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Ought Conscientious Refusals to Implement Reverse Triage Decisions be Accommodated?

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Abstract Although one can argue that they do not represent a radical departure from existing practices, protocols for reverse triage certainly step beyond what is ordinarily done in medicine and healthcare. Nevertheless, there seems to be some degree of moral concern regarding the ethical legitimacy of practicing reverse triage in the context of a pandemic. Such concern can be taken as a reflection of the moral antipathy some exhibit towards current practices of withdrawing treatment—that is, when withdrawal of treatment is arguably in the best interests of patients—and a rejection of the purported normative insignificance of withholding and withdrawing. Given that the relevance of the psychological attitudes of some healthcare professionals to the moral assessment of withdrawing and withholding treatment continues to be debated, it would seem that some thought should be given to the introduction and implementation of reverse triage decisions in response to a pandemic. This brief paper will consider if provision should be made for healthcare professionals to conscientiously refuse to participate in reverse triage.

Keywords COVID-19 · Pandemic · Triage · Reverse triage · Withdrawing · Conscientious objection · Conscientious refusal

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Introduction

It seems clear that healthcare systems will manage the demand placed on lifesaving resources such as ICU beds and ventilation machines during a pandemic through the implementation of triage processes. At least at first, this will involve limiting access to ICU care. Patients who normally would have been admitted to ICU will instead be managed on standard wards for as long as possible in the hope that their condition will improve. The requisite potential for a patient to benefit will also rise. Treatment will be withheld from patients who may have been admitted to ICU under normal circumstances. Whilst such decisions are difficult, they are apiece with the ordinary practice of triage. However, at a certain point there will be a need to introduce protocols for reverse triage. This involves withdrawing treatment from patients who may yet benefit from continued ICU care and/or mechanical ventilation (Truog, Mitchell, and Daley 2020). Under ordinary circumstances such care is not withdrawn unless and until it is in the patient's best interests to do so; that is, it is only withdrawn when its continuation offers only the remotest possibility for clinical benefit. As such, protocols for reverse triage arguably step beyond what is usually done in medical practice.

The ethical justification for this practice would seem to be well founded and subject to a reasonably broad degree of acceptance, at least in the context of allocating scare resources with the potential to save lives during a pandemic. Nevertheless, there also seems to be a degree of moral unease. Indeed, even under ordinary

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conditions, there continues to be a not insignificant degree of moral antipathy towards current practices of withdrawing treatment from patients who no longer have any reasonable prospect of recovery. Given that the psychological attitudes of some healthcare professionals to withdrawing treatment continues to be seen as a source of moral concern (Dickenson 2000), it would seem that some thought should be given to the implementation of reverse triage during a pandemic. Should healthcare professionals who, on the basis of some ethical reservations, do not wish to participate in either making or implementing such decisions have their views accommodated?

Conscientious Refusals

In this context it is useful to draw a distinction between two terms that are usually treated as virtual synonyms: conscientious objection and conscientious refusal. Whilst exercising a right to conscientiously object will involve an act of conscientious refusal,[1] not all acts of conscientious refusal involve appealing to some formally codified right or, for that matter, established ethical principle. Even if there are some professional guidelines pertaining to conscientious refusals which set out how, in a general sense, professionals should behave if they wish to pursue such a course of action,[2] these kinds of refusals are generally made on a case-by-case basis. They may, of course, reflect some underlying moral issue or concern. However, these concerns may not be amenable to the kind of generalized form of expression ordinarily characteristic of moral or ethical claims. In at least some cases, conscientious refusals result from moral uncertainty and a certain degree of doubt or ambivalence.

In contrast to conscientious refusals, conscientious objections are formally established rights that relate to certain acts, practices, or issues. Whilst some argue that they require reasonable justification (Ben-Moshe 2019; Kantymir and McLeod 2014; Card 2017), conscientious objections can be seen as political devices that are deployed to facilitate and manage changes to—or *revolutions* in (Baker 2019)—established ethical positions regarding specific practices such as medical assistance in dying (MAiD), abortion, and contraception (Emmerich 2019; Montgomery 2015). Indeed, as Montgomery points out, "conscience clauses are historically situated and part of the ebb and flow of professional boundary work by which professional identities are constituted and reconstituted" (Montgomery 2015, 213). They arise in the context of changes that impact on the moral identity of healthcare professionals and are therefore enacted in particular times, places, and ethico-political contexts. They codify the way in which the ethical concerns of those who continue to demur from a newly established collective moral position are to be accommodated. They also set out any residual requirements that result from this accommodation, such as the need to refer patients to another non-objecting healthcare professional.[3]

Whilst clarity and precision are appropriately valued by those who comment on, discuss, and analyse the ethics of healthcare, they are not always available in practice. Furthermore, ethical arguments conducted in the academic literature are pursued without the kind of time pressures experienced in clinical practice. Whilst the academic pursuit of biomedical ethics certainly *informs* the practice of healthcare and, in particular, its normative structures and modes of governance, it is nevertheless the case that healthcare professionals must rely on their own resources. Indeed, they must do so in a context where the potential for both clinical and moral uncertainty is ultimately ineliminable. Thus, whilst some might think the picture just sketched offers insufficient clarity and precision when it comes to distinguishing between proper and improper claims to conscientiously object or refuse, the pursuit of such certainty can be or become misguided, or so I would

[1] Of course, one might think that there are no *acts* of conscientious objection and refusal; they are *inactions* and therefore require no justification. The distinction is, however, asinine. It is not merely that there is no distinction. Rather, the supposition that human actions, let alone the subset of morally significant human actions, necessarily involve some kind of physical effort cannot survive even the briefest of interrogations. Even if implementing a conscientious objection is an inaction—which, insofar as it requires some kind of communication or dialogue, is doubtful—refusing to countenance particular requests from one's patients has social or cultural meaning. Thus, at the very least, acts of conscientious objection and refusal both involve individuals acting on the basis of some kind of moral or political stance. To suppose otherwise is merely obtuse.

[2] The Australian Medical Association's (2019) *Position Statement on Conscientious Objection* offers an example of such generalized guidance. In my view, unless the (in)action being undertaken relates to some apsect of formal legislation concerning abortion or voluntary assisted dying, say, the matter at hand is one of *conscientious refusal*.

[3] Whilst such accommodations can be maintained in perpetuity, and this seems to be the implicit presumption of most existing conscience clauses, it may be appropriate to consider introducing time limits or "sunset clauses" on rights to consciously object (Montgomery 2015).

suggest. The issue of conscientious objection and its establishment arises in the context of moral change or revolution—that is, at precisely the point when the correct or, at least settled, predominant or preeminent moral point of view is in flux. Similarly, if we construe acts of conscientious refusal as reflecting the moral doubts or uncertainties of individual professionals, it seems clear that requirements for established principles and settled points of view articulated in terms that meet criteria of "reasonableness" is to miss something of the point.

Moral Uncertainty in Pandemic Triage

Arguably, the proposed shift in triage protocols during a pandemic represents a change in the moral landscape of practice, albeit one that is temporary and perhaps even minimal.[4] Furthermore, this shift or, at least, the potential for it to occur has clearly been anticipated. Whilst many have been writing triage protocols as part of the effort to respond to the potential challenges posed by COVID-19, there has long been a recognition that reverse triage would be introduced if and when the relevant situation occurred (Emmerich 2011). Nevertheless, the ramifications of practicing reverse triage during a pandemic have not been fully or comprehensively considered. Certainly, there has been no previous discussion of conscientious objection or refusal, at least to my knowledge. Whilst it may be that, in the aftermath of COVID-19, a more detailed approach to pandemic preparedness will be taken and, as part of that process, a right to conscientiously object might be recognized or rejected, there is no established position at present. Thus, the issue at hand is one of conscientious refusals to be involved in the practice of reverse triage in a pandemic, whether or not such refusals should be accommodated and, if so, how we should do so.

The account I have sketched is clearly one in which pragmatic concerns are of central significance. This stance is reinforced by the contingencies we face in regard to COVID-19 and similar pandemics. In essence, the practice of triage is a pragmatic approach to the allocation and management of healthcare resources. Whilst there is a shift in the underlying moral reasoning required to justify the practice, the introduction of reverse triage protocols is nevertheless an extension of this pragmatic approach. However, whilst withholding treatment when it is appropriate to do so does not generally trouble healthcare professionals, withdrawing treatment continues to be a source of moral anxiety, at least for some. Given that reverse triage entails withdrawing treatment that would normally be continued, its introduction has the potential to play on existing moral uncertainties.[5] There are, no doubt, many instances of healthcare professionals disagreeing about the withdrawal of treatment from specific patients, perhaps even to the point where an individual professional has recused themselves from further involvement with a particular case. One might construe such actions in terms of healthcare professionals *effectively* engaging in acts of conscientious refusal.

There is no established or codified right to conscientiously object to the withdrawal of treatment in either ordinary or extraordinary circumstances. Furthermore, those who would question the practice as a matter of principle, as opposed to being ambivalent about certain examples or cases, would quickly find that it is impractical for them to work in particular settings, such as ICUs, where it is not an uncommon occurrence. Thus, whilst there seems to be some degree of ethical ambivalence towards the practice of withdrawing treatment, including even amongst those who regularly encounter it in their professional lives, the practice does not occasion outright opposition.[6] Nevertheless, there is a risk that this ambivalence will be heightened by the introduction of reverse triage, including amongst those who recognize the underlying need, purpose, and ethical basis for such protocols. In some cases, that may result

[4] They might be considered to be a temporary "state of exception" rather than a "revolution" per se. Pointing this out does not, of course, mean the former is without issue. At minimum, we should be concerned to ensure states of exception are indeed exceptional—that is, whether the new provisions are indeed justified by the unusualness of the circumstances and whether they will in fact be rescinded at some later point in time.

[5] We should recognize that healthcare professionals cannot be unambiguously sorted into two distinct and mutually exclusive camps; those who do and those who do not object to withdrawing treatment. Certainly, it would seem that the majority accept the ethical propriety of withdrawing treatment, at least as it is commonly practiced. Equally, it also seems that many are uncertain about the ethics of withdrawing treatment in certain circumstances or cases.

[6] As a reviewer helpfully points out, particular cases certainly occasion outright opposition. One might point to Terri Schiavo, Tony Bland and, more recently, the case of Charlie Gard. However, whilst it is true to say that the judgement issued in Airedale NHS Trust v Bland [1993] established certain legal precedents, the fact that certain cases occasion dispute merely reinforces the fact that the practice of withdrawing treatment is not opposed in principle. At minimum, then, it is not the subject of a generalized opposition by a significant number of healthcare professionals such that they might seek to establish a right of non-participation as a result of their conscientious objection.

in individual professionals not wishing to be involved in either making or implementing reverse triage discussions. In effect, they will be inclined to conscientiously refuse to participate. In all likelihood this refusal will extend to not participating in the relevant decision-making processes and to not being involved in actual withdrawal of treatment. It is also possible that some might refuse to be involved in the delivery of any and all patient care that results from what they consider to be related a morally flawed decision-making process.

In the latter case this may amount to refusing to treat or care for any and all pandemic patients. Even in the worst of scenarios, there will still be non-pandemic patients and so this may not amount to refusing to act in one's professional capacity. However, it would seem to be an overreaction. First, if one *truly* felt that reverse triage was immoral to the degree implied by this reaction, it may be better to resign as a healthcare professional and to argue this point of view more broadly. Second, during a pandemic, healthcare professionals are a scarce resource. Accommodating conscientious refusals to participate in the care of pandemic patients in general will clearly compromise the pandemic response as a whole. As with conscientious objections, conscientious refusals meet their limit when they threaten or compromise the care provided to patients. This type of refusal must therefore be seen as illegitimate.

The same cannot be said of conscientious refusals that have a more restricted scope. The nature of pandemic triage is such that decision-making will need to be centralized, at least to some degree (Biddison et al. 2014). The use of triage teams and officers means that triage decisions will be concentrated in fewer hands than would normally be the case. Thus, as long as some qualified individuals were prepared to make triage decision in the required way then accommodating the conscientious refusals of particular healthcare professionals should not give cause for concern, even if they could be considered candidates for roles on the triage team as a function of their particular expertise. Similar thinking can be applied to conscientious refusals to withdraw treatment. Indeed, if only for practical purposes, it is probably wise for those who do not wish to participate in the withdrawal of treatment from patients who may yet benefit from its continuance—that is, those who are being subject to a reverse triage decision—to also be recused from involvement in any withdrawal of treatment. This includes from patients who no longer have any prospect of recovery, those who would normally be encountered by the professional who conscientiously refuses their involvement in reverse triage.

Of course, if and when such conscientious refusals begin to impact the healthcare sector's response to the pandemic as a whole, then consideration would have to be given to rejecting such claims. A situation such as this might arise in rural hospitals that generally serve smaller populations, albeit across a larger geographic area. However, rather than simply reject such claims or the policy as a whole, it may be wise to first appeal to the healthcare professionals concerned. Of course, if a significant number of healthcare professionals were unwilling to enact the prescribed triage protocols, then one should carefully reconsider the ethical basis of those protocols in the light of the concerns being raised. If they are found to be wanting, then they should be amended. If not, then attention should be given to the communication of those protocols and the ethical rationale that underpins them. If, as I have suggested, rather than being a function of an explicit, reasoned, and fully articulated ethical perspective, conscientious refusals to participate in reverse triage reflect a degree of moral uncertainty or ambivalence then a good faith engagement with the concerns of healthcare professionals will likely result in sufficient acceptance of the practice if not necessarily an outright endorsement.

Conclusion

Reverse triage protocols are a response to the overwhelming crisis that a pandemic scenario has the potential to create. Whilst that does not justify acting unethically, it will no doubt result in greater degrees of ethical ambivalence and uncertainty. This brief article has argued that healthcare professionals should be able to conscientiously refuse to participate in the practice of reverse triage during a pandemic. The scope of this accommodation extends to not being involved in the triage decision-making processes as well as not being compelled to withdraw care from patients. The comments I have offered do not imply that a right to conscientiously object should be formally established. Moral concerns about reverse triage can be associated with persistent moral uncertainties about withdrawing treatment. As such, the position that has been set forth is primarily pragmatic and reflects the need for expedience. In addition, it is unlikely to cause any significant difficulties when it comes to implementation. If this

proves not to be the case not only would we have to give further thought to the accommodation of such conscientious refusals, we would have to reflect upon the justification of reverse triage protocols and the way healthcare professionals have been involved in debates about their introduction.

References

Australian Medical Association. 2019. *AMA position statement on conscientious objection*. https://ama.com.au/position-statement/conscientious-objection-2019. Accessed August 27, 2020.

Baker, R. 2019. *The structure of moral revolutions: Studies of changes in the morality of abortion, death, and the bioethics revolution*. Cambridge, MA: MIT Press.

Ben-Moshe, N. 2019. The truth behind conscientious objection in medicine. *Journal of Medical Ethics* 45(6): 404–410.

Biddison, L.D., K.A. Berkowitz, B. Courtney, et al. 2014. Ethical considerations: Care of the critically ill and injured during pandemics and disasters: Chest consensus statement. *Chest* 146(4 suppl): e145S–e155S.

Card, R.F. 2017. The inevitability of assessing reasons in debates about conscientious objection in medicine. *Cambridge Quarterly of Healthcare Ethics* 26(1): 82–96.

Dickenson, D.L. 2000. Are medical ethicists out of touch? Practitioner attitudes in the US and UK towards decisions at the end of life. *Journal of Medical Ethics* 26(4): 254–260.

Emmerich, N. 2011. Anti-theory in action? Planning for pandemics, triage and ICU or: How not to bite a bullet. *Medicine, Health Care and Philosophy* 14(1): 91–100.

———. 2019. Conscientious objection should not be equated with moral objection: A response to Ben-Moshe. *Journal of Medical Ethics* 45(10): 673–674.

Kantymir, L., and C. McLeod. 2014. Justification for conscience exemptions in health care. *Bioethics* 28(1): 16–23.

Montgomery, J. 2015. Conscientious objection: Personal and professional ethics in the public square. *Medical Law Review* 23(2): 200–220.

Truog, R.D., C. Mitchell, and G.Q. Daley. 2020. The toughest triage—allocating ventilators in a pandemic. *New England Journal of Medicine* 382(21): 1973–1975.