

Ethical Choices in a Medical Emergency –
A Pediatrics Perspective

Bauer, Dooley and Wallington
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Flu pandemics and natural disasters quickly raise potent ethical questions for any community. This document is focused on one of the central ethical dilemmas faced in such emergencies. How should scarce, life-saving medical resources be distributed? When there is far more need for medical resources (e.g. ventilators or flu vaccines) than there are resources available, who should receive them? Typically in medicine, individuals are treated according to their need for medical care. For example, an EMT will give priority to the most injured at the scene of an accident. During large-scale pandemics or emergencies, however, the number of sick may so overwhelm the amount of medical care available that difficult choices must be made to determine who should receive care or what level of care they will receive. This paper highlights a few preliminary considerations for making such choices, as discussed by the Medical Emergency Preparedness - Pediatrics (MEP-P) ethics group based in Anchorage, Alaska.

This group is specifically concerned with the fate of children in rationing scarce medical resources during disasters. Children are often ignored or only briefly considered by the ethics literature on disaster preparedness. This should be corrected. Children make up a significant portion of our population, and their needs deserve consideration. Additionally, children often have specific needs which differ markedly from adult needs, during a medical disaster. Medical staff working with children may require specialized training to help with a ventilator, determine prescription dosing or provide other kinds of pediatric care. They may be isolated from their families and need special emotional support. Also, their immature immune systems may be less likely to survive in some situations, and yet, children can often recover more quickly than adults. How should these factors influence where children fall in the list of those who need medical care in a disaster? Is it right to say that children should generally receive more resources than adults or fewer? If we must choose between children in allocating scarce medical resources, what is a fair way to choose? These are among the most important questions that have concerned us during this project.

1. Medical Ethics in Disasters – A Focus on Communities

We follow other ethical guidelines in disaster preparedness in saying that wide-scale disasters must refocus the resources of our medical teams. Medical professionals are suddenly confronted with a public health crisis during a pandemic or other natural disaster. Such disasters call for a difficult role change for many professionals. Rather than simply being concerned with treating their individual patients, they are asked to think about the hundreds or thousands of people whose lives may be in danger. During wide-scale disasters, however, this shift in focus is essential. As individuals, we will not fare nearly as well unless public health issues are addressed systematically. A flu virus, of course, is not the property of a single person. In addition, we are usually indebted to the communities that have nurtured, or in some way, supported us. We may also simply believe it is right to care for one another in times of great need, out of a sense of human solidarity. Therefore, from a variety of moral perspectives, it seems right for our medical professionals to shift their attention to the well-being of all of us, as a community, rather than simply focusing on the needs of their individual patients.

The triage criteria we propose rest on the belief that survivability is one of the chief values for our communities during a large-scale disaster. This means that those with the least

chance of survival will be given all of the support and palliative, or comfort, care that the system can afford, but they may not receive scarce medical resources during a disaster. The MEP-P ethics group has developed a scoring system using the patient's clinical condition. This system will be used by medical professionals, on our recommendations, to determine the degree of injury or sickness of an individual and whether or not he or she has a fairly good chance of survival. Treatment is assigned on the basis of those chances.

Survivability is an ethically justifiable criterion to use during a public health disaster, such as a pandemic or devastating earthquake. Our communities cannot prosper without the substantial presence of healthy, active individuals. Further, as others have argued, focusing on survivability often makes us good stewards of the limited resources we have in a disaster. We owe it to one another to provide the most benefit to those in need with the medical assets available.

We must briefly acknowledge that the shift to focusing on public health and survivability may be quite difficult for our doctors, nurses, and other medical professionals to make, even in times of disaster. Doctors and nurses see themselves as having duties to particular patients they are caring for, rather than to the whole community. Though medical professionals will still have basic duties towards any patient they encounter during a disaster, they will not be able to put their own patients ahead of others who have a better of chance of surviving. Also, according to the triage principles we have proposed, we believe that it will be sometimes necessary for medical professionals to provide only palliative care for some of the sick and injured whom they might be able to save in normal situations. This position shifts medical resources towards those who have a better chance of surviving. Emotionally, this will be a great strain on caring health care providers. Those physicians who are actually caring for individuals will not be asked to make such decisions. Other medical professionals not directly involved with the patients will do so for them. Yet, we highly recommend support and training for the medical professionals who will be asked to provide this difficult kind of medical care. It will not be easy for anyone involved.

2. Duties Towards Children

It may be particularly hard for medical professionals to use triage criteria with respect to children during a disaster. Children seem to have a special place in our communities, and more specifically, in our families. It is clear to most that parents have a special duty towards their children, however, should we, as a larger community, give particular consideration to children?

Before answering this question, we would like to first emphasize that we have not always recognized specific duties towards children as a society. The lack of universal health care for children in this country is only one example. Though the U.S. has a system specifically designed to provide health care to our seniors, no such national system exists for children.

In addition, there seem to be good reasons to give children fewer resources than adults, all things considered, in times of disaster. Children's immaturity – both physical and behavioral – does pose certain liabilities during a disaster. As mentioned earlier, children may require more time and energy from medical professionals during a disaster than an adult in a similar situation. Kids often require an attendant to monitor their adherence to the doctor's orders. They may also need additional assistance from adults with their ventilators or other medical equipment or treatment. Though some of these tasks can be performed by non-medically trained individuals, assistants for children will need to be organized, and in the face of a dire emergency, this may seem like an onerous task. Further, practice of pediatric medicine requires special training. Those medical professionals who care for children will need additional education if they do not already have a background in pediatrics. In addition, children generally have more immature

immune systems than adults. They may be more susceptible to sickness. Finally, children may not be able to help other victims of a disaster to the extent that adults often can. Children may not be as useful in a community's struggle to contend with a disaster. These points may lead one to think that adults should generally receive priority for scarce medical resources in a disaster.

We believe that disaster preparedness is a particularly appropriate project to begin re-focusing our communities' values towards children and prevent any possible neglect in this area. This returns us to an earlier question: should we give particular consideration to children and their needs in a disaster? There may be several reasons to do so.

Parents have the primary duty to care for the needs of their children, but during a large-scale disaster, most parents will not be able to fulfill those duties. Most will not be able to provide the medical care their children need. Many will not be able to keep their children free from disease and harm. Parents are dependent on the larger systems of the community to care, in part, for their children.

Further, children are the most vulnerable members of our communities. We may have a responsibility to care for them on that ground alone. Children sometimes cannot speak to their own needs and preferences. They frequently need others to make choices for them. In addition, children are usually unable to defend themselves in the face of physical threats. They need our care, and we should attempt to meet that need, given their great dependence on adults. In addition, it may weaken the relationships of trust and responsibility in our society if we do not attempt to care for our most vulnerable members.

Last, but not least, children are essential to the regeneration and flourishing of our societies. Children typically outlive their parents, and with children go our communities' cultural and technical knowledge. Further, children offer new perspectives on the habits and values we take for granted. They are one of the most dependable sources of novelty in any community. For these reasons, it is in the interests of our communities to provide medical support for our children, even in times of extreme emergency.

We recommend that children be considered equally with adults in the process of triaging scarce medical resources. This means that if a child has a comparable survival rate to an adult, given his or her clinical triage scores, then he or she should receive a comparable level of medical care, if at all possible. There are certainly costs in our communities ensuring as much care as possible for children who have reasonable chances to survive. Children offer many benefits to our society. They also have an advantage over adults in survival rates. Their young immune systems can more quickly recover from illness. Children tend to have the uncanny ability to "bounce back". Perhaps just as important from an ethical perspective, however, are our duties to children as extremely vulnerable members of our societies.

Part of the triage plan proposed by this group contains criteria by which some children will be given palliative care, if appropriate, rather than life-saving medical treatment. Again, such criteria are necessary only when medical supplies are extremely scarce. There simply will not be enough medical resources to go around. One of our most intensive discussions as a group has centered on the fate of children with very difficult disorders that will require a life-time of intensive, daily care. We chose the following language to describe such cases: those children with "...a prognosis for expected lifelong assistance with most basic activities of daily living (i.e. toileting, dressing, feeding, and respiration)..." will not be provided life-saving medical treatment during a disaster scenario. All children require care of one form or another. We do not believe,

however, that in a large-scale disaster, we can afford to provide the resources necessary to treat children who suffer from these kinds of debilitating disorders.

Our reasons for this proposal rest heavily on the ethical values discussed earlier. We have an obligation to use the few medical resources available to provide the greatest benefit that is ethically feasible. Medical professionals are dedicated to saving lives and furthering the health and well-being of our communities. Part of our calculation, then, must involve an estimate of how many children medical staff can save in a given disaster. We believe this is a value we can all agree on. Those children who require substantially more resources than others during a disaster, as described above, (and even after the disaster, in a resources-bare community), cannot receive life-saving medical resources, given these values. Further, children who suffer from such disorders may have a lower chance of survival than children who do not. This point supports the same conclusion.

Our recommendations for the ethics of medically treating children during a disaster comes at the end of considerable discussion among doctors, nurses, and other medical professionals across several hospitals in and around Anchorage, as well as ethicists from a variety of backgrounds. Yet, there is much more to do. We look forward to expanding these conversations to include other medical professionals across the state of Alaska, and most importantly, the public. Guidelines for disaster preparedness touch at the heart of our values as a community. We hope that further conversations about these issues, though difficult, will help us reflect on our priorities and commitments and enable us to better meet our future public health challenges together.

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