

**Anti-Theory in Action? Planning for Pandemics, Triage and ICU.
Or: How not to bite a bullet.**

Nathan Emmerich.

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Nathan Emmerich
School of Sociology, Social Policy and Social Work, Queen's University Belfast. Belfast.
Northern Ireland. BT7 1NN.
e-mail: nathan.emmerich@gmail.com

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Abstract: Anti-theory is a multi-faceted critique of moral theory which, it appears, is undergoing something of reassessment. In a recent paper Hämäläinen discusses the relevance of an anti-theoretical perspective for the activity of applied ethics. This paper explores her view of anti-theory. In particular I examine its relevance for understanding the formal guidance on pandemic flu planning issues by the Department of Health (DoH) in the UK and some subsequent discussions around triage and reverse triage decisions which may be considered by both Primary and Secondary Care Trusts (PCTs and SCTs)¹ in setting their own policies and which may face clinicians in the eventuality of a pandemic. Following Hämäläinen in contrasting reflective equilibrium with her anti-theory inspired suggestion of an instrumental approach to moral theory in practice I demonstrate how this understanding complements the diversity of our intuitive moral judgements. Consequentially I suggest that this anti-theoretical instrumental approach is in greater accord with the conditions under which such policy planning and decision making is, or will be, made. Furthermore, on the grounds of keeping open the ethical dimensions of medical practice in conditions of uncertainty, i.e. during a pandemic, I suggest that the anti-theoretical instrumental perspective is, ethically, the preferable approach to producing such policies and guidelines.

Key Words: Ethics; Anti-Theory; Pandemic Flu Planning; Triage

¹ On the division between Primary and Secondary Care Trusts in the UK National Health Service see: <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx> [Accessed August 2010].

1. Moral Theory and Anti-Theory:

'Anti-theory' is a term for a broad set of criticisms of, as Anscombe has it, modern moral philosophy (Anscombe, 1958). In some forms anti-theory is solely a rejection of Kantian and Utilitarian accounts of moral theory, a position which implies that virtue theory is 'anti-theoretical.' Anscombe, for example, criticises Kantian and Utilitarian moral theories for proceeding on the basis of a Christian inspired law-like account of ethics which fails to comprehend the necessity of both a virtue based morality and a naturalistic account of ethics rooted in the human (and not merely 'rational') subject. This, she supposes, should involve an "adequate philosophy of psychology," (Anscombe, 1958 p.1 & 4) by which she presumably means a reasonable, psychologically theoretical, account of moral psychology. We can see then that Anscombe's critique was not against 'theory' per se but the two dominant forms of moral philosophy; utilitarianism and deontology. This line of argument was taken up by the neo-Aristotelians, amongst others, who argued for the recognition of the importance of so called thick concepts in moral philosophy i.e. the need to accommodate broader, evaluative (value laden) moral concepts in moral theory. This perspective complimented a contemporary orientation to ethics which expressly emphasised the explicitly human dimension of ethics and morality. For example Murdoch attended to morality through literature (Murdoch 1997) whilst Williams directly explored the relevance of emotion for morality (Williams 1973, p.207–229). These approaches to ethics often ran alongside others which were inspired by Wittgensteinian insights into the limits of philosophy and human life i.e. anti-foundationalism, the nature of rule following and of language as use (Edwards 1989; Toulmin 1950).

Clarke suggests that "[a]nti theorists take the bold stance of being against any sort of normative theory which guides our behaviour by systematising and extending our moral judgements" (Clarke 1987, p.237–244).² However the ethical anti-theorist is not an ethical nihilist i.e. someone who simply rejects ethics and morality *tout court*. Rather they suggest that philosophical ethical theory is in some sense insufficient to determine or to motivate human moral judgement or by which some action can be pronounced right or good. If we accept that virtue theory does not systematise and extend our moral judgements but rather

² For a further guide to the issues raised in this section see: Richter 1999. (the first half of the monograph presents criticisms referred to here, the second half a number of responses from modern moral philosophy and philosophers). For Anti-theory more generally see: Clarke 1989.

gives a normative account of human flourishing which implies, but does not determine, our moral judgements then we can begin to see what type of stance is adopted by those who take an anti-theory approach to Kantian or Utilitarian ethical philosophy. They are rejecting the idea that moral practice can be derived, or determined, from the application of a judgement produced through purely formal or rational means such as a felicific calculus or categorical imperative.³

However Sorell, like Hämäläinen, does not think it plausible to suggest virtue theory is an ‘anti theory’ in the required way and offers the following definition of moral theory:

“[A] set of precepts of personal and role morality all unified by some overarching principle that rationalises the precepts, together with meta-ethical arguments about the nature of moral value and the way human beings recognise and act up it” (Sorell 1999, p.15).

On this account the requirement for something to be considered a theory is extended beyond a singular systematisation of moral judgement. Instead it relies on some principle which unifies and rationalises moral precepts to indicate when the conditions of being a moral theory is met. Thus virtue ethics counts as a moral theory as happiness or human flourishing (eudemonia) provides a unifying, overarching and rationalising principle for moral precepts but does not, as in the previous case, provide us with a systematisation or extension of our moral beliefs. On this account of moral theory the anti-theorist is rejecting the idea of morality as being justified or explained by a single unifying concept, such as eudemonia, the categorical imperative, or utility, which acts in concord with some set of (derived or non-derived) precepts.

At this level the theorist and anti-theorist are largely concerned with moral theory as a reified philosophical activity and its relevance to actual moral practice which takes place embedded in social reality. Philosophy, Wittgenstein suggested, “leaves everything as it is” (Wittgenstein 1953, §124). However the discipline applied ethics belies this semi-truism in attempting to bring moral philosophy into a closer relationship with the world and ‘social

³ There are of course more nuanced views of both Deontology and Utilitarianism. However the anti-theoretic critique of the neo-Aristotelians would be for the secondary position of either of these theories in respect of a virtue ethics backed by an adequate moral psychology.

reality’. Similarly the anti-theory critique is also in some senses an attempt to bring moral theory into a closer relationship with moral practice. Anti theory critiques such as Hämäläinen’s are suggesting that moral theory cannot be left untouched or untransformed by the social context in which they are used and by those who use them. If Wittgenstein is correct then applied ethics cannot be considered to be solely moral philosophy and, if we are to take anti-theory seriously, the consequence of ‘applying ethics’ is that the moral theory deployed becomes located within that social reality.⁴

1.1 Anti-theory and Applied Ethics:

In her paper ‘Is moral theory harmful in practice’ Hämäläinen notes that “the phenomena of modern moral theory is not a unitary one” (Hämäläinen 2009, p.564) and that as a consequence the anti-theorist is unable to give a unitary account of what is being objected to. This problem is compounded by the thought that anti-theorists are not objecting to moral theory *per se* but to some meta-moral “assumptions concerning their role in moral thought and moral life” (Hämäläinen 2009, p.564) namely that “[t]he purity of a idea structure is falsely seen as giving more rational and reliable guidance for practical life than the complex net of communal values and social and moral sensibilities... [that] we develop as human beings.” (Hämäläinen 2009, p.565)⁵ Like Caplan, Hämäläinen rejects the metaphorical ‘engineering model’ of applied ethics (Caplan 1980, p.27) and suggests that as applied ethicists we adopt an instrumental approach to moral theory. This would produce “a view of moral theory where different approaches are seen as enriching each other, and practical conflicts are approached from a multiplicity of angles. Moral philosophy, including moral theory, [would] work in a continuum with the reflective practices of human moral life” (Hämäläinen 2009),⁶ and as such it is suggested to be consistent with the “casuistic spirit of Jonsen and Toulmin” (Hämäläinen 2009, p.551)⁷ which permeates much of the reasoning found within applied ethics.

⁴ This point is widely acknowledged, albeit with differing concerns taking centre stage, and without the explicit promotion of an anti-theoretical stance *qua* moral philosophy in more applied domains. See: Benjamin 1990 & Momeyer, R. W. 1990.

⁵ In this context we might also think of Bourdieu’s dictum not to mistake the model of reality for the reality of the model (Bourdieu 1977, p.29).

⁶ On the relevance of reflection for human moral life ethics see: Williams 2006, Ch.9.

⁷ Hämäläinen cites: Jonsen, 1988.

Reflective equilibrium is also infused with a ‘casuistic spirit’ and goes some way to addressing anti-theoretical concerns by acknowledging that multiple theoretical and applied approaches exist in a mutually informative dialogue. The mainstay of this dialogue is to seek a particular systematisation and specification of theory which provides judgements compatible with our beliefs on some set of cases held to be morally comparable. Moral theory is articulated in the light of a range of cases and a stable account is sought through reflecting on the various arrangements of the theory and the corresponding judgments it would imply. A coherent equilibrium of moral judgement across the range of cases is sought. In contrast Hämäläinen suggests that:

“[The] role of moral theories in forming our moral perspective is still much weaker and more elusive than the role of moral theories in an approach aiming at reflective equilibrium, for the instrumental approach does not require that practical judgement should be harmonised with the theories one chooses to consider” (Hämäläinen 2009, p.552).⁸

Reflective equilibrium retains, as its ideal outcome, the ideal of a unified moral theory which is produced and refined via ongoing ethical reflection and available to all. In contrast the proposed instrumental approach accepts the possibility, indeed actuality, of multiple ethical theories being brought to bear on the world. Furthermore these ethical theories are potentially incommensurable in both nature and judgement. Hämäläinen continues to differentiate her instrumental approach from that of reflective equilibrium commenting that:

“[I]n applied ethics the aim of inquiry is to find morally defensible practical ways of going about, rather than a harmony of theoretical and practical considerations... [M]ixing theoretical approaches in applied ethics suggests that moral life and moral policy making do not require a coherent, action-guiding theory, but rather a pool of intellectual devices to illuminate aspects of moral problems” (Hämäläinen 2009, p.551).

Beauchamp and Childress may well mix theoretical approach to moral theory in producing their principlism. Nevertheless such principlism provides a dominant account of ethics which acts to exclude other forms of ethical engagement which could usefully illuminate the

⁸ Hämäläinen also comments that one of the main points for further attention would be working out the differences between varieties of reflective equilibrium and the instrumental approach she recommends.

problem at hand. Harmony across theoretical and practical considerations is one aim of reflective equilibrium and were this aim achieved it would be through producing a coherent and action guiding theory.⁹ It would seem that on this account an anti-theoretic, instrumental approach to moral theory which acts in concord with other intellectual devices and seeks only to illuminate aspects of moral problems may produce a range of recommendations. This has two further implications: first some recommendations may be mutually exclusive, i.e. that in regards some case two, or more, courses of action would be held to be morally acceptable; and second that practical moral judgements would not be required to ‘cohere’ across cases held to be logically equivalent, i.e. in different but morally comparable cases different judgements could be formed and different courses of action undertaken.

Something of these thoughts has already been noted by those considering the role of moral philosophers in discussions of public policy (Benjamin 1990, 375; Momeyer 1990, 391). In part their worry has been to ensure philosophers do not become compromised or tainted by the exigencies required of ‘public philosophy’ or philosopher orientated to the practical domain of policy formation. I would continue to suggest that Hämäläinen should be read as suggesting that applied ethics is not a branch of philosophy and such public philosophers or ethicists, of whatever hue, should not dogmatically stick to the internal logic of their originating discipline nor that of their preferred academic theories. Whilst applied ethics is a domain where insight from moral philosophy have been shown to be particularly valuable the over reliance on its methods and over adherence to its standards is detrimental to the activity at hand.¹⁰ In order to explore these points in a more concrete manner, and consistent with the approach recommended by Hämäläinen, I now turn to an examination of three specific ‘cases’ involving ethical analysis and policy formation at a number of administrative levels. First, however, I offer some scene setting to facilitate later discussion.

1. Planning for Pandemic Flu

Following the emergence of the H1N1 virus in 2009 and subsequent concerns over its potential for causing a worldwide pandemic the DoH published revised guidance for

⁹ For a discussion of the value of reflective equilibrium for bioethics see: Momeyer 2002.

¹⁰ See, for example, the discussion in: Toulmin, 1981.

pandemic influenza and associated planning. The guidance covers a multitude of areas.¹¹ Whilst it is difficult to imagine the consequences of a global pandemic influenza the DoH's responsibility is to do so and to provide guidance to PCTs and SCTs who then have their own planning responsibilities as do the various subdivisions of Care Trusts (CTs): Hospitals, Wards, General Practices, etc.¹² Various professional bodies provide advice and expertise to assist the planning undertaken by the DoH and CTs.¹³ The organisational planning of both the DoH and of SCTs is vitally important and has a complexity and depth which cannot be done justice to in what follows, even by limiting my remarks to certain aspects of such planning.¹⁴ This following characterisation, based on DoH guidelines, must suffice in order for the subsequent discussion to take place in the text which follows.¹⁵

In the eventuality of a pandemic influenza and as it escalates through the phases described by the DoH the standard procedures instigated by SCTs will be first to cancel outpatient appointments as well as elective and non-urgent surgeries. Health trusts will initially seek to isolate those with the influenza on particular wards but as the pandemic develops entire hospitals may be sequestered. At some point in this process attempts will be made to increase the number of intensive care beds. This is often referred to as surge planning.¹⁶

The DoH planning guidelines describe 5 phases of pandemic influenza which correspond to 5 triage stages relating to critical care.¹⁷ Phase 0 is indicative of normal, non-pandemic, service and phase 4 is indicative of near or actual collapse of the health service. There are then only 3

relevant phases and stages to our discussion. In phase 1 'closed' or inactive critical care beds are to be opened. In phase 2 existing Level 2 ICU beds are to be upgraded to Level 3 ICU beds. An example of level 2 ICU beds are post surgery recovery beds. As elective and non-emergency surgery will be cancelled these beds will be redeployed to level 3 ICU duties. During Phase 2 further Level 2 ICU beds will be created by using other clinical areas as required. Phase 2 is the phase of a pandemic when a radical increase in ICU beds will occur. Phase 3 is reached when all level 3 ICU beds are in use as are all beds which can be designated as level 2 ICU beds. The 3 corresponding triage stages form a set of guidelines for SCTs in setting their individual policies which, in the event of a pandemic developing through the corresponding phases, will guide the decision making of healthcare professionals.

It is important to note that there are not absolute definitional criteria which determine the phases of the pandemic. There are a number of ways to 'define' the phase or stage of a pandemic which range from the global (The World Health Organisation (WHO) issues notification of threat and actual pandemic levels), to the national and the local. Indeed the DoH guidelines discussed above reference local conditions in the move from pandemic phase 2 to pandemic phase 3 in relying on the total occupancy of maximally expanded ICU beds to determine the point of transition. Whilst the guidelines reference 'objective' or 'objectivised' conditions, the determination of when a phase of a pandemic changes is a matter for practical judgement, and is relatively clear cut. The same cannot be said of triage stages however.

2.1 Pandemic Influenza and ICU Triage:

Under the current guidance and in the context of critical care, phase 3 of a pandemic begins, almost by definition, when the increased number of ICU beds made available during phase 2 becomes fully occupied. This indicates that the phases of pandemic influenza are locally defined and not nationally specified. Whilst a SCT or a particular hospital is in phase 2 the ICU will adopt a robust triaging strategy which is nevertheless based on usual practice. Just as the threshold for passing into and out of ICU beds varies over the course of the year the criteria for entry into and out of ICU varies over the course of phase 1 and 2 of a pandemic. In these phases there is one difference to ICU treatment of patients from normal practice. In the expectation of an escalating level of illness in the population and commensurate demand on ICU beds the treatment of existing ICU patients may not be escalated if their condition

¹¹ The full range of DoH documents, including legacy documents, regarding pandemic influenza planning are available from <http://www.dh.gov.uk/en/Publichealth/Flu/PandemicFlu/index.htm> [Accessed 3/11/09].

¹² In this paper I will be considering hospital ICUs and therefore the planning of SCT. See Note 1.

¹³ Most notable for our purposes is that provided by The Intensive Care Society, particularly through articles published in the Journal of the Intensive Care Society, a number of which have been cited in DoH Pandemic Influenza Publications.

¹⁴ The document most heavily drawn is: Pandemic Flu: Managing Demand and Capacity in Health Care Organisations. (Surge) Department of Health, London. April 2009.

¹⁵ It should be noted that I am not suggesting that the scenarios and decisions presented below are the actual position or implication of any one SCT's policy regarding ICUs and pandemic influenza merely that in the context of devising and revising policies for responding to pandemic influenza such scenarios are being discussed in the way considered.

¹⁶ See: Kelen 2006; Kraus 2007. Which focus on a discussion of discharge from hospital rather than discharge from ICU to a lesser level of hospital based care. For a brief discussion of the possible utility of such practices for cases of 'scarce' or stretched resource in non-pandemic conditions see: McD Taylor 2006.

¹⁷ It is important to note that these phases and stages are specific to critical or intensive care services and not global definitions of pandemic influenza for all national planning. See Appendix 13 of Pandemic Flu: Managing Demand and Capacity in Health Care Organisations. (Surge) Department of Health, London. April 2009.

significantly deteriorates. Treatment will not be withdrawn but neither will it necessarily be increased.

Once an influenza pandemic reaches phase 3 then stage 3 triaging becomes operational. In stage 3 triaging treatment options for patients in ICU options will be limited; as before treatment will not be escalated in the case of deteriorating condition of a patient. The guidance also makes provision for possible withdrawal of care from a patient whose condition is deteriorating or failing to improve. In the case of pandemic influenza patients' assessment of condition and need is made on the basis of the Sequential Organ Failure Assessment (SOFA) scale. This information coupled with clinical expertise will indicate patient prognosis. Flu patients discharged from ICU on the basis of a worsening prognosis will be highly likely to die. However their discharge will result in an ICU bed becoming available for a patient who it is believed has a better chance of benefiting from ICU care. This patient, it is hoped, will require less ICU care and so others will also be able to receive care. There is no exact science in this area which might ensure that this is what will occur. The SOFA scale is an attempt to render clinical decision making objective or standardised; such an attempt can never be completely successful. Clinicians must still exercise their clinical judgement in determining the score. At best such tools can only provide a guide to clinicians faced with such decisions. In the context of allocation of scarce resources such decisions will be taken with the aim of producing the best outcome for the patient population as a whole. Unfortunately the achievement of this aim cannot be absolutely guaranteed.

2.2 Concepts of Triage and Reverse Triage:

The concept and practice of triage is a normal part of everyday healthcare, particularly in emergency settings.¹⁸ The prioritisation of one patient over another according to medical need is an example of triage. The sorting of the injured into groups according to their medical need and the medical resources available is another aspect of triage. This type of triage is most often seen in cases of war and natural or man-made disasters. One aspect of this kind of triage is that some patients are deemed to need too great a level of medical attention or, to put

¹⁸ It is interesting to note that both 'intensive care' itself and triaging have their roots in battlefield innovations. Whilst modern intensive care practice and hospital ICUs date from the 1950s they are linked to the work of Florence Nightingale in organising care for those wounded in the Crimean War. Triage emerged from the practices of French doctors on the battlefields of World War one. See: Weil 2004 & Chipman 1980.

it another way: too great a share of medical resources. These patients will either be left untreated or given palliative care only. In such cases these decisions are deemed necessary in order that limited medical resources may be used to the greatest effect and for there to be the greatest benefit for the greatest number. In this respect triage is an inherently utilitarian approach to large scale medical emergencies. From Hämäläinen's anti-theory perspective a utilitarian approach might, on reflection, be the most appropriate tool available from the 'pool of intellectual devices' on offer. However this should not prevent other tools being used to illuminate more specific problems in the application of triaging either generally or in specific case.

In the normal course of healthcare, triage is applied to patients as they present for treatment. Patients who are already being treated are not part of the triage process. The care of patients in the wards of a particular hospital is not affected by the needs of patients arriving in the casualty department. In the case of a large scale emergency, say a multiple vehicle accident, the care of a patient in a particular hospital might, to a small degree, be affected by the redeployment of staff to a hospital's casualty department, they remain outside of any formal triage process. Triage is the prioritisation of incoming patients.

Reverse triage is the inclusion of patients who are already being treated the triaging process.¹⁹ This involves 'reversing' a treatment decision that has already been made.²⁰ In practice this means the withdrawal of medical care from one patient in order that others who would not otherwise receive treatment may be treated. The process can be further divided into two types. The first type involves the withdrawal of treatment from patients earlier than might otherwise be considered optimal. The second type involves the withdrawal of life saving treatment from individuals.²¹ In such case there should be a well founded expectation that some other patient who needed short term ICU treatment will also have their life saved. Reverse triage aims at saving more lives than would be the case were it not practiced.

¹⁹ The original meaning of reverse triage comes from the emergency medical practices of the battlefield where it meant treating first those who could be returned to the field or those who would then be able to treat others. This meaning has fallen into disuse as it is largely irrelevant to emergency medical practice outside of warzones.

²⁰ This is not the original meaning of the term reverse in this phrase. See Note 16.

²¹ Some might not wish to class this type of action as reverse triage but rather under titles such as Selective Limitation of Treatment (SLI) or Selective Withdrawal of Treatment (SWT). Regardless it appears to me that SLI/ SWT is properly described as reverse triage and whilst in some case these alternate descriptions may be useful as I adopt the perspective that there is a relationship between these practices I prefer to maintain the use of the term reverse triage as treatment is not being withdrawn on the grounds of futility.

In considering phase 3 triaging, it would seem there has been instigated a new regimen of utilitarian reasoning where previously there was one of 'everyday' medical reasoning. In the case of a pandemic and of pandemic planning a more explicitly utilitarian reasoning takes over. There is certainly an argument to be made that the basis for much of modern medical ethical decision making is in fact utilitarian.²² It certainly seems to be the predominant mode of reasoning with regard to triaging and the allocation of (scarce) medical resources.²³ Yet in practice it might be supposed that this is tempered by principles of democracy, ethos of the medical profession and of wider society. In planning for a pandemic influenza it appears something of this ethos is lost to utilitarian emergency medical ethical decision making.²⁴

The above is, I think, a non-contentious although relatively simplistic description of triage and reverse triage in modern healthcare. Such is the reality of pandemic influenza that the kind of triaging described above will be practiced. However the increasing relevance of utilitarian reasoning in pandemic planning cannot, anti-theoretically, be permitted to lead us to assume that such decisions can, will or should be made on these grounds in practice. The individuals involved in such decision must exercise their own moral responsibility and be permitted to bring their own perspective to the situation.

3. Pandemic Influenza Triaging in ICU

Having considered the concepts of triage and reverse triage and the DoH guidance on pandemic flu planning, I now turn to a consideration of a pre-existing non-flu patient in ICU when a reverse triage policy is implemented. I then follow this with two comparable 'cases' which may occur under pandemic flu and be raised for discussion under the rubric of the DoH guidelines by those planning for pandemic at the SCT level. In what follows my intention is to suggest that there is a logical parallel between these cases. However I would suggest an instinctively different conclusion is often drawn regarding what should be done in each case.

²² An example being: Maclean 1993.

²³ Consider the general tenor of the argument regarding the natural turn to utilitarian reasoning likely to be a result of increasing the managerial responsibilities of general practitioners presented in: Smith 1994.

²⁴ Consider: Christian 2006, and the responding article: Melnychuk 2006.

3.1 Pandemic triaging in ICU

The cases of reverse triage that are likely to immediately occur in the eventuality of an influenza pandemic reaching phase 3 will be cases of pre-existing ICU patients who are expected to need to remain in ICU for some length of time. Whilst the guidance issued by the DoH considers the reverse triaging of flu patients it does not explicitly consider or address the triaging of pre-existent non-flu patients. Individuals who have been in road traffic accidents may need to remain in ICUs for some time. Patients with neurological trauma or who are severely burned often require intensive care which may last for weeks or even months. Were a pandemic to reach phase 3, hospital staff would have to address the question of whether treatment should be withdrawn from patients requiring long term intensive care in favour of providing intensive care to a number of patients with flu.

In phase 3 the guidance is clear that intensive care may be withdrawn from flu patients who do not appear to be improving. These patients will be discharged to standard care wards where it is hoped they might recover but where in fact they will receive palliative care and, in all likelihood, die. This will allow other flu patients to receive intensive care with the hope being that they will improve and then will be discharged from ICU to make way for other flu patients.

The question I wish to raise here is whether pre-existing non-flu patients should be included in this reverse triaging process. The utilitarian position is I think quite clear that they should be. Perhaps it would also be the case that on the grounds of equality they should be. However one might note that staff may have formed a relationship with such patients making such decisions emotionally more complex. One might also note that in the lead up to a stage 3 declaration staff will become increasingly aware of the possibility that such decisions will have to be taken raising the prospect that their activities at this point come to be seen as 'futile' given the expected eventualities which will occur. Such eventualities are likely to be emotionally distressing for staff and patients' families.

I do not intend to attempt an answer to the dilemma I have raised. Instead I turn to a brief description of two cases which operate at the level of policy and embody these kinds of decisions. They are constructed as logical parallels but, I would suggest, often prompt our moral intuitions to different conclusions.

3.2 Pandemic Triage in two Adult ICUs

It is worth noting that there are multiple forms of ICUs. These include but are not limited to: post-surgery recovery; neonatal units; paediatric units; coronary and cardiac units; neurological units; burn units; dedicated respiratory units; and geriatric units. The multiple varieties of ICUs demonstrate that my remarks will be highly relevant to patients and healthcare professionals in the event of pandemic influenza. As such ICUs often operate at maximal or near maximal capacity.

Many patients spend some time in ICUs and this is particularly true of those in specialist ICUs. For example, patients in Burn ICUs are often so severely injured that they will require weeks or even months of care. These specialist units exist precisely in order to provide such care in conditions where particular expertise and innovations – such as controlled airflow – are available to prevent further infection. Upon commencement of pandemic phase 3 and the instigation of a reverse triage policy patients requiring long-term treatment may be discharged from ICU and given palliative care only. If we consider specialist ICUs we could conclude that the patient population of entire wards should be discharged to a normal level of care and palliated. This would be done in favour of redeploying that ward and its resources to non-specialist intensive care for the treatment of flu patients. This would be expected to result in a greater number of lives saved.

3.3 Pandemic Influenza Triage in Paediatric and Neonatal ICUs:

Neonatal ICUs are, for the most part, populated by infants born some weeks before term. Such neonates often require long term ventilation. In the eventuality of a pandemic it could very well be the case that a SCT may consider the closure of a neonatal ICU in favour of providing a greater number of ICU beds to paediatric patients.²⁵

Some resources of a neonatal ICU are not directly transferable to paediatric ICU; the incubation and ventilation units for preterm infants are not suitable for even relatively young full term babies. However, neonatal ICU represents clinical resources in terms of hospital

²⁵ This is particularly pertinent to the possibility of an H1N1 pandemic which appears to have a greater than normal effect on children. See: Gordon 2009.

floor space and in terms of medical and nursing staff. If a reallocation of resources from neonatal to paediatric ICU were to take place this would mean the withdrawal of treatment from neonates in favour of the provision of treatment to children. The [re]allocation of resources in this utilitarian calculation indicates that one neonatal life may equate to a number of paediatric lives.

3.4 Case Discussion:

The possibility that care could be withdrawn from patients in a specialised ICU in favour of those needing ICU due to pandemic influenza is correctly described as being cases of reverse triage. In the eventuality of a pandemic there will be a greater number of paediatric patients in need of intensive care than there are beds available in either adult specialist or paediatric ICUs. Consideration of reverse triage policies permitted under DoH guidance indicates that these cases, as constructed, suggest that that care should be withdrawn from certain patients in favour of others who will receive greater benefit.

It seems to me that in the case of the individual patient we are likely to suggest care should be withdrawn. In the case of the adult ICU wards we are likely to suggest, albeit with a greater degree of reluctance, that care is also withdrawn from all of the long-term patients in specialist ICU wards. In the case concerning the neonatal and paediatric ICUs I would suggest that most people would be resistant to the idea of withdrawing care from the neonates even in favour of paediatric patients. In this final case a utilitarian basis for ethical decision making would be rejected, or only very reluctantly accepted, despite the apparent near identical moral structure of the cases, as I have constructed them.

Whilst consideration has likely been given to the withdrawal of treatment from adult ICU patients during a pandemic it is my perception that those involved in planning for pandemic influenza have not directly considered the closure of neonatal ICUs in order to increase the level of intensive care available to paediatric influenza patients. Neither has there been a suggestion that reverse triage should be applied to individual long-term paediatric patients in favour of other children suffering from pandemic influenza in need of intensive care. The

utilitarianism of pandemic influenza planning is it seems restricted to adult ICU.²⁶ Regardless of the seemingly objective utilitarian logic in reverse triaging adult patients from ICU in the case of neonatal and paediatric intensive care in favour of young influenza patients I would suggest that almost no one intuitively thinks that this would be the correct thing to do.

4. Conclusion:

I have discussed three cases where in the eventuality of pandemic flu reverse triaging may occur: first the reverse triage of an individual adult long-term ICU patient in favour of flu patients; second the reverse triage of all long-term adult patients on a specialist ICU ward in order that it may be rededicated to the care of flu patients; and third the reverse triage of an entire neo-natal ICU in favour of paediatric flu patients. The first case was introduced in order to present the general contours of reverse triage decision making in this context. The second and third cases are proposed as expanded versions of the first and as logical parallels of each other.

If we accept that this is the case it would seem that the dictates of rational consistency require that the same moral assessment regarding the permissibility of reverse triage to be made. This is true in the case of reflective equilibrium as it makes the meta-moral assumption of a single unified theory of morality but it is not true in the case of Hämäläinen's anti-theory inspired instrumental approach to plural moral theories. If one accepts a reflective equilibrium stance reverse triage is, in like situations, either acceptable or it is not and the cases above must be decided in the same way. In the case of the instrumental approach to moral theory such cases do not (morally) have to be decided in the same way; one might advocate reverse triage for adult ICU wards but not for neonatal and paediatric ICU wards. This may be done on the basis of utilitarian reasoning in the first case and deontological reasoning in the second.

There may be other ways of making different decisions in each of these cases. One might morally differentiate between them on the grounds that one pertains to adults and the other to babies and children. To do so would be to suggest that children have a greater or different

²⁶ O'Donnell (2008) would probably suggest that this is due to the rule of altruism. Yet if we remind ourselves that ICU triaging in a pandemic is an example of the metaphorical 'lifeboat ethics' then it would seem the chivalrous sailor's who sent women and children to the lifeboats first is alive, well and planning for pandemic influenza.

moral significance than adults. This may be the case. However, since the examples as constructed propose the reverse triaging of adults in favour of other adults and children in favour of other children on a utilitarian basis I cannot see that this particular differentiation between the cases has any force in this instance. In order for it to make a difference here there must be some feature of children which would prevent reverse triage being morally applied to them. I do not think such a thing exists.

In order to further examine the question of when reverse triage is appropriately practiced, we might raise the question of when such decisions ought to be taken. The DoH guidelines on pandemic flu certainly permit reverse triage to be practiced but they do not specify when reverse triage ought to be practiced. If we consider that each SCT produces its own internal guidance through planning for pandemic flu then it might be that such documents may give specific instructions or conditions regarding how reverse triage decisions ought to be taken. In effect the decision making being arranged at this point is highly removed from the actual context in which such decisions will be implemented. However such documents might reiterate the DoH guidelines on the permissibility of reverse triaging and whilst they might provide greater detail on the local institutions they might leave the specific conditions of when and how such decisions are taken to clinicians who will be 'on the ground' and in context.

A SCT's planning may have greater specificity and detail than that offered by the DoH insofar as details of the resources to be managed can be specified. Consequentially, direct consideration can be given to this ward, that unit, some building or entire hospitals. Obviously SCT planning is primarily aimed at practical and pragmatic arrangements for managing an escalating flu pandemic and so the policies put in place need to remain flexible in order to respond adequately to the unpredictable nature of the situation as it develops. Given the complexities of such planning it is unlikely that any guidance will adequately anticipate all the morally relevant features of the situation as it arises. The ethical aspects of such decisions which are anticipated and the concept of reverse triage itself is likely to be passed to an ethics committee for comment. The appropriate methodology and tasks of ethics committees have been extensively considered elsewhere (Hester 2008; Hedgcock 2008; Dickenson 2006; Boden 2009). For our current purposes it will suffice to consider the utility of reflective equilibrium and the anti-theoretical instrumental approach and the nature of ethical review of pandemic policy making.

It is often assumed that reflective equilibrium is compatible with or indeed representative of a particular ethico-political perspective. Such an approach involves group deliberation of theories and cases with the aim being to reach a mutually agreeable, coherent solution to both the theoretical dimensions and the particular cases considered. Thus the stance taken can be extended to new cases as and when they occur. However, Clarke claims that as “Daniels and Rawls formulate reflective equilibrium, it occurs only within the judgements, norms and theories of a single person” (Clarke 1987).²⁷ Reflective equilibrium is an ethical process engaged in by individuals who, of course, will be informed by their social and cultural reality and its diversity, often represented by, or embodied in, other people and their perspectives. However, there is no guarantee that the judgements, norms and theories of multiple persons will cohere in the way required by reflective equilibrium. Here we might consider Toulmin’s point regarding his experience of the US National Commission for the Behaviour of Human Subjects of Biomedical and Behavioural Research. He notes that whilst there could be agreement and consensus about substantive points under discussion the differences among the commissioners were only fully revealed when each began referencing and appealing to principles to justify the broadly agreed upon points (Toulmin 1950, p.31-32). If it is the case that such commissions and committees often come to a substantive agreement on particular ethical issues or cases as a result of sets of incommensurable ethical theories and principles, and I would suggest that they do, then it would seem that the work of such committees as a whole is better understood by an instrumental, anti-theoretical approach to moral theory than it is described by reflective equilibrium. Whilst this leaves intact the possibility that individual judgements are reached through a process of reflective equilibrium it raises questions about the proper role of the philosopher on the ethics committee of the kind I have raised above under the rubric of ‘public philosophy.’ These questions are equally present for the ethicist both as someone who is responsible for giving expert and impartial advice or as someone who sits as a lay (non-expert) member of the committee.

Those planning for pandemic flu seek and receive expert advice from many quarters. In the case of advice on the ethical dimension of their planning such advice may be motivated by a number of ethical perspectives. Furthermore their planning and the implicit ethical commitments it carries with it is aimed at guiding the activity and work of multiple

²⁷ Clarke references Rawls (1971) and Daniels (1979).

individuals who themselves will have their own ethical perspectives. Clearly in large organisations some degree of individual ethical autonomy is sacrificed for the greater good of the project. One only needs to think of the professional ethics and guidelines issues by the GMC to all doctors to see this in action in the present context. However, one only needs to reference the provisions for conscientious objection to abortion on the part of doctors to comprehend the idea that a balance must be struck between determinate professional ethical rules or principles and the ethical autonomy of individual medical professionals. This balance must also be struck in guidance issued by those planning for pandemic flu. In doing so they may describe in general terms the conditions for certain decisions and their ethical implications however they should not seek to specify fully determinate positions on such issues as reverse triage. As a result guidance contained within reverse triage policy regarding specialist adult and neo-natal ICU wards should remain open and, as a consequence, the action taken in different cases may, even in the same hospital, be answered differently by those ultimately responsible for taking such decisions as and when they occur.

In the medical ethics classroom it is often remarked that law and ethics are two different things. Too often medical ethical guidance and medical ethicists seek to imitate the law in specifying determinate ethical positions expressed with the authority of moral theory.²⁸ Hämäläinen’s instrumental, some might say ecumenical, approach to moral theory and deliberation in applied ethics returns to us a sense of the multiplicity and plurality of moral life at the cost of philosophical purity. This anti-theory critique is no longer aimed at undermining the activity of philosophical moral theory itself, rather it is aimed at tempering its use in the public sphere where its tendency to obscure its own meta-ethical and meta-moral assumptions result in moral philosophy or applied ethics too often masquerading as something which can unproblematically provide objective certainty. Our desire for such certainty is motivated, in part, by a society arranged so that we escape responsibility for, and susceptibility to, the subjective ethical and moral lives we lead (Bauman 1993). In planning for pandemic flu we would be doing a disservice to those healthcare professionals who will be unable to escape their responsibilities if we wrongly supposed we had succeeded. We must be very wary of both asking and answering the abstract ethical questions we pose to ourselves with certainty when in fact they are intended merely to contribute to the debate and inform as

²⁸ For an extensive critique of this trend in modern society more generally see: Bauman 1993.

best we can the decisions of those who will face these questions, not in the abstract, and, regardless of our efforts, with a great deal of uncertainty.

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