Editorial

CLINICAL ETHICS

Clinical Ethics
1–4

DOI: 10.1177/14777509221094471
journals.sagepub.com/home/cet
SAGE

Rationing in pediatric hospitalizations during COVID-19: A step back to move forward

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Abstract

The latest Omicron variant of the novel coronavirus has itself created a novel situation—bringing attention to the topic of healthcare rationing among hospitalized pediatric patients. This may be the first time that many pediatricians, nurses, parents, and public health officials have been compelled to engage in uncomfortable discussions about the allocation of medical care/resources. Simply put, finite budgets, resources, and a dwindling healthcare workforce do not permit all patients to receive unlimited medical care. Triage and bedside rationing decisions are happening in a range of difficult everyday circumstances both implicitly and explicitly, but in ways not recognized by even the best ethically framed intentions. Clinicians and hospital administrators have largely been left on their own "to flatten the rationing curve" in hopes that resources never have to be explicitly rationed at their facility. Unfortunately, the downstream result is a misinformed and distrustful public (i.e. parents, guardians, and caregivers) filled with people who are already burdened with inflammatory pseudoscience narratives and deficits in health literacy. This paper aims to elevate a more thoughtful conversation about healthcare rationing by analyzing some existing ethical principles/framework developed for rationing decision making during previous emergency responses and drawing from the day-to-day clinical perspectives of a frontline pediatric acute care/hospitalist.

Keywords

Clinical ethics, public health, clinical ethics, bioethics and medical ethics, clinical ethics, health care

Introduction

The latest Omicron variant of the novel coronavirus has itself created a *novel situation*—bringing attention to the topic of healthcare rationing among hospitalized pediatric patients. This may be the first time that many pediatricians, nurses, parents, and public health officials have been compelled to engage in uncomfortable discussions about the allocation of medical care/resources. Simply put, finite budgets, resources, and a dwindling healthcare workforce do not permit all patients to receive unlimited medical care. Triage and bedside rationing decisions are happening in a range of difficult everyday circumstances both implicitly and explicitly,[1] but in ways not recognized by even the best ethically framed intentions. Clinicians and hospital administrators have largely been left on their own "to flatten the rationing curve" in hopes that resources never have to be explicitly rationed at their facility. Unfortunately, the downstream result is a misinformed and distrustful public (i.e. parents, guardians, and caregivers) filled with people who are already burdened with inflammatory pseudoscience narratives and deficits in health literacy.[2] This paper aims to elevate a more thoughtful conversation about healthcare rationing by analyzing some existing ethical principles/framework developed for rationing decision making during previous emergency responses and drawing from the day-to-day clinical perspectives of a frontline pediatric acute care/hospitalist

COVID-19 rationing in the pediatric context

On 11 March 2020, the World Health Organization (WHO) declared that the global spread of the coronavirus disease, COVID-19, was a *pandemic*.[3] At the time of writing, the

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WHO has reported an additional 15 million cases of COVID-19 (for the week ending on 16 January 2022).[4] Here in the United States, the *Omicron* variant has pushed our infection rates to a staggering average of 800,000 + new cases per day and a 98% increase in the previous 2 weeks.[5] Symptomatically, children are less severely affected than adults, though the emergence of pediatric post-COVID-19 complications such as *multi-system inflammatory syndrome* (MIS-C) has been challenging to diagnose and treat. Unlike other COVID-19 variant surges, more (unvaccinated) children are being impacted this time around due to the significant transmissibility factor and record-breaking infection rates. Despite the alarming increase in COVID-19 pediatric hospitalizations, which is set against a polarized backdrop of dissenting opinions on masking/vaccination, widespread school closures, and an unprecedented shortage of skilled healthcare workers, the public that access health care services remain largely unfamiliar about why bedside rationing decisions are necessary and inevitable. To be attentive and thoughtful participants in this sociopolitical conversation about rationing methods in a pandemic, the public deserves to be well informed.

Since the beginning of COVID-19, much of the attention in bioethics academia and public health agenda regarding allocation of care/resources (e.g. diagnostic tests, intensive care beds, ventilators, and personal protective equipment) have mainly focused on vulnerable and/or elderly patients. There are multiple publications exploring the ethical implications of rationing ICU beds, equipment, and resources, and a fair amount of scholarly literature has gone into developing "triage teams" (or triage tools).[6] Internationally, there has been ethical analysis and guideline consensus development to support intensive care rationing decisions (if and when health care resources are overwhelmed).[7] But implicit in many of these guidelines and triage tools are the notion that rationing decisions *do not* occur during "everyday" scenarios [i.e. They only occur when resources are in danger of being truly overwhelmed].[8] The pediatric context adds an additional layer of complexity because most advanced healthcare systems in the world have traditionally adopted a "*rule of rescue*" mentality. This usually favors *beneficence* (appropriateness and proportionality) over consideration of *distributive justice* in maximizing health outcomes for children.[9] As a result, there is hesitance to formally address bedside rationing as an inherent and inevitable task of (pediatric) critical care clinicians and nurses.[10] Discomfort raised by this topic should not lead us to deny its occurrence. Instead, healthcare rationing decisions warrant transparent dialogues, public attention, and community engagement. The following discussion will briefly present some philosophical conflicts of traditional principles and introduce the contemporary forward-thinking *ethico-procedural framework* that relates to healthcare rationing in the pediatric population.

The ethico-procedural framework for rationing

A rationing decision occurs when a patient is denied care/therapy from which they could benefit.[11] Rationing decisions are not inherently the same as decisions to withhold (or withdraw care/therapy) based on a patient's best interests. For instance, deeming a treatment *ineffective* and then withholding that treatment is not considered a rationing decision, but rather one that was made based on the patient's best interests. Some opponents argue that rationing should occur solely at the political or hospital executive level.[12] While others agree that healthcare professionals should have an indirect role in the rationing decision-making process through their involvement at either the policy or guideline development level (but not directly at the bedside).[13] Even wording found in the official "Code of Ethics" from the American Medical Association (AMA) does not make any definitive reference to bedside rationing decisions ("The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest […] and to advocate for their patients' welfare.)[14] Consequently, there is no clear ethical line between bedside rationing (and resource allocation) decisions, but rather they are a continuum.[15]

There are conflicts in the academic literature about how bioethical principles should guide real-life rationing decisions and even discrepancies in the interpretation of these principles as they relate to the concept of *distributive justice*. The following principles are commonly cited and widely accepted in the bioethical context but can be problematic when applied to contemporary thinking regarding rationing decisions.[16]

1. **Egalitarianism**—treats all patients equally. This approach includes a "*first come, first served*" mindset, which fails to account for the various factors that may contribute to systematic bias and/or lack of access for certain vulnerable members of society (e.g. neonates and children).
2. **Utilitarianism**—benefits the greatest number of people. This approach lacks the requirement(s) and/or explanation(s) to justify comparing certain lives to save others, which is very challenging to comprehend in the pediatric context.
3. **Prioritarianism**—favors the "worse off" patients like the youngest or the sickest This theory called the "*rule of rescue*" could be viewed as counterproductive especially when one decides to treat only those who are considered to be "worse off", rather than those who are healthier and more likely to recover.
4. **Individual liberty and maximizing individual freedom**—promoting and rewarding social usefulness. This approach to maximize liberty to promote other values fails to recognize the intrinsic importance of

individuals and focus on the perceived benefits in which society can derive from them.

Perhaps, the more relevant and practical framework for bedside rationing decisions is the **ethico-procedural approach** as described by Norman Daniels and James Sabin (2002). Daniels and Sabin proposed four conditions for a fair "rationing" and "resource allocation" process[11,17] (also known as the *"accountability for reasonableness"*):

1. **Publicity condition**—the rationale for all decisions regarding both direct and indirect limits to care and their rationales must be publicly accessible.
2. **Relevance condition**—the rationale for decisions must aim to provide a reasonable explanation based on evidence, sound reasonings, and ethical principles that all parties can agree upon.
3. **Appeals condition**—there is a mechanism to challenge and/or dispute rationing decision(s), including the opportunity for revising of rationing decision(s) as new clinical evidence or argument(s) become available.
4. **Enforcement condition**—there is either voluntary or public regulation of the process to ensure that the first three conditions are met.

Many COVID-19 adults and pediatric hospital units have attempted to fulfill these four conditions with their rationing guidelines. Most emergency departments and ICUs will typically defer major rationing decision making to a "triage team" that is comprised of members who are independent from bedside clinician(s). Hospital systems can fulfill the first condition by publicly making rationing guidelines available on their institutional website and regularly communicating with local news media. Invariably, dealing with unpalatable rationing decisions in the pediatric population is a complex and ethically fraught task, even if all four conditions are satisfied.[8] Attempting to balance the priorities of pediatric patients with the greatest need and those with the greatest capacity to benefit from hospitalization could raise even more ethical questions. Thus, the overall variability in frameworks utilized to ration health care/resources emphasizes the need for continuous re-evaluation of ethical standards that underscore these decisions in non-hypothetical real-life situations. Appealing or acting spontaneously to values that have not been adequately reflected upon or discussed in a transparent and deliberative manner will ultimately lead to undesirable outcomes and possibly accusations of unethical practices by the public.[18]

Bedside rationing: Everyday implicit and explicit decisions

It's essential to acknowledge that rationing decisions pervade our daily practice both implicitly and explicitly. **Implicit** rationing can include deferring (or denying) access to care by setting more stringent eligibility criteria and/or thresholds for admission to the children's hospital (e.g. severe respiratory distress, sepsis, etc.). This means pediatric patients would have to be triaged as "more acutely ill", or there were overall fewer patients admitted for observation/monitoring. Both points suggest that some patients were denied potentially beneficial treatment during times of bed/staffing shortages. Imposing barriers such as (1) the requirement for insurance approval of referrals before a pediatric patient can be admitted to the hospital to receive care by a particular specialist (e.g. long-term electroencephalogram video monitoring) and (2) the use of waiting list(s) for elective surgical procedure(s) are two additional examples of implicit rationing methods that have been routinely implemented during COVID-19. It's noteworthy to mention that patients and their families are often unaware these rationing decisions are being made behind the scenes. Finally, physicians and nurses in the hospital must continually balance the medical needs of their patients based on acuity levels and against their "nonprofessional" obligations (e.g. responsibilities to their families). Therefore, the reality of practice in hospitals is that pediatric patients are occasionally denied of a potential benefit—however small—through implicit rationing decisions made at the bedside.[16] An **explicit** type of rationing is the pediatric emergency department triage unit. A triage system works by categorizing incoming pediatric patients based on the initial assessment of their illness and/or likelihood of a prompt recovery. Explicit rationing decisions based on *clinical judgement* are often the ones most susceptible to *personal biases* and could potentially become problematic when they lack transparency and consistency.[19] In general, implicit rationing raises more concerns about fairness than explicit rationing because the basis of decisions is not formally disclosed, and personal biases may exert undue influences on those decisions.[16]

Forward reflections

Rationing of health care is necessary, inevitable, and ethically complex especially for hospitalized pediatric patients. However, talking openly about bedside rationing in an honest and responsible manner can support processes and ethical principles that the public will understand as legitimate. This is an opportune moment for those of us in public health to pause, reflect, and reconsider how health rights have generally been 'ethically' idealized, but too often untethered from sincere colloquial democratic debates free of inflammatory megaphone narratives. Taking a step back and accepting the reality of rationing in the ongoing COVID-19 pandemic in no way implies foregoing scrutiny of any given decision (or policy) in the future. In fact, one the most positive outcomes of this crisis moving forward might be that we will gain a collective awareness that health is a fundamental right of a democratic society and health systems are social institutions directly influenced by our united actions (or lack thereof).

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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