



Ethics in Pediatrics

Ian Mitchell • Juliet R. Guichon

Ethics in Pediatrics

Achieving Excellence When Helping Children



Ian Mitchell Alberta Children's Hospital and Cumming School of Medicine Calgary, AB, Canada Juliet R. Guichon Cumming School of Medicine University of Calgary Calgary, AB, Canada

ISBN 978-3-030-22616-9 ISBN 978-3-030-22617-6 (eBook) https://doi.org/10.1007/978-3-030-22617-6

© Springer Nature Switzerland AG 2019

This work is subject to copyright. All rights are reserved by the Publisher, whether the whole or part of the material is concerned, specifically the rights of translation, reprinting, reuse of illustrations, recitation, broadcasting, reproduction on microfilms or in any other physical way, and transmission or information storage and retrieval, electronic adaptation, computer software, or by similar or dissimilar methodology now known or hereafter developed.

The use of general descriptive names, registered names, trademarks, service marks, etc. in this publication does not imply, even in the absence of a specific statement, that such names are exempt from the relevant protective laws and regulations and therefore free for general use.

The publisher, the authors, and the editors are safe to assume that the advice and information in this book are believed to be true and accurate at the date of publication. Neither the publisher nor the authors or the editors give a warranty, express or implied, with respect to the material contained herein or for any errors or omissions that may have been made. The publisher remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

This Springer imprint is published by the registered company Springer Nature Switzerland AG. The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland

For all students and trainees over decades who have asked questions and challenged me to give meaningful answers.

Ian Mitchell

For Mary-Claire, and with love for Raymond-Laurent and Sophie-Charlotte. Juliet R. Guichon

Preface

Pediatrics developed as a medical specialty in the late nineteenth century. In the latter part of the twentieth century and the first part of the twenty-first century, we have seen remarkable enhancement of child health around the world. Such advance has resulted mainly from a rise in economic well-being, in addition to improved hygiene, nutrition, and vaccination. These positive changes have been due also to improvements in pediatric care.

Such improvements include a wide range of new technologies and diagnostic tests and many new drugs including the latest biological agents. At the same time, pediatrics has changed considerably, as has all of medicine. The specialty has welcomed women, who are likely to be in the majority in the near future. In most places in North America and Europe, the specialty has become more welcoming of people who are gay, lesbian, bisexual, trans, queer, or other. The working arrangements of pediatricians have also changed, with the rise in subspecialists, and the general restriction in the time physicians, including pediatricians, will devote to their practice.

Despite the enormous changes, we continue to see trainee pediatricians who are committed to excellence in their care of children.

It is in that context that we developed this book. Two bioethicists with different, but complementary, backgrounds have written this work. The first, IM, is trained in pediatrics and has worked both in Europe and North America. He has been involved in ethics education and scholarship for about a quarter of a century and has a higher degree in Bioethics. The other author, JRG, has lived in four nations and has a background in law and legal scholarship. They have taught collaboratively and participate jointly in research projects and advocacy. They challenge one another and aim to ensure clarity in the ethical ideas articulated and advanced here.

The ethical practice of pediatrics is changing, just as pediatric practice constantly changes and as the pediatric work force changes. We understand pediatrics to be a triadic specialty, with the focus on the child, a general deference to the role of parents in decision-making (or the child, if sufficiently mature), and a definite role for the pediatrician. The process has been described as joint decision-making. We would emphasize that the deference to parental decision-making is never absolute.

viii Preface

Recently, one of us (IM) entered the hospital cafeteria and with tray in hand approached the seating area. As he passed two colleagues seated at a table, he saw that they were engaged in animated discussion and might even have been arguing with one another. He decided to nod politely and to move along to another table with different colleagues. As he went past the two colleagues, he heard one of them say to the other, "The problem with your group is that you allow issues of morals and ethics to get in the way of medical decision making." This is one instance when the colleague was not confronted at the time. It did not seem that a hospital cafeteria was the right place. Later, a meeting with the colleague was sought, and the view that issues of morals and ethics are involved in every action physicians take was advanced. That colleague was not convinced, but the interaction was an impetus to complete this book!

The content of the book is based on continuing contact with trainees and colleagues in pediatrics, the anxieties and concerns they express to us, and our own observations on pediatric practice. Such exchanges have informed personal choices of what is important to address, therefore, the content of this book. We have arranged the contents in five parts. Part I gives the background to pediatrics, including comments on boundary issues and how to obtain help when confronted with ethics issues. Part II addresses consent and confidentiality. We have called Part III "Everyday Issues," dealing with prenatal and pregnancy issues, child abuse, children with medical complexity, and advocacy. We also include in Part III a section "Misunderstandings and Disagreements" that offers help in a variety of perplexing situations. Part IV has topics that we regard as important, but do not fit neatly into other chapters, such as responding to errors, research, teenagers, and cost. Finally, Part V is our view of the topics that will be sources of anxiety and concern in the near future.

The book is not and cannot be comprehensive; it does offer information on most of the ethical problems that physicians in pediatrics, at any level of experience, will encounter

We believe that this book is relevant to all who are involved in pediatrics, whatever their level of training or specific role. There is material for the beginner and also many sections that will provoke thought in those more experienced. We have addressed a myriad of ethical issues and have identified areas in which ethical concepts are evolving.

Calgary, AB, Canada

Ian Mitchell Juliet R. Guichon

Acknowledgments

The authors thank Springer Nature for agreeing to publish this work and for the support they have received from Floor Oosting, Executive Editor, Applied Ethics, Social Sciences and Humanities, and Christopher Wilby, Assistant Editor, Applied Ethics. Monica Ruff checked and collated references and abbreviations with meticulous care. Pediatric residents, Drs. Jody Platt, Simone Kortbeek, and Rubeeta Gill, gave invaluable help in developing the proposal, reviewing medical accuracy in our stories, and ensuring we were aware of the ethical concerns facing today's trainees. Dr. Kathryn Kenny helped us understand some of the nuances in reproduction and obstetrics. Dr. Julie Lauzon patiently explained some of the current complexities of genetics. Drs. Candice Bjornson and Kirsten Ebbert pointed out some issues to be included. Of course, despite the excellent help, errors might have crept in; if so, then the authors bear full responsibility. The cover illustration is by Jennifer Caldwell. Jennifer is a teenager who has a talent for art. She has had many contacts with Alberta Children's Hospital. Jennifer enjoys life and her art.

Ian Mitchell is grateful for the unwavering support of Anne, his late wife, throughout his career and the patience of his sons and daughters-in-law, David and Meredith, Neil, and Shonna. Inspiration comes from the "Mitchell cousins," Jordan, Ryan, Alexander, and Isabel.

Juliet Guichon thanks pediatricians for welcoming in their midst a scholar trained in law. She is grateful to her husband, Alain Verbeke, for his remarkable example and loving support, to her children, Raymond-Laurent, Mary-Claire, and Sophie-Charlotte, for their cheerful tolerance and the inspiration they offer daily, and to Editha Clemente for making many good things possible.

Contents

Pa	rt I B	ackground to Pediatrics	
1	What	t Is My Medical Specialty All About?	3
	1.1		3
	1.2	Introductory Story: Emily	4
	1.3		5
		1.3.1 Who Are Pediatricians?	5
		1.3.2 What Is a Pediatrician and What Is Pediatrics	
		About?	6
	1.4	Brief History of Pediatrics	7
	1.5	· · · · · · · · · · · · · · · · · · ·	8
	1.6	How the Work of Pediatricians Changes with	
			9
	1.7	Who Chooses Pediatrics?	3
	1.8	Gender and Pediatrics	Δ
		1.8.1 Gender: People Who Identify as Women	Δ
		1.8.2 People Who Identify as Gay, Lesbian,	
		Bi-Sexual, Trans, Queer or Other	6
		1.8.3 Summary of Changes	9
	1.9	Life At Work and the Rest of Life	20
	1.10	Ethical Concepts and Pediatrics	2
		1.10.1 Four Principles (Principlism)	2
		1.10.2 Pediatric Character and Virtues	9
	1.11	Professionalism and Pediatrics	5
		1.11.1 Physician Autonomy	ϵ
	1.12	Parents and Family-Centered Care (FCC)	8
	1.13	Using Patients to Train Pediatricians	2
	1.14	Conclusion	2
	D . C	4	٠,

xii Contents

2	What Are the Boundaries Between My Role, Children and				
	Paren	nts, and Others Involved in Pediatrics?	49		
	2.1	Boundaries: Definition and Scope of the Problem	50		
	2.2	Boundaries and Power Imbalance	50		
	2.3	General Issues About Relationships with Patients			
		and Families	51		
		2.3.1 Sharing Our Personal Lives with Families	52		
	2.4	Exchange of Gifts	54		
	2.5	Relationships with Colleagues	54		
	2.6	Disagreements	55		
	2.7	Should We Treat Our Own Children?	56		
	2.8	Is Seeing a Patient Without a Referral an Issue			
		of Etiquette or Morals?	57		
	2.9	Boundaries in Research	58		
	2.10	Conscientious Objections	59		
	2.11	Conclusion	61		
	Refere	ences.	61		
•					
3		Can I Receive Help with Ethics Issues?	63 63		
	3.1	Background	64		
		Introductory Story			
	3.3	Why Were Clinical Ethics Committees Founded?	64		
	3.4	When Were Pediatric Ethics Committees Developed?	68		
	3.5	What Are the Main Issues Addressed by Pediatric			
		Ethics Committees and How Do They Function?	68		
	3.6	Are the Committees Successful?	70		
	3.7	Comment on Riley	72		
	3.8	What Is the Future of Ethics Committees?	73		
	3.9	What Other Resources Are Available to Pediatric			
		Trainees Facing Ethical Challenges?	74		
	3.10	Conclusion	75		
	Refere	ences	75		
.					
Pa	rt II T	The Basics			
4	How]	Do I Know from Whom I Need Permission and When			
	I Hav	re It?	79		
	4.1	Introductory Story: Dr. Wilson and Consent	80		
	4.2	Dr. Wilson Seeks Parental Permission:			
		Operationalizing Consent	81		
	4.3	Young Parents	83		
	4.4	Information to Be Provided	84		
		4.4.1 Historical Background	84		
	4.5	Best Interests	86		
		4.5.1 Seeking Consent to Treatment or Treatment			
		Withdrawal When Parents and Physicians			
		Absolutely Disagree	88		

Contents xiii

	4.6		Parental Decision-Making	90
	4.7		nication and How Communication of Information	
			ved	93
	4.8			96
	4.9		Decision Making: Legal Guardians	
			y Parents) and Physicians Deciding in Consort	98
	4.10		Consent Is Not Needed: Emergencies	99
	4.11		o I Do When a Minor Comes Without a Parent	
			mergency Department	101
	4.12		cticalities of Seeking Consent: Case Examples	102
	4.13		cticalities of Seeking Consent in Suspected Case	
		_	ect, Abuse or Self-Harm: Case Examples	112
	4.14		sion	114
	Refere	ences		114
5	What	Goes in t	he Chart and Who Can See It?	117
	5.1		etory Story	117
	5.2		w	119
	5.3		ation for Protection of Confidentiality	120
	5.4		tent Breaches	121
	5.5		sness	122
	5.6		ng Confidentiality	123
	5.7		Centered Care and Confidentiality	123
	5.8	•	king	125
	5.9		ntiality Is About More Than Written Records	126
	5.10		and Confidentiality	126
	5.11		n Grow and Develop.	127
	5.12		dentiality a Valid Concept After Death?	128
	5.13		We Keep Information from Children?	129
	5.14		ing with Immigrant Families and with Minority	12)
	0.11		s Within Western Society	131
	5.15		ntiality and Genetics	132
	5.16		Children Know Their Origins?	133
	5.17		Children Conceived by Assisted Reproductive	100
	0.117		ogies (ART) Know Their Origins?	134
	5.18		We May Release Information About a Patient	138
	5.19		We Must Release Information	140
	5.20		an-Initiated Breaches of Confidentiality	145
	5.21	•	ntiality, Social Media and Technology	146
	0.21	5.21.1	Definition and Effects of Social Media	146
		5.21.2	Disclosure of Child's Health Information	1.0
		3.21.2	by Parents Online	148
		5.21.3	Disclosure by Pre-teens and Teens of Their	1 10
		3.21.3	Own Health Information on Social Media	149
		5.21.4	Use of Social Media to Gain Advantage	149
		5.21.4	Social Media in Physicians' Day-to-Day Work	151
		J.41.J	Social Micala III I Hystelans Day to Day Wolk	101

xiv Contents

	5.22	Pediatricians' Personal Use of Social Media	151
	5.23	Are Physicians Entitled to Privacy Regarding Their	
		Own Lives?	151
	5.24	Confidentiality and Education of Health Care Professionals	153
		5.24.1 Confidentiality and Education Overview	154
		5.24.2 Bedside Teaching and Confidentiality	154
	5.25	Conclusion	156
	Refere	ences	157
Pai	rt III	Everyday Issues	
6		Happened Before Birth and How Is This Relevant	
		e Child Now?	163
	6.1	Overview of Topic	164
	6.2	Introductory Story	165
	6.3	Preconception Genetic Testing and Screening	165
	6.4	Pregnancy or Prenatal Testing	169
	6.5	Reproductive Freedom	171
		6.5.1 Can We Forcibly Protect a Fetus?	174
	6.6	Advanced Reproductive Technology (ART)	178
	6.7	Fetal Surgery	180
	6.8	Should Children Be Conceived by ART to Benefit	
		Another Child?	181
	6.9	Prematurity	182
	6.10	Delivery Recommendations	185
	6.11	Newborn Screening	185
		6.11.1 Chase's Newborn Screen	186
		6.11.2 Comments on Neonatal Screening	187
		6.11.3 Ethical Concerns with Neonatal Screening	189
	6.12	Conclusion	192
	Refere	ences	192
_			
7		nk Someone Has or Is Deliberating Harming This	405
		I. I Think There Is Neglect of the Child. Help!	197
	7.1	Introduction, Significance and History of Recognition	100
		of Child Abuse	198
	7.2	What Is Child Abuse?	199
		7.2.1 Neglect	200
		7.2.2 Emotional Abuse	200
		7.2.3 Sexual Abuse	201
		7.2.4 Physical Abuse	201
		7.2.5 Female Genital Cutting	202
		7.2.6 Medical Child Abuse	202
	7.3	Evolving and Controversial Issues	203
		7.3.1 Physical Punishment	204
		7.3.2 Diet in Childhood	205
		7.3.3 Immunizations	205

Contents xv

	7.4	Duty of	f Physicians Regarding Child Abuse	206
	7.5	How A	buse Might Present	207
		7.5.1	Why Is Aurora Not Gaining Weight?	207
		7.5.2	A Day in Emergency	209
		7.5.3	Sonja Has Problems at School	210
		7.5.4	Charley's Story	210
		7.5.5	Caught in the Crossfire	211
	7.6	Conflic	et Over Treatment (Parental Unwillingness	
		to Cons	sent to Necessary Medical Treatment)	212
	7.7		ing Child Abuse: Benefits and Responsibility	213
	7.8	Conclu	sion	215
	Refere	ences		215
0	What	A 1	Dalas in the Many Issues that Anise with Children	
8		•	Roles in the Many Issues that Arise with Children	
			ribed as Being Medically Complex? How Do	
			Long-Term Care of These Fragile Children,	
			ospital, At Home, At School or in Long Term	219
	8.1		re?	219
	8.2		ction	220
	8.3		tte's Story	220
	6.3		en with Medical Complexity, Incidence	221
			planation for Rise	
		8.3.1	Rising Incidence	222
	0.4	8.3.2	Reasons for Rising Incidence.	222
	8.4	_	for Children with Medical Complexity in Hospital	224
		8.4.1	Introduction to Caring for Children with Medical	22.4
		0.4.2	Complexity in Hospital	224
		8.4.2	Approach to Decision Making	225
		8.4.3	Coordination of Multiple Specialists	227
		8.4.4	Must Recognize and Support Unusual Parental	220
		0.45	Role, Such as "Extraordinary" Mother	228
		8.4.5 8.4.6	Must Trust the Parents But Be Attentive	229 229
		8.4.7	•	230
		8.4.7	Need for Vigilance Regarding Boundaries	
			Help Manage Response to Invasion of Privacy	230
		8.4.9	Help Prevent and Manage Conflict.	231 232
	0.5	8.4.10	Maintenance of Professional Duty to Child	232
	8.5		That Mean Home Care Should Be Encouraged	222
			C Children and Youth	233
		8.5.1	Home and Community Care Are Ideal	233
		8.5.2	Independence and Self-Care of Citizens Is Relevant	234
		8.5.3	Family as Primary Care Provider	234
		8.5.4	Citizenship as Entitlement to Rights and Justice	234
		8.5.5	Preparing Parents for Transition to Home	235

xvi Contents

8.6	Ensurin	g Continuity	235
	8.6.1	Definition of Continuity	235
	8.6.2	Parents Value Continuity Which Benefits Child	235
	8.6.3	Relational Continuity	236
	8.6.4	Informational Continuity	237
	8.6.5	Management Continuity	237
8.7	Gatheri	ng Resources	237
	8.7.1	Home Care Staff/Equipment	237
	8.7.2	Ready to Provide Care at Home?	239
	8.7.3	Ensuring Parents Are Competent	239
8.8	Ethicall	y Pushing Reluctant Parents to Take Child Home	239
8.9		y Restraining Parents Whose Child Isn't Ready	
		ne or Have a Child Ready for Home, But	
		Aren't	240
8.10		ges of Caring for CMC at Home for Pediatricians	241
8.11		t Home	242
	8.11.1	Must Visit the Child at Home and Rules for	
		So Doing	243
	8.11.2	Principles to Follow When for Caring for	
		Child at Home	243
	8.11.3	Need for Vigilance Regarding Boundaries	244
	8.11.4	Help Manage Response to Invasion of Privacy	244
	8.11.5	Supervision of Homecare Professional	245
	8.11.6	Relational Boundaries	245
	8.11.7	Maintenance of Professional Duty to Child	245
8.12	Pediatri	cians Must Advocate for Clinical Services	246
8.13	Need fo	or Collaboration	246
8.14		s of CMC	247
	8.14.1	Financial Cost to System	247
	8.14.2	Financial Cost to Family	247
	8.14.3	Caregiving Burden of Family	248
	8.14.4	Maternal Employment and Health	248
	8.14.5	Overall Effects on the Family	249
	8.14.6	The Life of Siblings	251
8.15	System	Responses to CMC	252
	8.15.1	Introduction	252
	8.15.2	System Has Changed to Accommodate the	
		CMC Situation	253
	8.15.3	Systems Are Just Learning How to Address CMC	253
	8.15.4	Focus on Continuity	254
	8.15.5	Medical Home	254
8.16		Life Issues	254
	8.16.1	Mohammed's Story	254
	8.16.2	Comments on Mohammed's Life and Death	255

Contents xvii

	8.17	Transitioning the CMC Child to Adult Care	256
		8.17.1 Children with Medical Complexity Must Transition	256
		8.17.2 Many Adults Exist Who Were CMC	256
		8.17.3 Transitioning to Adult Care Is Not a New Problem	257
		8.17.4 Transition Requires Both Destination and Process	258
		8.17.5 Consensus Statement on Transition	258
		8.17.6 Despite Good Will, Many Transition Barriers Exist	259
	8.18	Conclusion	259
	Refere	nces.	260
9	What	Can I Do to Advocate for this Child, and for Children	
		lim or Her?	263
	9.1	Descriptions and Scope of Advocacy	263
	9.2	Levels of Advocacy	265
		9.2.1 Micro-level Advocacy	267
		9.2.2 Meso-level Advocacy	267
		9.2.3 Macro-level Advocacy	269
	9.3	Common Objections to Advocacy	270
	9.4	Micro or Case Level Advocacy: Why Advocacy Matters	
		to Individual Children (Micro or Case Advocacy)	272
	9.5	Meso-level Advocacy: When One Family's Story Leads	
		to Change for Many Families	274
		9.5.1 Alex's Story	274
		9.5.2 Comments on Alex's Story	275
	9.6	Meso Level Advocacy: A Second Case	275
		9.6.1 Dr. Gomez and Hudson	275
		9.6.2 Comments on Dr. Gomez and Hudson Story	276
	9.7	Macro Advocacy: Tobacco Control	277
	9.8	Requirements of Advocacy	279
	9.9	Conclusion	279
	Refere	nces	279
10			
10		and How Do I Stop Certain Treatments, Accepting Death Is Near?	283
			284
	10.1	Child Death Is No Longer Common	
	10.2		285
	10.3	Choices Are Rarely Wrong	286
	10.4	Gabriel's Story	287
	10.5	Comment on the Choice to Labor and to Deliver Knowing	207
	10.6	a Child Will Die	287
	10.6	Riley Redux	288
	10.7	Comments on Riley	288
	10.8	Metaphors and Miracles.	290 290
	10.9	Costs	290
	10.11	Brain Death and Organ Donation	292

xviii Contents

	10.12	Organ Donation After the Circulatory Determination	
		of Death (DCDD)	295
	10.13	Scarlett's Story	296
	10.14	Comment on Scarlett's Story	296
	10.15	When a Child Dies At the Hand of a Caregiver	297
		10.15.1 Russell's Story	298
		10.15.2 Comments on Stephanie's Death	299
	10.16	Medical Assistance in Dying	300
		10.16.1 Liam's Story	302
		10.16.2 Comments on Liam's Story	303
	10.17	Hope	303
	10.18	Reflections on Charlie Gard	305
	10.19	Meetings with the Family After Death	306
	10.20	Self Care When a Child Is Dying or Has Died	306
	10.21	Conclusion	309
	Refere	ences	309
11	Micun	derstandings and Disagreements	313
11	11.1	Relationships with Children, Parents, and Families	313
	11.1	Systemic Racism and Misunderstanding	315
	11.2	11.2.1 Immigrant Beliefs Impact Medical Care: Lia	313
		Lee's Story	316
		11.2.2 Harmful Cultural Practice	317
		11.2.3 Cultural Practices to Be Tolerated?	318
	11.3	Specific Common Disagreements	320
	11.5	11.3.1 If Vaccination Is So Good, Then Why Isn't	320
		Every Child Fully Immunized?	320
		11.3.2 Dr. Brooks and Juliana	320
		11.3.3 Comments and Help for Dr. Brookes	321
	11.4	The Parents Want an Intervention That We Think Is	322
	11.4	Not Indicated or Might Even Be Harmful	323
		11.4.1 Dr. Brooks and Kiera	323
		11.4.1 Dr. Brooks and Kiera	324
	11.5	Requests for Interventions That Are Not Supported	324
	11.5	by Scientific Evidence	325
		11.5.1 Dr. Riviera and Reagan	327
		11.5.2 Comments on Dr. Riviera and Reagan	327
		11.5.3 Dr. Cayenne and Jacob.	328
		11.5.4 Dr. Capperelli and Peyton	328
		11.5.5 Comments on Jacob and Peyton's Treatments	328
		11.5.6 Dr. Torres and Miles.	330
		11.5.7 Comments on Dr. Torres and Miles	330
	11.6	Racism and Sexism Affecting Family Choice of Physician	331
	11.0	11.6.1 Dr. Riviera (Again) and Declan	331
		11.6.2 Comments on Dealing with Declan's Mother	332
	11.7	Conclusion	333
		ences.	333
	1101010		

Contents xix

Par	t IV	Special Situations	
12	Oh N	o! I Saw a Mistake, or I Made a Mistake	339
	12.1	Chance's Story	339
	12.2	Comment on Chance	340
	12.3	Open Recognition of Medical Error	340
	12.4	Disclosure	344
		12.4.1 First Disclosure Meeting	345
		12.4.2 Second Disclosure Meeting: Responsibility and Apology	345
	12.5	Apologies	346
		12.5.1 Murray's Story	347
		12.5.2 Comments on Murray's Story	348
	12.6	Challenges of Disclosure and Apology for Systematic	
		Error: Jack Adcock and Rory Staunton	348
		12.6.1 Jack's Story	348
		12.6.2 Rory's Story	349
		12.6.3 Comment on Responses to Jack and Rory's	
		Deaths	349
	12.7	Summing Up: Austen's Story	350
		12.7.1 Comment on Austen	350
	12.8	Ignoring Neonatal Pain, a Collective Pediatric Error?	351
	12.9	Focus on Error or Focus on What Is Done Well?	353
	12.10		354
	12.11		355
	Refer	ences	355
13	Quest	tions About Research Involving Children	359
	13.1	Research in Children: Introduction	360
	13.2	History of Research in Children	360
	13.3	Has Research Made a Difference to Children?	361
	13.4	Is Research on Children Ethical?	362
	13.5	What Do We Call Children in Research and Does it Matter?	363
	13.6	What Types of Research Are Relevant to Children	364
	13.7	Who Decides What Research Is Conducted in Pediatrics?	365
	13.8	What Research Should Be Conducted in Pediatrics?	367
	13.9	Conducting Immoral Research	368
	13.10		369
	13.11	Have Regulations Made a Difference?	371
	13.12		372
		13.12.1 The Researcher	372
		13.12.2 The Research Funder ("Sponsor")	373
	13.13		375
	13.14	Common Questions About Pediatric Research	377
		13.14.1 Comments on Consent/Permission	377
		13.14.2 Research on Emergency Management	379

xx Contents

		13.14.3	How Long Can Research Take?	379
		13.14.4	Describing an "Interesting" Case in the	
			Medical Literature	380
		13.14.5	What If a Study Is "Quality Improvement" (QI)	380
	13.15	Working	g with Research Ethics Review Boards/Committees	381
		13.15.1	Dr. Cox and Child in Research Program	382
		13.15.2	Comment on Dr. Cox's Patient	382
		13.15.3	Dr. Richardson's Project	383
		13.15.4	Comment on Ethics Review of Dr. Richardson's	
			Project	383
	13.16	Education	onal Research	384
		13.16.1	Dr. Ortiz Completes a Survey	385
		13.16.2	What Should Dr. Ortiz Do Now?	385
	13.17	Conclus	sion	386
	Refere	nces		386
	**7 1 *	• • • •		201
14		_	Adolescents	391
	14.1		's Story	391
	14.2		and Overview of Medical Care of Adolescents	392
	14.3		to Samuel's Story	394
	14.4	-	active Issues	395
		14.4.1	Confidentiality and Reproduction	395
		14.4.2	Possibility of Absence of Lawful Consent	207
			to Sexual Activity	397
		14.4.3	Physician's Duty Regarding Sexual and	200
			Reproductive Advice Is to the Adolescent	398
		14.4.4	Adolescent Use of Contraception and Parents:	•
			An Angry Mother	399
		14.4.5	Pregnancy in Teens	400
		14.4.6	Termination of Pregnancy Generally:	
			An Overview	401
		14.4.7	Legality of Abortion	403
		14.4.8	Can Teens Consent to Abortion?	404
		14.4.9	Some Teen Abortion Cases	405
	14.5		cy in Adolescents	406
	14.6		Identity	407
	14.7		Dysphoria	408
	14.8		action and Developmental Delay	409
	14.9		Disorders	410
	14.10		eents Seeking Performance Enhancing Drugs	412
	14.11		oning to Adult Services	413
	14.12		ss Children	414
	14.13	_	ing Care	415
	14.14		sion	415
			ing	416
	Refere	nces		416

Contents xxi

15	Why I	s There So Much Talk About Cost in Health Care Today?	419
	15.1	Introduction	419
	15.2	Landen's Story	420
		15.2.1 Comments on Landen's Story	420
	15.3	Attention to Costs.	422
	15.4	Health Care Systems	423
		15.4.1 Single Payer System, Employment-Based	
		Systems, Premiums, US Situation	424
	15.5	Global Aspects	425
	15.6	Comparing Costs	425
	15.7	Choosing Wisely	426
	15.8	Ethical Aspects	427
		15.8.1 Right to Healthcare	428
		15.8.2 Utilitarian and Communitarian Concepts	429
	15.9	Accountability for Reasonableness	429
	15.10	Political Aspects	430
	15.11	Micro Allocation	431
		15.11.1 What Should Dr. Culshaw Do?	433
		15.11.2 Comments on Dr. Culshaw's Problem	433
		15.11.3 Triage in Priority Setting	433
	15.12	Meso Allocation	434
		15.12.1 A New Service?	435
		15.12.2 Comment on Dr. Dehaney's Proposal	435
	15.13	Macro Allocation	436
		15.13.1 Paradoxes of Funding	437
	15.14	Is Crowd Funding the Solution to Funding New	
		Intervention?	437
	15.15	Conclusion	438
	Refere	nces.	438
Par	t V C	onclusion – Looking Toward the Future	
			443
16	16.1	usion: Looking Toward the Future	443
	10.1	Genetics	443
			4.4.2
		of Genetic Information	444
		16.1.2 Routine Newborn Whole Genome Sequencing	445
	160	16.1.3 Direct to Consumer Genetic Tests	447
	16.2	Precision and Personalized Medicine.	449
	16.3	Internet and Social Media Use in Pediatrics	451
	16.4	Costs of Healthcare	452
	16.5	Focus on the Child	453
	Refere	nces	454

About the Authors

Ian Mitchell received his medical education in Edinburgh, Scotland where he also had training in pediatrics, pediatric lung disease, and pediatric critical care. He has been involved in bioethics for over 30 years and earned a graduate degree in Bioethics from the Medical College of Wisconsin. Dr. Mitchell has held leadership positions in bioethics at local and national levels including serving as Director, Office of Medical Bioethics; Faculty of Medicine, University of Calgary; and President, Canadian Bioethics Society. He has been a Member of the Canadian Medical Association Committee on Ethics, the Bioethics Committee, Canadian Paediatric Society and the Canadian TriCouncil Panel on Research Ethics. He has held bioethics educational positions including Chair, Undergraduate Teaching in Bioethics; Course Lead, Introduction to Bioethics for University of Calgary Residents; and Co-Chair, Ethics and Professionalism, Pediatric Residents, Alberta Children's Hospital. Dr. Mitchell has published extensively in pediatrics and bioethics, with approximately 200 peer-reviewed articles, editorials and invited articles, book chapters, and books. He has received many awards for ethics teaching and other awards including the Community Service Award for work with parents whose child has died of sudden infant death syndrome, Faculty Association, University of Calgary, 2011; Vic Chernick Award for outstanding contributions to Pediatric Respirology in Canada, Assembly of Canadian Paediatric Respirologists, 2012; and Canadian Medical Association, Dr. William Marsden Award in Medical Ethics, 2013, which is awarded to individuals who have demonstrated exemplary leadership, commitment, and dedication to the cause of advancing and promoting excellence in the field of medical ethics in Canada; for that award, he was cited as using "insight, innovation and fearlessness...". The Canadian Bioethics Society, in 2015, bestowed on him the Distinguished Service Award.

Juliet Guichon is an Associate Professor at the University of Calgary's Cumming School of Medicine in Calgary, Canada. Her work focuses on bioethics issues particularly as they relate to law, journalism, and sometimes religion. She has authored academic articles, presented at academic conferences, and was Senior Editor of the book entitled *The Right to Know One's Origins: Assisted Human Reproduction and*

xxiv About the Authors

the Best Interests of Children (Brussels: ASP). A grant Recipient and award-winning Lecturer and Seminar Leader, Dr. Guichon is a frequent Contributor to public debate and has founded six child health advocacy groups. She has been invited by the Canadian House of Commons and Senate to testify in public hearings on health matters and is the Recipient of the Canadian Medical Association Medal of Honor and the Canadian Public Health Association's National Public Health Hero Award. A graduate of Yale University, she earned two law degrees at Oxford University where she was a Commonwealth Scholar and a doctoral degree in law at the University of Toronto where she was elected Don of Hall of Massey College. She was called to the Bar of Ontario. A native of Calgary, Canada, she has taught at the Universities of Toronto and Brussels.

Abbreviations

AAP American Academy of Pediatrics

AAPHR American Association of Physicians for Human Rights ACMG American College of Medical Genetics and Genomics

ADHD Attention Deficit Hyperactivity Disorder

AE Adverse Event

AIDS Acquired Immunodeficiency Syndrome

AMA American Medical Association ART Assisted Reproductive Technology

ASR Acute Stress Response

BPD Bronchopulmonary Dysplasia

CADTH Canadian Agency for Drugs and Technologies in Health

CAM Complementary and Alternative Medicine

CCC Child-Centered Care

CCCs Complex Chronic Conditions

CDC Centers for Disease Control (United States)

CEC Clinical Ethics Committee

CF Cystic Fibrosis

CFSPID CF Screen-Positive Inconclusive Diagnosis

CMC Child with Medical Complexity

CMPA Canadian Medical Protective Association

COI Conflicts of Interests
CP Cerebral Palsy

CPAP Continuous Positive Airway Pressure
CPR Cardiopulmonary Resuscitation
CSP Child Standardized Patient
CT Computed Tomography

DCDD Donation after the Circulatory Determination of Death

DTC Direct to Consumer
ECC Early Childhood Caries
ED Emergency Department
EEG Electroencephalogram

xxvi Abbreviations

ENT Ears, Nose, Throat

ETS Environmental Tobacco Smoke FCC Parents- and Family-Centered Care

FFM Five-Factor Model FGC Female Genital Cutting GDP Gross Domestic Product

HATH Heterosexual Attitudes Toward Homosexuality

HEEADSSS Home, Education/Employment, Eating, peer group Activities,

Drugs, Sexuality, Suicide/Depression, Safety

HIV Human Immunodeficiency Virus

HPV Human Papillomavirus ICU Intensive Care Unit IM Ian Mitchell

IOM Institute of Medicine (United States)

IRB Institutional Review Board

IV Intravenous

IVF In Vitro Fertilization JRG Juliet R. Guichon

LGBTQ+ Gay, Lesbian, Bisexual, Trans, Queer, or Questioning

LSMT Life-Sustaining Medical Treatment
MAID Medical Assistance in Dying
MCC Medically Complex Child
MGA Male Genital Alteration
MRI Magnetic Resonance Imaging
MRP Most Responsible Physician

NBS Newborn Screening

NHMRC National Health and Medical Research Council (Australia)

NHS National Health Service (UK)

NICE National Institute for Health and Care Excellence (UK)

NICU Neonatal Intensive Care Unit
NIPT Non-Invasive Prenatal Testing
NIS Nationwide Inpatient Sample (USA)

NSPCC National Society for the Protection of Children (UK)

OCAP Ownership, Control, Access, and Possession

OECD Organization for Economic Cooperation and Development

OSCE Objective Structured Clinical Examination

PaCT Palliative Care Team
PCC Patient Centered Care
PDSA Plan-Do-Study-Act

PGD Preimplantation Genetic Diagnosis PICU Pediatric Intensive Care Unit

PKU Phenylketonuria

PTSD Post-Traumatic Stress Disorder QALYS Quality Adjusted Life Years

QI Quality Improvement

Abbreviations xxvii

RCPCH Royal College of Paediatrics and Child Health (UK)

REB Research Ethics Board
SDM Shared Decision-Making
SIDS Sudden Infant Death Syndrome
sJIA systemic Juvenile Idiopathic Arthritis

SMA Spinal Muscular Atrophy SP Standardized Patient

STD Sexually Transmitted Disease
WGS Whole-Genome Sequencing
WHO World Health Organization

YCHW Youth Community Health Worker

Part I Background to Pediatrics