportation challenges, and isolation restrictions significantly affected the ability of patients living in some communities to access care.

Equity considerations can be overlooked when the healthcare system becomes strained. Existing inequities are compounded by a lack of support to improve access and quality of care for people among equity-deserving groups. For example, interpretation services are essential to achieve effective communication, complex decision-making, and provide therapeutic management for linguistic minorities (30). During COVID-19, both formal and informal (e.g., family member/friend) interpretation services were depleted due to overwhelming hospital demands and visitor restrictions (31), transforming a routine aspect of care into an exception, and negatively affecting overall care standards. Some Canadian hospitals have implemented technology-driven interpretation services (32) and virtual care (31) to reduce linguistic barriers moving forward.

Although Ontario's Triage Framework was never deployed, studies have shown that some triage tools might have inappropriately deprioritized Black patients, patients with disabilities (33), and Indigenous patients (34,35) because screening tools indicated these individuals have a lower chance of survival than was actually the case. These effects may be mitigated in the future through avoidance of tools with poorer (or unknown) prognostic value in equity-deserving groups, when possible.

Participant Considerations for Future Resource Allocation Frameworks

Participants outlined several considerations for future both resource allocation frameworks and triage avoidant strategies. First, they emphasized the importance of collaboration and consultation with relevant parties when developing frameworks, highlighting the use of an equity-based lens to account for the needs of diverse populations. They also stressed the need for increased healthcare provider training, particularly in the areas of human rights, cultural safety, and trauma-informed care. Participants noted that clear communication regarding diagnoses and care trajectories is essential, as is the inclusion of in-hospital supports to assist with daily living needs and communication barriers. Public education and transparency were also highlighted, with participants emphasizing the importance of educating the public about healthcare system constraints and mechanisms, as well as fostering transparent engagement between providers and system users to build trust. Broadly, resource allocation frameworks should anticipate surges in demand and potential inequities, aiming to mitigate the negative impacts of triage-avoidant strategies on equity-deserving groups.

A Resource Allocation Framework Reflecting the Experiences of Decision-Makers, Clinicians, and Equity-Deserving Groups is Required

Our participants felt that COVID-19 exacerbated existing inequities in access to emergency care, and argued for an equitable approach to managing limited healthcare resources, whether triage or triage-avoidant strategies are used. A resource allocation framework grounded in equity-based principles could provide actionable strategies to mitigate inequities during demand surges, helping to ensure that equity-deserving groups are not disproportionately affected when resources are scarce.

While some frameworks cite the importance of equity in triage and triage-avoidant strategies, implementing equity-based decisions is challenging. For example, the American Medical Association provides suggestions on embedding equity in crisis preparedness and response in health systems, including a "shift to race and identity-explicit approaches that promote equitable crisis response processes and outcomes" and "embed[ding] equity in all emergency response structures", but practical implications are not discussed (36, p.8). Complementing this, Downar et al. (8) developed a multi-level critical care triage framework that incorporates fairness, consistency, and equity considerations across hospitals, emphasizing consultation with Indigenous, Black, racialized, older adult, and disability rights stakeholders.

Our participants' experiences echo this framework, highlighting the value of stakeholder engagement in shaping protocols. Building further, the Accountability for Reasonableness (A4R) framework argues that legitimacy and fairness in resource allocation require a deliberative process that is transparent (37), based on reasons stakeholders can agree are relevant, revisable in light of new evidence, and enforceable (38). Applying A4R to our findings emphasizes that procedural justice, such as clear reasoning, transparency, and mechanisms for revision, is crucial for embedding equity-oriented principles in practice, especially when healthcare providers are faced with rapidly evolving crises.

Representation and Power within Equity-Focused Organizations

While our recruitment included organizations among government, healthcare, and advocacy sectors, it is important to note that those contributing to decision-making discussions may not have been individuals among equity-deserving communities. This raises important questions about how equitable power structures are within organizations that aim to promote equity — specifically, whose voices are centred in decision-making and whose perspectives may remain underrepresented. For instance, the development of healthcare frameworks and strategies is often led by healthcare professionals and/or leaders with limited direct involvement of patients, family caregivers, or members of the general public (39). Indeed, engaging equity-deserving groups in these processes presents both opportunity as well as complexity: engagement can help ensure that frameworks and strategies reflect lived experiences and mitigate structural inequities, yet it also requires careful attention to tokenism, accessibility, and the distribution of decision-making authority (40,41). The fact that both the triage framework and triage-avoidant strategies were developed as the pandemic was unfolding created a time-pressure that precluded extensive consultation and engagement.

Strengths and Limitations

This project engaged representatives among a variety of organizations, including governmental, educational, and non-profit sectors. A notable strength of this work is the documented perceptions of a broad range of interested parties on the effects of efforts to avoid triage, which can inform future considerations for framework development. Additionally, we have identified several system-level recommendations that can be brought forward when developing and implementing future frameworks.

We nonetheless encountered recruitment challenges engaging participants on a national scale; we were only able to secure representation from five provinces. Additionally, we faced difficulties recruiting individuals who could both articulate the experiences of equity-deserving groups during COVID-19 and had an in-depth knowledge of the healthcare system. This limited representation may hinder our understanding of how changes within the healthcare system affected individuals and communities beyond COVID-19. Moreover, because our findings represent participants' perspectives, we cannot confirm that these perspectives are reflected in empirical data from the pandemic (e.g., whether marginalized individuals were transferred more often than non-marginalized individuals in the same situation). We are studying this data in a separate study.

Finally, we had poor representation from First Nations, Inuit, Métis and urbanized Indigenous peoples. Recognizing the First Nations principles of Ownership, Control, Access, and Possession (OCAP) in data collection processes (42), we invited representatives to engage in a preliminary conversation before the recruitment phase and requested letters of support from organizations to indicate their approval for the research coordinator to invite representatives from the organization to participate in the research study. We also faced challenges engaging other members of equity-deserving groups, as only approximately 30% of participants identified as a person of colour or among equity-deserving groups. This limited representation may influence the extent to which our findings reflect the experiences of all equity-deserving groups and underscores the importance of developing more inclusive recruitment strategies in future studies.

CONCLUSIONS

This study contributes to the literature by documenting the perspectives of representatives of diverse organizational backgrounds, as well as members of equity-deserving groups, on how triage-avoidant strategies disproportionately harmed their organizations and the populations they serve. The study also gathered insights on organization-specific actions that were implemented to mitigate these effects, and we identified system-level recommendations for future strategies to reduce harm. The synthesized findings highlight key elements that should be considered when developing equitable resource allocation frameworks. Our findings can inform the development and implementation of triage-avoidant (and triage) strategies that better reflect the views and experiences of decision-makers, clinicians and/or groups equity-deserving groups, and ensure that care is delivered more equitably while trying to maximize lives saved. Future research is necessary to explore the practical implementation of equity-focused triage-avoidant strategies.

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Conflits d'intérêts

JD a co-écrit le cadre de référence ontarien « Norme de soins cliniques d'urgence en cas d'afflux massif de patients ». Afin de limiter les biais, JD n'a examiné aucune transcription et n'a pas participé à l'analyse des données. Un autre membre de l'équipe de recherche, SV, a participé à l'étude. Afin de limiter les biais, SV n'a examiné aucune transcription et n'a pas participé à l'analyse des données. Les autres auteurs n'ont aucun conflit d'intérêts à déclarer. Cécile Bensimon est éditrice de la revue, et Maxwell J. Smith est membre de son Comité consultatif de rédaction. Ni l'une ni l'autre de ces personnes n'a participé, à quelque étape que ce soit, au processus d'évaluation ou à la décision d'accepter ce manuscrit.

Conflicts of Interest

JD was a co-author of Ontario's "Critical Care Clinical Emergency Standard of Care (ESofC) for Major Surge" framework. To mitigate bias, JD did not review any transcripts and was not involved in the data analysis process. One broader study team member, SV, participated in the study. To mitigate bias, SV did not review any transcripts and was not involved in the data analysis process. Cécile Bensimon is an editor of the journal, and Maxwell J. Smith is a member of the Editorial Advisory Board. Neither were involved at any stage in the review or acceptance of this manuscript.

Édition/Editors: Aliya Affdal

Les éditeurs suivent les recommandations et les procédures décrites dans le Core Practices de COPE. Plus précisément, ils travaillent pour s'assurer des plus hautes normes éthiques de la publication, y compris l'identification et la gestion des conflits d'intérêts (pour les éditeurs et pour les auteurs), la juste évaluation des manuscrits et la publication de manuscrits qui répondent aux normes d'excellence de la revue.

The editors follow the recommendations and procedures outlined in the COPE Core Practices. Specifically, the editors will work to ensure the highest ethical standards of publication, including: the identification and management of conflicts of interest (for editors and for authors), the fair evaluation of manuscripts, and the publication of manuscripts that meet the journal's standards of excellence.

Évaluation/Peer-Review: Maria Klimenko & Manisha Pahwa
Les recommandations des évaluateurs externes sont prises en considération de façon sérieuse par les éditeurs et les auteurs dans la préparation des manuscrits pour publication. Toutefois, être nommé comme évaluateurs n'indique pas nécessairement l'approbation de ce manuscrit. Les éditeurs de la *Revue canadienne de bioéthique* assument la responsabilité entière de l'acceptation finale et de la publication d'un article.
Reviewer evaluations are given serious consideration by the editors and authors in the preparation of manuscripts for publication. Nonetheless, being named as a reviewer does not necessarily denote approval of a manuscript; the editors of *Canadian Journal of Bioethics* take full responsibility for final acceptance and publication of an article.

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APPENDIX 1: SUPPLEMENTARY FILE A – FOCUS GROUP/INTERVIEW GUIDE

Today we're going to be having a conversation to better understand your views on how the COVID-19 pandemic was managed in hospitals and how that impacted [*insert group topic here*] individuals and communities. Our overall aim is to develop a framework for allocating healthcare resources during future overwhelming surges in demand, such as another pandemic, while trying to avoid disproportionate effects upon marginalized individuals.

We're going to be talking today about 'triage'. Triage is commonly used in emergency departments to prioritize those who are most likely to benefit from care before those who are less likely to benefit from care. During the COVID-19 pandemic, there was concern that we would need to start a triage process for critical care beds. This was referred to as the triage protocol, which was developed but never implemented. Instead of using the protocol, efforts were made to redirect healthcare resources towards the Intensive Care Unit and expanding capacity well beyond normal. These are what we'll be referring to as "triage-avoidant" strategies. While they were effective in preventing the need for Intensive Care Unit triage they did have consequences for patients, healthcare providers and others.

We want to understand your unique experiences and ideas on this topic. We'll be asking a series of questions and opening the floor up for discussion.

1. Please describe the organization you are representing today and your professional role at that organization.
2. During the COVID-19 pandemic, provinces and territories implemented triage-avoidant strategies (i.e. strategies that aimed to prevent unsustainable demands on the critical care system due to COVID-19). I will list some strategies. Please let me know how you think these strategies impacted those that you and/or your organization represent?
    a. Cancelling/postponing non- Intensive Care Unit services (e.g. chemotherapy, non-emergency surgery) so that staff can be redeployed to the Intensive Care Unit.
    b. Cancelling/postponing scheduled procedures that often require Intensive Care Unit care (e.g. cardiac surgery, organ transplant) to preserve Intensive Care Unit capacity for COVID-19 patients
    c. Transferring or rerouting critically ill patients to other facilities and regions
    d. Staffing ratios/redistribution of staff (e.g. having each nurse care for more patients than usual for them?
    e. Surging Intensive Care Unit admissions over normal capacity (admitting more patients than usual)
    f. Adjusting the standard of care provided (e.g., keeping patients on the ward who would at other times have been admitted to Intensive Care Unit; placing more stringent criteria for access to tests, treatments, or transfer to hospital or Intensive Care Unit)
3. Did your organization take any specific actions to minimize effects upon your organization's community, or monitor whether such effects were taking place? *(Skip if short on time)*
4. How can we decrease the disproportionate effects of these triage-avoidant strategies on marginalized communities in the future?
5. Looking forward, understanding there may be another pandemic, how would you advise decision-makers approach the challenge of limited critical care resources?
    a. Would you advise implementing a triage protocol or revised triage protocol? Would you advise implementing any of the above triage-avoidant strategies again? Or both?
6. Do you have anything to add that you did not yet get a chance to say?