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AAP News

Pediatricians facing myriad moral dilemmas during COVID-19 pandemic

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Editor's note: *For the latest news on coronavirus disease 2019, visit https://www.aappublications.org/news/2020/01/28/coronavirus.*

The coronavirus disease 2019 (COVID-19) pandemic has impacted clinical practice for all of us and forced us to grapple with tough ethical problems.

For many of us, this is the first time that we have had to think about health care rationing in non-hypothetical terms. We also are faced with rethinking our conceptions of professional obligations, self-care and moral identity - thorny on a good day and potentially agonizing as we are forced to balance our duties to individual patients with larger public health goals.

For most of our careers, children have been mostly immune to overt rationing, with the exception of solid organ transplantation and a few other finite resources. More recently, but before the pandemic, we have talked more openly about more insidious ways that we distribute scarce resources like intensive care beds, have faced devastating shortages of cancer drugs that children need and debated who will have access to impossibly expensive treatments like nusinersen for spinal muscular atrophy.

But now, we are talking about true, real-time rationing.

Pediatric ethicists around the country are working to offer systematic, evidence-based and just approaches to how children, with and without COVID-19 infection, should fare in allocation frameworks.

The first-line approach is to use objective illness severity scores that immunize patients from bias and discrimination and maximize the impact of limited resources. In general, we agree that resources are best invested in survivors, but survival can be defined in the short or long term. Illness severity scores predicting mortality in adults are not validated in children. Illness scores for children are not validated in neonates. No illness severity scores are perfect. Bioethicists also are working to advise institutions on whether factors such as age, functional status and neurologic prognosis should be used in allocation frameworks, initially or as heartbreaking tie-breakers.

We also must work through what it means to be a physician during a public health crisis that threatens not only our patients but ourselves and our families. When merely leaving the house feels like a life-threatening undertaking, how should we feel about walking into the fire? Pediatricians continue to work in emergency departments, respiratory clinics and inpatient units, risking exposure during every shift.

In principle, vigilant social distancing and proper use of personal protective equipment (PPE) should protect us, but this reminds us of the critical importance of judicious and scientifically informed use of PPE and raises important questions about how to include trainees and students in clinical care. Throughout this pandemic, we will have to ask ourselves how far our moral duties to medicine should take us and how much time and space we can justifiably carve out for our other needs and obligations.

In addition to the weighty issues of scarce resource allocation and professional duty, some of us, particularly our pediatric colleagues trained in adult care as well, consider the ethical implications of redeployment to help care for the anticipated legions of sick adults, potentially well outside of our usual clinical comfort zones. We can ask ourselves if it's fair to patients to be cared for by physicians who are being so intellectually stretched, but we also must consider the consequences of the alternative when there simply are not enough doctors to take care of patients who need help.

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Pediatricians working in pediatric referral centers will have to think about balancing efforts to free up resources for sick adults and those to preserve access to highly specialized, resource-intensive therapies for children. As COVID-19 spreads, children with conditions such as prematurity, congenital heart disease, cystic fibrosis and sickle cell disease will continue to need care in children's hospitals. Ultimately, we may need to carefully consider the role of heroic and long-shot therapies that are unlikely to return the desired outcome.

Outpatient pediatricians, many of whom are providing routine pediatric care from their phones, tablets and computers, will need to re-envision how to form and maintain a therapeutic alliance with patients and their parents in a time when even basic human connection is constrained.

The career bioethicists among us have our work cut out for us this spring, as we advise institutions and individuals on how to navigate these rough waters. We will rely, as we always have, on your insight and experience to help us understand what the most pressing questions are and how we can help you answer them.

Pediatricians can discuss their questions on the AAP COVID-19 Discussion Board at https://collaborate.aap.org/COVID-19/Pages/default.aspx.

Dr. Laventhal is a member of the AAP Section on Bioethics Executive Committee.

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