And all children are facing restrictions on socializing and outdoor games as well as erratic schooling and other stresses, such as lacking access to Wi-Fi or a space of their own. They may not have access to areas for safe exercise, as playgrounds are closed, and the combination of low exercise and high screen time may lead to increased childhood obesity. Just when schools are gaining experience in becoming "trauma informed," children have been cut off from what may be their primary source of assistance, or even basic needs such as food. For many children, school is the most stable environment in their lives.

Dealing with ACEs

The CDC outlines several strategies to prevent or at least ameliorate ACEs. These include strengthening economic supports to families, ensuring a strong start for children, teaching skills to both children and parents, and connecting youth to caring adults and activities. An important element is intervening early through enhanced primary care and integrated family-centered treatment. Along with reducing stigma, these elements can be a blueprint for the future.

Some children are resilient and weather these ACEs with little apparent difficulty. Others can be helped to develop resilience with the ongoing guidance of an adult.[9] And some will carry the burdens of these experiences with them into adulthood, hindering their personal relationships, educational progress, and work opportunities. It is important to recognize this need now while the pandemic still rages and not just when its long-term consequences become apparent. Does preventive bioethics exist? If not, we should invent it now.

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Avoiding Ineffective End-of-Life Care: *A Lesson from Triage?*

by STEPHEN R. LATHAM

Like many bioethicists, I've been involved in the last few weeks with hospitals' efforts to articulate triage policies—helping to draft one in my own state and consulting with hospitals in two others. The work has been difficult—emotionally taxing, logistically complicated, and intellectually challenging. But throughout, in each hospital, a simple point has struck me repeatedly: working on triage issues has dramatically highlighted the extent to which we are still doing end-of-life care badly.

Whatever the correct details of a pandemic triage policy (assuming that it is ethical to implement one at all), a core principle has to be that it aims to save more lives than would be saved by simply treating patients on a first-come-first-served basis under usual standards of care. A baseline standard of any such policy has to be that scarce resources should be shifted away from those patients who are unlikely

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Every intensivist in America can name a patient in their unit right now who is receiving invasive critical care at the request of proxy decision-makers but will not survive to discharge.

to survive hospital treatment for their conditions. This is a decidedly minimal standard; it does not begin to engage with debates about whether quality of life or life years saved or resources expended in achieving survival should also count in making decisions about allocation of scarce hospital resources.

What factors should contribute to a judgment that a given Covid-19 patient is unlikely to survive? The seriousness of their symptoms upon arrival at the hospital is of course a factor. But another extremely important factor is the presence of additional medical conditions—comorbidities—that will complicate or interfere with treatment of the patient's condition or compromise the body's ability to fight off the coronavirus. It's been shown that a patient who is also suffering from severe congestive heart failure, severe diabetes, high blood pressure, and possibly other conditions is extremely unlikely to survive inpatient treatment for Covid-19. We need not decide now which of the many possible serious comorbidities should be included in a triage policy. It's enough to be confident that some should be and that, when the triage policy is implemented, some severely ill Covid-19 patients with comorbidities will be denied intensive care unit beds or access to ventilation.

The trouble is—and this was spotted in each of the hospitals with which I was involved—that at the moment of triage implementation, there will already be many Covid-19 patients lying in ICU beds and attached to ventilators who would not have been offered those resources under the triage standards. They will be getting those resources because they arrived yesterday, or last week. And if the policy is supposed to save more lives than a first-come-first-served policy would, then the hospital faces the grim possibility of withdrawing care from those already-admitted patients who are using scarce resources but who no longer fit the criteria for access to them. Only if this is done can the scarce resources be reallocated.

In other words, the minimalist triage policy has teeth—saves resources and lives—only if the regular practice of hospitals outside pandemic emergency is to offer intensive and invasive treatment to patients who, in the judgment of their treating physicians, will not survive that treatment. And, of course, it is the practice of hospitals to offer such treatment to such patients, unless an explicit and legally valid objection is raised to its provision by the patient or the patient's surrogate. Every intensivist in America can name a patient in their unit right now who is receiving invasive critical care at the request of proxy decision-makers but will not survive to discharge. Some of these patients were admitted to the ICU even though treating physicians were sure that they would not survive to discharge. Others were admitted in the hope that intensive treatment would improve their conditions, but treatment has continued even after the hope is gone.

Perhaps our collective confrontation with the realities of pandemic shortage will lead us to realize that these practices are both wasteful and cruel. Perhaps the courage we mustered to face this fact in a time of crisis will allow us to continue facing it when the crisis passes.