NUS National University of Singapore
Centre for Biomedical Ethics
Yong Loo Lin School of Medicine

CBmE PANDEMIC ETHICS SERIES

Care of Minors and Exposure of Uninfected Persons

Working Paper 1

This working paper is part of a series written by the Centre for Biomedical Ethics, Yong Loo Lin School of Medicine, National University of Singapore, and is intended to provide information for healthcare professionals and decision-makers on ethical issues arising from the COVID-19 pandemic. The views expressed do not, in themselves, reflect official government policy on these matters. Contributors to the series are listed on the last page.

REFERENCES

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Care of Minors and Exposure of Uninfected Persons[1]

Key Ethical Principles

1	Public health and safety	Minimise risk of further community transmission.
2	Best interests of the child	Responsibility to safeguard and promote the child's welfare.
3	Parental autonomy	Presumption that parental responsibilities can be exercised free of State intervention. The State may intervene in limited circumstances to protect children, e.g. where the parent is "unable to provide adequate food, clothing, medical aid, lodging, care or other necessities of life" (Children & Young Person's Act, s. 4(c)(i)).
4	Emerging autonomy of minors	Minors with sufficient understanding and capacity should participate in decision-making about their care arrangements, and to the extent possible be supported to do so.

Parental autonomy should be respected to the greatest degree possible unless there are over-riding child welfare or public health considerations. Public health restrictions on liberty, including parental autonomy, should be the least restrictive necessary to achieve the public health goal.

Good communication is essential in this context. Ideally decision-making would be a shared process between clinicians, parents and (where appropriate) children. Any decision to separate parents and children should be communicated respectfully, compassionately, and with empathetic understanding of the strong parental instinct for physical closeness to support and protect their child when they are sick.

Virtual communication and e-presence should be facilitated to support communication between the parent and child if separated.

[1] Scope: This applies to situations involving minors (infants, children and adolescents) and may also be applicable to the care of adults with a disability (for example a person with a learning or cognitive disability).

Case scenario 1:

All guardians (either both parents, or one single parent) test positive for COVID-19 and are isolated in a medical facility. How should their children, who are asymptomatic and have tested negative for COVID-19, be cared for?

1. The following childcare arrangements are appropriate quarantine options:

   A. One family friend or relative moves into the child(ren)'s home

   B. One State-approved caregiver moves into the child(ren)'s home

   C. One family friend or relative moves with the child(ren) into a State quarantine facility

   D. One State caregiver moves with the child(ren) into a State quarantine facility

2. Care giving arrangements must balance public safety, the children's welfare and parental autonomy. For the children's welfare, the optimal arrangement is for the children to be in a familiar location, with a familiar person and with their siblings.

3. During quarantine, the following considerations should guide childcare arrangements, to the extent possible:

   A. To minimize community transmission, children should be isolated for the recommended (currently 14 days) quarantine period.

   B. To minimise risk of viral exposure, and distress and disruption for the child(ren), the same caregiver should be used for the recommended quarantine period.

   C. The optimal place to quarantine children is in their own home because displacement to a different location may be disorienting and distressing. From a public health perspective, removing the children elsewhere, e.g. home of a relative or foster home, may expose everyone in the new location to potential infection (children may be harbouring the virus even though they are asymptomatic and tested negative).

D. Parents should be encouraged to make advance plans for their children's care in case they contract coronavirus. Such plans are not legally binding on the State. However, on the grounds of parental autonomy the parents' choice of caregivers in their advance plans should be preferred over State-appointed caregivers, unless the caregivers chosen by the parent(s) refuse to care for the children, or on the balance of probabilities the appointment of the caregivers chosen by the parents would not be in the best interests of the children.

E. If the parents did not, or are unable to express their choice of caregivers (too unwell and/or lack mental capacity to decide), then standard child welfare processes should be followed, including vetting of State-appointed caregivers to provide the appropriate standard of care for the children, whose needs may vary depending on age and/or any special needs. Children or other dependants with disabilities may have existing trusted and competent caregivers, and/or care plans. To the extent possible, quarantine should align with existing care plans. The views of children with sufficient understanding and capacity should be considered, where reasonable. The potential caregivers should be advised of the risk of contracting coronavirus from the children, and appointed only if they voluntarily accept the caregiving responsibilities and risk involved. The caregiver should be provided with PPE, IPC training, and appropriate financial support to care for the children.

F. The WHO guidance dated 27 May 2020 on 'Clinical management of COVID-19' recommends that mothers and infants should remain together, especially immediately after birth, regardless of whether they or their infants have suspected or confirmed COVID-19.

G. If children and parents both test positive (or if asymptomatic children subsequently test positive), they should be admitted together where possible, taking into account the clinical context, such as the split between paediatric and general medicine and the severity of the parent and child's condition.

H. Parents and children who are separated should have access to psychological support if feasible.

Case scenario 2:

A minor tests positive for COVID-19 and is admitted for medical isolation. Should an asymptomatic parent be allowed to stay in the medical facility with their child?

1

The appropriate response here will depend on the age of the child, the risk to the parent (both in terms of their personal health and the public health impact of further transmission) and the views of the parents (parental autonomy).

2

If the child is an infant, young child, or would be especially distressed without the parent, *and* if the parent wishes to stay; this should be facilitated where possible on the grounds of the child's best interests and parental autonomy.

3

Parents are best able to decide about their own personal health risk and should not be prevented from being with the child on paternalistic grounds.

4

There needs to be an overriding public health threat that would justify interfering with parental autonomy in order to prevent the parent from staying.

5

In order to reduce transmission risk, only one parent (who should not rotate) should be permitted to stay with their child.

6

The parent should be provided with appropriate personal protective equipment (PPE) and receive Infection Prevention and Control (IPC) training to minimize their chances of contracting coronavirus and other nosocomial infections.

7

If only one parent is available but is immunocompromised or has existing medical conditions that substantially increases their risk of COVID-19 disease severity, for public health reasons it is appropriate *not* to allow the parent to be admitted with their child because of the public health burden should the parent become very ill as a consequence of contracting coronavirus.

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