Ethical Issues in Pediatric Anesthesia

The Day Surgery Child with a URI

David B. Waisel, MD, Senior Associate in Anesthesia, Children’s Hospital Boston, Assistant in Anaesthesia, Harvard Medical School Email: david.waisel@childrens.harvard.edu

Marvin S. Cohen, MD, Associate Professor and Vice Chairman for Clinical Affairs, Director of Pediatric Anesthesiology, UTMB Email: mscohen@utmb.edu

CASE: A 3 year old boy is scheduled as an outpatient for an inguinal hernia repair. The patient had been healthy until 7 days ago when he developed a yellowish-green rhinorrhea for three days. For the past four days he has had clear rhinorrhea. He has had no productive cough or temperature and has not been lethargic. He has no allergies. On physical exam his lungs sound clear without wheezing or rales.

Should you cancel/postpone this case until the patient is completely recovered? What medical knowledge would you use to decide? Would you decide differently if the patient had a productive cough? Elevated temperature? No history of colored rhinorrhea? Current colored rhinorrhea? What other factors would be relevant? What information would be relevant for informed consent and refusal?

Upper respiratory tract infections lead to complications, but limits to our medical knowledge prevent us from predicting outcomes with certainty. According to one study, there was no increase in adverse anesthetic outcomes from laryngospasm, bronchospasm, desaturation and postintubation croup in the hands of experienced physicians. Considering the difficulty of studying this topic, the literature and the concerns about disproportionate risk, I would devolve to Cote’s statement that “all we can say regarding children with (mild) URIs is yes, there is an increased risk for laryngospasm, bronchospasm, desaturation and postintubation croup. No, waiting may not significantly reduce these risks unless we wait 4-6 weeks or longer. Yes, the child will likely have another URI by then if it is wintertime. Yes, I will provide the safest anesthesia possible for your child. Yes, I can reduce the risk for these complications because I will tailor my anesthetic prescription (e.g., propofol instead of thiopental, laryngeal mask airway or face mask instead of an endotracheal tube if appropriate, albuterol in the operating room, and so forth) around the child’s needs and the needs for the surgical procedure, but I cannot reduce that risk to zero. Yes, these same complications can occur even when the child does not have a URI. Yes, administration of anesthesia is risky and occasionally associated with unpredictable responses to anesthetic drugs. We are left with our best clinical judgment about an individual patient undergoing a specific procedure for a specific duration of time by a specific surgeon that requires endotracheal intubation that may or may not involve admission to the hospital who also has or has had a recent URI and, by the way, whose grandparents have flown across the country and both parents (smokers) have taken a day off work.” Social factors may be relevant as our medical knowledge is somewhat soft. Medical decisions involving patients and families will always have multiple dimensions; social, familial, economic, professional.
Assuming that you recommend postponing the procedure, would you be willing to reconsider if the mother stated that her insurance would run out in the next few days? What if the mother would lose her job if she had to take more time off? What if the family had arranged for the grandparents to fly in from out of state to care for the other children? Who should make this decision? How should a decision be reached?

Patients, parents, other surrogate decision-makers and physicians use the concepts of best interests to guide decision-making about health care when the ability to apply self-determination is impossible, such as with an infant or a child with severe developmental delay. This inability therefore requires a surrogate decision maker, usually a parent, to select the care that is in the child's best interests. The difficulties arise in determining who will make the decision and in the assumption that there is always one best choice. Parents who are present and capable of participating in the decision-making process are well suited to be the primary decision-makers for their children. This is in part due to society's respect for the concept of the family, and the assumption that parents care greatly for their children. It is also reasonable to assume that the child will incorporate some of the parents' values as the child grows and matures, making the values of the parents a practical approximation of the future values of the child. For these reasons, parents have extensive leeway in determining what is in a child's best interests. By the same token, there is wide latitude of what constitutes acceptable decision-making in today's multicultural society, so it is often believed that there may not be one best choice, but several reasonable and good choices, depending on how the patient and family weigh benefits and burdens. The parents may consider non-medical factors as part of this decision process. These factors may affect the child and family as much if not more than the disease itself. Given the uncertainty of our medical knowledge we may want to consider social and economic factors that will affect the child and family.

The mother insists on having the procedure done even though you think it is not in the best interests of the child. Are you required or should you follow the mother’s wishes?

Parents and medical personnel may disagree about what is in the best interests of the child. One way to decide what is in the best interests of the child is to define what choices fall outside of the range of acceptable decision-making. The extent to which one intervenes between a patient and his surrogate's decision depends primarily on how harmful the decision is to the patient. Criteria to make this determination include the amount of harm to the child by the intervention or its absence, the likelihood of success and the overall risk-to-benefit ratio. The continuum between unacceptable and acceptable treatment is clear at the extremes, but ambiguous in the middle. For example, while postoperative epidural pain therapy may be optimal, it is generally acceptable for the parents to choose to forgo regional analgesia and use parenteral analgesia. It is unacceptable, however, for the parent to refuse all forms of pain therapy. Although anesthesiologists must respect the diversity of values in society and the relationship between the parent and the child, decision-making that imperils the health of a child needs to be challenged. The anesthesiologist who believes the parent is choosing an unacceptable treatment should determine the basis of this judgment, address those specific concerns, and involve other caregivers as well as social work services both to offer an assessment of the appropriateness of care and to engage the parent in discussion. Charging a parent of not acting in the child's best interests has significant social, fiscal and familial ramifications. If, however, after exhausting other options the anesthesiologist
believes the parent has chosen unacceptable treatment, the anesthesiologist should report the situation to proper child welfare authorities for possible legal action.

A majority of commentators believe that anesthesiologists may refuse to provide care when they ethically or morally disagree with the procedure or situation. Although physicians have an obligation to altruistically provide care, this requisite does not always oblige physicians to subjugate their morals. Further, society and medicine have a fundamental interest in preserving the moral fabric of individual physicians. Anesthesiologists should perform care that violates their consciences and possibly weakens their moral constitutions only in critical, presumably life-or-death, circumstances. More practically, an anesthesiologist who ethically or morally disagrees with a patient’s choice will have difficulty in providing the care requested. In a nonemergent situation, such an anesthesiologist should withdraw from or refuse patient care. The anesthesiologist may then be obligated to make a reasonable effort to find a competent and willing replacement. In some cases, anesthesiologists may find the requirement to locate a willing colleague ethically objectionable.

A minority would argue that physicians may not refuse to provide care when they ethically or morally disagree with the procedure. This argument is based on the idea that physicians have been granted the privilege of a rationally granted skill by society. In exchange for this opportunity, physicians have made a social contract to provide comprehensive care within the bounds of what is acceptable in the community. Whether one wholly embraces this premise does not obviate the worthy point that physicians should make an effort to temper their beliefs in the service of patients and should only refuse to provide care in carefully considered situations.

Physicians may also ethically refuse to provide care if they believe the patient's choice is too inappropriate or likely to result in harm. Determining that an anesthetic choice is inappropriate is difficult and should not be invoked lightly or out of convenience. A good rule of thumb may be that the patient's choice and the resultant risks must be sufficiently extreme as to elicit a similar response from at least several other anesthesiologists. In addition, anesthesiologists may refuse to provide care if the anesthesiologist does not feel qualified to provide the needed care. Anesthesiologists may not refuse care when refusal is not based on an ethical or moral disagreement. For example, it is unethical for an anesthesiologist to refuse to care for patients based on race, gender, or disease status, such as patients infected with the human immunodeficiency virus.

Should an 8 year old child participate in the discussion? What about a 12 year old? Children of these ages have a right to assent to procedures and treatments. At what age should the child have veto power over a procedure?

When a child become older, informed assent should be incorporated in the process. Informed assent acknowledges that while most pediatric patients cannot legally consent to medical care, pediatric patients should share in decision-making to the extent their development permits. The participation of children should increase as they grow older and depends on both the patient's maturity and the consequences involved in the decision.
To reflect these values, pediatric caregivers are moving away from the concept of obtaining informed consent from the parent and are replacing it with the concept of informed permission. Informed permission has the same requirements as informed consent, but it recognizes that the doctrine of informed consent may only apply when individuals make autonomous decision for themselves, and not when surrogates make decisions. Informed permission provides a way to acknowledge this distinction while still honoring the relationship between the parent and the child.

Anesthesiologists should attempt to achieve both informed permission from the parent or surrogate and assent as appropriate from the pediatric patient. School age children are developing decision-making capacity, so anesthesiologists should seek both informed permission from the parent and assent and participatory decision-making from the patient. Such situations may include whether to sedate a 6 year old prior to an inhalation induction, to use an inhalation or intravenous induction of anesthesia in an 8 year old and to place an epidural for postoperative analgesia in a 12 year old. Some adolescents and young adults over 14 will have developed decision-making capacity and anesthesiologists should try to fulfill the ethical requirements of consent while obtaining assent.

While assent is a useful concept it needs to be broadened to include giving mature children the possibility of saying no instead of forcing them to have a procedure. If the parent or guardian gives informed permission to a procedure and the minor objects, the minor's wishes should be respected when possible, if agreement to the treatment cannot be negotiated. Achieving the patient's assent may necessitate further discussions with the patient, parents, and other providers, and such discussions may best take place away from the operating room. Clinicians should seek the assistance of others experienced in conflict resolution to help resolve the dispute with a minimum of rancor. However, if the minor's life is in danger or health is seriously imperiled, the parent's or guardian's consent should be deemed sufficient and the procedure should be carried out.

If there are two sets of guardians who should participate in the discussion? Should only the legal guardians be allowed to participate?

All parties with moral and legal standing should be encouraged to participate. That means that all relevant guardians should participate in discussions. Questions of legal guardianship should be clarified if any dispute arises. Social work and risk management can be very helpful in these manners. If the parents/guardians disagree as to whether or not to consent, the Office of General Counsel should be consulted. If the minor is accompanied by the parent with custody rights (the "in custody" parent) the "in custody" parent's consent should be obtained. If it is not possible to obtain the "in custody" parent's consent, all efforts made to obtain such consent should be documented in the patient's medical record and treatment initiated. Consent may be obtained over the phone if necessary.
The surgeon states that too many of his cases are being cancelled in your group and he is going to speak to the administrator. Is this a relevant concern? What avenues are available to pursue these issues?

For anesthesiologists, a foremost clinical conflict of interest is production pressure. Production pressure has been defined as “the internal or external pressure on the anesthesiologist to keep the operating room schedule moving along speedily.” Production pressure may influence whether anesthesiologists postpone a case or perform clinical and technical duties with inappropriate haste, thus putting their patients at increased risk. Gains may be external, including increased referrals and positive feedback, or they may be internal. It is imperative that physicians recognize these incentives and deal with them openly and honestly. Anesthesiologists have an obligation to the patient and themselves only to provide care within their skills and to recognize when economic and administrative pressures may induce them to do otherwise. Anesthesiologists should attempt to design systems that minimize production pressures.

Instead of this being your case a colleague without specialized pediatric training is involved. You feel that his proceeding with the case is dangerous. Should you become part of the discussion even if not asked?

Specialists have professional responsibilities nationally and locally. Nationally, we are responsible for advancing, disseminating and implementing knowledge. On a community/hospital level specialists in Pediatric Anesthesia should participate in developing and implementing guidelines for the care of children undergoing anesthesia and sedation. They should be involved in credentialing appropriate providers of this care. On a case by case basis, specialists should be available for immediate consultation with other providers. They should be intimately involved in the quality review process for all pediatric patients. Pediatric anesthesia specialists must use their best professional judgment when and how to intervene if they perceive harm may be done to a patient. Unfortunately, specifics regarding when a specialist is obligated to intervene is poorly defined in literature and practice.
Elements of Consent and Assent as defined by the American Academy of Pediatrics, Committee on Bioethics

Consent
1. Adequate provision of information including the nature of the ailment or condition, the nature of the proposed diagnostic steps or treatment and the probability of their success; the existence and nature of the risks involved; and the existence, potential benefits, and risks of recommended alternative treatments (including the choice of no treatment).
2. Assessment of the patient's understanding of the above information.
3. Assessment, if only tacit, of the capacity of the patient or surrogate to make the necessary decisions.
4. Assurance, insofar as it is possible, that the patient has the freedom to choose among the medical alternatives without coercion or manipulation.

Assent
1. Helping the patient achieve a developmentally appropriate awareness of the nature of his or her condition.
2. Telling the patient what he or she can expect with tests and treatment.
3. Making a clinical assessment of the patient's understanding of the situation and the factors influencing how he or she is responding (including whether there is inappropriate pressure to accept testing or therapy).
4. Soliciting an expression of the patient's willingness to accept the proposed care.

Approaches to Pediatric Consent

This broad outline is a guide. Specific circumstances always must be taken into consideration. When children are in the upper range of an age bracket, inclusion of a higher technique, such as the use of assent for a six year old, may be appropriate.

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<tr>
<th>Age</th>
<th>Decision-making Capacity</th>
<th>Technique</th>
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<tr>
<td>Under 6 years</td>
<td>None</td>
<td>Best Interests Standard</td>
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<tr>
<td>Ages 6 – 12 years</td>
<td>Developing</td>
<td>Informed Permission</td>
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<td></td>
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<td>Informed Assent</td>
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<tr>
<td>Ages 12 – 18 years</td>
<td>Mostly developed</td>
<td>Informed Assent</td>
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<tr>
<td>Mature Minor</td>
<td>Developed, as legally determined by a judge</td>
<td>Informed Consent</td>
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<tr>
<td>Emancipated Minor</td>
<td>Developed, as determined by a situation</td>
<td>Informed Consent</td>
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References


